UNIVERSITY OF BIRMINGHAM

Building on strong foundations

Eight top tips to embed strengths-based practice in adult social care

September 2023

We build
We activate

birmingham.ac.uk

Introduction

Strengths-based practice seeks to return social care to its core principles of social justice, respect, and diversity, through changing the relationship between professionals and the people who they support. It moves from a system based on what people cannot do for themselves and how services can meet these deficits to one which starts from what is important to the person and the assets which they and their families already hold. Strength-based practice is community orientated and involves statutory, voluntary organisations and informal networks. These agencies look to be complementing and building on their shared resources rather than replacing, duplicating, and competing. It has the potential to improve the quality of life and outcomes for people and their families as well as to reduce their need to rely on long-term and expensive social care services. Different terms are used to describe strengths-based practice depending on the sector and profession, but the fundamental principles are endorsed by social work, occupational therapy, nursing, and care and support providers.

This report is based a research project which studied three local authorities in England which were highly committed to strengths-based practice (York, Camden, and Birmingham). Each sought to embed this approach throughout their social care system by introducing new services and interventions and through supporting their front-line social care practitioners to reflect these principles in their day-to-day work. Through reflecting on their collective learning and experiences, it has been possible to identify eight "top tips" which can help other local areas who wish to become more strengths-based in how they plan and deliver social care.

Authors

Robin Miller[1], Jerry Tew[1], Philip Kinghorn[2] and Editor Musekiwa[1]

[1]School of Social Policy, [2]Institute of Applied Health Research University of Birmingham

Correspondence

For further information or to discuss the wider research please contact Professor Robin Miller (r.s.miller@bham.ac.uk) or Professor Jerry Tew (j.j.c.tew@bham.ac.uk)

Acknowledgements

The research team would like to thank our case studies sites for their commitment and perseverance in the project even through the difficult days of the COVID 19 pandemic. We would also like to thank the helpful insights provided through our lived experience panel.

Disclaimer

The views expressed are those of the authors and not necessarily those of the NIHR School for Social Care Research, NIHR or Department of Health and Social Care.

Further information

For more details of this research project and wider social care research at the University of Birmingham please see:

birmingham.ac.uk/schools/social-policy/research/adult-social-care/index.aspx

Tip one: **Co-production is key**

The principles that inform strengths-based practice with individuals and families should also inform the overall design of the local system and how available funding is invested.

This is not a new aspiration – the importance of co-production with people with lived experience and communities has been recognised for some time. Achieving such co-production requires though a long-term collaboration with people and communities. This enables the development of a trust-based relationship in which all contributors can express their viewpoints even if they do not agree.

Effective co-production requires an alignment of core values and objectives, moving outside and beyond narrow conversations around social care as provision of services, and instead exploring what would enable people to have safe, valued, and positive lives. This may not be easy when the starting point reflects institutionalised expectations among all stakeholders and based on previous experience people may fear that such discussions are a pretext for taking away current service provision. It may be helpful to look to a vision statement to underpin co-production, such as the one articulated by the Social Care Future movement:

We want to live in the place we call home with the people and things that we love, doing what matters to us in communities where we look out for one another.

Developing co-productive relationships is not only the role of the dedicated 'involvement officers' but all those with influence in the social care system. In one local authority, a lived experience consultant has been invited to be a part of all senior management meetings, thereby encouraging a shift to a 'doing with' approach to strategic decision making. The opportunity to contribute should not only be given to those who find it relatively easy to express their opinions but also those who are often excluded due to the mode of communications and bias in the associated processes. This will require investment of time and resources alongside a willingness to be challenged on how opportunities can be shared more equitably.

Good practice example: **York co-production group**

The York Centre for Voluntary Services employed a Co-production Champion in 2021 to support a wider transformation of mental health services in partnership with the NHS and the City Council. The Champion co-ordinates a network which brings together commissioners, providers, people who use services, carers, and the wider community. Co-production is defined as "an equal relationship between people who use services and the people responsible for services. They work together, from design to delivery, sharing strategic decision-making about policies as well as decisions about the best way to deliver services".

The aims of the network include ensuring that people within York are involved in the co-design of mental health support, providing space for people with experience of mental ill health to work together, and giving challenge and constructive feedback to the mental health partnership. Initially the network was based around meetings with an agenda-based structure which covered a range of topics. However, attendance at these meetings fell away over time and the network has now moved to a series of workstream based activities which reflect people's priorities, including mental health rehabilitation, eating disorders and neurodiversity. To facilitate discussion, the related groups have adopted a conversational café approach based around clear questions which enables people with lived experience and professionals to contribute. If someone raises an issue which is separate to the core topic, then this is recorded on a 'park it' board for discussion at a future meeting.

Alongside the style of the meeting, the Co-Production Champion is available 15 minutes before the meeting and afterwards to provide opportunities for people to prepare for discussions and debrief afterwards. The Champion also meets with people on an individual basis who are thinking of getting involved in the network so that they can understand how it works – people are allowed to engage and contribute at their own pace. The network has established a clear set of values for how they operate which include - Give others a chance to speak, Respect everyone, Openness and honest, and Speak from your experience. Recognising that such discussions could raise difficult issues, the network has an arrangement with a local counselling service if someone would like to talk to someone.

For more details, please contact Co-Production Champion Jack Woodhams: **jack.woodhams@yorkcvs.org.uk**

Good practice example: **Camden Autism Hub**

The Autism Hub came into being in 2018, officially launched during World Autism Awareness Week. It's a user led service, by and for autistic adults who do not have an accompanying learning disability. There was little provision for adults diagnosed with autism later in life and this group of autistic adults, would fall through the gaps in services only to be told they do not meet the criteria and ultimately left without the support they need.

The idea for the Hub came about when the Camden and Islington Autism Project and Asperger's London Area Group got together with commissioners and professionals to collaborate on how to improve the quality of life for autistic adults in the area. The initiative took a whole person approach, to connecting people to resources, services and organisations from a central point.

The Autism Hub offer advocacy, peer led support, expert advice, training, information, and signposting to service users, their families/ carers and other professionals, as well as specialist autism counselling and therapeutic support.

Other initiatives have come out of the collaboration through the Autism Hub such as the Autism Hub Covid Response Project 2020 (Where users teamed up with commissioners to initiate a Covid Response Project to support autistic residents who were adversely affected by the pandemic). The Autism Hub has been able to foster new relationships where services listen and act in peoples' best interest and in Partnership.

For more info about Camden Autism Hub see:
www.theautismhub.org.uk

Tip two: **Leadership throughout the system**

Strengths-based practice requires substantial changes to the ways in which money is used, processes are configured, and what is seen important in front-line work. Such scale of transformation requires transformational leadership throughout the local authority.

Senior directors and elected members have the power to develop the overall organisational vision and decide on the allocation of staff and other resources. However, it is often practice leads such as Principal Social Workers, Lead Occupational Therapists and Commissioning Leads who are best placed to develop the vision and embed and operationalise this within organisational processes and everyday practice. This can only work well in practice if there is active ownership and buy-in from staff at all levels of the organisation –a network of champions can be helpful to support the local implementation of innovations.

Experience from our research sites suggests that leadership for change is often demonstrated by motivated front-line practitioners who value the opportunity to engage in a more creative and co-productive way with citizens, families, and communities. First line and middle managers can find it harder to create space for inspirational leadership when much of their role has been oriented towards meeting targets and managing workflows. It may therefore be particularly important to work with frontline and middle managers to explore how they can be practice leaders and put in place the necessary educational and supervisory enablers. This may also require reducing and reconfiguring organisational expectation in relation to performance management functions. Suitably enabled, practice leaders can provide supportive team environments providing opportunities for reflection and challenge.

Leadership must adapt as the context in which strengths-based practice is being implemented changes over time. It is vital that it does not come down to one or two core people to provide the momentum for change as they will move on from their roles over time. A network of leaders is a much stronger arrangement as they can provide peer support and help to educate and support those who are new into such roles. The overall aim is to develop a culture of strengths-based practice based on shared learning and reflection.

Good practice example: **Senior and dispersed leadership in Birmingham**

In a large local authority such as Birmingham, reorienting the whole system of social care provision was a major challenge, and a top-down approach to leadership would have been unlikely to have been successful. While the Director (with support from the Cabinet member) gave a clear and unwavering commitment that the direction of travel was towards strength-based practice, they did not provide the blueprint as to how this was to be achieved. As the scale of the challenge was acknowledged to be great, there was a sense that 'tinkering around the edges' was not going to be sufficient and that proposals for change would need to be ambitious.

The initiative was taken by the Principal Social Worker, and others in practice development or commissioning roles, who researched what approaches might be most effective in taking this forward in Birmingham. Out of this, worked-up proposals were pitched to the Director for approval.

This generated a dispersal of ownership, expertise, and enthusiasm, with the people who had developed proposals leading their implementation across the organisation. A key element of this leadership was a clear articulation of shared values – that the new ways of working were about enabling people to have better lives, rather than processing people according to organisational procedures. In turn, this values-driven approach connected well with an organisation-wide coaching-based programme (Owning and Driving Performance), which encouraged staff to take greater leadership in relation to developing their own practice and that of their teams.

Good practice example: **Complex needs network**

Early in 2018, discussions began in York about how organisations and services could work better together to support people with complex needs. The idea emerged of involved creating a "network" which would bring together those supporting people with complex needs in the same room, to learn, challenge and achieve change. The network involves people with lived experience, frontline workers and strategic leads from public services and the voluntary and community sector. They come together to innovate and collaborate to make York a better place for people with multiple disadvantages in life.

Regular meetings are held which are open to all members and share current activity, make decisions about how the network can move forward, and bring in learning from outside of the city. Alongside the whole network meetings, groups take forward priorities including how to jointly commission for systems change, how to compensate people with lived experience for their involvement in co-production and using creative activities to bring about change. People with lived experience are involved in all these groups and they are testing out innovative approaches to bringing people together and making decisions.

The network has helped to articulate a common set of values which are shared by strategic leaders within York (and other members of the network). This followed a survey of members in which they were asked to identify the current culture within York, what mattered to them personally, and what culture they would like to see in the future. Participants agreed that the network should be based on values of community involvement, cross-group collaboration, and adaptability.

For more info re the Multiple Complex Needs Network see: **yorkmcn.org/about**

Tip three: **A clear strategy with agreed principles**

It is easy to underestimate the scale of change that is necessary to embed strengths-based practice. A necessary starting point is to develop a simple and clear vision and share the values that underpin this.

Whilst many local authorities can achieve the creation of a vision, what they find more challenging is to develop a detailed step-by-step strategy (or theory of change) whereby the whole-system change promised by the vision can be achieved in practice. Often local authorities focus mainly on social work and care management practices and related underlying organisational processes such as record systems. These are important but strengths-based practice requires much wider engagement, including from those who commission and contract services and from independent social care providers. Developing an explicit strategic plan with a clear 'theory of change' of 'what will happen when' articulates the overall aspiration, who will be expected to be responsible for which element, and how activities will lead to the necessary changes. This strategy should be developed with people with lived experience and communities and with practitioners. It needs to be co-ordinated with other key partners such as housing and health to ensure that there are not competing initiatives and the funding available across the partners is used effectively.

It is important to review the plan periodically to ensure that the planned activities are still relevant, and learning gained through the implementation process can be used to further improve the approach. Publishing updates and making these available in accessible formats helps people to understand the bigger picture and how they fit in. Alongside this core plan will be wider corporate and partnership strategies, and strategies to improve the health and wellbeing of place based or condition related populations. Agreeing a common set of strengths-based principles ensures that these are reflected in all new developments.

Good practice example: **Camden What Matters strategy**

'What Matters' was launched in 2019 across the whole service and sets out how social care and local partners should work with people across the entire service. It details the overall approach, and ties into the overall strategy – The Camden Approach to Adult Social Care, having conversations and building relationships where people are at the centre of all decisions. The focus is on supporting people, connecting communities, early help and prevention while building on people's strengths, skills and ambitions. This is based around working with all partners in neighbourhoods – connecting people to the things that matter to them, and offering early help when people need it.

The What Matters strategy builds on people's strengths and what matters to them, a citizen-led approach with a strong role for voluntary and community organisations and a desire to better align social care teams with local neighbourhoods. It took about 18 months of preparation and was shaped through speaking with residents to understand what matters to them regarding their health and wellbeing and how they want to access services. Although partially interrupted by the covid lockdown, there was an implementation strategy that sought to engage with people across the entire service, including the offer of a highly valued coaching skills programme to help people to reorient their interactions with fellow staff as well as with residents and communities. Alongside this, new workflow and recording systems were introduced to encourage and guide strength-based practice.

While at the beginning the visions was not clear although rooted in 3 conversations model, this evolved into 'What Matters' interlinks with all the existing strengths-based approaches which are deployed locally. There is a strong commitment to developing plans through participation and coproduction with the people they most impact.

Tip four: **Twin track the individual and the community**

Central to strengths-based practice is a recognition that the provision of formal public services will often not be a sufficient or appropriate way of enabling people to live the life they want.

Instead, the new approach helps people where possible to gain the support that they would benefit from through their own skills and knowledge, from their networks of family and friends, and from their local communities. It is important therefore that strengths-based transformation programmes not only consider how professional practice with individuals can be improved but also how the resources of families and communities can be enhanced.

The voluntary and community sector, and the infrastructure organisations and networks which support them, therefore make a vital contribution to strengths-based practice. This requires a fundamental shift from commissioning relationships based around contracting to provide specific and limited services according to agreed specifications to a new co-productive relationship with voluntary and community sector organisations (including very local micro-organisations) around growing community assets (such as networks, meeting places and shared activities). It is important within the design of these holistic offers that they are accessible to the whole population and not only those with less complex needs.

The voluntary and community sector has a good understanding of what is important to people who share a common condition or social challenge, or who are living in the same geographic locality. Delegating responsibility for planning and co-ordination to such organisations can facilitate a more dynamic and community-informed approach. As with other co-productive initiatives, it is important to ensure that there is a shared vision and alignment of values across collaborating organisations – including a genuine commitment to inclusivity and working alongside people to maximise their potential rather than just doing things for them.

Good practice example: **Local area co-ordination**

Local Area Co-ordination (LAC) was introduced in York in 2017 across three wards. It is strategically overseen by the York LAC Leadership Group of cross system partners which is chaired by the Executive member of Health and Adult Social Care. It now employs thirteen co-ordinators and two seniors and is embedded across the city. LAC seeks to create networks of support around people to increase independence and reduce dependence on statutory services. Locality based co-ordinators provide a single accessible point of contact for people in their community and so simplify the system. LAC views people as valued citizens in their communities and helps them to pursue their vision for a good life through staying safe, strong, healthy, connected and in control.

The model works over three levels – individual, community and systemic. Through coordinators 'walking alongside' people, citizens are encouraged and supported to build on their own agency and capabilities. Often people have forgotten about their experiences, hidden talents, and skills – conversations with Coordinators help them to tap into this. As well as supporting individuals, co-ordinators work with community partners to recognise and grow their local assets through developing new connections and non-service options which are inclusive. LAC also gathers information from citizens and communities across the city and uses this intelligence to inform strategic change.

One example of LAC is Dee's story, which started when she was diagnosed with a rare form of bone cancer and had to undergo a life-changing operation. She became dependent on a wheelchair and felt that she had lost her independence but did not want to become a burden to her family. Dee was introduced by the Pastoral Worker at her child' school to a Local Area Coordinator.

To support Dee in being able to purchase a new scooter and address a local gap in support, they set up together the New Earswick Community Motability Scheme. For more information see: **lacnetwork.org/dees-story**

Good practice example: **Neighbourhood network schemes in Birmingham**

The model developed in Birmingham involves commissioning an umbrella voluntary organisation for each parliamentary constituency area to co-ordinate (and, where appropriate, pass funding on to) smaller scale capacity building and support initiatives in local communities within their area. Initially, the focus was on opportunities, access, and support for older people, but the brief was subsequently extended across those any adults who may access social care. A key to success has been taking time to find a local voluntary organisation with which to partner in each constituency that had the right fit in terms of values, had capability in community development or capacity building rather than just having expertise in service provision, was not allied just to a particular section of the community and had good links at grass-roots level. While this could result in delays in getting the Scheme up-and-running in certain constituencies, it was seen as important to set up each Scheme on the right footing from the start.

The first task was community asset mapping. In one constituency the umbrella organisation found over 300 formal or informal organisations or networks that were operating within their area. Alongside this, they made links with local social care teams – attending (or even hosting) team meetings. The value of these connections became particularly important during the covid lockdown where the infrastructure of street level networks and organisations provided the link between social care practitioners and vulnerable people who were potentially 'marooned' in their homes. It proved vital in ensuring that they were safe, had food and medicines, and had some contact with the outside world (albeit at a distance).

Tip five: **Draw on the support of others**

Each local authority will be best placed to understand the needs and context of their local populations and the resources and services required for strengths-based practice.

Alongside this local expertise, there are several national organisations or networks who have developed models of practice relevant to strengths-based working. Where this is financially possible, engaging with such opportunities can enable implementation to build on previous learning, use established frameworks and tools, and to connect with other authorities who can provide peer challenge and support. External input may be particularly valuable in the early stages of innovation as staff start to build a sense of how it can work in practice – including the need to unlearn the old as well as embrace the new. It can also make a major contribution later if, as can often happen, the process of innovation stalls and practice can revert to familiar and more reactive or defensive ways of working when under pressure. Often there may be a need to take stock, review and learn from what may not be working so effectively. It can be important to focus on how to make strength-based innovations self-sustaining and mutually reinforcing once the initial enthusiasm for change has worn off.

Universities can also helpfully contribute to the development of a strengths-based programme. They can advise on how best to evaluate impacts and the various tools to understand aspects such as quality of life. There is increasing national funding for social care research and participating in such studies can provide academic insights and analysis of local data. Fellowship programmes can provide training and time for social care practitioners to gain the sills and confidence to undertake research themselves.

Good practice example: **Partners for change and Three Conversations**

Rather than devise their own implementation programme from scratch for the Three Conversations approach, Camden and Birmingham both enlisted Partners for Change to work with teams as to why and how they would be changing their practice – drawing upon the expertise and experience of implementation elsewhere. These sessions were able to address issues such as the fear that offering people a much fuller conversation at the point of first contact would result in a deluge of work that would be impossible to control. Although challenging (e.g. in the 'banning' of the use of any words associated with old-style care management practice), the message was one of liberating front line staff to do the sort of work that they came into the job to do.

In the earlier stages, the external input from partners for Change was crucial in maintaining a belief that radically new ways of working could actually work in practice. Over time, by utilising mechanisms such as peer processes of sharing 'stories of difference', confidence and expertise within the local authority began to grow and become self-reinforcing.

However, later on in the process, there could be a tendency for initial enthusiasm and motivation (and clarity of understanding of the new model) to wane a little in the face of pressures and challenges – and for staff to revert to familiar (although potentially counter-productive) ways of responding to these. At this point, Partners for Change could be enlisted to be part of an organisational 'refresh' – regaining clarity as to where they wanted to go and what may have emerged as internal or external barriers that may have made this journey more difficult. For more information on Partners for Change, visit **partners4change.co.uk/the-three-conversations**

Good practice example:

Practice networks for local area co-ordination and family group conferencing

York, Camden and Birmingham each benefit by being active members of national Practice Networks. There are Practice Networks for both Local Area Co-ordination and Family Group Conferencing which are hosted by Community Catalysts. These networks can provide several useful functions. Most importantly, they provide an easily accessible way for local authorities to share and learn from the experiences of others – both in terms of what has worked well for them, but also how they may have experienced challenges and how they have sought to overcome these. They also provide opportunities to disseminate what is being learned from research and service evaluations – which may help to build the evidence base with which to underpin the business case for developing new initiatives.

Perhaps most fundamentally, these Networks help to safeguard the fidelity of the approach – helping to be clear as to what are the core defining features that make each approach work. Openness to peer challenge can help resist and address tendencies for approaches to be 'watered down' in the face of organisational pressures, but thereby also to lose their efficacy.

For more information on the Local Area coordination Network, visit **lacnetwork.org**

For more information on the Family and Group Conferencing Research and Practice Network, visit **fgcforadults.org.uk**

Tip six: **Look for the strengths of everyone**

It is a common (but wrong) assumption that strengths-based practice is only appropriate for people who are more able and independent. This misapprehension can be due to an unconscious bias about the lack of potential of those who face more complex challenges to have a better quality of life and to make decisions over their care.

Although it may require much more skilled and persistent engagement than a simple assessment for a care package, strength-based approaches can in fact substantially improve outcomes for people in such circumstances. 'Sticking like glue' while people are (re)connected with one another, conflicts are resolved, or solutions are explored can pay dividends in terms of new opportunities, better support, and enhanced capability. Although, in many instances, this may also serve to reduce people's reliance on long-term care, a strength-based approach is just as important where such services are needed on an ongoing basis – but the focus can still be how such services can contribute to maximising people's capability to have the sort of life that they want and stay connected with the people that matter to them.

The principles of strengths-based practice can be applied to people whatever their circumstances. Those living in residential care for example may have more limited options in some aspects of their life, but they may still have skills and knowledge which will enable them to retain control over elements of their care or which could be of benefit to others. Similarly, informal networks such as family and friends or engaging with a much-loved community activity may be hugely important to them and maintaining these connections vital to a better quality of life.

Enabling practitioners to recognise these strengths and to embed them within risk assessment and management processes will often require training and reflection in individual and group supervision. It is also important to discuss with partners as there can be challenge around points of transition such as hospital discharge.

Good practice example: **From interview with older person**

Margaret is 80 years old and lives alone. She was not coping very well at looking after herself and undertaking practical tasks in her home, and presented as depressed. She was very socially isolated and had minimal contact even with her elder brother who lived some distance away.

Following some initial contact with Age Concern, a practitioner using a Local Area Coordination approach connected with her. Instead of arranging a care plan of support services, Tracey took time to build a relationship and find out why Margaret was finding it difficult to cope. It emerged that her son had always lived with her but had died around 20 years previously. She had not been able to get over this loss and she said that she had wanted to join him.

Tracey 'listened to me while I spoke to her about my son... before I met Tracey. I felt like I wanted to join my son but since Tracey made me look at things differently and you can't blame yourself - which I was [doing] because he was my son.'

Tracey arranged for some minor practical adaptations within the home, and alongside this started to talk about what a different future might look like for Margaret, and, in particular, how she might make social contacts with other people within the community in which she lived.

Tracey 'has been good. Apparently, for 80-year-olds... well, I ought to go to mix with other people, but I haven't wanted to do that. I haven't felt in that frame of mind. I am looking forward to my future now ... It's beautiful. I like [groups] or meetings for me to join and get to interact with other people.'

Good practice example: **From case files of younger person with complex needs**

Lynette is a young woman with learning disabilities, epilepsy and chronic fatigue who was having less engagement in life and interests outside the family home than she would have liked. In the casenotes, the practitioner describes her as 'an enthusiastic and vibrant person who would like achieve things'. However, her ability to get around and access the opportunities that she wanted was compromised by her having had episodes of crying, disorientation and confusion when out in the community.

Instead of seeing these episodes as a 'deficit' that would limit Lynette's life, the practitioner used a 3 Conversations approach and took the time to find out what were the underlying triggers for these episodes. These included stress around budgeting and relationships, and social anxieties around feeling that she was being compared unfavourably with other people (including family members) who did not have learning disabilities. This could be compounded by poor diet and skipping meals, which could contribute to fatigue and weakness.

The way forward was seen in terms of Lynette getting the support she needed (mainly with travel) in order to engage with the people and the activities that gave her a sense of being valued. Alongside this, Lynette committed to managing her diet and health better in order to give her more strength. This served to reduce the frequency of her distressing episodes which, in turn built up her confidence that she could be more independent.

The casenotes report that 'At the review meeting [Lynette] spoke positively about working on her health to get better and have a better quality of life. She would like a relationship and become more financially independent by getting a job.' To this end, she had enrolled at college to study maths and English and had registered with the Job Hub and an Employment Skills Workshop which she attended last term. She will also be starting an English & Maths course.

Tip seven:
Plan for turbulence and seek unexpected opportunities

The environment in which social care operates seems relentlessly prone to policy uncertainty and financial challenges. In addition to such external distractions, strengths-based programmes will also face internal disruptions related to key staff members moving on to new roles and/or organisational restructurings.

Overcoming such potential adversities must be built into a programme from the beginning as the question is when disruptions will arrive not if they will be experienced at all.

Difficult times can not only result in additional challenges, but also result unexpected opportunities. COVID 19 caused huge disruption to all aspects of personal and public lives, and severely impacted on local authorities' intended plans to implement and embed new strength-based ways of working. However, it became clear that working co-productively with the micro-infrastructure of community networks and organisations was the only way in which those most vulnerable could receive essentials such as food and medicines.

There were also many examples of statutory partners feeling able to be more innovative and to overcome long standing barriers relating to process or sharing of resources.

Engaging networks of stakeholders and champions from within and external to the local authority helps to provide momentum and memory when key individuals move on. The principles of strengths-based practice are supported by parties of all persuasions and elected members will often be active in the same area for a long time. This should mean that the approach can survive changes to who has political power if cross-party support is sought. People with lived experience can be powerful advocates for change for the long-term, particularly if this was co-produced with them from the beginning.

Tip eight: **Gather data and feedback to reflect on progress and review plans**

Creating momentum for change and getting a strengths-based transformation programme underway take a considerable amount of commitment, energy, and resources.

It is therefore understandable that most such initiatives do not feel that they have the capacity to properly think through how they will evaluate before activities get underway but can do this further down the line. Unfortunately, this means that opportunities to set a baseline of activity and outcomes are lost and the demands of delivery result in evaluation processes not being properly introduced. Not putting in place a clear evaluation framework means that opportunities to further improve the implementation will not always be recognised and the extent to which a programme has achieved its overall outcomes will not be known. This can mean that a strengths-based approach which is successfully improving practice cannot provide sufficient evidence to local decision makers which makes it difficult to argue for continued investment.

Evaluations should ideally include both quantitative aspects such as service activity and performance data, and qualitative aspects such as focus groups and interviews with stakeholders including practitioners and people with lived experience. Using collaborative approaches such as world cafes can provide considerable practical insights and opportunities for stakeholders to connect around shared interests. Strengths-based working has a focus on supporting people to prevent further deterioration of their situation and draw on informal support rather than formal services which can make traditional approaches to understand impacts difficult. There are though validated research tools available which are simple to use and provide robust insights into what difference new practices have made to their lives and what is important to them in relation to the support that they receive.

Good practice example: **Insights from ICECAP in this project**

ICECAP tools support the measurement of "capability" within evaluations through considering an individual's ability to 'do' and 'be' the things that are important in their life. There is a suite of ICECAP ((ICEpop CAPability measure for Adults) measures (questionnaires) for use with different population groups. ICECAP-A and ICECAP-O assess general well-being and have been developed for use with the general adult population, and older people, respectively. They each have five questions (also referred to as 'attributes'):

- The ability to have love, friendship & support (A & O)
- The ability to feel settled and secure (A) / Thinking about the future without concern (O)
- The ability to achieve & progress in life (A) / Doing things that make you feel valued (O)
- The ability to experience enjoyment & pleasure (A & O)
- The ability to be independent (A & O)

The measures are intended (and are suitable) for self-completion, but our experience has demonstrated that those who engage with adult social care can experience 'form fatigue' and find the idea of completing a questionnaire off-putting. For this reason within this research project, the ICECAP questionnaire was completed with participants during a short interview. We chose to use the ICECAP-O questionnaire, despite there being a wide spread of ages in our sample population, as the wording of the questions would be better suited to those potentially facing challenging and complex circumstances.

In this research we were able to track cases where well-being improved, remained stable or deteriorated. We were also able to identify where participants felt they were able to achieve what was important to them, and where that ability was constrained. The interview helped to identify enabling factors and frustrations or constraints and help us to understand the questionnaire data in their local context.

ICECAP measures are free to access, but their use should be registered with the University of Bristol: **bristol.ac.uk/population-health-sciences/projects/icecap**

Designed and printed by

UNIVERSITY OF BIRMINGHAM | Creative Media

Edgbaston, Birmingham,
B15 2TT, United Kingdom
birmingham.ac.uk