A THEORY OF CHANGE FOR 'THE THREE CONVERSATIONS'

Care Policy and Evaluation Centre (CPEC) Summary

1 Introduction

The Three Conversations (3Cs) is a strengths and relationships-based approach to providing services that work collaboratively with people seeking support. 'Strengths' or 'asset-based' approaches, rather than focussing on what is lacking, set out to recognise the strengths in individuals, those around them, and their communities, to support people to be independent, and focus services where they are most needed. There is little research on how strengths-based approaches are operating in practice, or what the impacts are. Our research set out to understand how 3Cs is experienced, by both practitioners and by people seeking and receiving support, and to work out what factors need to be considered when trying to find out if the approach is effective.

Reading time:

15 - 20 minutes

Who is this for:

Anyone concerned with planning and monitoring implementation of 3Cs

Contents:

2 How is 3Cs meant to work?

An important aim of 3Cs is to avoid lengthy assessments of needs. Instead, the intention is for a series of 'Conversations' to take place. 'Conversations' are really stages, so can involve several contacts:

Conversation 1: 'Listening and making a connection', not assessing whether people qualify for services.

Conversation 2: 'Working intensively with people in crisis', working in partnership to put together an 'emergency plan' and sticking with people to make that plan work.

Conversation 3: (only when the preceding two stages are exhausted) 'Build a good life', discussing longer-term support needs, and desired outcomes.

3 The 3Cs Rules

3Cs is promoted by the organisation Partners4Change who set out the following rules that govern 3Cs:

1. Abandon assessment for services as our 'offer of value' for ever
2. Always start conversations with the assets and strengths of people, families and communities.
3. Always exhaust Conversations 1 and 2 before having Conversation 3, and test this out with colleagues.
4. Never plan long term in a crisis.
5. Stick to people like glue during Conversation 2: there is nothing more important than supporting someone to regain control of their life.
6. No hand-offs, no referrals, no triage, no waiting lists.
7. We are not the experts – people and families are.
8. Know about the neighbourhoods and communities that people are living in.
9. Always work collaboratively with other members of the community support system.

4 The Theory of Change

The Theory of Change represents our analysis of what stakeholders contributing to this research (Adult Social Care staff including front-line practitioners and managers; people who use services and carers; voluntary sector) have told us about how 3Cs works, or could work, in practice, and what is, or could be, achieved at each step. The Theory of Change can be used to assess whether key features of the approach are in place, and therefore whether any evaluation is able to comment on the effectiveness of 3Cs. It can also be used when planning and monitoring implementation.

The Outcomes in the 'Activities and Outcomes' diagram can be assessed to review whether 3Cs is working as intended. The diagram shows, on the right, how each outcome needs to be achieved for the next step to work. On the left are the Activities needed to make these Outcomes happen. Other components included in the Theory of Change are Rationale, Assumptions and Indicators.

RATIONALE

These are the key rationales underlying the theory of why 3Cs should work:

1	By addressing needs and crises early, tailoring support better to people's lives and drawing on existing strengths, in the person and their networks, you can make more effective use of limited resources, reducing unnecessary dependency on services and calls on other services in the future.
2	Relationship-building leads to better communication, shared understanding and engagement, resulting in better outcomes for people and systems.

ACTIVITIES

Overarching: Frontline staff and managers exercise agency to respond to people's circumstances *see box below

Admin systems, esp. record-keeping, are reviewed/ revised to be proportionate and support strengths-based practice

Management take an enabling, trusting and listening approach

Teams work together with other teams/ sectors to develop shared ethos and approach

Staff build relationships and enhance trust through: quick responses (short wait times); helpful first-person answering call; no initial formal assessment of needs/ eligibility; listening and understanding

Highlighting people's strengths; acknowledging preferences and wishes; understanding social networks and sources of support; creatively co-developing solutions

Checking back with people; keeping in touch where needed; keeping people informed

Keeping knowledge/ directories about community sector updated and relationships supported

Linking people to appropriate and available support in the community, taking account of their existing and previous contacts and connections

Staff work intensively with people and their support networks during crises, and are contactable

Plans put in place during a crisis are flagged as short-term, and reviewed, not left open

As needed, longer-term, shared plans in place; clear understanding of review processes

*** Key overarching activities include:**

- Jointly problem-solving, consulting, advising, e.g. develop and share practice skills and ideas (through "Huddles", peer support, mentoring, training; refection; relationships)
- Seeking creative solutions and trying new things
- Bringing in other support as needed, not "handover"
- Independently authorising spending to speed good responses

OUTCOMES

STAFF AND MANAGEMENT

Staff are proactive and skilled in their strength-based practice

Staff spend more time with people and less on paperwork

Staff feel satisfied, empowered and supported to practice in a proactive, strengths-based, creative and collegial way

Teams communicate around shared ethos and put in necessary supports and solutions

PEOPLE USING SERVICES AND CARERS

People, including carers, feel listened to and supported. They know who to contact

People and their informal support networks connect with practitioners in identifying strengths and what is important to them and developing approaches to supporting wellbeing. They feel empowered

COMMUNITIES

Staff know about available community resources; Community assets are available and sustained (not overburdened)

People, including carers, use community assets to support their wellbeing; People feel connected to communities

INTERMEDIATE OUTCOMES

Crises are stabilised and people feel better able to avoid or deal with future crises

Support, interventions, aids and adaptations are in place to address current difficulties, and/or prevent future needs

LONGER-TERM OUTCOMES

People live their lives in a place and way that suits them

Best use made of adult social care and broader resources; there is less demand for health and social care services

IMPACT
Improved health and wellbeing of people in better-connected communities

ASSUMPTIONS

The following are assumed to be in place for 3Cs to work:

1	There is a consensus, including among senior management, that previous performance-management-based systems are not working and a new approach is needed.
2	Community resources exist, and can be sustained, supported and made use of (i.e. they can meet demand).
3	Carers are not overburdened.
4	Current IT systems can support the changes needed.
5	'Paperwork'/documentation that is needed to communicate/arrange resources/intervention within teams and with other teams/services/sites are in place (kept or replaced) e.g. staff can access the information they need to take a role with the person seeking support.
6	Other teams/sectors are on board (e.g. because they were included in initial discussions) (e.g. brokerage, commissioning, NHS, and housing services). They share the ethos and do not create barriers to implementation (e.g. by requiring Assessment, or giving people seeking support different expectations).
7	The process is compliant with legal frameworks and staff understand this.
8	The process does not affect people's rights to formal assessment and support; formal assessments can be conducted if people wish.
9	New staff members are trained, informed and mentored to support working effectively within the approach, with reflective support as they develop their 3Cs practice.
10	Everyone has equal access to support from Adult Social Care.

INDICATORS

Indicators can be collected in relation to the five areas of outcomes:

Staff and management

People using services and carers

Community

Intermediate outcomes

Longer-term outcomes

Example indicators related to each outcome are in Appendix 1.

Indicators can be collected using surveys; conversations; feedback/complaint systems; audits; and routine data collection systems.

To support meaningful evaluation a broad set of Outcome Indicators can be considered alongside key metrics such as 'Conversion rate' (reductions in proportion of people coming to adult social care who receive Long Term Care packages) and 'Returners rate', that is, the proportion of people whose contact with adult social care ends, that return within a given period (such as 3 months, 1 year).

5 Danger areas

Major danger areas where there appeared to be divergence from the approach represented in the Theory of Change in case study sites were:

1. The time spent 'Paperwork'/documentation is widely perceived not to have reduced; staff are completing parallel sets of documentation in some cases – pre-3Cs documentation (e.g. case notes) and the new Conversations documentation
2. Managers, including team managers, did not always support the ethos and may not be sufficiently supported to work in a listening, trusting, and strengths-based way themselves
3. Huddles and reflection meetings do not always continue and the reflective process around new and creative ways of working gets lost
4. Frontline staff and team managers' ability to make spending decisions (to support quick responses and creative, person-centred practice) did not continue. (In some cases these were later reintroduced)
5. Quick responses to people seeking support often did not happen (however some teams did make this work, getting rid of waiting lists)
6. There can be reluctance to give out practitioner contact details to people seeking support, or using services, leading to waste of time and effort when people have to go back to initial contact centres, and undermining relationships
7. Performance management targets may continue to create perverse incentives (e.g. pressure to close Conversation 1s; pressure to close cases/refer instead of keeping overview/checking back)
8. Lack of staff time can lead to Conversation 2s being left open longer than necessary, sometimes resulting in high spend on care support where no eligibility assessment has taken place
9. Initial work on 'directories' of local support was not maintained and/or not made available to communities
10. 'Checking back' on whether support was working out often did not happen, particularly at Conversation 1 phase.

The context in which the research was carried out in 2021-2023 should be noted.
Austerity policies, the Covid-19 pandemic and other socioeconomic and political developments meant the research took place during a time of growing constraints on Adult Social Care budgets at the same time as increasing levels of need in the community, increasing demand for services, increasing difficulty in filling staff vacancies and, during part of the research period, the closure of many voluntary and community sector services.

6 Findings from people who use services and carers

We spoke to individuals who had had contact with services in study sites, carers' organisations and our public advisory group, and convened focus groups with people who use adult social care services and carers, to find out about what processes and outcomes are of key importance for people in contact with adult social care. These informed the Theory of Change. In addition, we summarise key points below.

People are satisfied with adult social care when:

a) They've been heard and understood; no one has been rude or dismissive to them; staff have been responsive and competent

b) Sufficient support has been agreed and is in place; their current situation is manageable

c) They are not too anxious about the future, including about the sustainability of their current financial situation

d) They feel they have some control over their circumstances (this often involves continuing to manage difficult, demanding situations themselves)

People are dissatisfied with adult social care when:

Information and contact

a) They get very little information about who is working with them, what is happening and what they can expect next;

b) They have to repeatedly call the switchboard, repeatedly re-tell their story and are not able to directly speak to someone who knows about their situation;

c) They cannot easily find out how the system works or what their rights and entitlement are

Waiting

d) They spend a lot of time waiting – for a call back, for an assessment, for aids, tech and adaptations – and have to repeatedly phone to chase things up

e) It takes a long time for a response to a crisis

Valuing carers

f) They experience the strain of consistently caring for someone (all the emotional, financial, and other personal commitment this requires) and do not feel their needs have been considered; they feel undervalued and worry about becoming overwhelmed

In addition, we heard from both people who use services and carers that for some, there is a disinclination to share honest feedback with services, sometimes because they do not believe it will lead to any change, and sometimes because of fear that there will be reprisals in terms of the services they receive.

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https://www.sscr.nihr.ac.uk/projects/p157/

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Authors: Madeleine Stevens, Michael Clark, Jessica Carlisle, Nicola Brimblecombe, Miranda MacGill

We have created an Excel workbook based on the Theory of Change for use in practice.

If you would like a copy of the workbook, or have any comments on this document, please contact Madeleine Stevens

M.Stevens@lse.ac.uk

How to cite

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Appendix 1 Example Indicators

Outcomes	Existing measures/tools that could be used in an (academic) evaluation	Local authority potential audit/data collection
STAFF		
Staff are proactive & skilled in their strengths-based practice	*Audit template – strengths-based practice* (Tew et al)	Strengths-based practice audit tool Supervision audits Feedback from people contacting services and professional partners
Staff spend more time with people & less on paperwork	Time use survey methods (e.g. www.timeuse.org/) Social Work Watch survey methods [last done 2016]	Staff survey/discussion Audit ['caseloads' may not be useful indicator of workloads and may disincentivise longer, productive relationships with services/checking back etc]
Staff feel satisfied, empowered and supported to practice in a proactive, strengths-based, creative and collegiate way	*ASCOT-STAFF* [currently in development] *Workers quality of life scales*	Staff survey/discussion/auditor attend Huddles Supervision Do Huddles & reflection meetings etc take place? What happens in them? Recruitment and retention rates Staff sickness Staff forums Staff satisfaction surveys
Teams communicate around shared ethos and put in necessary supports and solutions		Audit Staff survey/discussion

Outcomes	Existing measures/tools that could be used in an (academic) evaluation	Local authority potential audit/data collection
PEOPLE WHO USE SERVICES AND CARERS		
People, including carers, feel listened to and supported. They know who they can contact	*Adult Social Care User Survey* *PERCCI* [relates to care received and 'careworkers' but could be adapted] *Carer-Reported Quality of Life Score (PSS SACE)* *ASCOT carer* *Carer Experience Scale (CES)*	'In-time feedback' from people, including carers, soon after, or as part of the contact e.g. through conversation (with option to communicate with someone outside the conversation), text survey, mobile-friendly online survey; (asking did you feel listened to/feel confident about next steps?) Complaints/compliments (including from carers forums/hubs); Stories of difference; Audit/surveys – were carers' situations considered and responded to?
People and their informal support networks connect with practitioners in identifying strengths & what is important to them, and developing approaches to supporting wellbeing. They feel empowered	*PERCCI* Relational outcome measures – trust, confidence; therapeutic alliance Many available measures including *Working Alliance Inventory* *Therapeutic Alliance Quality Scale*	Conversations and surveys with those who have been in contact with services (e.g. did the worker do what they said they would do?) Strengths-based practice audit tool Supervision audits Case file audits
COMMUNITY		
Staff know about available community resources. Community assets are available and sustained (not overburdened)	*Community Index Score* Assets and use of assets	Audit of paperwork/care packages (what are people linked with? Any follow-up?) Staff survey Is there a directory/resource; when updated; how often accessed? Engagement activity with voluntary and community sector; Joint work/forums with commissioners, what's working well/not well, identifying and addressing gaps

Outcomes	Existing measures/tools that could be used in an (academic) evaluation	Local authority potential audit/data collection
COMMUNITY		
People, including carers, use community assets to support their wellbeing. People feel connected to communities	*Short Social Capital Assessment Tool (SASCAT)* *Community Index Score* *Community Life survey* *Buckner's Neighbourhood Cohesion Index* *Oslo social support scale (OSSS-3)* *Short Social Capital Assessment Tool (SASCAT)* *Loneliness* ONS: UCLA 3-item Loneliness Scale + Direct measure *WARM* Taking the temperature of local communities: The Wellbeing and Resilience Measure	Community audit and community survey Commissioning reports Provider forums Provider contract management reviews
INTERMEDIATE OUTCOMES		
Support, interventions, aids and adaptations are in place to address current difficulties and/or prevent future needs	CASPAR self-assessment tool for person-home fit	Surveys/discussions with people seeking support Qualitative audit of paperwork Service/supports waiting lists/time taken to put in place
Crises are stabilised and people feel better able to avoid or deal with future crises	Work on developing and validating measurement is needed. Measuring resilience may be a proxy e.g. *Brief Resilience Scale*	Qualitative audit of paperwork Short-term reviews of Conversation 2s taking place? 'Revolving door' % returners to adult social care within 3 months/1 year Review of payment card/practitioner short-term spend
LONGER-TERM OUTCOMES		
Best use made of adult social care & broader resources; there is less demand for health and social care services	*SALT returns* *Adult Social Care Activity and Finance Report (ASCFR)* *Standard cost-effectiveness evaluation methods/PSSRU Unit costs* *Adult Social Care User Survey*	Audit including of care plans Audit by population sociodemographic characteristics Reviews taking place Returners % Conversion rate (% getting in touch who go on to have Long Term Care plans) To set against indicators of service experience and wellbeing
People live their lives in a place and way that suits them	*ASCOT-SCT4* ICECAP-O *AQOL 8D* *Other (non-carer/service user) wellbeing scales e.g. WEMWBS; ICECAP-A*	Surveys/discussions with people seeking support Audit Reflection CQC 'I and we' statements