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CASELOADS FOR CHILDREN AND YOUNG PEOPLE'S SOCIAL PRESCRIBING, EVIDENCE SUMMARY

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Background

During the development of guidance to support the delivery of social prescribing for children and young people, it emerged from the stakeholder meeting that little was known about the evidence base for caseloads in adult and CYP social prescribing. We undertook scoping searches of the literature to flag key studies, algorithms for calculation, and any key issues. Searches were run in March 2020.

Caseloads

A range of recommended maximum caseloads are recommended for roles with a similar scope to the CYP link worker, which differ according to profession and role. Considering the services around the child, we would place CYP link worker in the targeted or early intervention space. Some of the roles explored below reflect statutory intervention with complex cases, which means the level of difficulty they are dealing with may be greater, e.g. the social worker. Even within those professions there will be variation: an early help social worker, for example, will have a higher caseload than a child protection social worker.

Importantly, some services conceptualise caseload as the numbers held 'at any one time' and others as the numbers worked with over a given time (e.g. in a year). We do not present evidence here to suggest one approach is preferable to another, but clearly there are differential implications for service planning and monitoring thresholds and entry into the service.

Roles

Health visitors[1] report increasing caseload size in England. 44% having caseloads of over 400 children (28% in 2015) and 28% report having between 500 and 1000+ children (12% in 2015). The Institute recommends a maximum (current, at any one time) caseload of 250 children for the health visiting service to be able to have the impact it should (Institute of Health Visiting, 2018).

Children and young people's **IAPT practitioners**, often called **Psychological Wellbeing Practitioners** (PWP) are probably the closest thing in mental health support that currently matches the social prescribing role. Rather than providing 'therapy', PWPs act in a coaching role, working collaboratively with the client to choose the direction of the sessions. To provide the client with a flexible and accessible service, sessions can utilise a number of formats, including face-to-face, telephone, psychoeducation groups, and computerised CBT. At this level of intervention, caseload volume and client turnover are high; a PWP may help over 250 clients per year.

[1] Health visitors will carry a portfolio of cases, ranging from universal intervention to targeted (Universal Plus) for those with additional needs and difficulties, as well as complex cases (Universal Partnership Plus).

Current **Social Prescribing Link workers** typically have a (mostly adult) caseload of up to 250 people per year. Typically, the LW will work with individuals over 3 months and have approximately 6-12 contact sessions. This equates to a caseload of 60 current cases, if we assume an average of a 3- month period of contact (NHS England, 2019).

Troubled Families keyworkers have a maximum current (i.e. at any one time) caseload of five families which means that they can see families several times a week and provide intensive support, which social workers in this local authority don't have time to do (Ministry of Housing, Communities and Local Government, 2018).

The average (current, at any one time) caseload per **Children and Family Social Worker** is 16.9 according to latest figures, however, this is a national average, and there encompasses a range of caseload averages per authority from 12-32 (Department of Education, 2019).

An evaluation of **Care Navigators in primary care** on the Isle of Wight showed that care navigators handled complex caseloads (persons with long term conditions) for up to 60 people at any one time and the average caseload for a CN was 41 (Wessex Academic Health Science Network, 2018).

The maximum (current, at any one time) caseload should of a **Named Nurse for Looked After Children** should be no more than 50* looked after children (in addition to the operational, training and education aspects of the role). *The precise caseload of looked after children held by the Named Nurse will be dependent on the complexity, geography, population and size of the catchment area served. (Royal College of Paediatrics and Child Health, 2015).

Algorithms

There are multiple methods for calculating capacity and workload. Below we outline some of these approaches, as they appear in an NHSE workforce planning report: https://www.england.nhs.uk/wp- content/uploads/2013/11/nqb-how-to-guid.pdf

"Cassandra™" allows specialist advanced practice nurses to draw on a representative sample of their work and was a response to diary care exercise/ time and motion studies in common use which did not adequately capture the complexity of the work. The tool was developed by Dr Alison Leary by clustering data from a more complex dataset (Pandora). It has been used in several national studies and is now free to download as a spreadsheet from www.alisonleary.co.uk

The Alexa Caseload Tool™ was developed by Dr Alison Leary with the National Cancer Action Team (NCAT) quality in nursing group. It is used to determine the optimum caseload of a specialist nurse against best practice. It is based on the work of lung Clinical Nurse Specialists, but the methodology can be applied to Clinical Nurse Specialists who manage patients with other long-term conditions2. It uses previously modelled activity and national data to calculate a recommended caseload and is available at: www.alisonleary.co.uk or www.cancertoolkit.co.uk

Lastly, a similar, but simpler approach has been demonstrated by family psychotherapists (with a particularly useful table detailing complexity (p.3): https://www.aft.org.uk/SpringboardWebApp/userfiles/aft/file/Members/GuidanceonCaseloadandCl

Key issues highlighted from other sectors

NOTE: In the text below we use excerpts from original cited reports, not original text, to highlight issues in authors' own phrasing.

[2]An example of how the modelling was applied to MS Nursing: https://support.mstrust.org.uk/file/modelling- sustainable-caseloads.pdf

High caseloads mean social workers do not have enough time to build strong **relationships with children and families.** The Education Select Committee also found that excessive caseloads could lead to 'extremely low' social work **morale**. The Inquiry found further evidence for this, suggesting that reduction in caseload is an important factor in helping to retain staff and achieve better outcomes for children in the long run. Several submissions indicated that reducing the number of cases per social worker was an important factor in reducing **workplace pressure** and enabling staff to establish higher quality relationships with families (National Children's Bureau, 2017).

There is no consensus over what an appropriate caseload for a case manager is. Department of Health guidance suggested that community matrons are likely to have caseloads of between 50 and 80 patients requiring clinical intervention and care coordination (Department of Health 2005). This guidance also suggests that more than 80 patients would make a clinician's caseload 'unsustainable' (p 39). The case manager's role also includes a number of activities that are not related to providing direct care, such as administrative tasks, attending or delivering training sessions and attending meetings. This can affect case managers' capacity to provide care for all patients on their caseloads (Sargent et al 2008).

Some studies have explored issues relating to size of caseload (Boaden et al 2006; Sargent et al 2008; Russell et al 2009). They show that the number of patients deemed to be manageable in a caseload is influenced by various factors:

- the nature of patients' conditions;
- the proportion of patients at high risk (it has been suggested that high-risk patients should not exceed 10–15 per cent of the caseload– see Sargent et al 2008);
- the experience of APNs/community matrons in working with patients with complex needs patients' socio-demographic profiles;
- patients' circumstances (specifically home environment and access to informal care support);
- patients' geographical location (urban or rural settings);
- patients' individual characteristics (for example, willingness to engage with community matrons); and
- time needed for non-clinical activities.

The Evercare evaluation showed that caseloads of approximately 50 patients were deemed to be the 'upper manageable limit' (Boaden et al 2006, p 66).

If a caseload becomes unmanageable, case managers are at risk of providing a **reactive service** that largely responds to crises rather than providing the proactive and preventive service intended (Sargent et al 2008; Russell et al 2009). Case managers with caseloads in excess of 50 have reported **work-related stress** (Sargent et al 2008).

Research on ideal caseload size has been carried out only from case managers' perspectives so far. Therefore, it is difficult to appraise this from the perspective of patients, their carers, or commissioners (King's Fund, 2011).

Shepard and Rosairo (2008:242) highlight the training needed to manage high caseload volumes and the ability to start small and grow caseload as ability/ competency increases:

"In our view, training for low-intensity interventions should include a particular emphasis on assessment, risk management and caseload management, given the challenges of high throughput and large caseloads: these issues are indeed prioritised in the curriculum."

The effect (of increasing caseloads) is to diminish the universality of health visiting (relating to the footnote above about balanced portfolios) and hence the tacit contract with the public to be a non-stigmatising, equitable service for all until children go to school (Institute of Health Visiting, 2018).

We located one relevant review: Community matron caseload numbers: a literature review by Auckland (2013). This review took the Sargent (2008) findings as themes to frame further findings in the literature. The review concluded there is a wide variation regarding the optimum caseload number ranging from 14 patients in intensive case management to 80-100 families per fulltime health visitor. A number of included studies do not specify caseload numbers due to the complexity of the task. However, what clearly emerges is that the factors that impact on case management appear to correlate with the issues identified by Sargent et al (2008).

Key finding

The literature points towards the fact that **large caseloads lead to reactive care rather than proactive care.**

Outstanding questions

Some questions remain unanswered yet relevant to better understand caseload issues:

- How does complexity alter the number that one worker can manage?
- What is complexity?
    - What does complexity look like for social prescribing? Does this describe complex mental health needs or varied additional needs over and above the mental health difficulties?
- How are complex cases categorised and managed across the team?
- What is the impact on the child and family of the worker high caseload?
- How does administrative support affect caseload? One of the findings of the Family Nurse Partnership service was that caseload management would be easier with more administrative support due to the bureaucratic demands of statutory services: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_ data/file/213367/FN-final-report-Jan-13.pdf

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