

# **REVIEW OF THE ENABLEMENT SERVICE**

**Report of Derbyshire County Council's Improvement and Scrutiny  
Committee - People**

**December 2018**

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## **1. Introduction**

The County Council's Enablement Service provides short-term, intensive support to individuals who are considered vulnerable due to their mental health needs and who are experiencing difficulties managing their day to day lives. Support is offered over a period of up to six weeks and aims to help the client become more independent and overcome social, practical, financial and emotional difficulties.

It is a relatively new service (established approximately 2 years ago) and consequently some aspects of the service are still developing. The Service Level Agreement is currently being reviewed by the Adult Care Department's Commissioning Team and, where appropriate, this will be revised. It was therefore considered timely to conduct a scrutiny review alongside the department's own review to evaluate the service from a lay person's perspective. This would help identify what is working well, what challenges exist and what (if anything) might be done differently.

## **2. Approach to the review**

The approach to the Scrutiny review was to conduct a series of discussions with staff who delivered, managed or commissioned the service or who referred clients to the service. The review working group considered performance data and client feedback and also observed an Enablement Service meeting where representatives from a broad range of teams are brought together (on a bi-monthly basis) to discuss the service.

The working group met with the following position holders:

- Commissioning Service Manager
- Enablement Service Manager and Team Managers
- Senior Enablement Workers
- Enablement Workers
- Hospital Liaison Social Workers and Senior Practitioners

The discussions followed a standard format. People were first asked to describe their role in the service (or their involvement with the service) and then members of the working group asked a series of questions about service delivery, staff training, outcomes, data monitoring, referral mechanisms, care pathways, communication (within the service and with service partners), and perceptions of the client experience. Throughout each discussion staff were invited to identify areas of best practice, make suggestions about how the service could be improved and raise any concerns. Everyone participating in the review was assured that the final report would not attribute comments to individual staff members, although it would be possible to identify the

particular staff group that had made the comment. The key points raised during each session are presented in Appendix 1.

### **3. The Enablement Service - Background Information**

The Enablement Service was established in 2016 with a view to transforming the existing Direct Care Mental Health Service into a service focussed on early intervention, recovery, personalisation and social inclusion.

To access the service, people who are vulnerable due to their mental health needs must be resident in Derbyshire (excluding Derby City) and of working age. Referrals are encouraged from primary and secondary health care and social care professionals, emergency services, criminal justice agencies, voluntary sector partner agencies and via self-referral. Clients go through an initial triage assessment undertaken by one of Adult Care's mental health fieldwork locality teams and, if it is appropriate, receive up to six weeks support from the Enablement Service. The support offered includes help in building confidence with daily living tasks (shopping, travelling, cooking, cleaning and managing finances). During the enablement period, the client is subject to continued assessment to determine whether there is a requirement for on-going support and what form that support should take.

The stated aims of the service are:

- To provide timely, flexible, intensive, professional/specialist support (initially for up to six weeks/reviewed at six weeks) with the aim of increasing independence and overcoming social, practical, financial and emotional difficulties.
- To enable people to attain their potential in terms of daily living and to achieve their optimum level of functioning and independence with the lowest level of on-going support.
- To promote social inclusion and participation by building connections with people beyond health and social care agencies and by introducing people to new activities, community resources and sources of support.
- To prevent people from requiring more intensive or longer term input and to reduce the need for a secondary referral to mental health services or hospital admission.
- To prevent crisis escalation and offer crisis intervention
- To facilitate a smooth exit and a successful transition from secondary mental health services back into the community.
- To enable and support people to develop skills, interests and social confidence to promote improved mental health and emotional wellbeing.
- To promote recovery and resilience.
- To enable clients to gain confidence in their everyday living skills, their self-management of their illness and their day to day life.

- To support clients to build meaningful occupation into their daily routine including maintaining or working towards paid employment.

## 4. Review Findings

From the discussions held during the course of the review it is clear that the Enablement Service fulfils an important role and is well respected by Senior Practitioners and Hospital Liaison Social Workers who refer clients to it. Representatives from the management team through to the enablement workers (who work directly with the clients) were passionate about supporting service users and looking for opportunities to help clients to become more independent. However, in successive discussions it was striking how each staff group gave a nuanced account of the service and at times expressed conflicting perceptions of how well the service is meeting client need. These differences in view point suggest that some theoretical components of the Enablement and Recovery Model are not, in practice, operating as intended. As a relatively new service this is to be expected and the observations below are intended as constructive feedback to drive forward service improvement.

### 4.1. Service Delivery Model

- The need for greater flexibility in the duration of the service was highlighted at all group discussions. It was acknowledged that in some circumstances a six week period of enablement was sufficient, however frequently when supporting clients with complex needs the six week time period is insufficient and too restrictive. Examples provided where 6 weeks was insufficient included work with clients who have severe and enduring mental health and cases where a considerable amount of preparatory work is required to help a client access welfare benefits and “set up home” before other goals can be addressed. Enablement workers also mentioned other practicalities that need to be overcome such as waiting for a bus pass application to be processed.
- It was frequently emphasised that the success of any intervention is predicated on the enablement worker establishing a trusted relationship and that this is a process that takes time with many clients needing a period of adjustment whilst they get to know the support worker. It can be challenging for a client to “open up” and share personal issues and emotions with a case worker, and therefore knowing that the enablement period is only for 6 weeks not all clients are prepared to invest in a short term relationship.
- The vision of achieving parity between the Reablement Service (for physical health conditions) and the Enablement Service (for mental health conditions) was questioned by many contributors to this review as it does not appear to be evidence based or outcome focused.

- The ambition of the Council's Direct Care Service delivering 70% short-term support, 15% long-term support and 15% group work was viewed as somewhat arbitrary when it comes to supporting clients with mental health conditions and it was observed that the actual split that was being achieved varied across the county.
- If a client has ongoing eligible needs after the enablement period their case goes out to "brokerage". Social workers and enablement workers alike commented that the delay in being transferred to a different service can be counterproductive as the client's progress is at best put on hold and at worst regresses. For example, the client may experience a dip in confidence and become less independent, also when transferred to a different service the client is required to go through another cycle of relationship building. Senior practitioners in particular had reservations about the current approach lacking client choice.
- There was a general view that extending the potential period of enablement by a few additional weeks up to a period of perhaps 12 weeks (to allow the client sufficient time to meet their enablement goals) would be more cost effective in the long term. It was stated that an extended offer might make the difference between the client not needing further support because they have achieved their goals and the client requiring a long-term support package. Currently it is possible at the four week review stage for the enablement period to be extended beyond six weeks. However in reality this can be difficult to arrange as an extension requires approval from senior management and is quite a bureaucratic process requiring the referring social worker to undertake a considerable amount of "paperwork". Furthermore, the client would usually be required to make a financial contribution to the additional weeks of service.
- The Enablement Service is targeted at working age people and the hope is that clients become sufficiently independent to find paid employment. However the Enablement Service operates Monday to Friday between the hours of 9 to 5. At the meeting with senior practitioners an example was provided where a client was struggling to hold down her 9 to 5 job and needed support but was unable to access the Enablement Service. It was also noted that for some clients it can be isolating not to have access to the Enablement Service over the weekend period.
- Hospital Liaison Social Workers stated that it would be beneficial if the Enablement Service could make contact with clients whilst they are still in hospital. This would allow preparations to be made and facilitate the development of supportive reassuring relationships prior to discharge.

#### **4.2. Recovery and Peer Support Groups**

- At the end of the enablement period a client maybe referred to the Recovery and Peer Support Service. This service aims to help people to improve and maintain their mental health and wellbeing through the provision of local peer support groups and networking opportunities.
- Groups are viewed as an effective way of supporting clients who do not need an individual long term offer. Prior to the establishment of the Enablement Service, groups were supported and run by support workers from Direct Care. The groups are now co-ordinated by private providers.
- During discussions about recovery and peer support groups it emerged that the new model is not effective in all cases. Social workers shared anecdotal reports that a number of groups have ceased operating because attendance fell after the groups became self-directing.
- The Enablement Service Manager and Team Managers stated that some self-managing groups are running successfully but suggested that there may be room for a mix of self-directed groups and groups supported by community workers.
- Enablement workers and the senior enablement workers highlighted the fact that the onus is now on the person with the mental health issue to motivate themselves to attend the group. The client needs to remember when it is on, get themselves there and possibly be involved in the organisation of the group. A prominent concern is that without an encouraging phone call from a case worker clients often lack the confidence to attend.
- When a client is transferred to the Recovery and Peer Support Service the client is discharged from Direct Care services, and the Social Worker has no ongoing contact with them. Previously through the support workers leading the groups, social workers would get feedback about clients and if anyone was identified as “struggling” they could be followed-up. Now there is concern that if a client becomes unwell and withdraws from a group they may “fall through the gap” and be unsupported.
- A key component of the Enablement and Recovery Model is the development of community peer-support to promote and facilitate increased self-management of mental health, as well as the development of opportunities for meaningful occupation and activities, access to training, education, volunteering and support to enter or maintain employment. However this new approach is being delivered in a climate of voluntary sector funding cuts and accessing community services is increasingly difficult and this has an impact on the wellbeing of clients.

### 4.3. Training for Enablement Workers

- A clear message from those working directly with clients was that they would like training to be more tailored to the enablement worker role. In their view many of the generic courses offered are too basic for the situations and circumstances that enablement workers frequently find themselves in.
- Staff who worked as Support Workers, before the establishment of the Enablement Service, feel that there are less on-the-job learning and development opportunities. One example of this is that enablement workers do not attend multidisciplinary meetings to discuss complex cases.
- Whilst new recruits to enablement worker role are of a high standard, it is felt that the training they receive is not targeted sufficiently towards supporting people with mental health needs and working with cases in the community. The training is similar to what a care worker would receive if working in a residential setting. Therefore often it falls to senior enablement workers to impart their knowledge to new enablement workers on a case by case basis.
- Enablement workers do not require any role specific qualifications (or experience) to be recruited. However once in post they are encouraged to work towards an NVQ Level 2 qualification. Senior enablement workers are required to have an NVQ Level 3 qualification.
- A one day enablement training course has been developed and delivered to 50 of the potential 56 enablement workers. Also the management team have recently drawn up a matrix of training courses that are available. The majority of courses are generic to mainstream community care work but there are also some mental health specific courses, for example, autism awareness.
- Feedback from front-line staff to the review working group about the one day training course for enablement workers was that it did little to clarify the role. It didn't provide clear direction as to where the boundaries of the service lie.
- The management team anticipate that the service will grow to meet demand and that more staff will need to be recruited. They are also aware that as a consequence a good staff retention (with many employees having been in their current role or a similar role for more than 5 years) the service benefits from the skills and knowledge that staff have built up over time (particularly when they had access to a comprehensive mental health training programme provided by the health service). Therefore as the service expands there may be a need for a more detailed and specific mental health training programme to avoid a future skills shortage.

#### **4.4. The Role of an Enablement Worker**

- Enablement workers are clear about their role in supporting clients to achieve the goals in their personal service plans however there are other activities that fall outside of this and staff feel they have received mixed messages about whether they should or should not be undertaking these activities. Previously, when working as caseworkers, they supported clients to access welfare benefits but now it is not clear who undertakes this role. Help from other agencies to apply for benefits is increasingly limited and difficult to access. If a client is not receiving any income, they are vulnerable and it is hard to make progress towards achieving the enablement goals when there are financial and other important social circumstances that need to be addressed.
- As part of their role enablement workers are required to write up notes, research resources in the locality and make connections with local community groups. Currently there is limited desk space for this type of work and staff are not issued with mobile technology that facilitates this. The management team indicated that having more office space was desirable and having a base would mean that workers would feel more of a team and would have opportunities to liaise with colleagues.

#### **4.5. Personal Safety of Enablement Workers**

- Enablement workers provide support within the homes of service users and generally work alone. Therefore it is important that appropriate measures and procedures are in place to ensure the personal safety of the enablement worker and client, in the event of an emergency.
- Both enablement workers and the senior enablement workers said that they were not confident that the current means of communication would be adequate in the event of an emergency. The mobile phone handsets provided are unreliable, have a short battery life and mobile phone signals are poor in some areas of the county.
- Another matter raised with regard to personal safety was that enablement workers do not have access to up-to-date client records and this can put the enablement worker at risk. For example, if a client has recently become unwell or if there has been an incident over the weekend the enablement worker may, with no prior knowledge, walk into a challenging situation on Monday morning. A proposed solution put forward was to allow team members to have access to Mosaic - the computerised system where client records are stored. This would ensure that those working directly with clients could access information regarding a client's condition, triggers and changes in circumstances.



#### **4.6. Staff Morale**

- During discussions the working group heard conflicting perceptions about staff turnover. Frontline staff perceived that there was a high staff turnover and felt that this was linked to a reduction in job satisfaction and low staff morale. Conversely the team leaders spoke of high staff retention rates.
- Senior practitioners commented that there was low morale amongst the enablement workers and suggested that more should be done to ensure that they felt more valued and recognised as an integral part of the recovery process.

#### **4.7. Data Collection and Management**

- The working group considered a performance report covering a 12 month period between August 2017 and July 2018. It was noted that outcomes were not consistently recorded and that 36% (255) of the personal service plans had no recorded outcome. Clearly there is a need to significantly improve the recording of outcomes and it is understood that work is underway to achieve this. A Recovering Quality of Life questionnaire is being introduced and the roll out of this provides an opportunity to highlight the importance of recording outcomes.
- Enablement Workers are required to write a log outlining which goals have been attempted and what outcomes have been achieved. This is emailed to Business Services who upload the information on to the Mosaic system. The enablement workers are not in a position to know whether the outcomes are recorded on Mosaic correctly, nor can they refer back to the information at later date or see what another case worker has written about the client. The enablement worker is required to destroy the progress update after it has been emailed to the Business Services so they do not have a record of their previous interaction with the client.

#### **4.8. Documentation and Communication**

- It would appear that the format of Personal Service Plans have evolved overtime. The enablement workers reported that the plans have increased in length without providing any more relevant information. This makes it time consuming to extract the pertinent points and difficult for the service user to understand the plan. They also felt that there is a lot of duplication in the Personal Service Plans.
- Enablement workers reported that former working relationships within the Health Service meant there was better communication between staff from different disciplines and there was an educational element where staff learnt from each other. The sharing of information and knowledge between staff helped to build confidence and a better understanding of how to meet client needs. It was stated that it is not uncommon to work with clients who

suffer from psychosis or delusions and having the knowledge of how to handle these situations is very important to avoid putting the client under too much pressure.

- Senior practitioners commented that it can often be beneficial to speak directly to the enablement worker who is supporting the client to gain feedback about progress. However this is not always encouraged, perhaps because in the Reablement Service the line of communication would not be directly with the home help but with their supervisor.

#### **4.9. Independent Providers**

- There was general consensus that the capacity of the private sector to provide effective services (staffed by experienced support workers) varies across the county. In some areas this can mean that there are considerable delays in service provision.
- Social workers periodically review the support that is in place for each client because a person's mental health can fluctuate. For example, at the point of referral to a private provider a generic service may be appropriate as the client only requires support with relatively simple tasks (such as shopping), however if their mental health declines it may be that they would benefit from a more specialised service.

### **5. Recommendations**

The working group makes the following recommendations:

1. The Strategic Director for Adult Care revisits the Enablement Service delivery model with a view to adopting an evidence based approach with greater emphasis on client need and less focus on achieving parity between the Enablement Service and the Reablement Service. Areas to consider include the duration of the service, the operating hours, and work with clients prior to hospital discharge.
2. The Strategic Director for Adult Care undertakes a case study review to evaluate the effectiveness of the Recovery and Peer Support model. Key lines of enquiry should explore the sustainability of peer support groups (including the frequency and duration that clients attend) client experiences and outcomes (including increased independence, employment, re-referral rates to the Enablement Service or other support services, hospital admissions and non-engagement).
3. The Service Manager ensures that role specific training is made available to the enablement workers with a greater emphasis being place on

supporting clients with mental health conditions in the community. Furthermore, to ensure that training better equips staff to fulfil their role and to avoid potential skill shortages in the future, frontline staff are given the opportunity to contribute to the process of identifying development opportunities and training courses.

4. The Service Manager takes action to ensure that there is clarity about the role of an enablement worker so that the staff team and referring professionals know which support activities fall within and which fall outside of the role. In addition, the management team should adopt a transparent approach to team building. They should acknowledge issues of low staff morale, identify opportunities to empower employees, give recognition and demonstrate that staff skills, knowledge and experience are valued.
5. The Strategic Director for Adult Care takes action so that there are robust measures and procedures in place to ensure the personal safety of enablement workers, in the event of an emergency, and that all team members have access to relevant and up-to-date client information.
6. The Service Manager reviews the mechanisms in place for recording service outcomes and ensures that outcomes are routinely, reliably and comprehensively recorded for each client
7. The Service Manager undertakes a documentation review to ensure the format and content of the Personal Service Plans are fit for purpose.

## Appendix 1: Evidence from Contributors

The key points raised during each discussion are presented below

### COMMISSIONING SERVICE MANAGER

- The Enablement Service is a new offer and marks a shift in culture. Historically the Council's Direct Care Team had an in-house service and supported clients on a long-term basis. There was a perception, however, that providing long term support (often over several years) led, in some circumstances, to co-dependent relationships between the client and the support worker. Therefore, rather than supporting the client to become independent, it was felt that there was the potential to create continued demand for the service.
- The delivery model for the Enablement Service is modelled on the Reablement Service that is offered to older people with physical needs. One of the reasons for this was to achieve parity between the service offer for people with physical health needs and services for people with mental health needs.
- The new service is clearly defined. It is aimed at working age people with mental health conditions and is available for up to a period of six weeks and is free of charge to the client.
- The desired outcome is to arrive at a situation where the client has no on-going eligible needs because they have been supported to become more independent and they can be signposted to universal services within the community.
- If at the end of the six week enablement period the client still has eligible needs, the case goes through brokerage and an independent provider from the private sector takes on the case.
- As this is a relatively new service there has been a period of learning. In some localities there are gaps in the availability of suitable independent providers. Also sometimes it has been difficult to find an independent provider who is prepared to offer a package of a few hours per week. Experience has shown that independent providers are less interested in small care packages.
- When the Enablement Service was established the aim was for the Council's Direct Care Service to deliver 70% short-term support 15% long-term support and 15% group work. The department is now undertaking a review of the service level agreement to see if support is being delivered in line with these ambitions and how effective this approach has been.

- Early indications suggest that the desired split between long term and short-term support is being achieved in some parts of the county and not others.
- Some areas in the county have adopted a single assessor model. This means that all assessments for a particular area team are undertaken by an identified social worker and in effect the cases go through a single triage point. One of the benefits of this approach is that the single assessor is on the “lookout” for clients that would benefit from the Enablement Service and consequently develops a heightened understanding of what factors and indications are most relevant when considering a referral to the Enablement Service.
- In other area teams, referrals go to a number of social workers and it appears that there are less referrals to the Enablement Service. It is thought that individual social workers have different referral thresholds and therefore there is not a consistent interpretation of the referral thresholds.
- In Erewash there is a high demand for the Enablement Service. One reason for this may be the single assessor model but also in this area a considerable amount of partnership working has been undertaken with local mental health trusts, GP’s, and local voluntary sectors to promote the pathway.
- In Chesterfield there is less short-term support being provided (45% of cases) compared to other areas such as Erewash (80%). The service managers have reviewed the long term cases in Chesterfield and believe the reason why there is more long term support being provided by Direct Care is that this particular client group have more complex needs and also the required ongoing support packages are not available from the market.
- The service level agreement between the Council’s own Commissioning Team and Direct Care, sets out how performance of the service will be measured. The Management Information Team is responsible for collecting and analysing performance data and since the inception of the Enablement Service has undertaken a considerable amount of development work. Most of the required data has now been entered into Framework-I, with only a small amount of information being captured via local data reporting systems to track the activity of enablement teams

## **ENABLEMENT SERVICE MANAGER AND TEAM MANAGERS**

### **Training**

- The management team have recently developed two draft training matrices which list the relevant training for senior enable workers and enablement workers. Many of the training courses are generic to mainstream community care work but there are also some mental health specific courses, for example, autism awareness.
- Enablement workers do not require any specific qualifications to be recruited. However once in post they are encouraged to work towards an NVQ Level 2 qualification. Senior enablement workers are required to have an NVQ Level 3 qualification.
- A one day enablement training course has been developed and rolled out. 50 out of the potential 56 enablement workers have attended this course. It is designed as an interactive course where participants consider fictitious case studies and learn through responding to a series of questions inviting them to make decisions about how they would support the client in each case study.
- It is anticipated that the service will need to grow to meet demand and that more staff will need to be recruited. The service has a high staff retention rate with many of the staff having been with the service in excess of 5 years. At the present time there are six full-time equivalent vacancies. As a consequence a good staff retention the service benefits from the skills and knowledge that staff have built up over time. Training used to be more extensive and specific when it was delivered by the Health Service and staff had access to a comprehensive mental health training programme. A large proportion of the staff who attended these training events are still with the service. However, in years ahead if something is not done to replicate the detailed mental health training the service may find itself with a skills shortage.

### **Service Delivery Model**

- Greater flexibility in the duration of the service would be welcomed. Six weeks of support is sufficient for some clients but often longer is needed for graded exposure work and to support clients with more complex needs. Offering support for a few additional weeks so that the client meets their enablement goals may be more cost effective than stopping enablement at six weeks and referring the client to long-term support.
- Re-referral rates are currently low although some clients do return to the service.

- The support offered by private providers is variable and not consistent across the County. It should also be borne in mind that a person's mental health can fluctuate. At the point of referral to a private provider a generic service maybe appropriate because the client may only require support with relatively simple tasks such as shopping, however if their mental health declines it may be that they require a more specialised service. Social workers periodically review the support that is in place.
- Adoption of the enablement model has led to a change in approach in how the Enablement Service provides long term support when there is no private provider service available. In such cases the support is provided by enablement workers but now when working with clients with severe and enduring mental health staff are more mindful of avoiding co-dependency and instead focus on the principles of enablement and moving clients forward.
- The service has been promoted through liaison with social work teams, health professionals and events held in hospitals. Since all referrals are passed to the service via a social worker there is little information available about the initial point of referral i.e. whether from a GP, Hospital or through a self-referral.

### **Team Accommodation**

- The role requires enablement workers to write up logs, research resources in the locality and make connections with local community groups. Currently there is limited desk space for this type of work. When accommodation was considered it took into account what was effective for the care worker community role, but enablement workers have greater need for office space. Having a base would also help staff members to feel more of a team and provide opportunities to liaise with colleagues.

### **Recovery and Peer Support Groups**

- Some recovery and peer support groups have become self-managing and are running successfully. This is very good for the clients involved. However, there may be room for a mix of self-directing groups and groups supported by a community worker. Some groups have been unable to support themselves and consequently have folded, in other areas it has been fortunate that Adult Education have stepped in to support groups.
- To date the clients that have been directed to recovery and peer support do not have eligible needs. Work is being carried out to consider what support should be provided to those with eligible needs.

## **SENIOR ENABLEMENT WORKERS**

### **Job Role**

- Senior Enablement Workers line manage the Enablement Workers. The role is to supervise the work of the team, balance caseloads and allocate new referrals as appropriate. They do not work with individual clients per se.
- The Enablement Service supports a client group with a diverse range of mental health conditions for example depression, anxiety, bi-polar disorder, schizophrenia, and personality disorders. Increasingly the service is supporting clients with a history of drug and alcohol misuse. There is a number of referral pathways including via social workers, GPS, hospital discharges, prison releases and self-referral.
- The Enablement Service was set up as a six-week service offer in order for it to be in-line with the Reablement Service provided to people with physical conditions. As part of the change process staff who had previously been supporting clients in the community with mental health conditions were downgraded to grade 5 positions. The rationale being that they would be taking on a role with less responsibility and did not require a specific qualification. Following the restructure there has been a high staff turnover and consequently a loss of skills and knowledge from the service. It is anticipated that there may be a further loss of staff as people continue to look for better paid positions.
- Whilst the role has been classified as being less demanding in terms of responsibility, increasingly enablement workers are being asked to work with clients with more complex needs and who present greater risk because of drug and alcohol issues.

### **Training**

- Staff who worked as Support Workers, before the Enablement Service was established, feel that there are less on the job learning and development opportunities. One example of this is that as Enablement workers they no longer attend multidisciplinary meetings to discuss complex cases.
- Whilst new recruits to enablement worker positions are of a high standard, the training they receive is not targeted sufficiently towards supporting people with mental health needs who are living independently in the community. The training provided is similar to that offered to care workers operating in residential setting. Therefore often it falls to senior enablement workers to impart their knowledge to new enablement workers on a case by case basis.



- Senior enablement workers have raised the issue of training for new enablement workers. They have requested that greater emphasis is placed on supporting clients with mental health conditions so that enablement workers are better equipped to fulfil the role. For some time, assurances have been given that this will be addressed.

### **Service Delivery Model**

- The inflexibility in the duration of the service (i.e. the service offer of up to six weeks) is at times problematic. On occasions it can take six weeks to build a relationship of trust with a service user or it might take 4 weeks for a bus pass to arrive before graded exposure work can begin on supporting a service user to travel on public transport. For the service to be more effective greater emphasis should be put on client need and less focus on achieving parity between the Enablement Service and the Reablement Service.
- At four weeks the social worker reviews each case. If there is ongoing need the social worker can extend the support available to the client but the extended support will not necessarily be provided by the Enablement Service. The client may be referred to a different service. Referral to a different provider may mean that there is a break in service provision and a period of time when the client is not receiving any support at all.
- The inflexibility of the service can also be detrimental from a member of staff's point of view. Having to stop work with a client when progress is being made towards the goals in their personal service plan is frustrating and impacts negatively on job satisfaction and staff morale. Sometimes it leaves staff feeling that clients are going through a "revolving door" whereby the client goes in and out of hospital and the funding to support them sometimes comes from the health budget and sometimes comes from the social care budget.
- Based on experience, senior enablement workers expressed the view that it would be more cost effective in the long term if the service offer was for a period of up to 12 weeks. This is something that was suggested from the outset when the new service was being developed and the enablement teams would very much welcome this decision being reviewed. They feel that an extended offer might make the difference between the client not needing further support because they have achieved their goals and the client requiring a long-term support package.
- Anecdotally there is a perception that some social workers choose not to refer to the Enablement Service because they feel that the six weeks isn't a sufficiently long period of time for the client to achieve the required level of recovery.

## **Personal Safety**

- Senior enablement workers feel that the safety procedures for staff working alone in the homes of service users are not sufficiently robust. In the event of a dangerous situation arising staff are not equipped with an effective means of raising the alarm and consequently their personal safety could be at risk. The phones provided are not fit for purpose, often staff are unable to make outgoing calls and the battery life of the phones provided is very short. Also there is no "Call Angel" on the phones that could be used in the event of an emergency. The only safety equipment provided is a personal alarm that makes a loud noise. The purpose of the alarm is to create a distraction and to "buy" a few seconds to get away from a dangerous situation. These concerns have been raised with the management team but have not been satisfactorily resolved.
- Another issue relating to personal safety is that there is not a mechanism to ensure that enablement workers have direct access to up-to-date client information. Therefore, if a client has recently become unwell or if there has been an incident over the weekend the Enablement Worker may, with no prior knowledge, walk into a difficult situation on Monday morning. Senior enablement workers feel a solution to this would be to allow team members to have access to Mosaic - the computerised system where client records are stored.
- There is growing concern amongst senior enablement workers that the peer support and recovery model is not meeting the needs of some clients. Peer support and recovery groups are being delivered across Derbyshire by private providers. In the main the groups are not run by development workers but by volunteers. For a person with an enduring mental health issue, who may lack the confidence or motivation, it is very challenging for them to attend a social group independently. The concern is that after being referred to a peer support group a client will, without the ongoing encouragement from a support worker, stop attending. Consequently, they may become more vulnerable and isolated and risk falling ill and ultimately suffer "out of sight".

## **ENABLEMENT WORKERS**

### **Job Role**

- Enablement workers provide direct support to the service users. They are issued with a Personal Service Plan for the client and have up to six weeks to help the client achieve the goals identified in the plan.
- For each client a social worker writes a short-term support assessment plan. A senior enablement worker then uses that information to produce a document for the enablement workers to work from.
- There is a lot of duplication in the Personal Service Plans. The format of the plans has evolved overtime and they have increased in length without providing any more relevant information. This makes it difficult for the service user to understand the plan.
- "It is rewarding to be able to help people and most times we can make a difference for the clients. We enjoy our jobs but at times it is frustrating that we are limited with the time available to us to meet the goals".
- On hospital discharge there is often a lot of preparatory work to be done such as supporting clients to make applications to get welfare benefits reinstated and the management of medications. Other agencies don't tend to pick this work (or there is a considerable waiting list) so although these activities are not part of the new role the enablement workers have to undertake these tasks before moving on to the goals specified in the plan. It can take several weeks to get an appointment with the appropriate agency, for example the Job Centre.
- A Personal Service Plan may set a goal of travelling independently on public transport. To facilitate this, often a bus pass application has to be made and there can be a delay of several weeks before work can begin on meeting this goal.
- The delay in the initial payment under a new universal credit claim means that many clients have very little money available to them to do activities during the enablement period.

### **Service Delivery Model**

- In many cases the six week timeframe is too rigid. It is particularly problematic with clients who have complex needs. A one size fits all approach is rarely appropriate for clients with mental health conditions. Quite simply the model of providing six weeks support doesn't fit the client group as neatly as the Reablement Service fits clients with physical health conditions.
- Engaging with the client, building trust and developing a good relationship is crucial to the success of the service. Six weeks is a very short timeframe to achieve effective engagement.

- It's not uncommon for clients to lead chaotic lives and this adds to the complexity of a case. Basic needs such as accommodation and financial issues have to be addressed before an enablement worker can move on to the social goals identified in the plan. A client may have debt problems, substance misuse issues or their house maybe in an unliveable condition.
- Whilst it is possible at the four week review stage for the enablement period to be extended beyond six weeks in reality this can be difficult to arrange because an extension requires approval from senior management and is quite a bureaucratic process requiring the referring social worker to undertake a considerable amount of "paperwork". Furthermore, the client would usually be required to make a contribution to the additional weeks of service.

### **Personal Safety**

- In some circumstances the personal safety of an enablement worker can be an issue. If an incident were to occur staff are not confident that the current means of communication would be effective. The mobile phone handsets are unreliable and mobile phone signals are poor in some areas of the County.
- Enablement workers feel that not having access to up to date client records on the Mosaic system can put them at risk if there's been a recent change in the client's circumstances that they have not been informed about.

### **Training**

- Enablement workers described the approach to staff training as fragmented. It's possible for a person to start work as an enablement worker without any specific training, experience or qualifications in mental health. When taking on the role of an enablement worker new staff have been told to look at the list of training courses and identify any training that they feel would be suitable. This is difficult for a new member of staff because on entering the service they don't know what is applicable.
- The former working relationships within Health meant there was better communication between staff from different disciplines and there was an educational element where staff learnt from each other. The sharing of information and knowledge between staff helped to build confidence and a better understanding of how to meet client needs. It is not uncommon to work with clients who suffer from psychosis or delusions and having the knowledge of how to handle these situations is very important to avoid putting the client under too much pressure.

- The general feedback about the one day training course for enablement workers was that it did little to clarify the role. It didn't provide clear direction as to where the boundaries of the service lie. Staff feel they are receiving mixed messages. Obviously support workers understand about achieving the goals in the personal plan but there are other activities that fall outside of this and staff are not given clear direction as to whether they should or should not be undertaking these activities. Previously, as caseworkers, they supported clients to access welfare benefits but now it is not clear who undertakes this role. Help from other agencies to apply for benefits is increasingly limited and difficult to access. "If a client is not receiving any income, they are vulnerable and the situation cannot be ignored".

### **Client Records**

- Enablement workers are required to write a log outlining which goals have been attempted and what outcomes have been achieved. This is emailed to Business Services who upload the information on to the Mosaic system. The enablement workers are not in a position to know whether the outcomes are recorded on Mosaic correctly, nor can they refer back to the information at a later date or see what another case worker has written about the client. The enablement worker is required to destroy the progress update after it has been emailed to the Business Services so they do not have a record of their previous interaction with the client.
- Enablement workers feel that they would benefit from having, at least, read only access to Mosaic, so that they can see what other people have been doing with the client and how the client has responded.
- Generally, there is a risk assessment form for every client. However, the level of detail contained within the risk assessment is variable. On occasions the enablement worker only knows there is a risk when they are informed that two members of staff should attend. The risk assessment form doesn't include the triggers that might upset the client or information about elements of their illness that an enablement worker might find useful when supporting the client. Also the enablement worker is not usually informed of the client's diagnosis because this is not considered relevant to their role.

### **Follow-on Services**

- Towards the end of the six week enablement period a client may be referred on to a different service provider even though they are making progress towards achieving their goals with the Enablement Service.
- In the Erewash area there is a waiting list for follow-on services, therefore often there is a gap between finishing the Enablement Service and starting a new support service.

- Breaks in service can result in a client losing some of the independence they had achieved with the support of the Enablement Service.
- The capacity of the private sector to provide an effective service staffed by experienced support workers varies across the county.
- When a client is moved on to Recovery and Peer Support Services the client is discharged and the social worker has no ongoing contact with the client (unless they are doing an extended assessment).
- In their previous role as support workers staff were confident that they were keeping clients out of hospital. Now there is a perception that the number of hospital re-admissions has increased and as a consequence people are coming back in to the Enablement Service.

### **Communication**

- Working relationships with the senior enablement workers are positive and supportive. Communication is at its best when enablement workers and senior enablement workers are based in the same office but due to the large area that some teams cover this is not always possible. However, generally there is an opportunity to meet once a week to be advised about new referrals.
- Historically the support worker dealing directly with the client would have more dialogue with the referring social worker. Now the tendency is for the communication to be between the senior enablement worker and the social worker. The new model is predicated on enablement workers being in a directed role and delivering the support required to achieve the goals stated in the Personal Service Plan.
- When new cases are allocated the aim is for the enablement worker and senior enablement worker to both be present at the first meeting with the client.

### **Staff Morale**

- Working in a diminished role has had a negative impact on staff morale. In addition to adjusting to a reduction in salary staff have received underlying messages that the role does not require the level of knowledge that they have accrued overtime.

## **HOSPITAL LIAISON SOCIAL WORKERS AND SENIOR PRACTITIONERS**

### **Referral Process**

- Work flow is managed differently in different parts of the county
- The South Derbyshire Team operates a primary assessor model whereby one person acts as a single triage point ensuring that clients are referred to the most appropriate service in a timely manner.
- The initial indications are that the primary assessor model can be effective in streamlining care pathways and managing capacity and demand. However, as the volume of assessments increase a point may be reached when there are too many assessments for one person and this may lead to a delay in referrals.
- The primary assessor model is to be adopted by other teams in the near future.

### **Hospital discharge**

- Hospital liaison social workers refer people to the Enablement Service in order to manage discharges in a timely manner and to increase a person's level of independence on discharge. The Enablement Service is highly regarded with approximately 80% of hospital dischargers being referred to the Enablement Service.
- Nationally there has been a reduction in the support available to help people make successful benefit claims or find accommodation.
- Through case work social workers are coming in contact with an increasing number of people who when admitted to hospital have no finance arrangements in place, have poor living accommodation and who have limited access to support. Consequently, this means that the enablement workers have to resolve a range of social care issues before they can address mental health needs identified in the care plan. In effect the Enablement Service is meeting the shortfall in support previously provided by other services.

### **Service Delivery Model**

- For people with severe and enduring mental health problems it is questionable how much progress against the desired outcomes can be made during a six week period of enablement.
- A large part of the service is providing emotional support. There needs to be a period of adjustment for the client as they get to know the support worker as it can be challenging to "open up" and share issues with a case worker. With the knowledge that the Enablement Service is only available for six weeks some clients may hold back and not invest in the relationship.

- At the end of the six week period, if the client has ongoing needs the procedure is to go out to brokerage so that an external agency can continue the work.
- Senior practitioners have some reservations about the current approach of going out to brokerage after six weeks. The approach lacks client choice. Although a client may be making progress towards their care plan goals and have built up a good relationship with the enablement worker, the client is required to transfer to a different service provider.
- While many agencies identify themselves as being equipped to support people with mental ill health, there have been occasions when agency staff have not had the necessary skills and knowledge to deliver the required support. The concern is that if clients are not properly supported their mental health may deteriorate and the client may return to hospital.
- The rationale and benefits of a time limited and outcome focused service are acknowledged. However, the aim of providing 70% short term support and 30% long term work is a somewhat arbitrary split when it comes to clients with mental health conditions. Furthermore striving for parity in the duration of the offer of the Reablement Service (for physical health conditions) and the Enablement Service (for mental health conditions) does not appear to be evidence based or outcome focused.
- The service is targeted at working age people and the hope is that clients become sufficiently independent to find paid employment. However the Enablement Service operates Monday to Friday between the hours of 9 and 5.

## **Communication**

- As a social worker it is sometimes easy to forget that the people working directly with the client do not have access to Mosaic and that they have to rely on information being passed down from senior enablement workers. More opportunities to have an ongoing dialogue with the “staff on the ground” would be beneficial and lead to a better exchange of information about progress, emerging concerns and changes in the client’s circumstances. In some areas of the county this happens routinely whilst in other areas enablement workers are discouraged from talking directly to the relevant social worker.
- It is assumed that the client’s enablement worker will have seen a copy of their assessment and plan prepared by the social worker, but that isn’t always the case.



- The information in the social workers assessment and plan is used by the senior enablement worker to write a Personal Service Plan for the client.
- It is possible that in the desire to capture all relevant service related information in one document the primary purpose of the individual client plan has been overlooked. It has almost reached the point that the outcomes are not the focus of the document anymore.
- The social worker undertakes a risk assessment for each case and then the senior enablement worker draws on this information to prepare another risk assessment. The social worker also visits the client's home and does an environmental check. Whether these processes can be streamlined is unclear.
- It is not always appropriate for the Reablement and the Enablement Service to mirror each other. Due to the needs of the client group enablement has to be a different service it can't be the same as re-enablement.
- In reablement it is unlikely that the social worker would need to speak directly to the home help, instead they will speak to their line manager but in enablement it is often beneficial if the social worker speaks to the person who is working directly with the client.
- In re-enablement there is no need for the support worker to work with the client in hospital but in enablement work, working with a client in hospital before they are discharged is often desirable, but there is a "blanket no" to the Enablement Service working with clients in hospital.
- The shape of the service shouldn't be driving how clients are being supported. It is the professional Judgements about what is best for the client that should drive the service.
- Generally the morale of enablement workers is currently low. They feel professionally under-valued and have had to adjust to a significant reduction in salary. "Clearly within the current climate of efficiency saving how they are remunerated is unlikely to change but as an organisation we could do more to acknowledge that they are an integral part of the recovery process."
- Enablement workers can be asked to undertake many tasks in a very short period of time. For example, if a person (who was previously homeless) is discharged from hospital the enablement worker might be asked to ensure that their accommodation is suitable, source furniture, arrange utilities and apply for welfare benefits. Enablement workers are asked to undertake this work because other agencies are not providing the support that they previously did.

- At a national level many services are being stretched in terms of the resources available to meet demand and senior practitioners feel that the impact that this is having needs to be clearly articulated to central government.

### **Recovery and Peer Support Groups**

- With the move across to the Enablement Service the groups that were led by DCC support workers were transferred to the Recovery and Peer Support Service. Anecdotally, social workers are hearing that many of the groups are no longer in operation because since groups have become self-directed attendance has fallen. As a consequence of this there are concerns that clients are coming back into “the system” and needing more “paid for support”. This is a county wide issue and needs to be addressed.
- Groups have been shown to be an effective way of supporting clients who do not need an individual long term offer. When support workers led each group the social worker was able to get feedback about clients who were not managing so well and could take action to ensure they received additional support.
- It was suggested that the Glossop Mental Health Project would be a good source of case studies that could be reviewed to evaluate the effectiveness of the peer support model.

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