The Health Foundation
Inspiring Improvement

Head, hands and heart: asset-based approaches in health care

A review of the conceptual evidence and case studies of asset-based approaches in health, care and wellbeing

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Research

April 2015

This research was commissioned and funded by the Health Foundation to help identify where and how improvements in health care quality can be made.
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Head, hands and heart: asset-based approaches in health care is published by the Health Foundation, 90 Long Acre, London WC2E 9RA

ISBN: 978-1-906461-60-7

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Acknowledgements

The authors would like express particular thanks to Jane Foot for the insights and critique offered throughout the key stages of this project and on its overall approach and methodology. In shaping the literature review, Jane provided a sound balance and challenge on the position of asset-based working in both health and the wider community development system. She also offered perspectives on current health and social policy that is shaping adoption of the models of asset-based approaches. Jane was integral to the development of the theory of change model presented in the report.

Our thanks are offered to all the participants from the case study sites that provided invaluable material for us to consider. In particular, thanks to Gary Loftus and colleagues at Forever Manchester for enabling access to neighbourhood residents and co-workers who offered frank and personal accounts of the impact of asset-based approaches.

We also thank participants in the telephone interviews and the sense-making events – all these people gave time and perspective freely and shaped the data phases of the work and our understanding.

Professor Jane South of Leeds Beckett University provided sound guidance in the methodology and offered useful reflections on our emerging ideas and findings. Jane also introduced the theory of change into our work.

Leeds Beckett University staff: Visiting Professor Mark Gamsu for advising and facilitation of the sense-making events; Dr Gianfranco Giuntoli and Ms Anke Roexe for their work on the literature search which was invaluable.

Particular acknowledgement is made to Dr Mike Grady of the Health Equity Team, UCL for his commentary on health inequalities.

The project advisory group provided steer and critical appraisal in the early phases of the work that proved useful in our direction setting.

Hannah Winney conducted the telephone interviews and summary analysis and Jayne Hopkins offered valuable contributions to key stages on our data analysis.

Finally, thanks to Matthew Tait at the Health Foundation for his stewardship.

Executive summary

Introduction

This report sets out some of the territory, opportunities and challenges in adopting asset-based approaches for improving health and wellbeing. The title, 'Head, hands and heart' refers to a well-known asset-mapping technique, in which participants are asked to respond to three questions: What knowledge do you have? ('head'); What skills do you have? ('hands'); What are you passionate about? ('heart').

The report introduces the theory and practice of asset-based approaches, explores some of the key principles for developing health assets and the evidence and mechanisms of impact on health outcomes of asset-based projects in the UK. It also identifies areas for further investigation.

The report is the result of research drawing on the mixed participatory and qualitative approaches that are widely used in social science research and theory testing. The research had four main data sources: a review of the literature, telephone interviews, case studies and sense-making events. The report is divided into two parts: part one summarises the theory and evidence behind asset-based approaches and part two gives details of six case studies, describing these approaches in action.

The conceptual and practical foundations of asset-based working are not necessarily easily understood by those new to this field. Even among practitioners whose work reflects or is guided by many aspects of asset-based practice, it is often more an intuitive sense of what is right that drives their work than a detailed grounding in the theoretical foundations of this field.

We hope that this report will help tie many of these threads together. Our aim is to engage a readership that is looking to introduce asset-based working into mainstream health and care sectors. We hope to challenge current practitioners in community development to look at the dimensions and benefits of developing assets for improving community health and wellbeing.

What is asset-based practice?

Asset-based practitioners have a different perspective to most other health and care professionals. Fundamentally, they ask the question 'what makes us healthy?' rather than 'what makes us ill?'

The aim of asset-based practice is to promote and strengthen the factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health. Practitioners' vision is to improve people's life chances by focusing on what improves their health and wellbeing and reduces preventable health inequities.

There is a wide range of practice that can be described as asset based. Broadly, asset-based working draws on three related strands of theory and practice:

1. **Salutogenic theory and the concept of positive health and wellbeing**
   'Salutogenesis' (from 'salus' (Latin = health) and 'genesis' (Greek = origin) – literally the origin of health) refers to the study of the origins and causes of health and wellbeing, including the mental, social and other resources that people draw on and that influence their wellbeing. Salutogenesis contrasts with and complements the more familiar pathogenic model, which emphasises the study of the causes and treatment of illness and disease.

2. **The concept of health assets**
   A health asset is any factor or resource which enhances the ability of individuals and communities to maintain and sustain health and wellbeing. Again this refers as much to mental, social and other resources as it does to material and physical resources, as factors that help build and maintain health and wellbeing.

3. **The emerging principles and learning from Asset-Based Community Development and related approaches**
   Asset-Based Community Development (ABCD) is a method of community and network building that starts by locating the assets, skills and capacities of citizens and local organisations, rather than focusing on their needs and deficits. The aim is to help people to improve their resilience, independence and wellbeing by focusing on what can be done through communities working together.

Together, these concepts give a vision of health that aims to promote positive health, care, support and wellbeing rather than simply tackling poor health, illness and disability.

Asset-based practice in a UK context

The research is set against a backdrop of marked changes in public sector services. Local authorities and health providers in the UK are faced with increasing constraints and challenges in budgets and resources. This context, along with the challenges posed by widening health inequalities, appears to be driving a shift toward more asset-based working in health, care and wellbeing.

Such developments are, however, emergent and not systematised. They are often illustrated in small projects and organisations, some not directly related to health and wellbeing, but which by the very nature of their focus and action are building assets for health and wellbeing.

There are promising early results of asset-based working in promoting health outcomes in the UK, building on and supporting the international evidence. There is strong evidence for the value of health assets, and growing evidence of how to promote and sustain those assets to benefit individuals, families and communities.

The full 'business case' for asset-based approaches in a UK health context is however still being developed, and there remain gaps in the evidence base. These especially include the mechanisms by which assets such as strong communities, social capital and self-esteem contribute to health and wellbeing, and the kinds of social action and practice that best grow and sustain individual and neighbourhood assets.

A theory of asset-based change

The use of programme evaluation methods such as theories of change and logic models can offer powerful perspectives on how and why change happens and outcomes are realised. We offer a conceptual model (a 'theory of change') as a means of illustrating the key stages local systems should consider and progress when making a shift toward asset-based working.

This theory of change has the following key components.

- **Reframing thinking, goals and outcomes**
  Exposure to underpinning ideas, reassessment of current practice and priorities towards asset-based working, and the identification of champions to drive change.
- **Recognising the assets available to achieve the change**
  Mapping and describing the individual, organisational, associational, economic, cultural and physical resources available to communities.
- **Mobilising assets for a purpose**
  Understanding and agreeing how community assets can be connected and used. New relationships, new approaches to leadership, systemic action across organisational boundaries.
- **Co-producing outcomes – on the pathway to the long-term goal**
  Co-production of services and outcomes by professionals and citizens. The coming together of equals, each with assets and strengths, around a common goal or a joint venture.

The principles of this theory of change were used to explore and analyse the drivers and mechanisms for change at work in the six case study projects that were investigated during this research.

Case study projects

A key requirement within the project was to identify and report on areas of asset-based practice through the use of case studies. We identified six suitable sites through the literature review, our network of contacts, by recommendation and via the telephone interviews. We tried to achieve representation from a wide geographical spread across the UK, a range of agencies and organisations within the statutory, voluntary and independent community sectors and organisations working with different groups, service users and/or community members.

Each case study project was interrogated in its local context as well as in terms of its application of asset principles as identified in the literature and evidence review. We took a 'whole system' approach, seeking to identify the 'reach' of the project in terms of community members and in the areas of impact, benefit and outcome.

Key findings from the research

- The well-researched concept of 'salutogenesis' provides a sound theoretical basis and strong evidence base to understand the factors and conditions that make people healthy.
- Asset-based ideas and practice give a vision of health that underpins and aims to promote positive health, care, support and wellbeing rather than simply tackling poor health, illness and disability.
- The principles of asset-based approaches value the resources, skills and knowledge that enhance the ability of individuals, families and communities to sustain good health and wellbeing.
- The values of asset-based thinking, underpinned by theoretical and conceptual models, can help us to understand and address the structural, material, social and relational barriers to individuals and communities achieving their full potential. This could make a significant contribution to tackling health and care inequalities.
- Asset-based approaches enable people to share their views and experiences of local services, access to health assets and their personal/collective aspirations. They allow active participation by the community in the planning, delivery and outcomes of services and the generation of community-based solutions. A 'theory of change' approach is useful to explore and analyse the mechanisms for change that are at work in asset-based initiatives.
- There is a real opportunity for researchers and those looking to evaluate the impact and outcomes of asset-based working. Social science has well-established approaches and a growing interest in the concept of how things change and the importance of causal and contextual mechanisms for explaining how and why interventions are successful.

Recommendations

The report has the following recommendations for researchers, practitioners and policy makers with an interest in asset-based working and the promotion of positive health outcomes in the UK.

- **Further develop and disseminate the working model for health assets**
  Asset-based working originated from three main strands that need to be brought together in a cohesive way that speaks to policymakers, practitioners and local people.
- **Continue to tackle health inequalities**
  If our vision is to improve people's life chances and to reduce preventable health inequities, our explicit aim should be to promote and strengthen those factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health.
- **Plan to incorporate asset-based approaches into mainstream public health activity**
  The term 'health' has become so associated with treating illness that it diverts people away from thinking about wellbeing. The outcomes from asset-based working should be part of an evidence-based pathway to the high-level public health outcomes of wellbeing and health equity.
- **Plan to integrate health assets and interventions that promote assets into health and wellbeing strategies**
  These should reflect the well-evidenced association between levels of good health and wellbeing and the strength of assets such as material wealth, social capital, social networks and resilience.
- **Champion asset-based approaches at local, regional and national levels**
  In the UK, system leaders can do this regionally and locally through Health and Wellbeing Boards and Partnerships. Nationally, we suggest it requires more explicit support and commitment by national health agencies and boards.
- **Prioritise NHS and local authority investment into asset-based community development for health and wellbeing**
  This is even more important at a time of restricted resources in public services and the impact of this on widening health inequalities.
- **Develop workforces and build community capacity to incorporate skills and knowledge on health assets and asset-based approaches**
  This should be reflected in the training and development of anyone who works with individuals, families or communities.
- **Create 'place-based outcomes'**
  The opportunity to plan and invest differently can be achieved through a redefinition of 'who' is in the system and what are the available or potential assets. Asset-based approaches enable local politicians, leaders and actors to view the local system differently, showing fidelity to co-production, resource shifting, asset building and sharing.

Introduction

Introduction

This report sets out some of the context and challenges of adopting asset-based thinking and asset-based approaches for improving health and wellbeing. In so doing, it outlines some of the key principles for developing health assets and draws on data and findings from interviews as well as case studies of initiatives in England, Scotland and Wales where asset-based approaches are being developed. We offer a new conceptual model, theory of change, as a means of illustrating the key stages local systems would need to consider and progress when making a shift toward asset-based working.

The title of this report, 'Head, hands and heart' refers to a well-known asset-mapping technique, in which participants are asked to respond to three questions:

- What knowledge do you have? ('Head')
- What skills do you have? ('Hands')
- What are you passionate about? ('Heart')

These questions are a way of drawing out and organising knowledge, at both the personal and community levels. In a sense, this research has asked the same questions of asset-based practice and practitioners, with the aim of drawing out knowledge about asset-based ways of working for a wider audience.

The report is divided into two parts: part one summarises the theory and evidence behind asset-based approaches and part two gives details of six case studies, describing these approaches in action.

The aim of the report is to introduce and inform the theory and practice of asset-based approaches to improving health, care and wellbeing services and outcomes. Though ambitious, our aim is to engage a readership that is looking to introduce asset-based working into mainstream health and care sectors.

We also hope to challenge current practitioners in community development to look at the dimensions and benefits of developing assets for improving community health and wellbeing.[1] This is not a neglected focus, but we are seeking to contribute to the further adoption of asset-based practices to support and enable individuals, families and communities to become increasingly active and empowered. While we do not champion asset-based approaches as a replacement for much-needed public services, we do see potential for these approaches to complement and contribute to active citizenship; more equal relationships between services, professionals and communities; and resources and investment being driven with and by local people.[2]

The report's framing of asset-based approaches as ways of improving health and wellbeing should make it of particular interest to those involved in strategic planning as members of health and wellbeing boards within local authorities and clinical commissioning groups (CCGs). Given our emphasis on conceptual and practical models for positive health and heath assets, practitioners in health and care services will also benefit from our perspectives on 'what makes us healthy'. Like others, we suggest a better balance between asset-based approaches and traditional deficit- and illness-based models of medical, care and public health practice.[3] We touch on both the current state of research, and the need to develop it further, and the evidence for asset-based approaches to health, care and wellbeing, especially in a UK context. It is hoped that this will assist researchers in developing areas for further investigation and inquiry. We see merit in a coordinated approach to the adoption of asset-based thinking, with cooperation across researchers, services, local people and communities – modelling the process and engaging all the assets.

Research methods

Our research methods draw on the mixed participative and qualitative approaches that are widely used in social science research and theory testing. Investigation using such approaches relates to community and systems development and also takes into account the context of operation. Research methods that explore language and meaning (corpus methods) do not necessarily follow a prescribed structure, thus allowing flexibility and reflexivity. The data generation and collection activities that we have used are closely aligned with these approaches and are consistent with 'Grounded Theory'.[4] Such methods do not adhere to any particular ideological perspective and are intended to provide relative objectivity.

Our findings were fed back to selected participants for review, comment and endorsement, through sense-making events, consultation with the case study projects, an advisory group and through the use of an 'adapted' Delphi method.[5] These approaches were used to build consensus and critique and were consistent with 'participatory action research'.[6,7]

We used four specific data sources:

1. a literature overview
2. telephone interviews
3. case studies
4. sense-making events

These sources were used sequentially, with the aim of developing a triangulated data set based on sources 1–3. The sense-making events were then used to test the evidence and hypotheses.

More detailed information on the research methods used is available in the appendix.

Part 1: Theory and evidence base

Chapter 1:
National context

Our work on the project has been set against a backdrop of marked changes in public sector services and local authorities facing increasing constraints in budgets and resources. This context, along with the challenges posed by widening health inequalities, appears to be driving a shift towards more asset-based working in health, care and wellbeing. However, such developments are emergent and not systematised. They are often illustrated in small projects and agencies, some of which are not directly related to health and wellbeing, but by the very nature of their focus and action are building assets for health and wellbeing.

Until recently, there has been no systematic commitment to put community or social relations at the heart of public health policy. However, both the Welsh and Scottish chief medical officers have prioritised asset-based working in their recent strategies to reduce health inequity.

- In his 2009 annual report, *Time for change*, Chief Medical Officer in Scotland Sir Harry Burns said a 'salutogenic' approach* was essential to narrow the gap in health and care outcomes for those at the lower end of the socio-economic spectrum. In 2013, he called for 'a new approach which allows individuals to feel more in control of their lives and social circumstances'. He added: 'The [assets] approach offers a coherent set of ideas and concepts for identifying and enhancing those protective factors which help individuals and communities maintain and enhance their health even when faced with adverse life circumstances.'[8]
- In 2011, Wales published its strategic action plan for reducing health inequalities, *Fairer health outcomes for all*.[9] It included 'developing health assets in communities' as one of its seven action areas. In 2010, Ruth Hussey (now the Chief Medical Officer for Wales), wrote: 'Assessing assets alongside needs will give a better understanding of communities and help build resilience, increase social capital and develop a better way of providing services.'[1]

In England, no similar priorities have been set at a national level, but several influential publications have put forward a vision of positive health and wellbeing, as well as the case for enhancing assets, especially strong communities. Examples include the following:

- The 2012 White Paper *Caring for our future: Reforming care and support* recognised that 'strong communities can improve our health and wellbeing and reduce health inequalities'.[10]
- The King's Fund handbook for health and wellbeing boards, *Improving the public's health: a resource guide for local authorities*, includes a chapter on the evidence for strong communities, wellbeing and resilience as one of the nine priorities for local action.[11]
- Recent NICE guidance on behaviour change recommends interventions and programmes that 'identify and build on the strengths of individuals and communities and the relationships within communities' and which help individuals 'feel positive of the benefits of health-enhancing behaviours and changing their behaviour' and 'recognise how their social contexts and relationships may affect their behaviour'.[12]
- The Department of Health's *Wellbeing: Why it matters in health policy?*[13] makes the case for a stronger focus on action for wellbeing to improve health outcomes. In doing so, it argues that this 'may ultimately reduce the healthcare burden... High levels of wellbeing directly affect good health. It is estimated that high levels of subjective wellbeing can increase life by four to 10 years compared with low levels of subjective wellbeing.'[14]

* Salutogenesis: from 'salus' (Latin = health) and 'genesis' (Greek = origin), literally the origin of health. This approach asks 'what makes people healthy?' and highlights the resources and capacities that positively impact on health and wellbeing.

Public Health England has committed to a 'life course' approach, which combines prevention and early intervention alongside a continuing deficit-based emphasis on targeting risky behaviours such as smoking, alcohol misuse and so on.[15] They argue that this has five key benefits in that it:

1. promotes a holistic approach that enhances the individual's total health and wellbeing
2. encourages an asset-based approach that understands risk factors and the importance of the family as a protective factor
3. focuses on outcomes and draws from the evidence base
4. concentrates on prevention and early intervention, including reducing health inequalities and preventable mortality
5. views public health as one agency for improving health and wellbeing outcomes.

Chapter 2:

Key concepts and their interrelationship

Positive health, care and wellbeing outcomes for individuals, families and communities fall far beyond the scope of the NHS or care services. As the Marmot Review made clear, the solutions to many of our health and social care challenges and widening health inequalities are rooted in tackling social, economic and environmental conditions.[16] The review calls for action to create a more level social gradient in health, reduce preventable illness and disease and ensure the fairer distribution of good health and positive wellbeing.

According to Morgan and Ziglio, 'A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and wellbeing. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses'.[3]

Health and wellbeing assets are found at individual, communal and organisational levels.[17] Assets are realised, expressed, mobilised and sustained through people's actions, connections and participation. At an individual level they include resilience, self-esteem, a sense of purpose and a commitment to learning. Community assets include family, friendships, supportive networks, intergenerational solidarity, community cohesion, religious tolerance and harmony. Organisational assets include environmental resources necessary for promoting physical, mental and social health; employment security and opportunities for work or voluntary service; safe and pleasant housing; political democracy and social justice. As this chapter shows, the link between levels of health and wellbeing and the strength and connectedness of health assets has been well researched and evidenced since the 1970s.

Assets that contribute to health and wellbeing

1. Communities

The Marmot Review identified six policy recommendations to reduce health inequalities, including creating 'healthy and sustainable places and communities'.[16]

The links that connect people within communities provide a source of resilience, access to support, opportunities for participation and added control over their lives; they have the potential to 'contribute to psychosocial wellbeing and as a result to other health outcomes'.[16]

Connectedness, networks, trust, reciprocity and feelings of belonging are the social glue that binds people and places together. They can be expressed or sustained by opportunities to participate and collaborate in civic engagement and community activity. The benefits of civic engagement, volunteering and participation are many. Volunteers gain immediate psychological benefits from giving, but also benefit over time through, for instance, skill- and knowledge-sharing, time-banking, peer support, or membership of social clubs.[18] Reciprocity is a key health asset.[2] 'Giving' is also one of the New Economics Foundation's (NEF) 'Five ways to wellbeing'.[19]

2. Social networks

Robert Putnam argued that civic organisations, particularly social networks, can create high levels of 'social capital', which has a well-established link to health and wellbeing at both individual and community levels. In *Bowling alone*, Putnam suggests four ways in which this happens:[20]

- Networks generate tangible resources such as money and support, which reduce stress as well as creating bridges across divides of power, status, knowledge and access.
- Being part of a network can reinforce positive behaviour through social norms as well as enforcing sanctions; but this can also reinforce negative behaviour.
- Social networks facilitate mobilisation and cooperation for mutual and individual benefit. Cohesive communities can lobby for improvements in their areas and in services. A breakdown in social cohesion and trust reduces the likelihood of collective action for mutual benefit and improved assets such as income, housing and green space.
- Involvement in community and social networks has a measurable positive biochemical effect on the body.[21] Social networks are shaped by ethnicity, class and gender; people's links tend to be 'like to like'. For those who are part of a marginalised community, this can limit access to mainstream networks and better jobs. Social action to increase 'bridging social capital' which crosses such divides, can impact on social equity by improving access to resources and power.[22,23]

3. Connectedness

The third asset that has been identified is the positive impact of social relationships. In a large meta-analytic review in 2010,[24] the quality and quantity of complex social relationships with family, friends, neighbours and social networks have been shown to affect morbidity and mortality. People with stronger social relationships have lower mortality rates than those with poor or inadequate social relationships. These effects are at least comparable to the well-established risk factors such as smoking, excessive alcohol consumption, obesity and lack of physical activity, and in some cases they are better.

According to Holt-Lundstad, Smith and Layton, 'Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill.'[24]

Loneliness has around twice the impact on early death as obesity. It can have a devastating impact on older people. Studies have linked loneliness to a range of health problems, from raised blood pressure and weakened immune system to a greater risk of depression and heart attack.[25]

4. Resilience

An individual's sense of coherence, resilience, confidence, meaning and purpose is related to the strength of their family, neighbourhood and social networks. Children with access to strong family networks, as well as their own social networks, are more likely to have better mental health, fewer behavioural problems and are less likely to engage in 'risky' behaviour.[26,27]

Individual resilience, the capacity to do well in the face of adversity, is promoted by long-term relationships in the family, neighbourhood and schools, alongside secure parenting, educational progress, satisfying work and support for self-esteem.

A resilient community has a 'collective held belief' in its 'ability to adapt and thrive in spite of adversity'.[28] The public sector needs to review and redesign services so that they build resilience.[29,30]

5. Psychosocial health

Good mental wellbeing and access to psychosocial resources are important to a person's chances and enjoyment of life. There is a marked social class gradient in mental illness and mental wellbeing and a clear relationship between mental wellbeing and material circumstances. Poor mental wellbeing is both a cause and a consequence of inequality and health inequity.

Asset-based approaches to health

Asset-based approaches to health nurture, sustain, protect and build the health assets in every individual, family and community in order to improve people's life chances and enhance positive health and wellbeing.

Asset-based practitioners take a different approach from other health and care professionals, asking the question 'What makes us healthy?' rather than 'What makes us ill?' (See Table 1 for a comparison of asset- and deficit-based approaches.) Their aim is to improve people's life chances by focusing on what improves their health and wellbeing and reducing preventable health inequities.

The Improvement and Development Agency's report into how an asset approach can improve community health and wellbeing, *A glass half-full*, described asset-based approaches as:

'Asset approaches make visible, value and utilise the skills, knowledge, connections and potential in a community.
They promote capacity, connectedness, reciprocity and social capital.
The aim is to redress the balance between meeting needs and nurturing the strengths and resources of people and communities.
Asset working seeks ways to value the assets, nurture and connect them for the benefit of individuals, families and neighbourhoods.
The professional's role is to support people to recognise and mobilise the assets and resources they have.'[1]

Institutions, public bodies and services have assets that can be used to improve wellbeing – including buildings, money, green spaces, service budgets, skills, power and voice. Often these assets are used just to meet immediate needs rather than to sustain the things that make us healthy. Services are often delivered in ways that undermine and disempower individuals' and families' capabilities.

An assets-based approach is not an alternative to good public services, but it challenges public services to work in more collaborative and less transactional ways and to transform their relationship with communities and those with poor health.[31]

Table 1: Comparing an asset-based approach to a deficit approach

Deficit approach	Asset-based approach
Start with deficiencies and needs – what a community needs	Start with strengths and potential – the assets of individuals and communities
Treat the illness and symptoms	Promote wellbeing and positive health Treat the whole person
React to problems	Foster strengths and assets to prevent problems
Do to	Work with
People are consumers of health services	People are co-producers of health outcomes
Emphasise the role and knowledge of professionals and agencies	Emphasise the role and knowledge of communities, networks and neighbourhood organisations Citizens act as peers and agents in their own health and work alongside professionals
Fix broken people	Empower people to take control of their lives and health Act as brokers, facilitators, catalysts, collaborators
Deliver intervention programmes	Work with local people to support their ideas, potential and priorities
View the social causes of ill health and inequality as outside the remit of health and care services	Work with citizens to tackle the social, economic and environmental determinants of health and challenge health inequalities
Focus on what a community does not have	Focus on what a community has and could have Collaborate and work alongside people to mobilise community, family and local care and support networks and resources Self-organisation and community organisation Support peer groups, social prescribing and local networks
Consult residents about health services	Work alongside citizens to improve health and care outcomes

Positive wellbeing is not separate from successful medical treatment for acute or life-limiting, long-term conditions. A person can be ill and have good wellbeing, or be healthy and have poor wellbeing. New work on recovery has identified wellbeing as a critical factor in post-clinical treatment, long-term condition management and changing the context so that the condition does not recur.[28] Strong family and social support, hope, positive attitudes and a network of peers and practitioners who work together are among the potential outcomes of asset-based working that enhance and complement medical treatment and care services. It is not either/or, but and/and.

Our research has found that asset-based working is developing from three main strands that need to be brought together in a cohesive way that speaks to both policymakers and practitioners:

1. The concept of positive health and wellbeing
2. Salutogenic theory
3. Emerging principles and learning from existing asset-based approaches.

1. The concept of positive health and wellbeing

The definition of positive health and wellbeing is derived from the 1986 World Health Organization (WHO) Ottawa Charter for Health Promotion:

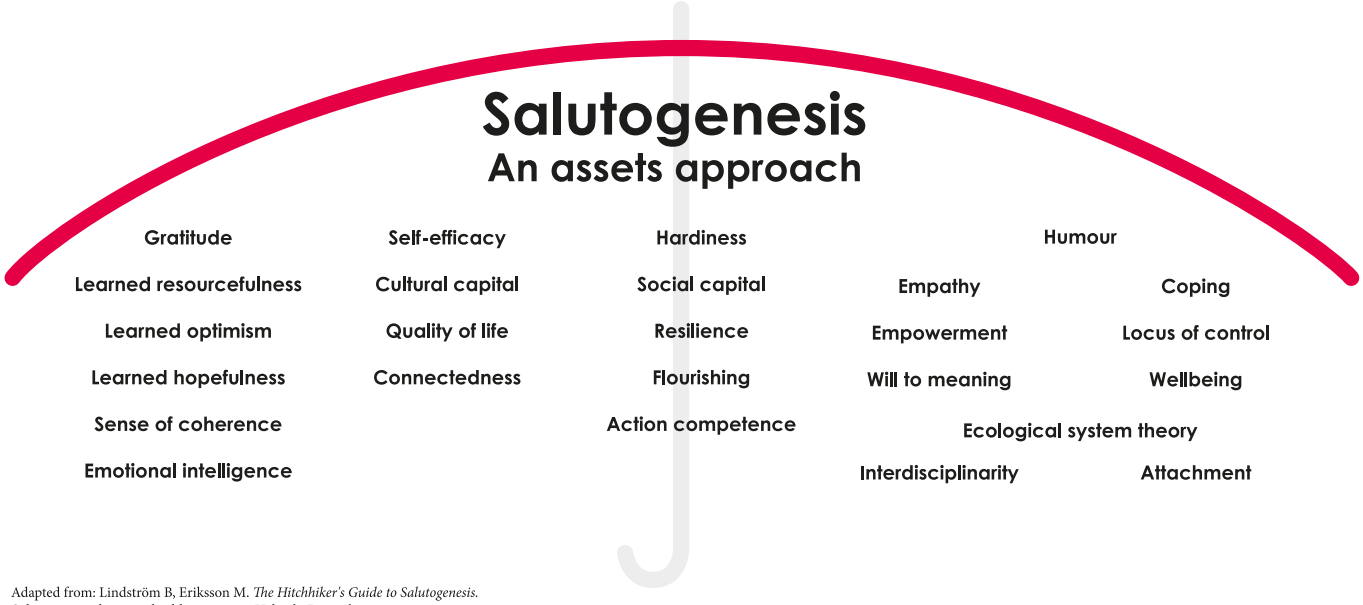
'Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities.'[32]

The 2012 WHO report on social determinants of health and the health divide in the WHO European region emphasises the importance of resources and assets to good health: 'The resilience, capabilities and strengths of individuals and communities need to be built on and the hazards and risks to which they are subjected need to be addressed.'[33]

2. Salutogenic theory

A salutogenic model of working highlights the resources and capacities that positively impact people's health and wellbeing, particularly their mental wellbeing (see Figure 1). It complements the more familiar pathogenic model that emphasises illness and disease.[32,34]

Figure 1: Asset and resource concepts under the salutogenic umbrella (Lindström and Eriksson) [34]



Adapted from: Lindström B, Eriksson M. *The Hitchhiker's Guide to Salutogenesis. Salutogenic pathways to health promotion*. Helsinki December 2010

The concept of salutogenesis was developed in the 1970s by Aaron Antonovsky (1923–1994) and was initially based on studies of women survivors of concentration camps. Antonovsky asked why some people in situations of material hardship and stress stay well while others do not. He described two key sets of factors that were important:

- sense of coherence
- generalised resistance resources.

Sense of coherence

Sense of coherence (SOC) is a measurable[35] personal and collective resource that leads to good health and wellbeing. Individuals with a strong SOC experience:

- comprehensibility: the cognitive ability to understand and find meaning in their situation
- meaningfulness: they have reasons to improve their health, are motivated, and they have hope and a positive outlook
- manageability: they believe that they have the skills, ability, support, help or resources (some or all of these) necessary to take care of life's challenges, and that these things are within their control.

People develop an SOC throughout their lives, but mainly in the first decade. This supports the Marmot Review policy objectives of 'giving every child the best start in life' and 'enabling young people to maximise their capabilities and have control over their lives',[16] and Bartley's findings about the factors that encourage resilience over the life course.[27]

Bengt Lindström and Monika Eriksson's extensive research (see below) supports the validity of Antonovsky's 'sense of coherence'. 'At the heart, finding everyday life meaningful, having well-functioning social networks, being in touch with one's inner life (psychological wellbeing), having clear coordinates in life (having an existential position) are all conducive to a strong sense of coherence and subsequently to good health, wellbeing and quality of life.'[34]

Generalised resistance resources

Generalised resistance resources (GRRs) are found within individuals and also in their immediate and distant environments. GRRs can have both material and non-material qualities. They provide a person with meaningful and coherent life experiences as resources at their disposal.

These resources are genetic, constitutional and psychosocial. They include material and financial wealth, knowledge, intelligence, ego, identity, coping strategies (rational, flexible, far-sighted), social support, commitment (continuance, cohesion, control), cultural stability, cultural norms, belief or faith, religion, philosophy, art, mysticism (a stable set of answers or explanations) and a preventive health orientation.

The key factor is a person's ability to use and reuse the resources for an intended purpose.

Over the last 10 years, Lindström and Eriksson have advanced the ideas of Antonovsky, studying the effectiveness and reliability of a strong SOC in promoting better health and the role of GRRs in this.[36]

They, along with many others,[37,38,39,40] conclude that there is a strong correlation between factors that measure mental health (optimism, hardiness, learned resourcefulness, locus of control, mastery, self-esteem and self-efficacy, acceptance of disability and social skills) and physical health. SOC is strongly and negatively related to perceived depression. According to Lindstrom and Eriksson, 'SOC seems to decrease the number of circulatory health problems in adults. People with a strong SOC have lower diastolic blood pressure, serum triglycerides, heart rate at rest and higher oxygen uptake capacity'.[41]

3. Emerging principles and learning from existing asset-based approaches

Asset-based approaches are built on the assumption that health and care services have become too focused on 'treating illness', to the detriment of promoting wellbeing. Similarly, not enough attention is paid to helping people with poor health to sustain or recover positive wellbeing in addition to managing their conditions.

Public health practice should instead aim to improve life chances and achieve wellbeing for all, in contrast to meeting deficit-based targets such as reducing mortality rates and changing risky or 'unhealthy' behaviours.

To achieve this, local strategies should set out to improve health and social care through:

- improved measures of physical and mental wellbeing
- greater positive experiences of caring and being cared for

- fostering a sense of connectedness
- encouraging greater citizen involvement and activity by people to promote their own interests and those of others and the creation of a flourishing civil society
- development of strong communities and social capital
- challenging and reducing health inequities
- developing policies aimed at tackling poverty and the social, economic and environmental determinants of health.

Success will depend on close collaboration between individuals, communities, social agencies, governments and health professionals and is not limited to the impact of health or social services.

Seeking positive health and wellbeing for all accords with the recommendations in the Marmot Review that health practice should work across the 'social gradient' and tackle the 'causes of the causes… the social hierarchy and the socially determined conditions in which people grow, live, work, and age' instead of focusing solely on the most disadvantaged.

It also complements the argument that subjective wellbeing is a more important measure of a country's success than economic growth[42] and that illness and physical ill health are not separate from physical or mental wellbeing. At the same time, the need to invest in prevention is increasingly accepted.

Asset-based community development (ABCD)

ABCD is a process of community building that starts by locating the assets, skills and capacities of residents, citizens' associations and local institutions.

The theory and practice were developed by John Kretzmann and John McKnight and explained in their 1993 book *Building communities inside out*, the best-known guide to asset-based practice.[43]

Once neighbourhood assets and capacities have been identified, ABCD seeks to connect those assets and to build strong relationships and reciprocal social networks. The ultimate aim is to mobilise local people to act on the things they care about and want to change.

ABCD shares many principles and assumptions with salutogenesis. These include the following:

- A focus on creating and nurturing positive factors, asking: What makes us healthy? What brings wellbeing? How to build strong communities?
- A focus on working with people's capacities and resources rather than their deficits or needs.
- The assets that Kretzmann and McKnight value – social capital, connectedness, empowerment, participation, networks, self-worth – align closely with the resources that salutogenic thinkers have demonstrated to be the sources and resources for health and wellbeing.
- Both approaches seek to mobilise a whole community to achieve positive change. For example, health promotion should not be restricted to those identified as at risk or unhealthy.
- Both approaches emphasise the importance of action on social justice. Inequity in health and wellbeing is a product of material and structural inequalities.
- Both place high value on promoting a sense of belonging, a capacity to control and finding meaning and self-worth. These psychosocial assets not only promote wellbeing and health, but they also lead to connected individuals and flourishing communities.
- Both put a high value on social relationships – the networks and connections in a community that reduce isolation and vulnerability to shocks.
- Both start with a premise that strong communities – whether of geography, identity or interests – generate resources, through fundraising, mutual aid, lobbying power, voice and empowerment. They are a buffer against isolation and insecurity.

While ABCD was not specifically developed in the context of health improvement, it has provided a solid foundation for the emergence of asset-based working to improve health and wellbeing.

The NHS-funded Health Empowerment Leverage Project (HELP) used a community development method very similar to ABCD. It produced impressive results, including: 'resilient and confident communities, healthier behaviour, better informed and responsive services, reduction in health inequalities and cost savings where pressure and spend are greatest'.[44]

Chapter 3:

Research into the impact of health programmes and interventions on health assets

A number of community-based health programmes have generated robust research and evaluation in recent years. These include health action zones, healthy living centres and neighbourhood renewal programmes, as well as recent initiatives such as 'Altogether Better'[45] and 'Well London'.[46] Although not all community-led programmes are explicitly asset based, a comparison and assessment of their accumulated learning would help support innovative practice and potentially inform the development of more effective practice in the future. Evidence that has been generated includes the following:

- Local government's 'Think Local Act Personal' was an asset-based programme that commissioned work on the economic benefits of building community capacity. The researchers found that friendship networks, time-banking and community navigator schemes reduced the need for services and generated public expenditure savings.[47]
- Research by South, White and Gamsu[2] includes case studies of the positive and reciprocal impact of volunteers, lay health workers and peers working as 'health champions' in and with their communities.
- A recent review of individual and community empowerment found evidence of empowerment strategies delivering improvements in health assets such as self-efficacy and self-esteem, sense of control and sense of community through broader networks and social support. However, there was little evidence of direct health impacts.[48]
- The evidence for successful health improvement interventions across local authority functions has been collated by The King's Fund. The topics covered include 'strong communities, wellbeing and resilience'.[11]

There is strong evidence for the value of health assets and a growing interest in how to protect, promote and sustain them in order to benefit individuals, families and communities. However, there has been no systematic commitment to their promotion through public health policy. More research is needed to explore how social, economic and psychosocial health assets affect positive health and wellbeing, how this occurs in different environments and contexts, and how these factors can be developed and maintained.

In other areas of asset-based work the evidence is still emerging, and more research is needed. These areas include the kinds of social action and practices that best grow and sustain individual and neighbourhood assets and their circumstances. An investigation into the mechanisms by which assets such as strong communities, elements of social capital and self-esteem affect health and wellbeing is also required. The mechanisms by which health assets are best mobilised and enacted will be of value to planners and practitioners of community development and may be a theme for future research and evaluation. The use of programme evaluation methods such as theory of change and logic models can also offer powerful perspectives on how and why change and outcomes are realised.

Chapter 4:

Criticism of asset-based approaches and responses to criticism

The case for a stronger focus on assets for health and the development of asset-based approaches to improve health, care and wellbeing services and outcomes has been and continues to be questioned. It would be remiss if the present review did not consider these criticisms. They fall into three main areas:

1. The absence of strong evidence to suggest that a focus on assets or asset-based approaches are effective means of improving health or reducing health inequalities.[49]

2. The practice of using asset-based approaches either unwittingly or deliberately disregards the power dynamics in society, and its emphasis on empowerment overshadows a necessary conversation about rights.[50]

3. While the idea of asset-based approaches has been around in some shape or form for nearly 50 years, the fact that people are still learning about it means that we are not presenting it in such a way that the idea connects with wider practice in health and care services.[51]

Some critics state that the asset-based approach is 'ill-defined and can encompass a wide variety of approaches and interventions which have little in common'.[52] Perhaps this criticism is understandable given the 'specialist' and reductive approaches that characterise not just modern medicine, but also much recent public health practice. Is there not a lesson here, namely that if one disturbs the status quo, which asset-based approaches surely do, then one should not expect support from those who either consider themselves to be at risk or who stand to lose the most from the changes that focusing more on assets would bring? 'Disruptive innovation' was never likely to find favour among certain powerful groups in health and care practice or in public health where, who can be cautious and risk averse. Some may be suspicious of both patient-led and community development approaches, which continue to be regarded as very low status in the medical hierarchy.[53] It is not the lack of evidence that seems to be the issue; rather, it is the lack of status of the evidence on asset-based approaches.

Supporters of asset-based approaches would argue that it is the very breadth and variety of these approaches that are their main strengths. They point to the complex and contestable nature of health, care and wellbeing and note that we are working in 'complex, adaptive systems' where simple, linear interventions are as likely to cause or exacerbate, rather than challenge, inequities in health and care outcomes.[52]

Criticism by those who cite a lack of evidence reveals a number of interesting assumptions. First, there seems to be an assumption that the model of health and care services developed in the UK have, by and large, been successful at tackling ill health. Those who favour a better balance between assets and deficits start from the premise that we have singularly failed to make significant headway in respect of tackling health inequalities or improving health and care services at a faster rate.[1,3,34,54,55,56] Many have criticised the medical model that underpins much of what still happens, and its failure to move beyond diagnosis and treatment of the problems to finding and implementing sustainable solutions and being held to account for this achievement.

However, we are not suggesting an either/or assets versus deficits approach to improving health, care and wellbeing services and outcomes. According to Foot, 'Asset-based approaches complement services and other activities that are intended to reduce inequalities in life chances and life circumstances and which meet needs in the community.'[55] Asset-based approaches, if complemented by effective treatment and good care,

can bring sustainable outcomes in physical and mental recovery, rehabilitation, management of long-term conditions and, most importantly, in bringing positive health and wellbeing and reduced health inequities.

In the USA, criticism of asset-based approaches has mainly focused on ABCD and the work of Kretzmann and McKnight. Critics speculate that an intrinsic conflict exists between the do-it-yourself, self-sufficiency perspective and accountability. They ask: if community members are encouraged to mobilise on their own accord, creatively bypass obstacles fashioned by unfair structures and mobilise their own resources and connections, when will local, regional and national policymakers ever feel pressured to adjust their policies?[57]

The main challenge to adopting an uncritical asset-based approach in the UK comes from Lynne Friedli. Her recent paper in *Critical public health* sets out her argument that a 'fatal weakness [of asset-based approaches] has been the failure to question the balance of power between public services, communities and corporate interests. As such, asset-based approaches sound the drum beat for the retreat of statutory, state provision of both public services and public.'[58]

In an earlier paper written in response to the launch of an Assets Alliance for Scotland she concluded,

> *'Cultural change in professional practice cannot be achieved without facing up to the impact of steep income and status hierarchies within the public sector. Or the wider debates… on rights, on redistribution, on minimum incomes, on policy shifts that have diminished social housing stock and its status and have privileged home ownership. Without these debates, assets approaches serve to encourage the fantasy that Scotland's problems can be tackled without the awkward task of addressing power and the reality of competing interests.'*[59]

While not using the same language, the Marmot Review recommends some similar priorities for achieving equity of health: a minimum income for healthy living, progressive taxation, fiscal policies and reducing the 'cliff edges' for people moving between benefits and work.[16]

On a positive note, Friedli argues that the strength of the assets movement is that it has generated discussion about redressing the balance of power: 'The major problem with an uncritical adoption of asset-based approaches is that it fails to distinguish between a radical critique of welfare, one that is firmly linked to an analysis of neo-liberal economics and the resultant attack on public health, care and welfare services that supports the further deregulation of markets and withdrawal of the social rights of citizens.'[58] A recent report on the introduction of ABCD in Scotland picks up Friedli's theme arguing that 'ABCD is a capitulation to neo-liberal values of individualisation and privatisation'.[60] Interestingly, the current UK government's introduction of 'Big Society' and its use of the lexicon of asset-based language have attracted similar criticism from many quarters, especially by community development practitioners. South, White and Gamsu agree: 'Citizenship is about democracy and rights. Involving members of the public in public health should not be about reducing public services. It is a way of reducing barriers to resources that support good health and should be framed as a strategy to increase equity in health.'[2]

Antony Morgan's article *Revitalising the evidence base for public health: an asset model*, first published in 2007, introduced the theory and practice of asset-based approaches to a much wider audience than its previously mainly academic followers.[3] In a recent paper, Morgan revisits some of the ideas in the original article. He sets out the most recent thinking on how we might address the gap between the theory and practice of asset-based approaches that could help connect with wider health, care and wellbeing services and observes that there seems to be 'some policy commitment to commission and support such work'.[51]

Morgan's challenge is to 'ensure that the criticisms or perceived weaknesses of the approach are taken seriously and that we think of ways of addressing them.'[51] He suggests a set of principles that can support the practical implementation of asset-based approaches:

- Prioritising theoretically based positive paradigms for wellbeing.
- Involving individuals and local communities effectively and appropriately.
- Connecting the individual with community and broader society.
- Working in a decision-focused, multi-professional and multidisciplinary way.
- Securing investment through a multi-method, evidence-based approach.

Chapter 5:

How does asset-based change occur? A 'theory of change'

Given the early stages of research and evaluation of asset-based approaches in the UK, there is an increasing need to understand the mechanisms that lead to change in system practice and the impact such changes have on communities and organisations.

Opportunities exist for researchers and those looking to evaluate the impact and outcomes of asset-based approaches. There are well-established participatory methods in the social sciences and there is growing interest in the concept of a mechanism for change. There is also an opportunity for strategic planners and commissioners to consider collaborating with researchers to demonstrate the impact of asset-based approaches in local communities. This could bring about collaboration to produce outcomes with a focus on the impact that positive social relationships have on health and wellbeing.

In the view of Sigour and Gruer, 'Measuring the impact of complex community interventions on health and social outcomes is not straightforward. Concepts like participation, community cohesion and social capital are difficult to define or measure, and interventions will inevitably be influenced by a host of other factors affecting the lives of individuals or the wider community.'[61] The systems in which asset-based approaches are being introduced are complex, with competing perspectives on what the issues, opportunities and responses are and need to be. Durie and Wyatt argue that understanding such complexity is crucial and that processes 'must emerge within communities, and… as a result… of a process of self-organisation.'[62] Forbes and Wainwright call for 'research to be viewed in the context of the lives of people most impacted'.[63]

In the field of programme and policy evaluation, scholars have highlighted the significance of causal mechanisms in explaining how and why programmes work.[64] In developing action from evidence, we need to know much more than just 'what works' – or even what works, for who, where, and in what circumstances. Davies notes that 'We also need to "know about" – to understand the nature, formation, natural history, interrelations and dynamics of social problems and social accomplishments. We need to "know why" – to be able to link the values that underpin actions to the formation of policies, strategies and support mechanisms. And we need practical "know-how" – the pragmatic knowledge about how to go about getting things done.'[65]

We have used a 'theory of change' approach[66] to explore and analyse the mechanisms for change that are at work in the asset based-projects we have reviewed in our field work. Such an approach is a key element of programme development and evaluation in social and organisational sciences. Its roots are in programme theory, in which understanding is gained about how interventions/actions work through chained events from which intermediate and final outcomes can be described.

Theory of change is about the 'central processes or drivers by which change comes about for individuals, groups or communities; this can be based on a formal research hypothesis or an unstated, tacit understanding about how things work'.[67] We suggest that theory of change methodology is well suited to asset-based approaches given the iterative and collaborative nature of the process, which involves aspects of systems and complexity thinking. Theory of change also reflects the principles of 'realistic evaluation', which holds that the context of the intervention is a critical feature in its outcome.[68]

The New Economics Foundation (NEF) has recently described the value of theory of change methods in strengthening commissioning in health services: '[A] Theory of Change is a method and evaluation tool for conceptualising how an organisation has impact. It outlines what an organisation achieves and, through a chain of inputs, activities, outputs and outcomes… describes the causal assumptions and rationality behind how an organisation has an impact.'[69]

In developing a theory of change approach, we referred to notes and data from the case study visits, the sense-making events with practitioners and policy leaders and notes made during the telephone interviews. The steps in the proposed model do not detail the intended or planned outcomes for each stage. Our model is illustrative and still at an iterative stage. In adopting theory of change into practice, efforts should be made to identify these elements in detail. This can be achieved through the use of 'logic model' diagrams to illustrate key processes, activities and stages.

Our model has four key stages, which are set out in figures 2 and 3 below. The stages are not linear, but may be ordered to suit the particular situation and context of the initiative. Intended or planned outcomes should be identified at key times in each element. The elements are:

- reframing towards assets
- recognising assets
- mobilising assets
- co-producing assets and outcomes.

Figure 2: The four elements in a theory of change approach for asset-based working

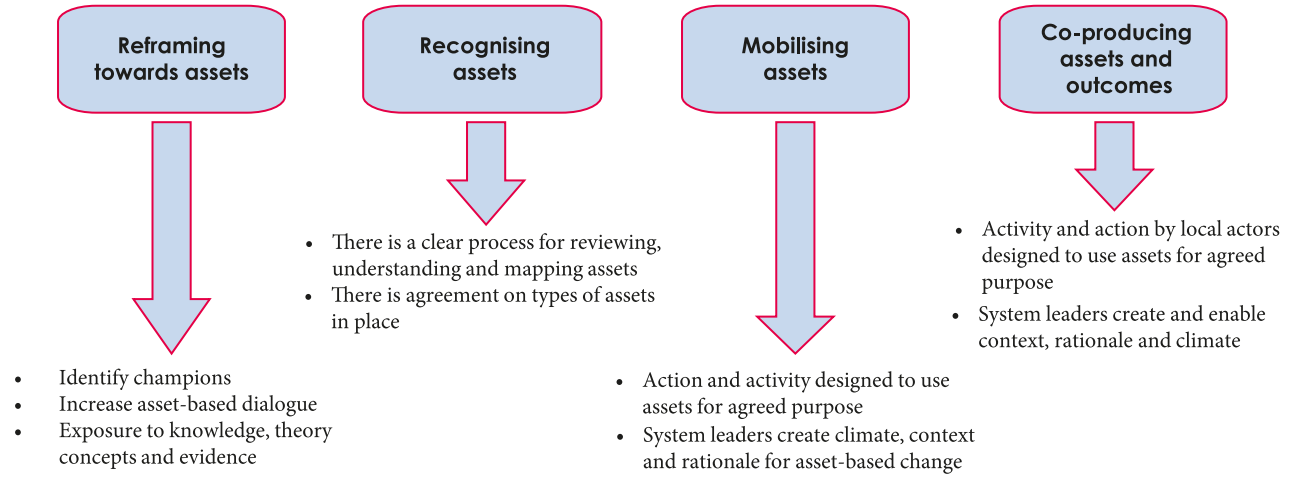
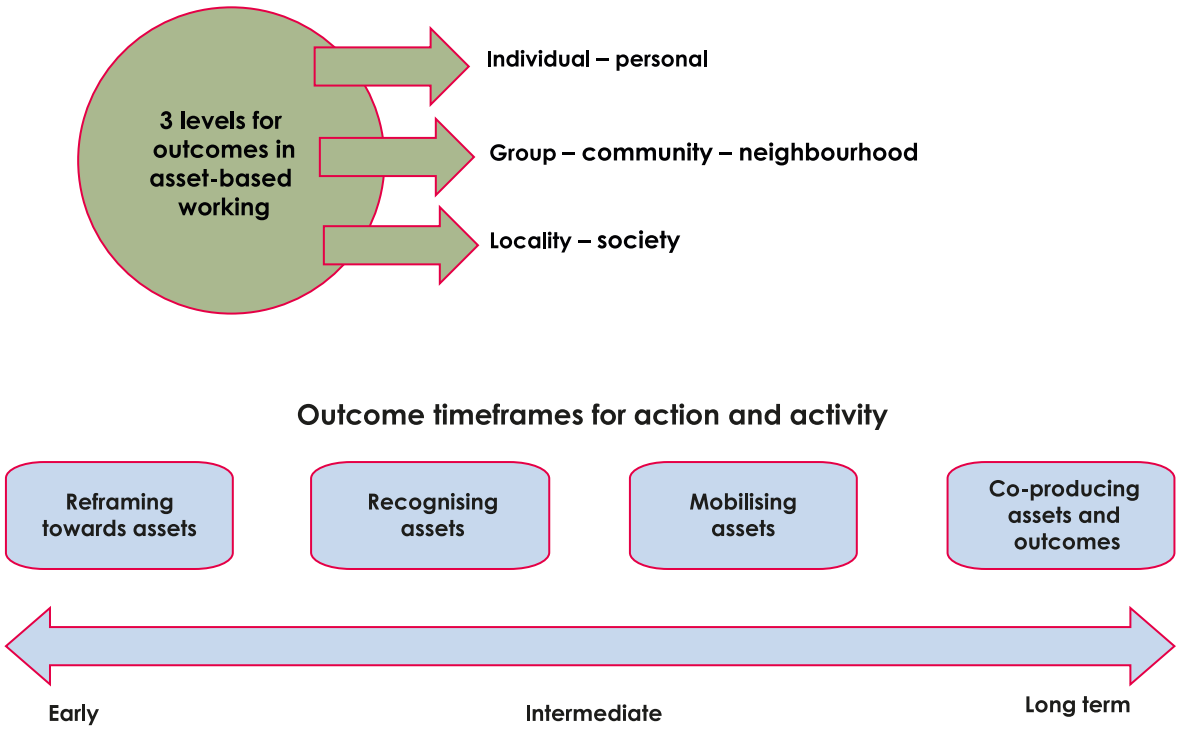


Figure 3: A theory of change for asset-based working – key elements and stages



Chapter 6:

Towards a theory of change: Learning from the case studies

We applied the principles of our Theory of Change approach to explore and analyse the drivers and mechanisms for change at work in the six case study projects discussed later. From the transcripts of the meetings and group sessions we identified how each project is reframing thinking towards goals and outcomes, recognising assets and going beyond asset mapping, mobilising assets for a purpose and co-producing outcomes on the pathway to the long-term goal of asset-based working.

Box 1 overleaf provides a short overview of each of the case study projects. More details is available in part 2.

Stages in the Theory of Change model: Perspectives from our case studies

1. Reframing towards assets: thinking, goals and outcomes

The reframing of thinking is an obvious but critical stage in the move toward asset-based working, and one that is often missed out, which can lead to inadequate implementation. Reframing can signal a shift in practice culture towards an asset-based model and is often seen as a significant step.

Reframing towards assets was mostly described as an explicit activity or event in teams, groups and organisations. Often the reframing was a systemic action. Against this backdrop, current practice and priorities can be reassessed and new outcomes defined. Whatever the trigger for the rethink, or the scale of the change envisaged, the first challenge is to change the culture. However, reframing people's thinking can be very difficult and time-consuming because exposure to asset-based approaches often challenges what we have previously taken for granted as a result of our professional training and organisational culture.

An essential feature of this 'reframing' in the context of asset-based approaches for health is to move away from disease, illness- or deficit-defined targets to longer-term outcomes.

> *'There has been resistance, probably due to culture and professional backgrounds linked with training [for the approach]. The deficit-based thinking might be more entrenched in older staff that trained and had worked in hospital based settings – though this is a generalisation – and it might be more strongly influenced by the service culture.'* (Lead Occupational Therapist – Kirkintilloch)

The introduction of asset-based thinking and practice affects how staff working in health and social care services value people, their families and communities. Changing to an asset-based approach offers and creates a new relational perspective. It is not a set of tools or techniques that can be applied without a change in organisational culture and individual practice. It must be a process, not a top-down plan. Action and activity must be connected and sequential.

Language is a huge signifier of changed values, which is why an emphasis on talking about assets – personal, collective and potential – is needed. Increasing focus needs to be placed on strengths and positive health, rather than sole attention to deficits and needs. For some practitioners and service users, although the language was new, it seemed as though they were merely relabelling old ways in the new language of 'assets', and that the new approach would need time to develop.

Box 1: An overview of the six case study projects

NHS Fife: reshaping care for older people

The Shine project in Fife, part of a Health Foundation funding programme, is taking an assets approach to supporting older people to live and thrive at home in ways that are safe and sustainable. This has involved specific clinical support teams talking with older people and their carers about their desired personal outcomes from service contact. Their approach starts with evidence that social networks, relationships and mutual support impact on people's wellbeing. Their hypothesis is that investment in these will reduce hospital admission and readmission rates for older people over time. The aim is to establish a 'proof of concept', which would inform local and wider plans for reshaping care for older people, including decisions about ward closures and redeployment of resources elsewhere in the system. The focus on skilling key workers in the pathway to focus on asset-based conversations has been supported by the use of the 'Talking Points: Personal Outcomes Approach',[70] which guides outcomes-based conversations that focus on the health and wellbeing goals that are important to older people and their carers.

The East Dunbartonshire Community Health Partnership – Kirkintilloch

The East Dunbartonshire Community Health Partnership, established in 2006, manages and delivers community-based healthcare services and leads health improvement programmes in the area. The case-study programme grew from an initial study by IRISS (Institute for Research and Innovation in Social Services) to undertake and report on a project about how an assets-based approach could improve mental health and wellbeing in East Dunbartonshire.[71] The study followed the closure of residential mental health hospitals during 1997–2000 as a result of the Community Care Act. Many of their services became commissioned services within the community to supplement medical services. The focus was on Kirkintilloch, a medium-sized town about eight miles from Glasgow.

Forever Manchester

Forever Manchester is one of 55 Community Foundations in the UK funded through the Big Lottery Fund's 'Fair Shares Trust' to build confidence, skills and experience of individuals and communities, build social capital, enhance liveability and improve sustainability. In 2011, Forever Manchester realised that their funding sources were going to change in the new political and economic climate. Since then they have transformed the way they organise and deliver support to neighbourhoods and communities. Through a deliberate and planned process that led to learning and adoption of ABCD principles and actions, Forever Manchester have instigated a range of asset-based initiatives across a range of localities. Significantly, these are defined and sustained by local residents in neighbourhoods.

Kimberworth Park Community Partnership – Rotherham

The membership of Kimberworth Park Community Partnership includes individuals, groups, agencies and organisations who work closely together to create a renewed sense of community spirit. They do this through delivering services/activities for people of all ages, to meet local aspirations and needs, including working with people with long-term health conditions and providing a befriending service. Based at the Chislett Youth and Community Centre in Rotherham, the partnership has grown from a community forum and became a registered charity in 2011.

Prospects for young people – Wrexham

Prospects focuses on providing continuity of care for children and young people along with a range of services to ensure the flexibility to offer 'the right placement at the right time'. Young people who come to one of Prospects' 11 children's homes in and around Wrexham often have multiple and complex needs, with typical backgrounds of family relationship breakdowns, attachment difficulties and histories of abuse. Carers and teachers work successfully with young people who present severe challenging behaviour.

Wirral Health and Wellbeing Board

Wirral Borough Council Health and Wellbeing Board is developing an asset-based strategy across the council. This is providing an insight into the mobilisation of a local authority through its statutory public health responsibilities towards an increasing focus on asset-based approaches and ABCD. The main drivers for the adoption of asset-based approaches in the Wirral have been rising poverty, budget cuts and the new opportunities and conversations that have arisen with the transfer of public health to the council, as well as the creation of the Health and Wellbeing Board. While the work is emergent, there is evidence of a collaborative ethos between public health leaders, elected members, community and voluntary sectors to agree a consensus on 'how' and 'why'.

In all of our case study areas, and through the discussions in the sense-making events, individual champions of asset-based working have been inspired to adopt a new perspective and have taken the lead in changing their understanding of the aims of public health and social care.

A reflective style to appraisal and personal development allows both staff and the organisation to reframe what works in the context in which they find themselves. This style of supervision and support helps staff to go well beyond their formal training and skills, as was the case in Wrexham, where 'individuals that really got it were created as champions to spread and maintain the practice'. In other projects, staff have been given training and peer support to reflect on and absorb the impact of this change in culture and development.

2. Recognising assets: beyond asset mapping

The case study interviews frequently involved discussions about the 'mapping of assets' in places. Although this is key to understanding the individual, organisational, associational, economic, cultural and physical resources available to communities, it is not an end in itself. Activity aimed at mapping assets is part of a wider concerted approach to a dialogue with and between local people, helping them to see the wealth of resources at their disposal. Critical to this is understanding and agreeing on what assets can be connected and how they can be used.

Our Theory of Change model offers a basis to explore these areas further. Recognising assets is seen as just one action in a sequence of activity. This fits with Beaulieu's critique of asset mapping, which suggests five key stages:

- understanding what assets are present
- building relationships to create leverage
- access to assets
- activity to mobilise assets for agreed purpose
- creating a shared vision for the future (through use of assets).[72]

The methods used to identify and map assets varied among the case study sites. They included traditional community asset mapping and circles of support (Kirkintilloch),[71] talking points (Fife), community conversations (Manchester) and 'appreciative inquiry',* which was applied in Wrexham 'explicitly to the training and implementation. It was consciously used to help staff to relate to the subtle difference between what they were doing and what they were being asked to do.'[73] Each represents a different way to organise discussions about assets through appreciative conversations and active listening. Critically, all of these methods involved conversations with local people at an individual, family and community level and within organisational teams.

The method by which asset recognition is undertaken and achieved is also key. We know that in ABCD, the use of community builders/community connectors has led to established approaches for mapping and describing types of assets, which can then enable thinking on issues such as power, access and control.

In an asset-based approach, the way that evidence is gathered, presented and used and the value that is put on this knowledge and information is important. Personal stories that describe the lived experience of people and places are very powerful and are widely used in asset-based working.

3. Mobilising assets: using assets for a purpose

Identifying assets through asset mapping is a critical feature of a positive dialogue. However, asset mapping is one event in a sequence and must be associated with an ambition in order for the assets to be connected, mobilised and put to work for an agreed purpose. Reframing and recognising assets are not enough on their own to make change happen. Mapping physical assets (such as buildings), economic assets (such as local employment opportunities) and cultural assets (such as libraries, arts activities) will not lead to action unless they are connected to individuals, associations and organisations – an obvious statement, but one that our work to date suggests needs re-emphasising.

The commitment to listen to individuals and help them mobilise and connect their assets to achieve their aspirations makes outcomes particular and personal. With this approach, other organisations with the potential to contribute to wellbeing outcomes can be identified and supported to refresh their priorities and attitudes, and to change the way they use their assets.

* Appreciative inquiry is an asset-based approach that originated from the field of organisational development. It aims to discover and build on what is working well in an organisation, group or community. Instead of focusing on problems and their causes, appreciative conversations ask what if the best features of the group happened more often, and how to make that happen.

As shown in the case studies of Manchester and Rotherham, ABCD can build and strengthen social networks, collective voices and community resilience. Investment in building, nurturing and sustaining individual, family and neighbourhood assets is critical.

Opportunities need to be made to bring people together to identify, mobilise and connect assets for a defined purpose. This is the seedbed for growing community activity, as a community builder from the Forever Manchester project explained:

> *'We use what we call "ideas work" sessions… using asset-based conversations. We talk about what people can do, what their aspirations are and what's good in the place they live.'*

Mobilising assets requires a new approach to leadership. This reflects the new emphasis on 'winning hearts and minds' (in reframing for assets), influencing peers and empowering staff to make relationships and work more collaboratively. Asset-based working benefits from a leadership style that is more developmental and collaborative. Asset approaches are not so reliant on positional authority.

In local communities, elected councillors can be key leaders in the system, both for their strategic decision-making powers and also as community leaders, connectors and influencers. This was the case in Rotherham, where a centre manager reports that ward councillors were 'very important in securing the asset transfer – one in particular has been pivotal in the initial discussions about the centre and had been the central contact'.

The need for systemic action across all agencies seems clear when adopting asset-based approaches to local issues, and interviewees in both Wrexham and Kirkintilloch highlighted the difficulties that can occur when holistic cross-agency cooperation is lacking.

In the Manchester case study, we saw how ABCD activity facilitated by community builders in a specific neighbourhood had engaged the local school team, the director of public health and the CEO of the social housing trust. While these relationships may be indirect or tangential to the local community activity, they do provide an opportunity to shape and reframe the wider system towards asset-based approaches and mobilising health assets over time.

Relationships, interactions, dialogue and connecting are all central features of asset-based practice. This is in contrast to the more transactional and standardised relationship between professionals, 'clients' and patients that has become typical of health and social care. A manager in Kirkintilloch suggested that modelling the asset-based approach alongside deficit-based approaches would 'shift the culture… and get a better balance than currently exists'.

Skilled staff will be needed, but different skills will be important: brokering, facilitation, community development and active listening will be key. Staff responsibilities will change as services are developed and redirected to more asset-based principles. Collaboration and networking skills are needed to support co-production, which is a fundamental building block of transforming outcomes.

4. Co-producing assets and outcomes: on the pathway to the long-term goal

In our telephone interviews and case studies, co-production was one of the most commonly quoted methods of asset-based working. But sometimes in health and care services the term is used to describe community consultation about service improvement where communities are very passive in the process. Typically these 'consultations' do not envisage the co-production of outcomes or even the recognition of the community assets that exist. Improved wellbeing and life chances for individuals, families or communities can only be achieved through services and communities working together.

Once asset principles and co-production are embraced, this should lead to a re-evaluation of outcomes. Instead of setting deficit-based goals or targets, higher aspirations should be set around physical, mental, emotional and spiritual wellbeing and improved life chances. Staff in Kirkintilloch used asset mapping with clients and obtained

> *'amazing results, even with those that they didn't think would take to it. It's about seeing the client as a human being with skills and a technique for making changes. It allowed them to pool resources and configure support to the individual based on their requirements and specific circumstances.'*

Collaborations are most effective when linked to the other stages of asset-based working (reframing towards, recognising and mobilising assets). Then the act of co-production represents the coming together of equals, each with assets and strengths, around a common goal or a joint venture.

Clearly, real co-production of public services does not mean just 'self-help' by individuals or 'self-organising' by communities; it requires the contribution of both citizens and services. When this occurs, better use is made of each other's assets and contributions, resulting in better outcomes.[75]

Most of our case study areas are already co-producing positive outcomes. For example, Wrexham Prospects is working with young people to help them achieve their dreams, while staff in Fife are creating new providers that can help the older residents achieve their aims. In Manchester and Rotherham, the outcome is a 'strong community' in the knowledge that this is good for health and wellbeing and essential if there is to be true 'collaboration of equals' between residents and local services. Kirkintilloch and Wirral are in the early stages of transformation, but envisage equally different approaches to agreeing positive outcomes and supporting individuals, families and communities to achieve this.

Perspectives on co-production of outcomes

'I knew about the community asset mapping locally and could understand the link between identifying personal assets, helping the client to understand their situation and to enable their ability to utilise community assets, support and activities. Occupational therapists (OTs) are strongly led by co-production principles; we don't do for people what they can do for themselves.' (Senior OT, Kirkintilloch)

'If we are to promote health assets that contribute to a person's health and wellbeing, a collaborative approach across different public services is required. This includes ensuring the active engagement of service users and the communities they live in. That approach will support and promote people's sense of coherence and hence their capacity to respond to an environment that is both comprehensible and manageable to them.'[74]

'The workers… came in friendly… not telling us what we need or how to do things… they helped us and worked with us…We trusted the Forever Manchester people… it just fitted… felt right what they were saying… it put us more in control of ourselves and things we wanted to do.' (Community member, Forever Manchester)

Chapter 7:

Recommendations

As a result of our research, we would like to make the following recommendations for researchers, practitioners and policymakers with an interest in asset-based working and the promotion of positive health outcomes in the UK:

- **Develop a working model for health assets.** This should be based on salutogenic theory, research evidence supporting the concept of health assets and the emerging principles and learning from asset-based practice.
- **Continue to tackle health inequalities.** Asset-based practitioners start from a different place from many who work in health and care services. Like them, we should ask the question 'what makes us well?' rather than 'what makes us ill?'. If our vision is to improve people's life chances and to reduce preventable health inequalities, our explicit aim should be to promote and strengthen those factors that support good health and wellbeing, protect against poor health and foster communities and networks that sustain health.
- **Plan to incorporate asset-based approaches into mainstream public health activity.** A key concept that underpins the development of asset-based practice is the idea of positive health. This envisages improved life chances and wellbeing for all as the overarching aim of public health practice, instead of more deficit-based targets of reduced mortality and morbidity. The term 'health' has become so associated with treating illness that it diverts people away from thinking about wellbeing. The outcomes from asset-based working should be part of an evidence-based pathway to the high-level public health outcomes of wellbeing and health equity.
- **Plan to integrate health assets and interventions that promote assets into health and wellbeing strategies.** These strategies should reflect the well-evidenced association between levels of good health and wellbeing and the strength of assets such as material wealth, social capital, a sense of coherence, social networks and support, community efficacy, resilience and social cohesion.
- **Champion asset-based approaches.** In the UK, system leaders can do this regionally and locally through health and wellbeing boards and partnerships. Nationally, this requires more explicit support and commitment by national health agencies and boards (Public Health England, NHS Scotland, Health in Wales, Health and Social Care Northern Ireland).
- **Prioritise NHS and local authority investment into asset-based community development for health and wellbeing.** This is even more important at a time of restricted resources in public services and the impact of this on widening health inequalities.
- **Develop our workforces and build community capacity to incorporate skills and knowledge on health assets and asset-based approaches.** This should be reflected in the training and development of anyone who works with individuals, families or communities.
- **Create 'place-based outcomes'.** The opportunity to plan and invest differently can be achieved through a redefinition of 'who' is in the system and what the available or potential assets are. Asset-based approaches enable local politicians, leaders and actors to view the local system differently, showing fidelity to co-production, resource shifting, asset building and sharing.

Part 2: Asset-based approaches in action

Chapter 8:

Case studies: Introduction

A key requirement within the project was to identify and report on areas of asset-based practice in localities and settings through the use of case studies. We identified six suitable sites for the case studies:

- NHS Fife: Reshaping care for older people
- The East Dunbartonshire Community Health Partnership with IRISS – Kirkintilloch
- Forever Manchester
- The Kimberworth Park Community Partnership – Rotherham
- Wirral Health and Wellbeing Board
- Wrexham – Prospects for young people.

These projects were identified through the literature review, through our network of contacts, by recommendation and via the telephone interviews. Where possible we tried to achieve representation from a wide geographical spread across the UK, a range of agencies, and organisations within the statutory, voluntary and independent community sectors and organisations working with different groups, service users and/or community members.

The criteria we applied when shortlisting suitable case study sites were to investigate those working on asset-based approaches in all of the following ways:

- their activities are informed by evidence, conceptual and/or theoretical models
- they are currently implementing and developing asset-based approaches in their day-to-day work
- they are attempting to evaluate the impact and benefits of their work on assets.

Each case study project was interrogated in its local context as well as in terms of its application of asset principles as identified in the literature and evidence review. We took a 'whole system' approach, seeking to identify the 'reach' of the project in terms of community members and in the areas of impact, benefit and outcome.

We attempted to identify the conceptual basis of the case studies to determine how the interventions related to the 'Theory of Change'. What did the project intend to do? What did it do? How was it intended to make changes? What other variables were considered and what variables influenced the work?

In addition to these themes, we gathered factual information on the following questions and areas.

- What is the issue being addressed – what is the health and social care emphasis?
- What is the context in which the project team is working in terms of environment, demographics, politics, policy, organisational?
- What is their working hypothesis about how the practice will provide a model for change?
- What is the design of the project in terms of key activities and objectives, resources, time frames, skills and partners?
- How are knowledge and learning managed and practice adapted?
- What is the approach to measuring and evaluating the project?
- What quantitative evidence is there for their effectiveness or lack of it?
- What are the implicit and explicit critical success factors, as perceived by the different players?
- Reflection on the effectiveness of an asset-based approach: what do they think worked and how/why?

Following email and telephone discussions with a key contact in each case study site, two members of the research team, Trevor Hopkins and Simon Rippon, visited three case study sites each. The case study researcher conducted interviews with key players including senior officers, middle management and frontline staff, volunteers and service users. The use of supporting documentation, strategic and operational plans, evaluation data and key reports (where available) provided useful background information. Where possible we observed key meetings/events that relate to the work of the site.

Following the data gathering, each case study was transcribed for thematic analysis. The transcribed notes from each site were interrogated to draw out the responses to the areas being investigated in relation to evidence, practice and evaluation. The findings from all six case studies were then compared for similarities and for any insights into areas that were having particular success that could help others with implementation of asset-based approaches. All six case studies were written up in summary, capturing the main points and any insightful quotes from participants. During this process, examples and quotes that illustrated particular approaches to asset-based working were highlighted.

Chapter 9:

NHS Fife: Reshaping care for older people

The Shine project in Fife,[76] part of a Health Foundation funding programme, is taking an assets approach to supporting older people to live and thrive at home in ways that are safe and sustainable. This has involved conducting different conversations with older people and their carers about personal outcomes, harnessing community resources and developing local 'micro-enterprises' to help achieve those outcomes.

This initiative came about as part of a crisis in the local health and care system, both the acute and community sectors, in responding to increased demand for services by older people.

Senior clinical leaders used the International Futures Forum 'Three Horizons Framework'[77] in discussions about what the ideal would look like, and how they could bridge the gap between their current practice and that ideal. This generated some 'promising pathways' to help them develop a new health economy that reflects the needs of an older population. One of those pathways was to 'nurture community and relationships, recognising that most recovery from illness and longer-term care takes place at home' (Senior OT Service Manager/Project Lead). They started from the evidence that social networks, relationships and mutual support impact positively on people's wellbeing. Their hypothesis was that if they invest in these, then over time there will be a positive change in hospital admission and readmission rates for older people.

The Shine initiative has two interdependent elements: different kinds of conversations with older people about their personal goals and wellbeing, and diversifying the local provision so that people can access services that will help them achieve their goals. The aim is to establish a 'proof of concept' that would convince local stakeholders and inform wider plans for reshaping care for older people, including difficult decisions about ward closures and redeployment of resources elsewhere in the system.

Personal outcomes

The Shine project uses the 'Talking Points: Personal Outcomes Approach',[78] which guides outcomes-based conversations that focus on health and wellbeing goals important to older people and their carers. The aim is to build on peoples' interests, skills, networks and contacts to enable them to remain socially engaged and minimise unnecessary dependency on services and formal support.

New providers and resources

The key to the project is stimulating a 'co-productive' way of working with each person, involving their natural networks to allow highly effective individual solutions to emerge and support new micro-providers based in local neighbourhoods to deliver aspects of individual support. The model of provider development is based on the work of Community Catalysts.[79]

Key findings from the case study

The project we studied in Fife had been set up to address the pressures on services for older people. However, the approach also enabled different conversations to take place between professionals and service users.

- Interviewees described developing different outcomes that were highly personal to each individual. This was measured by how the person felt or how they had changed after the conversation and whether they had been able to meet their aspirations.
- Language was very important, and there has been a conscious decision not to use terms such as 'assets'. These often mean nothing to older people and can

also be a 'turn-off' for many staff. One interviewee commented: 'Terminology can cause us to silo – no matter what we are trying to do'. The project involved a significant culture change for service users and staff. Peer supporters have helped staff to implement the approach. However, some older people struggled with the new model. This raises the question of whether champions or mentors for service users could be beneficial.

- Fife is taking a long-term approach to attempt whole system change at community level. Social workers are fully on board (ABCD fits well with their training and practice), but NHS (clinical) staff are harder to engage as they want evidence to persuade them of the benefits (see Chapter 4 for discussion of the criticism of asset-based approaches).
- Success has in part been down to engagement with an experienced local community development organisation called BRAG Enterprises (Benarty Regeneration Action Group). Practitioners have understood BRAG's importance as a community asset and have allowed it to play to its strengths. BRAG's remit was to develop the range and scope of micro-providers to support older people.
- Evaluation of the project has proved difficult, especially the attempt to show reduced costs. With the exception of a few individuals, savings have not been evident. The focus has been on personal outcomes, measured by before-and-after questions and reflective work built into the whole process.
- Criticism of the robustness of the evaluation ignores the fact that ABCD is a different approach requiring different methods of measuring success. The approach being taken in Fife is contextual evaluation and is appropriate to the work. The project has shown that quantitative, objective measuring tools do not easily lend themselves to highly subjective work. 'Standardised measures such as "Quality of Life" indicators (QoL) miss the point', noted one interviewee. This is reflective of our discussion on research and evaluation, which notes that suitable social science methods are relevant to asset-based working.
- The project is evolving and is slowly being introduced into mainstream work. They now have a group of managers who want to make this the way they do business. They have set up peer support sessions for staff who were finding it hard to change, and to support the training and practice. They have identified clinical champions who can work on this one day a week.

A report by the Shine team to the Health Foundation lists their learning points as follows:

- This is a radical culture shift, which we are only beginning to understand.
- Staff need support and permission to do things differently.
- Clients also need time to adjust to new ways of thinking about things.
- There is a wealth of enthusiasm and creative solutions from micro and social enterprises, the voluntary sector and the wider community.
- 'The devil is in the detail' – complex issues and interdependencies can be resolved through dialogue, negotiation and close partnership working.
- Conversations with patients have proved very fruitful and powerful, and reinforce the need to take this work forward despite its complexity.[80]

Chapter 10:

The East Dunbartonshire Community Health Partnership with IRISS – Kirkintilloch

As part of their new thinking, NHS Scotland and the Scottish government are promoting asset-based working in health and social care. In 2011, the Scottish Institute for Research and Innovation in Social Services (IRISS)[81] worked with the East Dunbartonshire Community Health Partnership and other agencies to pilot asset-based working with people with mental health problems.

The Community Health Partnership was invited to pilot this work and enable IRISS to research and evaluate the approach. Occupational therapists (OTs), social workers and voluntary sector providers were involved. This has meant that the project, which has continued beyond the pilot phase, did not evolve from an internal process of assessing current practice and as a consequence there has been some rethinking of what they were doing. This has had some consequences in terms of the depth of knowledge about asset theory and principles, remaining personal and professional doubts about the approach and the cultural changes needed to transform the approach for users. It is not clear whether the strategic intention and understanding behind this project is aligned with what actually happens in practice.

Recognising the assets

In the pilot phase, staff conducted participative engagement with mental health service users to discover and map the community assets that were available for positive mental health and wellbeing. They found that friends, family and local facilities such as green spaces were most important to people. Services did not play a central role. Mapping their personal assets and sources of resilience was less successful, as clients did not recognise their own strengths and skills, but tended instead to identify external sources of support.

An asset mapping tool, comprising appreciative questions, was given to OT staff to use with individuals as an assessment, diagnostic and evaluation framework alongside their existing processes. With this they could change the conversation between the user and professional staff to find out about their assets, ask what would improve their wellbeing, plot the client's progress and inform changes in their treatment. It was also intended to change the way staff saw service users.

Some staff found this valuable – mainly those who felt that this was the way they did things anyway and that the approach linked with their personal values, rather than from any knowledge of the theory or evidence for asset working. It was felt that the methods fitted particularly well with OT training. Voluntary sector staff liked the new methods, although this was more from an instinctive feeling than out of familiarity with the underpinning ideas. Other staff were more resistant to the approach. This may be as a result of their professional, especially clinical, training and experience, the health service culture and a history of nursing approaches in psychiatric hospitals.

Some of the service users liked the new approach and found it helpful. Others found it difficult to engage with or of little value. Some staff reported that some service users were 'habituated' into more traditional approaches and resistant to change. This might be explained by staff or service users not being introduced to the principles, theory or evidence of asset-based working, so they were not able to fully engage with the approach.

A voluntary sector-run peer support group, which takes referrals from the NHS OTs, deliberately does not focus on the mental health issue or define the users by their condition. The focus is on social support, wellbeing and creating positive experiences such as social outings,

volunteering opportunities and friendships. The users liked this more social and supportive style, which is not time limited like other treatment and support. Attending the group had improved their confidence and self-esteem, their feeling of stability and their ability to move back into the community from hospital.

Key findings from the case study

The asset model is being supported at a national strategic level in Scotland. Asset mapping is being carried out and is heavily based in practice and experience as well as personal instinct. Most practitioners state that there is no strong strategic direction for this despite Sir Harry Burns'* recommendations, and that it is not particularly well developed across organisations and systems. However, the strategic lead for older people at the local authority had prior knowledge of the approach through experiencing different models of service delivery. He demonstrated an open and flexible attitude to delivering across the system to get the best outcomes for service users. This begs the question of whether or not it is helpful to have senior organisational support. Or does high-level understanding and willingness become diluted as it cascades through management structures to the practitioner level?

- Voluntary sector organisations have embraced the approach more fully than the NHS, where there is patchy take-up and mixed views about its benefits. Most of the asset-based practitioners spoken to in this case study said the voluntary sector 'got it'. This was demonstrated across services and, in some cases, whole organisations.
- Opinion in the NHS was more mixed and, in some cases, there was resistance to change. This was especially common in clinical practitioners, older staff who had trained some years ago and among those who had previously worked in psychiatric hospitals/wards.
- There was broad agreement that the staff who understood and adopted the approach tended to work in this way anyway; the asset model backs up their practice and fits their perspective. They can see how assets approaches can be used and are able to compare them with similar frameworks or processes, such as solution-focused therapy.
- Practitioners valued the asset maps they had created with service users. These were used to track and demonstrate individual progress alongside a variety of other assessment and reviewing tools, not as a replacement for their usual methods but in addition to them. Asset maps are used simultaneously as an assessment, diagnostic and evaluation framework. Those using the maps regularly and successfully believe professionals need to be able to use their judgement to interpret the maps to aid understanding of progress.
- There was broad agreement that guidance should inform all levels of the system, from academic/strategic to practitioner level, and this should not be prescriptive. Guides, including examples applied to specific professions, would be useful tools to aid improvements and the adoption of practice.
- There was a clear consensus that context is vital and that externally set targets do not help these kinds of interventions/activities. Any work with people has to reflect their subjective experience and the context of their life, family and community. Effective evaluation requires a shift in thinking towards a greater focus on values and personal outcomes. Some suggested there was a need for common theoretical/evidence statements and associated measures/indicators that could be applied across individual outcomes.
- There was a sense that it is difficult to change practice in NHS and other 'mainstream' services. There is resistance from some practitioners/professional groups and a lack of senior or strategic support. Some expressed a view that it is easier to make changes in the voluntary sector (where there is more flexibility/fewer targets). Voluntary sector practitioners indicate that they still have targets to meet, but manage to meet these using assets-based work. Their view was that most difficulties arise from the power imbalances that sit in and between statutory organisations and services.

Two reports produced by IRISS have much more information about this project.[71,82]

* Harry Burns was the Chief Medical Officer for Scotland from 2005–2014. He was influential in introducing asset-based approaches to challenging health inequalities across Scotland in his 2009 report, *A time for change*. www.assetbasedconsulting.co.uk/uploads/publications/Health%20in%20Scotland%202009.pdf

Chapter 11:

Forever Manchester

Forever Manchester is one of 55 Community Foundations in the UK. It was funded through the Big Lottery Fund's Fair Share Trust to:

- build capacity – the confidence, skills and experience of individuals and communities
- build social capital – the networks, relationships and contacts of individual, voluntary and community groups and statutory bodies within communities
- enhance liveability – the physical space in which communities exist
- improve sustainability – a positive lasting legacy.

Rethinking the mission

For over 10 years, Forever Manchester has built strong connections with local communities via commissioned community projects. In 2011 the organisation realised that its funding sources would change in the new political and economic climate and they had to plan accordingly. Around this time, the CEO was introduced to ABCD at a national 'Fair Share Trust' conference. The focus and content of asset-based working strongly echoed his and Forever Manchester's core values. This has led to the adoption of a completely new way of implementing community development, with new goals and an internal review of practice and delivery.

Their 2011 annual report set out this new direction: 'Alongside the images of success, many of our neighbourhoods remain marginalised through poverty, ill health and isolation; people feel powerless at not having a say in the decisions that affect their lives and not having their views taken into account'. Instead of labelling people by their needs, Forever Manchester set out to focus on skills, talents and assets and on the possibilities to encourage real empowerment within their communities: 'Bringing people together over a common passion has a big impact in changing the way people view their community and themselves, giving people more hope for the future of their communities, rather than despairing that things will never improve'.[83]

What do they do differently in the organisation

Roles have been reoriented away from office-based grant giving and programme management towards working directly with individuals and groups at neighbourhood level. Two community builders were recruited, trained in ABCD approaches and given the job of creating opportunities for community conversations: listening to and supporting people to take community action at neighbourhood and street level.

'Team Parties' or away days are held for all staff to learn more about ABCD, discuss the new ways of working and review these against ABCD principles. This process is leading to greater understanding of the approach and embedding a different culture of thinking, doing and relating.

What do they do differently in the community

The community builders' role is to meet as many people as possible in communities and have what they call 'learning conversations'. They ask asset-based questions about people's passions: what they are good at, what they would like to do, what they think about the local community. They look for bumping spaces* and events that are going on where they can talk more with people. They also find people on Facebook and look for trends of what is going on and what people's ideas are. They aim to make connections between people with similar ideas.

* Physical places where connections and contact with local people can be achieved and fostered. In this example spaces such as bus stops, streets, shopping precincts, outside schools were cited as 'bumping spaces'.

Key findings from the case study

This work is led by an established community foundation. It was partially driven by a changing political agenda and the realisation that the existing approach was no longer having the desired effect. The way that practice had developed no longer fitted with their organisational and personal values. The change to a new direction seems to have been started with an informal 'Appreciative Inquiry' process.

Forever Manchester became aware of ABCD through a session run by Nurture Development.* They then adopted the approach as a set of principles for the whole organisation. The change was strongly connected to the core and personal values of senior staff. In practice they are doing several strands of work that are all classic ABCD methods.

- The biggest challenge in the initial phase of community practice has been working with other voluntary sector community-based organisations. This may be due to fears that Forever Manchester is reducing the reliance of individuals on their services and/or that funding is being diverted away from them and going directly into community activities.
- In just 18 months, all of the communities in which they have implemented the ABCD approach have reported a dramatic increase in the levels of community activity, social networking, groups and connections between residents. Overall, 60 community-led projects have emerged. Over 50 of these projects have secured Cash for Graft awards.†
- The project seems to have increased social trust. A local resident said, 'The workers aren't above their station… [they] come in friendly, not telling us what we need or how to do things. They helped us and worked with us. We trusted the Forever people… it just fitted, felt right what they were saying, put us more in control of ourselves and things we wanted to do'.
- There has been an impact on people's behaviour, feelings and their sense of coherence, control and self-esteem: 'This has been different for me. When I used mental health services, people were paid to listen [and it] didn't solve anything. I was still in an abusive relationship, still not going out, still not working… but taking tablets to help sort it out! How daft is that?'
- New community builder roles have been created in the organisation to further develop the reach of the model. Forever Manchester has recruited local residents involved in the early adoption work into these roles. This is a positive example of creating social value.

A measurable impact on health?

The familiar model of 'identify the problem and fix it' is not part of ABCD. Often the community builders do not know about a person's health problems and therefore do not collect evidence of those problems being fixed. As a community builder explains, 'We accept there are problems and deficits everywhere, but we don't start from there or focus on that. For example, some people we encounter might have mental health problems or disabilities, but we don't ask about that; we might not ever know, we don't dwell on that. It's all about possibilities, the positive…'

Forever Manchester has not really thought of itself as having an impact on people's health and wellbeing. This was not an immediate driver. Any connections with health services are very recent.

Success has also relied on agencies that support the neighbourhoods and work in a strength-based way with local residents. Forever Manchester has worked closely with housing associations, councils and the police to ensure that, collectively, they act as a catalyst for communities to tackle their own problems rather than as the providers of solutions. As the local social landlord put it, 'We are working in communities now that in the past we have failed to engage successfully with. We can measure the success through impact on personal health and wellbeing, confidence and aspiration'. They are now funding further work in the community and provided the Community House that is the hub for the community's activities.

Relationships with agencies for public health, education and community have continued to grow as Forever Manchester establishes local projects and seeks opportunities to inform and collaborate. In turn, this offers the potential to develop the local model, deepen the presence of ABCD and address some specific challenges on wellbeing and community resilience.

* Nurture Development is a consultancy organisation providing expertise on ABCD.

† Cash for Graft is an initiative within Forever Manchester's ABCD neighbourhood work where residents can access direct cash funding to instigate and support local initiatives and action arising from ABCD conversations.

Chapter 12:

The Kimberworth Park Community Partnership – Rotherham

The Chislett Community Centre in Kimberworth Park, Rotherham was built with money raised by the community literally 'brick by brick', and that has left a powerful legacy of pride and ownership of the building. By the late 1990s, despite being run-down, the Kimberworth Park area had missed out on council and regeneration funding. The centre was underused and was seen as just for young people rather than the whole community. A threat of closure mobilised some local people to reappraise the importance of the Chislett Community Centre and recognise what it could be. Now run by the Kimberworth Park Community Partnership, it is a lively place, valued and used by all sections of the local community. It has strong links with the council, the local further education college, churches and the clinical commissioning group (CCG). It became a registered charity in 2011 and has been transferred from council ownership to a management board made up solely of local people. It is now flourishing: employing staff, taking on bigger events and fundraising.

Individuals as assets and catalysts

An important catalyst for the new start were three motivated and determined individuals – the local vicar, a local councillor and a youth worker – whose attitudes to working with local people were critical. The vicar had discovered the ABCD guiding principle that one should never do for a community what it can do for itself, and described how this had profoundly changed his approach: 'I had a major realisation and political awakening when I was hit with the idea of not doing things **to** people but doing things **with** them. Since then my guiding principles have been never doing for communities what they can do themselves'. These individuals had valued and nurtured the assets in the community: their pride and resourcefulness, and the collective capacity to take back the centre and use it for the benefit of all. Combined with these individuals' personal assets – knowledge, relationships, networks and connections – the community was able to raise funds for new activities and win an asset transfer of the ownership of the centre. A 'Planning for Real' exercise capitalised on the existing strengths and mobilised people's energies and ideas for the future.

Mobilising the assets

Local volunteers, some of who have since trained as youth and community workers, now run and manage a growing range of activities and also support public organisations that use the centre to deliver their services.

- An outreach and detached youth work model has been adopted in order to have conversations with young people about issues relevant to them and to encourage them to come to the centre.
- Voice and influence sessions are run for young people to give them input into the community. There is an emphasis on building their self-esteem and self-confidence, giving them a chance to make a contribution and gain a sense of purpose; this is a positive way of tackling anti-social issues and poor school attendance.
- A school re-engagement project is run in conjunction with the education welfare service.
- The gym was needed by the community and funding for it was obtained from the Big Lottery Fund's Fair Share Trust.
- There is a befriending scheme to tackle social isolation.

By running activities for the whole community, the volunteers have reconnected age groups and different interests and built neighbourhood networks and support systems, which are new assets in the area.

Collaboration

There has been little connection with the health services in comparison with the council and other local agencies. One person who had worked as a 'health champion' found that the title had put local people off. It suggested that they were 'experts', and people did not like being told what to do; buddying with a man who had had a stroke and going with him to the gym as a friend had been more effective. More recently the partnership have managed to engage the local commissioners by highlighting the way their activities deliver NEF's 'Five Ways to Wellbeing'.*

Community organisations need to have credibility with the statutory services – especially the NHS – if they are to receive referrals and collaborate with other organisations. But the outcomes of the centre's work are hard to prove in the current view of what counts as evidence. There is a strong feeling that the ways in which they are asked to measure their activity do not support the work or show what people really care about in their lives. It is difficult to link this kind of local knowledge and learning to targets and formal evaluation.

The community partnership has developed its own systems of collecting evidence such as stories, photos and logs of events. Young people create portfolios and personal files to show their own progress. They use a spider or star diagram to measure personal progress towards different goals. They are trying to work with Ofsted and use the outcomes in *Every child matters*.[84]

This relative lack of awareness of the positive health impact of strong communities and of the contribution of ABCD to improved wellbeing is an important barrier. In the last decade it has been accepted that a strong community is an important element in reducing crime and the fear of crime, and the police have funded crime prevention work with communities. In comparison, the appreciation of the impact of strong communities and social networks on positive health and wellbeing is in its early days. While existing programmes are community based, they are rarely community led. Often, community development workers and community activists do not think explicitly about the health and wellbeing benefits of what they do, nor are many health and care services actively working with communities to build collective and individual assets.

Key findings from the case study

- In Kimberworth Park there were some very strong foundations to build on, including physical assets such as the Chislett Community Centre, which was built through a process of community action. This fostered a sense of history and ownership of the centre by local people.
- Other existing community assets included the local vicar, the council's community development officer for the area and local councillors. They all contributed to a sense that the local community recognised its strengths and what it valued.
- Our focus group revealed a strong sense that the community understood the balance between deficits and assets. Although the local area is often described as 'deprived', the community also understood that it had strengths.
- An assets-based approach can be seen in the culture of the community centre and its sense of place. It is both instinctive and learned through practice. People feel part of a community and there is a feeling of belonging. Social justice is used to describe personal values.
- There was evidence that the vicar, in particular, thinks/works in an asset-based way. His views on evaluation were that target-driven cultures do not support values-based work and that statistics do not tell the whole story: 'people's stories tell you how their lives have changed'.

The strategic lead at the centre shares the views expressed by the practitioners, but we found evidence that she is also linking practice with broader local issues/policies. She made some specific points.

- Community organisations need to have status and credibility in order for the statutory services (especially the NHS) to want to make referrals.
- Public health professionals often do not want to collaborate with small community- led/based organisations.
- Community development approaches do not have the same status as medical and clinical services.
- Evidence for social change needs to be different and much more contextual.
- Formal measuring regimes do not show what people care about.

* 'Five Ways to Well-being' is a set of evidence-based actions that promote people's wellbeing. They are: 'Connect, Be Active, Take Notice, Keep Learning and Give'. The Five Ways to Well-being were developed by NEF from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing. The Project, published in 2008 see: www.neweconomics.org/projects/entry/five-ways-to-well-being (accessed August 2014).

– Often staff and volunteers are so busy delivering the programme that evaluation gets pushed back – it is difficult to make it a priority.
– This is long-term work: outcomes cannot be demonstrated in short timescales.

On the surface, the community partnership might only be doing very good community development work, but clues in the information that was shared with us indicate that the work is also implicitly, if not explicitly, asset based. This was not always explained. Effective frontline volunteers and staff talk about their roles as 'what they do' and 'how they work'. An explicit understanding of asset-based approaches only becomes apparent in conversations with more senior staff. Maybe this is not such a bad thing.

Chapter 13:

Wirral Health and Wellbeing Board

Wirral Borough Council Health and Wellbeing Board is in the early days of developing an asset-based strategy for health and wellbeing across the council. This is a significant change of direction, and the main drivers for this change have been rising poverty in the area, budget cuts and the new opportunities and conversations that have arisen with the transfer of public health to the council, as well as the creation of the Health and Wellbeing Board itself. The scale of the budget reductions has led staff and councillors to conclude that they could not afford to continue as they had done in terms of funding programmes of intervention. A fundamental rethink was needed.

Rethinking the council's role

A new public health manager was already interested in and had experience of asset principles, saying, 'it taps into [my] personal values and beliefs… we have to… remember our public health roots, working with communities to take control of their lives… There's been a kind of competition: we're more deprived than you are, a league table almost, because that gets us money for programmes'. Now she describes the task as promoting resilience in order to manage demand for services.

Presentations were made in a Health and Wellbeing Board development session with 40 guests from partner organisations, the leader of the council and other politicians. A second meeting is now planned so that other councillors can hear the message. Following this event, the chief executive and the leader are introducing the ideas to their colleagues to build a 'coalition of the willing', developing the ideas into the new ways of working in the council and with partners in the area.

Top-down leadership

The current health and wellbeing strategy describes the vision as 'enabling people to live healthy lives, to tackle health inequalities and increase wellbeing'. It includes some references to the principles and insights of an asset-based approach, but the aim is for the new strategy to make more explicit reference to ABCD and asset-based approaches and to include a statement or description of what asset-based working means in the Wirral.

Key findings from the case study

- Analysis of asset-based working in the Wirral revealed a contrast in attitudes between public health staff working for the local authority and officers employed in the voluntary sector.
- All those interviewed talked about the impact of the current economic crisis, with the public health/local authority staff viewing the efficiencies agenda as a huge priority. In some ways, ABCD is seen as a possible way of making savings while still providing some level of support to communities and increasing opportunities for community action and citizenship.
- Voluntary organisations also identified some benefits and possible opportunities, for example, that asset-based working has led to greater scrutiny of existing services in terms of value for money and the benefits they deliver to service users.
- Generally, voluntary sector interviewees were more critical of the 'dependency culture' that has existed over the last two decades. In their view, reversing the mindset of individuals and communities that have become disempowered due to the actions of services is essential. One interviewee commented, 'Money is not a helpful motivator in this… we need to tap into and look at the natural resources in situ… use those and create methods for doing that'.

- There was a sense that the public health leaders in the Wirral have understood and embraced the principles of ABCD. A strategic approach to changing organisational culture was observed in the public health team, with action taken to engage strategic leads at board level in order to exert influence and shape direction.
- Some criticism was made of previous approaches, which involved significant health funding directed at target groups and specific issues or problems in communities. It was felt that services had been too focused on solving problems and that deprivation had simply been met with more funding.
- A contrast was drawn between the fluid, flexible approach of ABCD and the bureaucratic structure of a local authority. Staff talked about the need to document ABCD in council papers in order to record the approach formally, but felt that this could be counterproductive, as the approach relies on values and principles that cannot be described easily. At the same time, expressing them in policy does not necessarily mean they translate into practice. Similarly, ABCD does not function well if constrained by a target-driven culture, and is perhaps counterintuitive.
- Some interesting observations were made about clinicians (for example, those working for the CCG) and their attitudes to ABCD. It was felt that they posed a significant challenge to the implementation of an assets-based approach, with many needing to be convinced of the potential benefits. There was also a feeling that a convincing local evidence base had to be developed to support progress and adoption.
- However, interest in ABCD is building slowly and there is a growing sense that this is becoming the preferred approach. Staff are introducing salutogenic/health asset principles into policies by using asset-based language as policies are reviewed and updated. They also appear to be taking a long-term view and a whole organisation approach. Staff and users are being seen as assets and encouraged to find and use their strengths.
- In contrast, the two voluntary organisations we spoke to presented a quite different view, particularly in the context of budgetary constraint. One manager sees a potential opportunity to critique previous and current service delivery models. In his view these models have cost too much and have often not worked for many people and may even have had the unintended consequence of generating inequalities – a race to the bottom in terms of funding allocations.

Bottom-up change

As important as the high-level strategies that give permission for new ways of working and set a benchmark for assessing current programmes and practice is bottom-up cultural change: convincing staff across the organisation that this can make a difference.

They are consciously taking it slowly, building local case studies that will engage decision makers.

The most challenging aspect has been winning hearts and minds by showing people that the approach is capable of making a difference to people's lives and not just meeting targets.

One of the challenges for the council is how to embed the values and new ways of working, once people have been inspired and 'got' the ideas. One of the councillors is acting as a 'connector', convening a meeting that brings together those who want to keep up the momentum of the new ideas and commit to a shift to asset-based working.

Community development and community engagement

In their view, the effective delivery of the strategy will require participatory decision making, which relies on the empowerment of individuals and local communities. At the same time as developing asset-based thinking, the council is setting up four neighbourhood or constituency forums to make local areas more involved in decision making. There is currently an uneasy fit. They are too bureaucratic to be asset based, but face-to-face ABCD could become the community forum – people could create a community asset base with no formal involvement.

Chapter 14:

Wrexham – Prospects for young people

Putting young people in charge of their lives

Prospects provides residential homes and education in Wrexham, North Wales for young people who are experiencing emotional and behavioural difficulties or family breakdown, or who are living with physical and learning disabilities. Twenty-four local authorities (and now NHS organisations) from all over Wales and England have placed young people in Prospect's 11 home settings.

Person-centred planning

In the last 15 years, Prospects has turned its way of working with young people on its head. The organisation describes its approach as 'person-centred thinking and planning'. Its guiding principle is respect for the young person's abilities, assets and potential, rather than focusing on what has gone wrong in their life so far. The staff teams work to support each child's aspirations and expressed wishes for their life, helping them understand and manage their difficulties and build the relationships, skills and self-esteem they will need for lifelong wellbeing.

In Prospects, the young people are supported to reflect on their situation, to make an assessment of their own behaviour and to develop aspirations and consider how they want to meet them. That is the basis of the plan and of the subsequent staff contribution.

Whole system transformation

Adopting this values-led approach has necessitated a fundamental 'whole system' transformation of the organisation and of its staff's values, attitudes, culture and ways of working. This has been achieved in the following ways.

- Appreciative inquiry-based personal and staff development, which has helped staff to understand the differences between what they were doing and what they are doing now.
- The staff are recognised as assets in the organisation and are empowered to play to their strengths, given different responsibilities that will help them thrive and find ways to do the job. This helps with recruiting and retaining staff for the long term, providing stability and stronger relationships with the young people.
- The values chime with the experiences of staff in their own lives. Most people had experienced how it felt to be treated in a positive way.
- The CEO had had experience of the disempowering effect of the way the system treated young people and was highly motivated to make changes as a result. He has led the organisational change, but also embodies the change in values and attitudes in the way he manages staff.
- Naming the process and formalising it into structured tools has helped create confidence and a sense of momentum. Staff appreciate the 'reflective practice' personal development approach, and this has helped embed the values and methods in the organisation.
- Prospects actively recruits those who show they can care; staff who do not like the new approach might undermine the change. Induction training tries to show new staff the young person's perspective and how this relates to their own life experiences.
- Prospects has linked its person-centred planning work to the Care Quality Commission (CQC) outcomes both strategically and systematically. But it is not an easy fit. Prospects uses an outcomes framework, but questions whether measures such as

lower levels of self-harming or not assaulting anyone are useful positive outcomes for the children. The organisation has moved away from process measures to more meaningful positive outcomes.

– There are difficulties with the attitudes of other professionals and agencies such as social workers and police, who do not know the young people well enough to see their abilities and come in with the attitude that they know best.

What does Prospects do differently with the young people?

The aim is to help the young people reflect on and take responsibility for their lives and choices, which leads to increased self-awareness. Staff do not do things for young people, but encourage them to be in control and work to achieve their own goals. Written records of conversations or events are shared with the young people. The focus is on building confidence, relationships and self-awareness.

Key findings from the case study

Prospects provides a particularly interesting case study, as the asset-based, person-centred approach has been successfully and systematically applied across the whole organisation.

The appreciative inquiry training helped staff to understand what being truly person-centred involved. Some seemed to have a natural affinity for working in this way and were developed as 'champions' whose role was to facilitate wider adoption of the approaches.

Ultimately, it is felt that the approach is about values. One participant commented, 'Training can help, but it won't change values'. Those that do not share the perspective can undermine the potential positive effects of change. However, we found evidence that the champions attempt to connect people with Prospect's approach personally so that it makes sense to them because they are able to relate it to personal experience.

It was clear that at every level of the organisation the person-centred, asset-based approach has been adopted. Strong leadership has come from the director, all levels of management and across the frontline workforce. Not only were the young people encouraged to identify and work with positive attributes, but staff were also viewed as assets and had scope to play to their particular strengths.

Young people who took part talked about the service as being different from anything they had experienced before. They said they felt like they had a home and were part of a family. 'About Me' files helped them to understand their abilities and to think about the future. The process of creating and using the files seems to promote reflection and confirms how far the young person has come since starting on the project.

One of the young people commented, 'This gives you the space to find the words and say them. It moves you towards your own solutions and staff will negotiate with you. You can build up trust, but you are allowed to fail and improve'.

Interestingly, the 'About Me' files use the ABCD terminology of 'head, hands and heart', first proposed by McKnight and Kretzmann in their asset-mapping approach,[43] to draw out what the young person has to offer and what is important. (Head: what do I know? Hands: what can I do? Heart: What do I care about?)

The strongest message from everyone at Prospects was that the person-centred approach put the young person in control. Everything was a negotiation and outcomes were genuinely co-produced.

Chapter 15:

Lessons and evidence from the case studies

Practice and theory

Across all case studies and for the majority of frontline staff, the use of asset-based approaches and ABCD is mostly practice based, experiential and sometimes instinctive.

Formal knowledge and training often comes later and tends to back up what is already being done.

Usually, a more senior leader or 'activist' has some theoretical knowledge and/or is able to connect practice and theory.

Practitioners acknowledge that knowledge theory is helpful because it supports and justifies their perspective and approach. However, they also state that it is not as important as their personal values/principles, or those of their organisation. The gut feeling that they are 'doing the right thing' is very strong for many.

All the case studies demonstrate a balance of needs and assets and all are working in areas or with individuals and groups that are defined as 'in need' (whether due to location, circumstances or specific health issues). All are trying to identify and draw on the individual or community assets as one way of meeting the expressed needs of those with whom they work.

Evidence

Evidence is mainly practice based. Those involved report both personal change and/or seeing beneficial changes in others. For a community builder in Manchester, the question of using evidence to shape doing/action was perplexing: 'We're building the evidence as we go, here. I'm not applying or relying on theories and stuff, but I'm seeing the results, the evidence of how getting involved is affecting people… That's not to say I don't know about the theory, though.'

There are various ways in which practitioners have been introduced to new knowledge about the principles, evidence, and some of the theoretical ideas underpinning asset-based working. A focus group participant explained how the process developed in Wrexham: 'It started with evidence of the model, but chimed with their passions and full circle back to implementing an evidenced model. [Most people] saw very quickly the significant and positive impact on the young people and this motivates staff to continue and to spread the practice'.

Lack of success often occurs because people do not want or are unable to engage with the principles of an asset-based approach. Sometimes this is because of 'gatekeeping' in a community, or where practitioners think they know what is best for the service user. Barriers can also prevent the service user from engaging with the process. This can include poor previous experience of services in general (especially true of young people) or not really understanding what the process is about and how they might use it.

Another tension identified in both Kirkintilloch and the Wirral was when asset-based approaches were seen as just another tool, rather than – as in Wrexham – a rethinking of the whole approach to support. Many felt that asset-based approaches worked best if adopted as a comprehensive perspective or framework for thinking about service users, communities, staff and other local resources. It became particularly effective if used as a framework for developing and co-producing services.

Evaluation

There is a broad consensus that traditional evaluation methods are not appropriate for asset-based working. What is required is acknowledgement and understanding of the context in which the approach is being introduced. There is agreement that subjective

experience and personal stories can be powerful illustrations of change and can indicate the success of the approach. This view was voiced by a senior manager of adult care in Kirkintilloch, who said, 'Narrative accounts are valuable but in order for these to count we will need to make a shift in what we value as indicators of change. We must dignify the individual's contribution and participation by including their personal priorities and achievements. I hope that increased use of subjective measures will start to challenge the current target-driven culture'.

In a health system context, many respondents view the target culture as counterproductive. Performance measures and targets for referral or treatment are not ends in themselves, but contributors to outcomes such as improved self-esteem, more participation, social connectivity and better mental wellbeing.

There was consensus that current evaluation methods based on objective, statistical data had to be challenged and reviewed. All were supportive of some outcome focus and in some contexts, such as clinical settings, individually focused evaluation. In clinical settings, especially in mental health services, tools and methods are used to measure more subjective and individual progress and it might be possible to adapt these. For example, a senior mental health manager in Kirkintilloch noted that she had found deficit-based approaches unhelpful when she was a psychiatric nurse and asset-based approaches were 'much more useful in recovery. Mental health services and other NHS service interventions have not been good enough at enabling the patient – so it disempowers them. This pilot offered a chance to challenge that and to change practice'.

There was agreement across all case studies that it would be helpful to have some common theoretical principles to support practice and provide a framework for using asset-based approaches more consistently across organisations and systems. This would allow smaller, contextual, subjective evaluation to be done at individual and project level that was underpinned by a theoretical framework, and justified by the evidence for the approach.

It might also be possible to establish indicators within the broader principles of asset-based working and to link project outcomes to these. This would potentially take away the need for individual projects to find justification for their work.

Chapter 16:

Conclusion

This report sets out a position on the theory and practice of asset-based approaches. It explores some of the key principles for adopting and developing health assets and the evidence and mechanisms of impact on health, care and wellbeing outcomes of asset-based projects in the UK. It is set against a backdrop of marked changes in public sector services. Local authorities and health providers are faced with increasing constraints and challenges in budgets and resources. This, along with the challenges posed by widening health inequalities in many places, appears to be driving a shift towards a greater interest in asset-based working, albeit in a local and fragmented way. At the very least we are experiencing a number of local authorities, health service providers, commissioners and community organisations seeking opportunities to explore asset-based approaches for improving health, care and wellbeing.

We see potential in adopting asset-based approaches in the context of tackling health inequalities. However, this should not be at the expense of losing essential public and community services that support individuals, families and communities. We suggest that any new work on asset-based approaches needs to be integral to existing services, creating new relationships between citizens, professionals and practitioners with a focus on positive action for better outcomes.

Through our fieldwork with local sites we have seen and heard described at first hand the positive opportunities for people involved with asset-based working. However, these sites and projects are often emergent, bound in the current context of financial constraint and the wider structural and economic challenges of health and social inequalities. Often the projects and respondents we encountered were not directly related to health and wellbeing, but by the very nature of their focus and action are building assets for health and wellbeing.

We acknowledge the need for further research and evaluation of asset-based approaches for health and wellbeing, including Asset Based Community Development. Given the theoretical underpinnings and context of this work in communities and neighbourhoods, attention needs to be paid to methods of evaluation and related research.

We feel that the need to invest in and develop key workforces to refocus their practice to asset-based principles is obvious. At the same time, opportunities for developing local people to instigate activity for health, care and wellbeing with and alongside public sector providers, in a relationship of co-production, should be explored and enacted.

Our work offers an exploration of 'theory of change' and 'logic models' in the field of evaluation and research into asset-based working. Such methods can offer powerful perspectives on why change happens and how outcomes are realised. We offer these as a means of illustrating the key stages local systems should consider and progress when making a shift toward asset-based working.

To conclude, the shift toward asset-based approaches for improving health, care and wellbeing is not an either/or option between the public sector, local communities and neighbourhoods. We suggest it is both. The main challenge is to redress the balance between asset and deficit approaches. This could provide an opportunity for public and related sectors to recalibrate their focus and emphasis towards 'what creates health' and to invest in and collaborate with individuals, families and groups at a neighbourhood and community level to tackle health inequalities and improve health, care and wellbeing services and outcomes.

Appendix and references

Appendix: Research methods

Data sources and data gathering

1. The literature overview

In organising the review of the literature we worked with Dr Gianfranco Giuntoli, Research Fellow, and Ms Anke Roexe, Research Assistant, at Leeds Beckett University.

We carried out an initial search for the terms 'asset' and 'health' or 'wellbeing' (and all spelling variants). This initial search returned an unmanageable number of results. We decided to search for the terms in the titles of publications and exclude documents that refer to other possible uses of the word 'assets', such as those pertaining to property, management, finance or wealth. We only searched for publications in English and excluded news and trade journals from the search. We then screened the returned list of articles by reading the abstracts and selected those that were relevant to this research. This enabled us to produce a final list of literature for review. Each team member used a data extraction form when reviewing key articles. This was developed to ensure consistency in the review process.

We supplemented the data search with a short Delphi exercise with the project advisory group, asking members to list the five texts that have most influenced their theoretical understanding of assets and health and the development of their practice. This generated a further list of sources.

2. Telephone interviews

Telephone interviews were carried out using a semi-structured interview template designed for the project and developed with Leeds Beckett University. The telephone interviews were conducted by Hannah Winney, an independent researcher, over a period of six weeks from March to May 2013.

Subjects for the telephone interviews were chosen through our network of contacts, and all were identified as users of asset-based approaches in their work. They were drawn from a range of organisations, roles and levels of seniority. These included local councils, public health teams, universities, regional networks (statutory sector), private consultants and a range of voluntary sector organisations including some development trusts.

3. Case studies

A key requirement within the project was to identify and report on areas of asset-based practice in localities and settings through the use of case studies. We identified six suitable sites for the case studies. These were identified through the literature review, our network of contacts, by recommendation and via the telephone interviews. Where possible we tried to achieve representation from a wide geographical spread across the UK; a range of agencies and organisations within the statutory, voluntary and independent community sectors; and organisations working with different groups, service users and/or community members.

In addition to factual information, each case study project was interrogated in its local context as well as in terms of its application of asset principles as identified in the literature and evidence review. We took a 'whole system' approach, seeking to identify the 'reach' of the project in terms of community members and in the areas of impact, benefit and outcomes.

We attempted to identify the conceptual basis within the case studies to determine how the interventions related to the 'theory of change'. What did the project intend to do? Did it succeed in this? How was it intended to make changes? What other variables were considered and which of them influenced the work?

The data gathered from each case study was transcribed for thematic analysis. The findings from all six case studies were compared for similarities and examined for insights into areas of particular success that could help others to implement asset-based approaches.

4. Sense-making events: exploring emerging themes and analysis

As a means of testing out our emerging ideas and perspectives, we engaged two key groups that are shaping practice in asset-based working. They attended sense-making events in Leeds and London, designed and facilitated by Professors Jane South and Mark Gamsu of Leeds Beckett University.

At the first event we brought together practitioners from the case study sites and invited representatives from community-based projects where interest and activity on asset-based working are being practised. In these discussions we were keen to explore the knowledge, conceptual underpinnings and evidence that were shaping practice.

The second sense-making event had a different audience and purpose: we engaged with policy leaders, strategic planners, public health practitioners and academics about health, wellbeing and health inequalities. The aim of this event was to elicit perspectives and recommendations that might need to be developed in and across systems to progress asset-based approaches in health.

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ISBN: 978-1-906461-60-7