2024 - 2026

HARINGEY ADULTS STRENGTHS BASED PRACTICE MANUAL

BETTER OUTCOMES BETTER LIVES

HARINGEY COUNCIL | River Park House, 225 High Road, Wood Green, N22 8HQ
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Strengths-Based Practice Manual

1. Introduction

This practitioner manual has been developed to help practitioners understand their role in our new strengths-based model of practice. Strengths-based practice is not something new. As a standalone social work theory, it came into prominence in the 1980's. Since then, we have seen it present in aspects of new ways of working such as personalisation, direct payments and a focus on keeping people independent and within their own communities. The introduction of the Care Act (2014), although not specifically directing local authorities to use a strengths-based approach, does establish that they must or should perform their care and support functions in a particular way that is not dissimilar to and incorporates the core elements of a strengths-based approach.

In developing our model, we wanted to ensure it had very clear Haringey DNA embedded throughout, a model of strengths-based practice that was designed by our practitioners for our practitioners. This work was led through our pilot strengths-based team who planned, developed and tested the new model of practice while working from a locality-based approach in Tottenham. This work has been supported by Research in Practice who have supported the team in the development of the new model and with it the development of our Head, Heart, Hands philosophy.

This manual is not a paint by numbers approach – it is about getting the mindset, values and behaviours aligned – we want to see creativity and individuality from our workforce in the same way as we want to see each resident represented for who they are not what they are unable to do.

Note: The term resident in this document refer to the resident or their advocate(s)

2. Head, Heart, Hands

Head, Heart, Hands speaks to the way in which we connect and undertake our roles in adult social care. The importance of this approach is that all three need to be aligned to ensure that we are we are mentally, physically and emotionally competent in delivering a true strengths-based intervention. Below outlines how each of these elements directly influence how we undertake our interventions.

Head – **Intellectual knowledge, theory, methods, tools, legal literacy, research.**

Always developing and utilising our knowledge of communities, resources, legislations, policy, theory, research, and experience to aid our work with the people we work with.

Heart – **Emotional connectedness, ethical orientation, relational engagements.**

Approaching all work with empathy, compassion, integrity and commitment. Always prioritising positive, purposeful and genuine relationships with people we work with. Recognising this is our most critical resource in all our work and is highly valued by the people we work with.

Hands – **Application – the action we take. This is shaped by the head and the heart. Requires curiosity, creativity and courage.**

Ensuring that assessments, decisions and practice is guided by both the head and the heart. Taking time to be creative, curious and brave in supporting people to meet their needs and achieve positive change in a way that works for them.

What we know from looking at our practice is that we have been much more process than person driven and that is what we are looking to redress. We must ensure there is a balance in how we approach our roles to better support individuals in achieving their outcomes. In

many cases, we let our head and hands drive the intervention, but the heart must also be ever present to ensure all interventions are based around building positive relationships and are person centred.

The below table shows how the Head, Heart, Hands model can be viewed through values and the behaviours that reflect the ways in which we want to work in a Strengths-Based model.

Value	Behaviours
Open-mindedness	1. Celebrating successes, sharing meaningful moments such as special occasions, personal achievements, or challenges. 2. Using reflective group supervision to develop a culture of learning in which people feel able to step out of their comfort zone and explore different perspectives and approaches to their work. 3. To build psychological safety withing the team, which means people can question practice and learn from each other. 4. Understanding the uniqueness of individuals and avoiding reducing assessments to only that we are familiar with.
Thoughtfulness	1. Taking time to consider things from other perspectives. 2. Making sure we are considering the individual and their specific needs. 3. Using Head, Heart and Hands when working alongside others.
Honesty	1. Telling the truth, being open with information, 2. Being transparent when we can't do something and giving the reasons, 3. Feeling comfortable to say 'I don't know but I will do my best to find out' 4. Being prepared to have frank conversations about difficult sensitive issues including finances, risk and care
Positive Relationships	1. Recognising our relationships with each other and the people we work alongside are at the heart of all our work. 2. Having a genuine interest and regard for one another. 3. Showing empathy
Dependable	1. Feeling able to lean on others for knowledge and experience and willingness to share. 2. Being aware and responding to people when they need support. 3. Feeling comfortable in asking for support. 4. Honouring arrangements and commitments that you have made wherever possible. 5. Sticking with people when required to enable them to grow in confidence and skills.
Originality	1. Being prepared to challenge and disrupt systems or ways of working to consider other options. 2. Being prepared to contribute new ideas. Being creative and using imagination in our work. 3. Sharing and testing out ideas with others around. 4. Inviting and encouraging individuals we work with to contribute ideas to meeting care and support needs.
Empowerment	1. Encourage and motivate each other to achieve. 2. Supporting people to identify their abilities/strengths and potential. 3. Validating and highlighting strengths and potential when we see it.

3. Localities

We are changing the way in which we support our residents from a borough wide approach to a localities model which will split Haringey into three geographical areas (East, Central, West) against which we will then align our workforce. We see this model of working next to communities as an intrinsic element of successful Strengths-Based working. This ensures practitioners feel truly embedded into the areas they work and as such are better connected to the residents, resources, partners and professionals in that locality allowing us to develop positive and meaningful relationships with those we work with.

It is not just the council that is moving to this model but also our strategic partners, including housing, health, voluntary sector and mental health. By working in partnership, we want to ensure we have a simpler, more joined up local system that offers the right support at the right time which manages the growth in demand and reduces duplication in the system. We see the opportunity to work as integrated, multi-disciplinary teams from across the public sector tackling issues holistically, focused on relationship-building and getting to the root causes. This approach will ensure we have a workforce who feel connected to each other and able to work flexibly, better able to meet people's needs with a real strong link into community and voluntary sector organisations.

4. Legal and Ethical Practice

A cornerstone to the work we undertake is ensuring a high level of legal literacy. Practitioners should be confident in their duties and powers which key legislation such as the Care Act 2014, Mental Capacity Act 2005, Mental Health Act 1984, Human Rights Act 1998 have on their interactions and interventions with residents. Having a working knowledge of the legal frameworks in which we operate ensures we are able to make strong defensible decisions. It also allows for practitioners to be able to be more confident in working creatively, understanding ways in which the law can be used to achieve best outcomes for those that we support.

Additionally, it is crucial we recognise that a range of facets of strengths-based way of working are recognised within the legislation that we use, and in fact, speak to best practice in ensuring that our legal duties are being met. There is a fundamental link between the core duty in the Care Act - promote individual wellbeing - and a strengths-based approach. The department of health and social care's Strengths-based approach: Practice Framework and Practice Handbook provides more examples of this. In safeguarding, we are tasked with

Making Safeguarding Personal, very much highlighting the key elements of strengths-based practice by working with the individual to define the outcomes they want. In the Mental Capacity Act, the fourth principle is ensuring any action or decisions that need to be made are done in the person's best interest and the only way to determine that is by understanding the fundamental elements of what makes the residents who they are and therefore what decision they would want for themselves.

Practitioners must feel confident in the legal frameworks in which we operate and we will support you in this by ensuring we have a yearly training program co-facilitated with our legal team around the key elements of our legislative frameworks.

5. Relational Practice

The relationship is the intervention

A fundamental element of successful strengths-based working is the way in which we develop relationships, not just with our residents, but also with our partners. For too long we have been more process than person focused. The system in which we have worked in has prioritised criteria, frameworks and rigidity of practice, interactions led by paperwork not by people. We know that to truly support someone to achieve greater independence and improvements in their quality of life, we have to be able to create positive and open relationships with them. How we work with our residents, how we engage them, listen to them and understand them as individuals is crucial in delivering this. Furthermore, the relationships we develop with our partners are fundamental to delivering best possible outcomes for our residents.

The only way in which we can ensure successful outcomes for those that we support is by truly understanding them as individuals. People are not defined by their disability, diagnoses

or the things they cannot do. We must ensure that our interactions are not deficit based, instead focusing on what is strong, not what is wrong. Each resident we work with will be unique and it is by understanding their past experiences, dreams and aspirations, hobbies, passions, fears, strengths and what a good life for them would be that we get to ensure we are truly person centred in our approach. We will only be able to consistently and effectively meet residents' outcomes by developing positive relationships.

This talks very much to the 'heart' element of our Head, Heart, Hands model; making sure we make meaningful connections with those that we support. Residents need to feel that they are heard when they speak, that their unique experiences in life, what has defined them as individuals, where they wish to be in future and the outcomes they want from their life are central to all interventions and actions that we take. By working in this collaborative way with the resident we significantly increase the likelihood of improving independence and quality of life measures in a meaningful way.

6. Positive Risk Taking

Strengths-based social care promotes 'Positive risk-taking' or 'Risk enablement'. This is the premise that there is risk present in all things that we do and that there are acceptable levels of risk to the activities we undertake, if those activities give us a level of contentment, identity, entertainment or happiness. At times as practitioners we can be too focused on physical wellbeing at the detriment of emotional wellbeing. We must always balance these two elements to ensure neither physical nor emotional wellbeing is significantly outweighed by the other.

This approach will allow us to support people to live their best possible life, working towards achieving their outcomes and maximising their independence, opportunities and quality of

life. The role of practitioners is not to look at removing all risk but to support acceptable risk where there is clear benefit to the individual and how they wish to live their life.

Our roles should be about enabling our residents to maximise their opportunities and to consider their options, including any particular risks associated with an activity or decision that they are making. A strengths-based approach supports us to recognise that there are benefits to risks and that it can lead to positive outcomes in wellbeing for our residents when we work with them to better understand their circumstances and what ultimately brings meaning to their lives.

That said, practitioners must get the balance of risk and reward correct. Practitioners should always be mindful of an individual's Mental Capacity in being able to make these types of decisions and their ability to understand, retain and weigh up the risk. Where practitioners feel there are high levels of risk to an individual and there is a known or suspected impairment or disturbance of the mind or brain, it is the responsibility of the practitioner to ensure that they test the capacity of that individual. It is not sufficient to make an assumption of capacity in these circumstances. Further information can be found in our Mental Capacity Practitioner Manual.

7. Strengths-Based Assessments

The first thing to note about the new strengths-based assessment form is that it is considerably shorter than the assessment form that we have been using. We recognise that this will probably bring both relief and concern in equal measure, as it substantially reduces paperwork but in doing so also removes headings which practitioners have become used to following.

The whole idea of the new assessment is that it is a tool that can be adapted to best fit each resident. It ensures that we are not asking someone questions that have no relevance to their circumstances. It challenges us to be more competent in knowing and applying our own professional standards and the legislation that we operate in. It facilitates a conversation that is driven by the person not a process. It enshrines the principles of person-centred practice. It supports a relational approach to our intervention, ensuring that we see the person. It focuses on giving a true voice to the residents we support, so that we understand them as individuals not as lists of diagnosis and deficits.

However, it is just a tool, and a tool is useless unless it has someone skilled in using it. Some practitioners may adjust quicker than others in utilising the new documentation, but we expect there to be some challenges and time required to adjust for most. With any significant change in practice, we appreciate that it will take time to develop the necessary skills, knowledge and competency to fully utilise the new ways of working. Something we are keen to ensure that we avoid is practitioners rewriting the old assessment onto the new form. It is human nature to revert back to old behaviours, but it is key that our focus is on the person and that they drive the conversation not that we revert back to a way of deficit questioning.

The assessment has been designed so that it can be adapted by the practitioner for the person they are assessing. This means that the same assessment can be used for a preventative assessment, OT assessment or a Care Act assessment. This ensures that we have a consistent strengths-based approach to any of our interventions whether it is light touch or in-depth, dependent on the person and what outcomes they are looking to achieve.

My Story

Getting this part of the assessment correct is essential in ensuring that our interventions are person centred and outcome focused. This is about understanding the resident as an individual, not defining them based on their diagnoses and deficits. That is not to say that

things such as diagnosis and difficulties should not be recorded but it should not define who the person is; it should not be the key theme of how we write about someone.

Your role here is to engage the resident in a discussion that is driven by them so that the information obtained is done so in an organic conversation, be inquisitive as to who the person is that sits opposite you, get to understand what makes them who they are by asking the right questions. If we do not understand what is important to our residents, the journey they have been on, what drives them, their aspirations, their skills and talents, the things they love and the difficult roads that they have walked on, we will not be able to understand who they are and our interventions will be flawed. By encouraging greater thought in this area, it will allow practitioners the ability to effectively plan what alternative provision or support options can be considered to maximise that individual's independence and quality of life.

It is important for practitioners to ensure that this section also provides sufficient evidence in which to support a decision on eligibility as defined in The Care Act 2014. Further evidence and identification of outcomes can be included within the 'Outcomes I Wish to Achieve' and 'Care Act Eligibility' sections but the manager signing off your work must be clearly able to determine how you have come to any conclusion regarding the persons eligibility. For further information relating to the Care Act eligibility click here.

Additionally, practitioners should ensure that any identified risks are also documented within this section. Where there are high levels of risk that require a more robust management plan practitioners should access the standalone risk assessment on Liquid Logic.

My Strengths and Assets

Although this section is separate from My Story, we see these being intrinsically linked. Without having had the right type of discussions within the previous section you will not be able to populate this one. This is not about simply asking someone what their strengths are. If someone were to ask you what your strengths are, you may find this hard to quantify. This

is why it is so important to craft a conversation with the individual that allows them to naturally highlight the aspects of their lives that are seen as positive and where their internal and external strengths lie.

One of our core principles in adult social care is in improving independence and quality of life for our residents by building on the strengths that they already have. These can present themselves through a variety of forms such as skills, knowledge, personality traits, independence, health, family, friends, local connections, hobbies, accommodation, training, education and aspirations to name just a few. Understanding where strengths are present ensures we can build from solid foundations and significantly improve outcomes by ensuring that interventions and solutions are centred around assets and opportunity.

To support you in developing the right kind of questions to ask during your discussions with residents, we have a list of 50 strengths-based questions (appendix 1) you can refer to. These will help you to better engage with those we support moving away from deficit-based questions with a real focus on the individual and their strengths, independence and quality of life.

Wellbeing Scale

The inclusion of a wellbeing score gives us a greater focus on the effectiveness of our interventions for those that we support. This will help us to track the impact of what we do by getting the resident to score themselves when we first start working with them and then rescoring them at the review stage(s). This will ensure that we can clearly track the impact of the interventions and subsequent actions that are being undertaken by other agencies and/or commissioned services.

This will also make sure at the review stage that we are able to clearly identify reductions in wellbeing and respond accordingly. This might be the need to refocus the outcomes of the support being provided, adjust what is in place or adding something completely new so that

we can work with the resident to move their score upwards again to ensure that their outcomes are being met.

Additionally, this will also allow us to identify trends or reoccurring issues that are being experienced by residents. We are aware that residents' wellbeing may be impacted by a range of factors, some of which will be outside of the control of adult social services. This will help us to look systemically as a service at the issues being encountered by residents and allow us to tackle these at a borough level on issues such as poverty, housing, health outcomes etc.

Practitioners should use the scoring as prompts to ask and understand how the person perceives their wellbeing and crucially ask them how these scores could be improved. If someone scores themselves a 3, we want to know what would move that score upwards towards a 10. These discussions should be recorded in the 'Outcomes I wish to achieve section' and form a basis for the support plans completed.

Outcomes I wish to achieve

If the conversation with the resident has been done in the ways highlighted above, you should have clearly identified outcomes for what the person wants to be able to achieve. It is important that we articulate these views as expressed by the person that we are supporting. Capturing why it is important to them or the specifics of what they are looking to achieve is vital in ensuring that the outcomes are truly person centred. If we can understand what the outcomes mean to the resident, then we are better placed to help them to achieve them. What we must avoid is generic outcomes that are based on meeting need which lack any sense of the resident's own voice.

This section also provides the opportunity in which to explore with the resident how those outcomes could be met by pulling on their strengths and assets. It is a fundamental part of the new way of working for us to consider how outcomes could be met through creative

collaboration. We expect all practitioners to firstly consider the residents internal and external pool of strengths in which to meet those outcomes. Having considered these you may need to think about other means in which to support those outcomes to be met. First practitioners must consider the use of Assistive Technology, aids/equipment/adaptations, voluntary and community resources.

Next Steps

Next Steps should outline what actions are required either by the practitioner, resident or partners in ensuring outcomes can be met. Even if the individual we are supporting does not meet the criteria for statutory support as defined under the Care Act 2014, practitioners must provide information and advice to the resident to support them in achieving the outcomes they have set out. Our role is to support the independence and quality of life of our residents, regardless of their eligibility for services; we must think preventatively with everyone we engage with. Thinking holistically also means thinking how we support those who might not be eligible for services still get the right type of support from community and universal services. This helps to maintain their wellbeing and independence and is preventative. It is therefore crucial that practitioners consider all available options for residents that can support them in achieving outcomes, maintaining independence, increasing their quality of life and having a positive impact on their wellbeing.

Care Act Eligibility

Where assessments are being done to determine the eligibility of someone under the Care Act this section must be completed to show if the criteria have been met. You will note that there are no headings through this document that talk to the 3 criteria (shown below), with the expectation that practitioners will have a detailed knowledge of the Act and are able to obtain the required information to be able to make clear decisions on the resident’s eligibility.

1. The adult's needs arise from or are related to a physical or mental impairment or illness.
2. As a result of the adult's needs the adult is unable to achieve 2 or more of the specified outcomes (which are described in the guidance below).
3. As a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing.

8. Outcome-Based Support Planning

Completed support plans must ensure that they are person centred and individualised to the resident that they relate to. This is about working with the person to define meaningful and realistic aspirations that will have a positive impact on their wellbeing. Support plans should clearly define the outcome, timeframe, how it will be met through their strengths, progress and actions. Please refer to the Outcome Based Support Planning Practitioner Manual for a full overview as to how these should be completed.

9. Strength-Based Reviews

The review process is fundamental to ensure we have oversight of current support arrangements, particularly those of commissioned care services. The review allows us to work with the resident to understand any changes to their current circumstances, what has worked well and areas that need focus moving forward. Ensuring that we have clear outcomes determined for each review period is essential so that we can hold individuals and organisations accountable in ensuring that outcomes are met. Reviews should not be a passive tick box exercise but an opportunity to really explore with the individual as to what is working, what needs to change and what are new outcomes that they would like to achieve.

My Story

This is the same section that we have within the assessment, and this will pull through into each review. However, the first type of these reviews that are done for people already known to the service will be blank. As such, reviewers must ensure that this is populated in the same way it would be done in the assessment (see section 6) following the same principles.

For those reviews that are being done where there is a well developed 'My Story' section, it is still important to look at how we can add to this. People's lives do not remain static and similarly it will be important to ensure that key elements are added to this section at each review. It is also important to note that people's views and priorities may shift which will require the section to be updated, so please make sure you are taking the time with the person at the review to update this section as required.

This section, if well documented, will be hugely beneficial for practitioners when going out to see someone for the first time. It should provide a clear picture of the resident's motivations, aspirations, passions, hobbies achievements, challenges and strengths. If this section does not provide this, it is your responsibility to ensure that we obtain as much of the information relating to the individual as possible so that it fully reflects the individual we are supporting.

My Current View

This provides an opportunity for the resident to provide a general overview of how things have progressed since their assessment or last review. Practitioners should approach these discussions in the same ways as highlighted through this manual by being person centred and strengths-based and allowing the resident to lead the discussion. This should provide a good overview of their current events, success and challenges during this period and help the practitioner to understand any changes that may be required to better ensure outcomes are met moving forward.

Summary of Actions by Next Review

At this point of the review, the resident will have provided a clear view as to the things that have worked as well as the areas that need greater focus moving forward. This section is therefore crucial in determining what actions are required before the next review to ensure that progress continues to be made. You should work with the resident to define what needs to change, what actions are needed and who needs to do what so that we continue to see improvements to the resident's independence and quality of life. This is essential so that we put in place clear expectations of the individual, their network, commissioned services and partner organisations. Holding people and organisations accountable for what needs to be done is key and by doing so provides clarity for anyone looking at the review as to what actions are to be done. These may be very small changes to day-to-day support that improves the experience for the resident or may be fundamental changes in how the support hours are used or referrals or activities that need to take place. Practitioners should always refer to the previous defined outcomes at any review to confirm actions have been taken and if not a reason as to why. We must make sure that this section is given sufficient thought and is detailed, otherwise the effectiveness of achieving the resident's outcomes will be significantly diminished.

Wellbeing Score

The wellbeing score allows the resident to score their wellbeing at every review, with the most recent previous score from either their assessment or review being pulled through so that we have a comparison. This section allows us to track progress that the individual is making in meeting outcomes in the 4 key areas (independence, connection to community, social interaction and contentedness); allowing us to see how effective any of the planned actions had been in improving their overall wellbeing and if not why and what changes need to be made. This also supports the conversation as to helping residents identify the areas of

their life that they would like to improve and being able to identify what a good outcome for them would be.

Support Plan

Practitioners must ensure that any changes to the current support arrangements, including amendments to already existing outcomes must be updated within the support plan itself. The support plan must reflect the current arrangements that are in place and as progress is made in achieving outcomes, we will need to ensure these are tweaked, redefined or new aspects included that reflect the ongoing work being done.

10.Strength-Based Standards

We have developed a set of Strength-Based Standards that will support practitioners in understanding the expectations of them within the new role and provide clarity as to the way in which we see this model being effectively delivered. We will look to evidence this as part of your My Conversation to look at areas in which your practice is strong and areas that may require further development

- **Person-Centred** – Do we understand the person as an individual, as a person not as a diagnosis. Seeing what is strong not what's wrong. The support must fit the person not the other way around
- **Creative** – Must be able to think differently in how we support individuals (maximising community, family and individual strengths, reablement, AT, Aids and adaptations etc).
- **Flexible** – Must be able to adapt their intervention, conversation and approach to fit the individual they are supporting. Must be willing to work in a different way and in different models.

- **Outcome focused** – Must work with the individuals to define their outcomes. Must ensure we support people to gain greater independence and improve their quality of life.
- **Positive approach to risk** – Must be able to see risk as something that can support greater wellbeing. Our role is not to just reduce risk but to manage it and see it as an enabler.
- **Build and maintain positive relationships** – Relationships are the intervention. All strengths-based work is based on a relational approach to practice- staff must be given time to develop these relationships to ensure better outcomes.
- **Collaborative** – We must work with individuals in helping them to define their own outcomes and how these can be achieved. We must also foster collaborative relationships with our partners
- **Preventative** – Does the intervention ensure a holistic approach to the individual's needs, getting to the root cause and stopping or delaying the need for further or future input from services
- **Local Resource Knowledge** – We expect all practitioners to be embedded into their locality with a detailed knowledge of the local resources available to residents.
- **Resource responsibility** – Practitioners will be given greater autonomy around the commissioning of care but must ensure this responsibility is understood.
- **Strong legal literacy** – Practitioners need to be confident on their knowledge of the legislation, their roles, duties and powers without having to use scripted documentation.

11.Strength-Based Resources

Assistive Technology

Assistive Technology (AT) refers to devices or systems that help maintain or improve a person’s ability to do things in everyday life. We see Assistive Technology as a key tool in our strengths-based way of working.

Evidence shows that Assistive Technology can:

- Prevent the escalation of need and promote independence for adults with care and support needs.
- Act as an enabler for greater independence at home.
- Provide assurance and reduce stress for carers and families.
- Facilitate social connection.
- Less intrusive care for people living in supported living facilities and residential care, as well as those living at home.
- It allows us to identify and understand care needs, so better wrap around care can be put into place.
- Allows better information to help identify risks and issues earlier so prevent issues arising.
- Provide opportunities for efficiency savings.

Our Connected Care Service provides a range of support and expertise that can help you to identify the most appropriate devices for people. During office hours, there are specialist Assessors to identify appropriate equipment; and Technicians to install and ensure the equipment is working and residents and carers know how it works. The service receives referrals from a wide network including health and social care professionals, care agencies, the community and voluntary sector, and family members and friends. One of the key aspects

of the service is that it provides a 24 hour, 365 days a year emergency quick response if there is an emergency triggered in the home or when people are in the community.

The service is available to people of all ages who may feel vulnerable, unsafe or need support in their home or their community. This can include older people, those with physical, sensory or learning disabilities or at risk of falling, unwell or patients who have recently left hospital. In fact, anyone that may need support to live independently and safely.

We are working with people to understand what is important to them, what they may need and what role technology can play in meeting that. We are then exploring the market to identify new products that might meet that need and welcome discussions to help build understanding so can source suitable options.

Further information on the service can be found here.

AT Awareness Workshop and Case study information can be found on the learning platform here.

Aids and Adaptations

A fundamental support mechanism to enable people to live more independently is the utilisation of aids and adaptations within the home. Just one piece of equipment can be hugely significant in transforming a daily living task from being unachievable to achievable.

Occupational Therapists and to a lesser degree Trusted Assessors, can undertake assessments and provide aids and adaptations for individuals, which in turn supports them to live more independently. A simple aid is a piece of equipment that helps an individual manage everyday tasks at home, such as eating, getting out of bed or visiting the toilet, which will increase their independence.

Minor adaptations such as a grab rail, stair rail, chair raise and step alterations or major adaptations such as a stairlift, ramp for a wheelchair or level access shower are all can also be recommended following an assessment. More information can be found here.

Direct Payments

Direct Payments (DP) are the preferred choice for provision of community-based care in Haringey. This will enhance choice, control and independence of residents, as much as possible. This means:

- Introducing the idea of DP to residents and their families at the earliest opportunity.
- Discussing with residents that DP are a good way to be flexible and creative when managing their care.
- Considering a mixed package i.e. part DP, part council managed service, where this better meets needs, or the resident needs time to adjust to the responsibility of managing a DP.
- Recommending a pre-paid card or if they will be employing a personal (care) assistant, a Managed Account to ease the financial management and reduce the manual audit process of the payment.
- Referring residents to the peer-based Direct Payments Support Service, provided by Disability Action Haringey (DAH), for comprehensive advice and support on Direct Payments to potential, new and existing DP clients.

While this is the preferred option, it is always the resident's choice if they want to have a direct payment. We must also be satisfied that the resident understands what it involves and that the way they choose to use the money will meet their needs and achieve the agreed outcomes as stated in their support plan.

The Council has commissioned Disability Action Haringey (DAH) to deliver peer-based Direct Payment Support Services and to develop Haringey's Personal (care) Assistant market. DAH provides comprehensive advice and support on Direct Payments via an Independent Living Advisor and peer support to potential, new and existing DP holders. The service can help people gain an understanding of what Direct Payments are and how they can increase independence, choice and control over care needs, including helping people to think creatively about how best to meet their identified care and support outcomes. DAH also offer advice and support about the employment of a personal (care) assistant, including support to recruit via Find-a-pa.

Referrals for advice and support can be made by creating and completing the DAH Referral Form directly from the Documents screen in Mosaic and emailing the downloaded form to **referrral@d-a-h.org**.

DAH also accept self-referrals via telephone on 020 3355 0071 or via email info@d-a-h.org.

Community and Voluntary Resources

Key to supporting residents in accomplishing their outcomes will be in maximising the community and voluntary resources that residents can connect to. These can be a wide range of options (a list of some of these is provided below) and should always be considered before any commissioned service is provided by the local authority. Residents being connected into their local resources will provide connectivity for residents in their communities helping to build social capital.

Community Resources:

- Leisure Centres
- Libraries
- Coffee mornings

- Religious centre activities
- Sports clubs (bowling, football, tennis, rock climbing)
- Arts and Crafts
- Theatre Groups
- Dance Fitness
- Music
- Gardening and Growing
- Luncheon Clubs
- Dating
- Cycling
- Walking Groups
- Employment Support
- Colleges
- Volunteering
- Choirs
- Language courses
- Cultural Groups
- Befriending

To help practitioners in finding local community resources we have Haricare. Haricare is a website where you can find services, support, products and activities in Haringey and other forms of advice and information for adults who are elderly, have disabilities or long-term illness, and their families and carers. It has information about free or low-cost services. However, we do recognise that although this is a helpful tool there are a large number of resources in the community that we do not currently have on our system. As such, we need to ensure, when we identify any new or unreported community resource, we share this information with Haricare. Please identify any new or missing resources to Andrew, via andrew.tempest@haringey.gov.uk. A feature as we move into localities is having a detailed

knowledge of the local picture, it's people and resources and as such we must make sure that any community provisions are effectively promoted and accessible.

Work or Education

Dependent on the age of the resident we should always consider meaningful education or work opportunities as a way of meeting outcomes and improving quality of life. Work and education not only provide us with identity, self-worth and meaning but it allows us to have a certain quality of life through disposable income. Our role is to ensure that society does not disable those that we support and that they are afforded the same opportunities as everyone else. Disability or illness should not prevent our residents in bettering their current circumstances and creating a life that they are proud to live and contribute back to society. Always ensure that in the discussions we have with those that we support we explore how we can support them into education and employment.

Partnership working

Haringey is committed to ensuring that we have a systems approach to supporting our residents and as such utilising the expertise of our partners will be crucial. We should ensure that with any of our interventions with residents, we look at being as holistic as possible and identifying areas where we, and our partners, can support to achieve positive outcomes. Our role is to ensure we join the dots and make the right connections into internal and external partners.

Locality working will strengthen our ability to better understand our partners, develop positive working relationships and allow us to work more seamlessly in responding to the

needs of our residents. Our ability to work in close proximity to colleagues from health, mental health, housing, connected communities, reach and connect, housing, DWP and social prescribing will lead to more effective working and better outcomes.

12.Training & Support

We recognise that to fully embed and maximise this as a truly effective model of social care practice, we need to make sure that you as practitioners have every opportunity to develop your skills, knowledge, behaviours and values. In helping you to do this, our own internal training program will align itself to this new model of working. This will include training on Head, Heart, Hands, motivational interviewing, legal and ethical literacy, positive risk taking, courageous conversations, outcome-based support planning, making every contact count and unconscious bias. However, working in partnership with you, we want to continue to identify areas of practice that would benefit from commissioning training; so we would welcome any suggestions that you have as to what could further support your development.

Additionally, we have a range of other support mechanisms (listed below) that will help you both in self-directed learning and learning from peers. We also want to ensure that this model continues to be developed by you as practitioners and such would welcome your continued input at our social care forums.

Social Care Forums: These are regular meetings held every other Tuesday and provides an opportunity to discuss the issues that matter to you as practitioners and to look at ways in which we can improve practice and service delivery. Given the huge changes that adult social care in Haringey is undergoing, we need to make sure we have a unified voice so that we influence what these changes are. The forums are open to all to attend and are focused on areas in which we can improve practice and service delivery which will then be raised with

Senior Management and feedback provided at the next Forum. If you do not have this invite in your calendar, please contact christopher.atherton@hariney.gov.uk.

Workshops: Internal workshops are delivered to help support practitioners to look at specific practice areas in more depth and to allow discussion on how this impacts on practice. Practitioners are encouraged to recommend topic areas they would like to cover which will be delivered by the Principal Social Worker (Chris Atherton) and can look at a range of theoretical, legislative or practice related topics.

Case discussion: This is open to all practitioners every other Thursday who wish to bring any cases that they are working on but having difficulties in progressing. This is a supportive and reflective environment in which other practitioners will support each other in discussing the case and looking at ways in which outcomes can be met and how we can utilise a strengths-based approach to our practice. These sessions are really beneficial in helping to share knowledge, experience and good practice. If you do not have this invite in your calendar, please contact christopher.atherton@hariney.gov.uk.

Community Care Inform: Our membership gives all members of staff access to the latest research, legal rulings and good practice guides. The guides are designed to be easy to read and understand. Information is available when you want it and tailored to how you need it. There are also quick guides, for example, work as well on mobile so you can use them while on the move or before visiting a resident. If you do not have a login contact christopher.atherton@haringey.gov.uk.

North London Social Work Teaching Partnership: The Partnership is made up of six local authorities: Barnet, Camden, Enfield, Hackney, Haringey and Islington Councils, the charity Norwood and Middlesex University**.** This working partnership provides an array of benefits which can be found at www.northlondonsocialwork.co.uk and also includes flexible sessions

which are delivered as a webinar or as an interactive session dependant on the learning needs.

13. Strength-Based Working FAQ's

Why have the Care Act 2014 outcome domains been removed from the assessment form?

The Care Act 2014 sets the threshold which local authorities must meet to comply with the eligibility criteria for adults or carers needing care and support. Practitioners must be familiar with these outcome domains during assessments, but the Act does not confine a conversation to them. In line with strengths-based practice, this should promote a more open conversation led by the person so that they could share their own desired outcomes. Further info: www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/definition-outcomes

Will not having fewer questions and prompts in forms result in practitioners missing out vital information and putting the person at risk?

A good practitioner should be able to complete a holistic assessment without a guided form. When a practitioner writes an assessment, a manager's role includes checking and approving it and practitioners are also supposed to share the assessment/support plan with the person and/or their carer/s, so any missing information or changes should be made before it is completed. Having stripped back the assessment form to 7 pages, the more questions or prompts we add to the forms, the less open the conversation will be which is counterproductive to a strengths-based approach.

How can we be creative about support planning without knowing what is available in Haringey?

Knowing 'what's out there' is crucial in maximising assets within the community. Practitioners are encouraged to explore local resources through support via supervision, team meetings

and various case discussion forums that take place in Haringey. We are currently updating Haricare, which already has a catalogue of various services available to Haringey residents which practitioners can refer to: https://haricare.haringey.gov.uk/

Is strengths-based working just about saving money?

Strengths-based work does produce savings, a lot of the time - but it is not a cost cutting exercise itself. A strengths-based approach diverts our attention to developing a more meaningful conversation, by support planning in a more a person-centred way and by giving practitioners more time to work with the person on outcomes that matter to them. This should, inevitably, have an impact on savings as the model draws on individual and community strengths and creative support planning.

What support will I get to adopt a more strengths-based way of working?

Haringey have been working with Research in Practice to support practitioners develop a strengths-based approach. There have already been numerous presentations and workshops around the Head, Heart, Hands model as well as legal and ethical literacy in Strengths-Based practice in the last 12 months. Research in Practice have also worked closely with the Tottenham Strengths-Based Team, who delivered interactive presentations during 2021 to practitioners and managers – the recording of these are available upon request.

Your manager, during supervision and when providing you feedback regarding the assessments/support plans you submit, will also play a vital role in supporting you understand this approach.

Can I use prompt questions during an assessment?

Practitioners may want to use a set of prompt questions during an assessment, which can be helpful in motivating a person to engage in a conversation. However, if practitioners regularly

use the same or similar prompt questions, this disregards the aim of allowing the person to tell his/her own story and for each conversation to be unique.

How does strengths-based work with people who lack mental capacity?

As per the principles of the Mental Capacity Act 2005, practitioners should be creative in trying to ascertain the person's wishes about how s/he would like to receive care and support. A best interest decision would be needed when a person lacks mental capacity. In this instance, it would be equally important to find out about the person's story, strengths and wishes from the his/her support network.

Practitioners do not have enough time to 'look around' for what is out there, so how can we get support plans completed within 28 days?

Practitioners should aim to complete assessments/support plans within 28 days. However, there is an expectation in the coming months that managers will spend more time providing practitioners feedback on their work, as part of promoting a strengths-based approach which may add to the time it takes practitioners to complete work. We also expect practitioners to spend more time being creative with support planning and exploring different options in the community. Any delay in the 28-day period will need to be discussed with your manager on a case-by-case basis.

Does focusing on strengths mean ignoring the risks related to a person's care and support?

A strengths-based approach is not about ignoring risk. It is about not ignoring what the person can do, their potential and tapping into their immediate assets for 'solutions'.

How can I get involved in developing strengths-based practice?

Before the new strengths-based forms are officially rolled out to all teams, we have asked respective team managers to recommend practitioners who want to test out the forms with

their current cases. This includes the strengths-based assessment, support plan and review form as well as the strengths-based carer's assessment and support plan form. Practitioners trying out the new forms during this pilot period will be crucial in providing feedback to their managers and teams. If you would like to be involved in this testing phase, please speak to your manager.