

A High Impact Change Model for Strengths-Based Approaches



The Local Government Association and Association of Directors of Adult Social Services are **Partners in Care and Health (PCH)** working with well-respected organisations.

PCH helps councils to improve the way they deliver adult social care and public health services and helps Government understand the challenges faced by the sector.

The programme is a trusted network for developing and sharing best practice, developing tools and techniques, providing support and building connections. It is funded by the Department of Health and Social Care and offered to councils without charge.

www.local.gov.uk/PCH



Background to this work

We know that councils are keen to move to strengths-based practice and the CQC local authority assurance assessment framework also includes strengths-based elements.



“It’s not that we don’t have strengths — it’s that no one explains what they mean by it, or how it helps”



How this HICM was developed:

Our contractors Social Care Health Collaborative will explain how this piece of work was developed and how you can use it.



What is a strengths-based approach

A strengths-based approach means really getting to know and understanding a person's life and experiences and working with them to build on what they already do and have. This includes thinking about:

- The things that make people who they are – for example having a sense of humour, being patient or having confidence (their capabilities).
- What they like to (and can) do for themselves– with or without support (their abilities).
- How they have coped before when things have been difficult and how this could help them with their current situation (their resilience).
- Who they know that might be able to offer support - for example, their network of friends, family, and other people they know, such as people in their community (their assets).

adapted from Farragher, forthcoming 2026; and based on the DHSC Practice Framework, Baron et al., 2019



The High Impact Change mode

What is a High Impact Change Model?


- A High Impact Change Model is a practical guide that highlights the few changes that will make the biggest difference. It helps councils and adult social care teams focus on what really works to improve services and deliver better outcomes for people.

This model was developed using

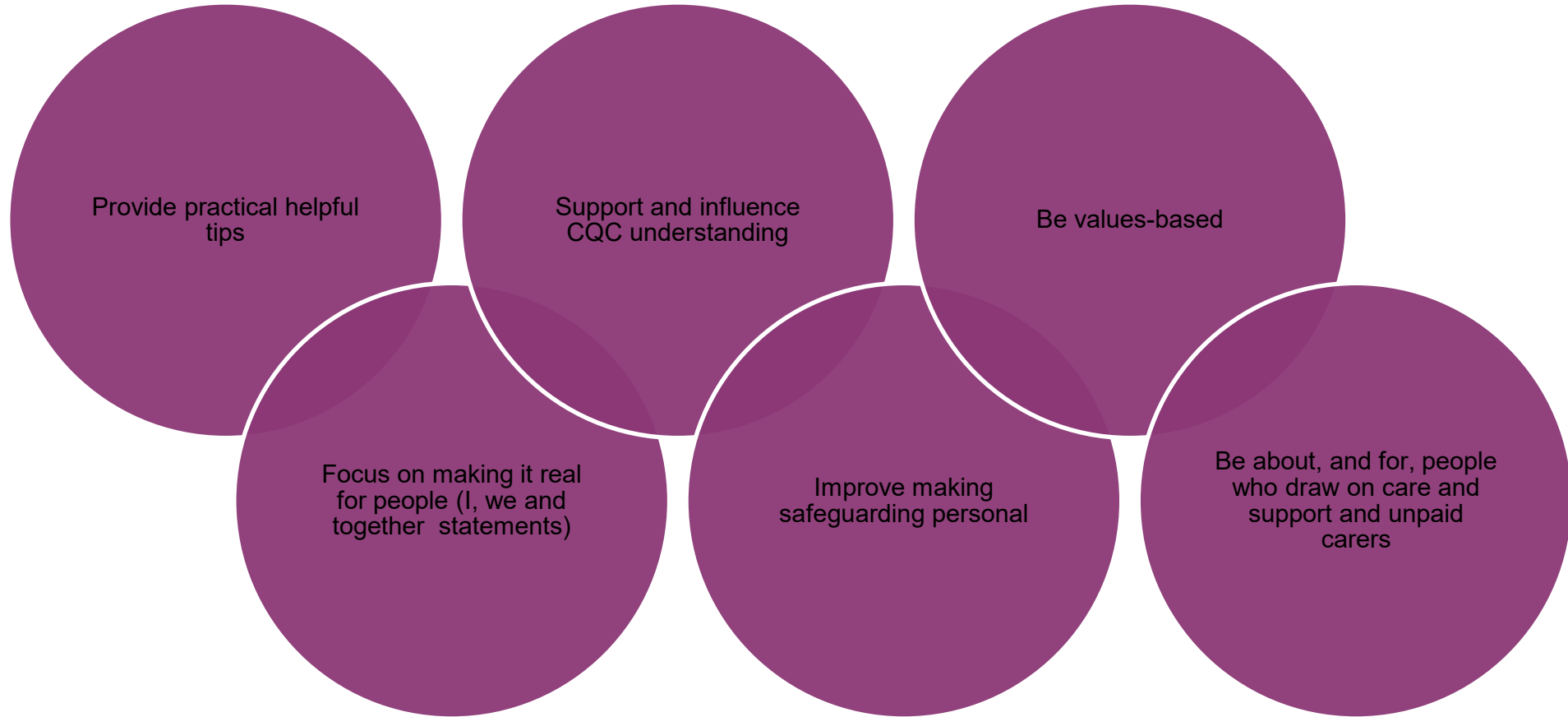
- An online survey, distributed through Partners in Care and Health networks and shared on LinkedIn.
- A working group made up of people from across adult social care including people with lived experience.
- Examples from other research and published evidence in adult social care that help us to know that these are the good changes to make



What Do We Want to Achieve?

- Focus on meaning and purpose in people's lives
 - Use 'I', 'we' and 'together' statements
 - Strengthen capability across the system
 - Support family, friends and unpaid carers
 - Embed equality, diversity and inclusion
- 

What the high impact model should achieve



High Impact Changes

Use ordinary
and positive
language

Align
assessments
with strengths
principles

Co-design
support plans

Create
strengths-
focused working
environments

Strengths-based
leadership

Review and
simplify systems

Build
communities of
practice

Measure what
matters

Sustain change
through learning
loops

Ensure equity in
outcomes and
experien

Change one: ordinary positive language

- **I statement:** I want to be described in words that reflect my life, my choices, and my strengths, not my deficits or challenges.
- **We statement:** We describe people together, using their own words, and avoid labels that limit or define them.
- **Together statement:** Together we replace jargon and deficit-focused language with phrases that recognise abilities, potential, and individuality



Change one: ordinary positive language

- Replace labels such as “challenging” or “non-compliant” with descriptions that people themselves would use.
- Identify labels and descriptions that we need to stop using e.g., “behavioural,” “double handler.”
- Write using the words that feel real to, and about, the person, to describe what is going on with their life. For example, saying “I sometimes forget things and need support to remind me” rather than saying someone has “cognitive decline.”
- Ensure recording is undertaken in a way that can be read by the person. Simplify language and sentences people can read and understand their own records.
- This means thinking about how it is written but also what is said. Professionals should ask themselves the question - how would I feel reading that statement or description, if it was about me?
- Embed culture of challenge and curiosity – this means that people working in adult social care can say if they think someone is not using strengths-based language.



Change two: strengths-based assessment

- **I statement** I can explain what a good day looks like for me and what helps me feel confident and connected.
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- **We statement:** We listen and make sure assessments focus on what matters to people, not just tasks or forms.
-
- **Together statement:** Together we use assessments to understand strengths, not deficits, and plan support that makes sense to the person.



Change two: strengths-based assessment

- Make sure the assessment is relevant and proportionate.
- Strengthen carers' support.
- Consider risk in the context of human rights, rather than just focusing on safety. This may mean having some challenging conversations with other professionals and sometimes family and friends to balance independence and risk.
- Use simple, human questions in assessments to help the person identify their needs.
- Consider the impact of these needs on the persons wellbeing.
- Do not use eligibility criteria to define what needs are. Only apply eligibility criteria after identification of need, and consideration of these on wellbeing to make sure the assessment is strengths-based.
- Ensure IT systems and auto-populated forms reinforce strengths-based language



Change three: codesign support plans with people

- **I statement:** I can tell you what matters to me and what I want to achieve with support.
-
- **We statement:** We work with people to make their goals clear and achievable.
-
- **Together statement:** Together we co-create plans that balance priorities, risks, and opportunities for growth.



Change three: codesign support plans

- Be clear about what the person thinks is important when there are risks involved, particularly if the person might not understand these risks

Include accessible tools for people with communication that support them to have their voice heard.

- Value emotional and psychological safety as highly as physical safety.
- Supportive leadership enables proactive, risk enablement rather than prioritising defensive practice.
- When people are in crisis, or at risk, focusing on getting to know people (relational approaches) and doing some things that might help quickly (timely strengths-based interventions) can make a big difference.
- This can improve both wellbeing but also the level of control a person has over their own life (empowerment).



Change four: environment focused on strengths

- **I statement:** I feel respected and heard when professionals value strengths, inclusion, and reflection.
- **We statement:** We reflect together, celebrate successes, and model strengths-based approaches in all interactions.
- **Together statement:** Together we create an environment where staff and people receiving support learn from each other and grow.



Change four: environment focused on strengths

- Build confidence through both formal training and a learning environment
- Group supervision as well as individual task-focused approaches provides time to think collaboratively about ways of promoting strengths.
- Encourage reflective supervision and take opportunities to consider the lessons learned.
- Celebrate individual stories these act as powerful reminders of what adult social care is about.
- Use funding agreement processes as strengths-based discussions, encouraging early and proactive solution finding. Strengths-based approaches support independence, resilience, and growth.
- Encourage the workforce to be aware of how their presence in someone's life is impacting on this.



Change five: Strengths-based leadership

- **I statement:** I feel respected and heard when leaders value strengths, inclusion, and reflection.
- **We statement:** We reflect together, celebrate successes, and model strengths-based approaches in all interactions.
- **Together statement:** Together we create an environment where staff and people receiving support learn from each other and grow.



Change five: Strengths-based leadership

- Focus on capability as well as capacity. Leadership should support individuals in the workforce to use their strengths and resilience.
- Use language and narrative of strengths, modelled from the top.
- Lots of slight changes can help make changes sustainable in the long term.
- Educate everyone. Set out and model expected behaviours, culture is important and system pressure can impact on how people work
- Focus on supporting strengths-based approaches when thinking about risks, capacity, and safeguarding . Don't prioritise keeping someone safe over independence and autonomy.
- Making sure systems and processes better can make things better for the workforce – but remember, it does not always mean people get better outcomes
- Leaders should explicitly embed equity, inclusion, and cultural awareness.



Change six: Review and simplify systems and tools

- **I statement:** I have an opportunity to feedback on how changes in adult social care are made and my voice makes a difference.
- **We statement:** We learn together through our shared experiences of how to make systems and tools better.
- **Together statement:** Together we make sure that the tools and approaches used by adult social care support our strengths



Change six: Review and simplify systems and tools

- Strengths-based approaches are not a project; they are a way of working - continuous learning and development are essential.
- Challenge planned and actual changes in practice through regular improvement cycles that are informed by people who draw on care and support, family, friends, and unpaid carers, to check if the changes have made a difference.
- Review IT systems and tools to ensure that they capture strengths



Change seven: Build strengths-based communities of practice

- **I statement:** I want to use my connections and community to live a fulfilling life.
- **We statement:** We explore and strengthen the natural networks, relationships, and assets around people.
- **Together statement:** Together we identify resources in the community, from local shops and clubs to voluntary groups, to support people in the ways that matter to them.



Change seven: Build strengths-based communities of practice

- Map community assets and share them via local directories.
- Ensure approaches are culturally relevant, equitable, and accessible to everyone.
- Engage with Strengths-Based Communities of Practice across providers and local authorities.
- Ensure people with lived experience shape and deliver guidance and training.
- Learn from other areas.



Change eight : Measure what matters

- **I statement:** I want to know that my experiences and feedback make a difference.
- **We statement:** We use lived experience to guide improvements, not just metrics or hours.
- **Together statement:** Together we learn from each other and continuously improve the way we support people.



Change eight : Measure what matters

- The number of interactions or conversations does not give an indication of strengths-based approaches, so using a simple count as a key metric will not help ascertain whether approaches are strengths-based.
- Research paid for by the [National Institute for Health and Care Research](#) suggests we should consider views of :
 - People with lived experience / people who draw on social care or social work.
 - Family, friends, and unpaid carers
 - The community
 - The adult social care workforce
 - Timeliness of access to support



Change eight : Measure what matters

- Focus on outcomes that matter: confidence, purpose, relationships, and independence. Include reported measures from people who draw on services, and their family, friends, and unpaid carers on strengths-based outcomes, such as control, achieving goals and wellbeing.
- Replace time and task support measures (for example the number of hours of care or visits per day a person has) with measures of things that make a difference to the person's life (purpose, connection, confidence).
- Include measures of practitioner's confidence and understanding and applying strengths-based approaches.
- Celebrate stories and small changes to sustain strengths-based approaches.



Change nine: Sustain change through learning loops

- **I statement:** My views are routinely sought in understanding how changes are making a difference.
- **We statement:** We will make sure that we seek feedback and insight on how to change and improve from people who draw on care and support as well as other professionals.
- **Together statement:** Together we will understand how changes in the way we work are making a difference to people



Change nine: Sustain change through learning loops

- Continuously challenge planned and actual changes in practice through regular improvement cycles that are informed by people who draw on care and support, family, friends, and unpaid carers, to check if the change has led to improvement for them (note this is also included as part of change six)
- Change and adapt systems and processes regularly, to support strengths-based approaches



Change ten: ensure equity in outcome and experience

- **I statement:** I want to be supported as I am, with my culture, identity, and life experiences respected.
- **We statement:** We recognise and value diversity, seeing it as a strength, not a challenge.
- **Together statement:** Together we work to remove barriers, ensure fair access, and include all voices equally in care and support decisions.



Change ten: ensure equity in outcome and experience

- Embed both strengths-based approaches and strengths-based approaches into every contact with people to improve equity in outcomes and experience.
- Recognise and value people's diversity as a strength not a challenge.
- Remember that equity does not mean treating everyone the same.
- Include prompts for staff to reflect on hidden barriers and systemic inequities.
- Consider how someone's identity and protected characteristics might have impacted on their past and previous experiences - particularly when considering issues such as capacity, safeguarding and risks.



Making it work Using strengths-based assessments

“I,”

“we”

and

“together”

I can explain what a good day looks like for me and what helps me feel confident and connected.

Together we use assessments to understand strengths, not deficits, and plan support that makes sense to the person.

We listen and make sure assessments focus on what matters to people, not just tasks or forms.

A strengths-based assessment should cover:

What a good day does
(or could) look like

Thinking about
solutions not just
problems

Looking at the support
that families, friends,
and communities
provide and how this
can be strengthened.

Making it work Using strengths-based assessments

- Setting goals and being realistic and creative about how they can be achieved
- Needs should be described by the person, with support if needed – these do not need to match the language of the eligibility criteria, and any professional description of need should be strengths-based.
- The impact on wellbeing of meeting the person's needs should also be described by the person themselves, with support if required.
- Only once individual needs and impact on wellbeing have been described should eligibility criteria be considered. Consider using checklists or other tools to determine eligibility to avoid having to use deficit phrasing when determining eligibility.
- Ensure that IT systems that auto populate forms and AI tools are supporting strengths-based language within assessments



Making it work Using strengths-based support planning

“I,”

“we”

and

“together”

I want to be treated as a person, not a system problem, when moving between hospital and home.

Together we make transitions smooth, safe, and centred on what matters to the individual.

We communicate clearly with people and families about choices and plans.



Making it work Using strengths-based support planning

- Talk to the person about what they want to achieve with their support.
- Co-produce the support options that work for the person.
- Consider things that help to increase independence, skills, and confidence.
- Consider structured reablement or enablement interventions (or both) as well as opportunities to develop networks and confidence.
- Offer technology options to further enhance opportunities.
- Work at the pace that is right for the person.
- Use personal budgets and offer self-directed support/direct payments/Individual service funds (ISFs) alongside other types of support



Making it work Using community and asset-based approaches

“I,”

“we”

and

“together”

I want to use my connections and community to live a fulfilling life.

Together we identify resources in the community, from local shops and clubs to voluntary groups, to support people in the ways that matter to them.

We explore and strengthen the natural networks, relationships, and assets around people.



Making it work Using community and asset-based approaches

- Work on the basis that a person just wants to live their life and may need some support to do this.
- Talk to the person about what “living their life” looks like. Really think about the language.
- Think about whole family approaches and the needs of family and friend carers and relatives
- People will have existing connections and relationships that can be strengthened or supported with formal or informal care.
- Join up conversations and do not expect people to understand the difference between health and social care or different parts of the Council (for example housing and social care).
- Community assets are not just social care and voluntary sector organisations, they are hairdressers, local shops and cafés, churches, clubs, allotments, etc.



Making it work Supporting mental capacity and best interests

“I,”

“we”

and

“together”

I want my choices and preferences to be understood and respected, even when risks exist.

Together we work to balance safety, autonomy, and empowerment in a collaborative way.

We use guidance to support decision-making without taking control away from the person.



Making it work Supporting mental capacity and best interests

Capacity

- Recognise that in social care you are continuously assessing capacity – even if this is informally.
- Keep it simple. What is the decision? Does the person understand it? What information will they need to make the decision? Can they understand that information? Can they retain it long enough to use the information to make the decision?
- Embed advocacy and supported decision-making at every stage.
- Break down individual decisions if necessary.
- Do not expect the person to be able to describe care and support needs to demonstrate capacity.



Making it work Supporting mental capacity and best interests

Best Interests

- Be familiar with case law on best interest's decisions.
- Be careful with balance sheets – use these to support not direct decisions.
- Recognise and resist defensive practice. Remember best interest decisions are for and about the person not what professionals would like to see happening.
- Remember the person is strong not vulnerable, see the strengths and build on these



Making it work: Making safeguarding personal

“I,”

“we”

and

“together”

I want my choices and preferences to be understood and respected, even when risks exist.

***Together** we work to balance safety, autonomy, and empowerment in a collaborative way.*

***We** seek the views of the person to understand what outcomes the person wants to achieve from the safeguarding intervention.*



Making it work making safeguarding personal

- The person should be given the opportunity to say what they want (the outcomes) from the safeguarding process if they are willing and able to do this.
- Make time to understand what is going on from the person's perspective. Particularly consider how a person's identity and protected characteristics might have an impact on their experiences and their ability to protect themselves.
- Does the person need someone to help them talk about what they want? Or can a family or friend help them? If not, then advocacy must be considered.
- Just because a person may not understand about keeping themselves safe, what they want should mean as much as if they did understand.
- Supporting the person to be safe is important - but so is making sure they want to be safe.



Making it work making safeguarding personal

- Remember the question posed by Justice Munby: What good is it making someone safer if it merely makes them miserable?.
- Think carefully about how you phrase questions and consider sensitively how you interpret the responses.
- Are there ways of supporting people to avoid or reduce being at risk by doing things to support before a crisis?
- Remember protecting someone is just one of the six important things to make safeguarding personal.
- Use language that makes sense to the person and do not use labels.
- Use these relationships not just to increase engagement but to maximise the person's control.



Making it work making safeguarding personal

- Do not allow external factors or other people's views to override the person's perspective.
- Make sure that checking a person understands what is happening (capacity assessments) support decision making. Do not use capacity as a reason to restrict decisions - use it to help people make decisions
- If a person does understand (has capacity) do not assume that support is not needed.
- Do not walk away if someone says they do not want support but if there are concerns about factors that may be presenting risk. Work with the person to explore and understand how the risks they face can be better managed.



Making it work making safeguarding personal

- Learning to take risks appropriately (e.g. for young people with care and support needs in transition to adulthood) should be personalised and enable people to live safe and happy lives.
- Take what is going on in a person's life, and around them, into account when developing plans.
- Think about what you write about a person – would you be ok reading that about yourself or a family member or friend?
- Make sure that people are included and welcome to take part in meetings about them, with support if needed.



Making it work in hospital discharge

“I,”

“we”

and

“together”

I want to be treated as a person, not a system problem, when moving between hospital and home.

Together we make transitions smooth, safe, and centred on what matters to the individual.

We communicate clearly with people and families about choices and plans.



Make it about the person not the system



Talk to the person in everyday language about what the choices are and what will happen after they get home. Use visual and communication tools for those who need them.



People should be supported in the context of the question “Why not home? Why not today?”



Include family and friends appropriately while keeping the person’s voice central.



Remember that even though a person may not need to remain in a hospital setting they may not feel very well and find making decisions difficult.



Support everyone to have a chance to get better at home with the opportunity for recovery, reablement and rehabilitation. Home is the best place to conduct assessments for long term care.

Making it work in hospital discharge

- We support someone to resume their usual life at home after a spell in hospital. This means always being the person's advocate, considering their capacity to make the right decision and providing appropriate support to manage risk.
- We understand that evidence demonstrates that staying in hospital leads to confusion, a reduction in physical strength and confidence (deconditioning) and loss of independence. This can lead to inappropriate placements in care homes from which people never return home
- We practice advocacy, empathy, and enable people to have choice and control over their lives. In the health setting it is important to help the person be heard and be part of the planning for their care as part of the multi-disciplinary team (or MDT).



Making it work in hospital discharge

- We ensure that advice and decision making support takes into account the persons mental capacity, their choices, their best interests and any safeguarding concerns.
- We provide information, advice and guidance about community support options and other local services, including to people who may fund their own care and support. We provide advice on social care charging arrangements and the financial assessment process.
- We are the link between community social care and the hospital setting. We ensure a proactive, preventative approach to stop people being admitted to hospital when they don't need to be and support safe and timely discharge.



Making it work to support family and friend relationships and unpaid carer roles.

“I,”

“we”

and

“together”

I want to be treated as a person, not a system problem, when moving between hospital and home.

Together we make transitions smooth, safe, and centred on what matters to the individual.

We communicate clearly with people and families about choices and plans.



Making it work to support family and friend relationships and unpaid carer roles

- Take time to listen to what family, friends and unpaid carers have to say as well as the person themselves.
- Treat family, friends, and unpaid carers as an equal partner in care when this is what the person wants – involve them in discussions and decision making alongside the person themselves.
- Use everyday language about what the options are – for themselves as carers (or as family and friends who are not in a caring role) and for the person who may draw on care and support.
- Be clear on when and how things may happen with timescales.



Making it work to support family and friend relationships and unpaid carer roles

- Recognise that emotional responses impact on the perception of how risky something is. To change this perspective, you have to change the way the risk feels, allow time for discussion, reassurance and understanding.
- Use advocacy and other support as needed – particularly if there are differences in the views of the person from those of the family member or friend.



Over to you!

We are really interested in your feedback and how you might use this toolkit.

