LIVING WELL
ACROSS LOCAL COMMUNITIES
prioritising wellbeing to reduce inequalities

The Asset Approach to Living Well

"the asset model may help to further explain the persistence of inequities despite the increased efforts by governments internationally to do something about them"[1]

This paper aims to provide a brief background on how and why the asset approach is integral to the improvement of health and well-being and reduction of inequalities in the North West. The asset approach has been of growing interest in many localities. It is intrinsic to the new ways of working across organisations, especially the development of Health & Well-being Boards, Needs Assessments and Strategies and crucially to the centrality of communities to public sector planning and provision.

The Context

Living Well[2] is the North West's call to action to reduce inequalities through prioritising well-being. The document has been developed through engagement with a wide range of partners[3] and recognises that there will be no lasting reduction in inequalities unless we create the conditions across local communities that support well-being and enable people to live well. Good well-being is a goal in itself but is also a determinant of life expectancy[4]. It will lead to better health, employment, productivity, education and better community cohesion, safety and connectedness. One of *Living Well*'s six statements of direction is that *"public investment in local communities builds on local strengths and assets to raise aspiration, build resilience and release potential".*

The concept sits alongside economic development and sustainable development as an integral part of a three pronged approach to achieving maximum potential within communities. Each interacts with the other and policy makers will need to make decisions whilst keeping all three

[1] Morgan M. & Ziglio E (2010) Revitalising the public health evidence base: an asset model in Morgan & Ziglio (Eds) *Health Assets in a Global Context: Theory, Methods, Action,* Springer
[2] NHS NW (2010) Living Well across communities: prioritising well-being to reduce inequalities, Manchester, NHS NW
[3] See Appendix 2
[4] Government Office for Science (2008) Mental capital and Well-being Final Report, London: HMSO, www.foresight.gov.uk

considerations in balance to achieve best investment decisions and best social value.

The Public Health White Paper, *Healthy Lives, Healthy People*[5] sets out a new approach to improving health through greater emphasis on well-being and prevention, building people's self-esteem, confidence and resilience, 'shifting power to local communities' and tackling the wider determinants of health. A key determinant, social relationships, was found in a recent meta analysis[6] to be a comparable risk factor for mortality as other traditional risk factors. The Mental Health strategy[7] outlines further evidence on the outcomes and economic impact of well-being.

Needs and Assets

Improving the public's health, reducing health inequalities and achieving other social goals have traditionally focussed on the deficits and problems of individuals and communities. Understanding communities by their high mortality and morbidity rates, high hospital admissions, high crime rates, high worklessness etc. is only seeing part of the picture. The common response to such problems has been to provide more services, valuing professional intervention as the answer and a focus on "the failure of individuals and local communities to avoid disease rather than their potential to create and sustain health and continued development"[1]. All too easily communities are seen as problem areas and people as passive recipients of services, almost surviving as consumers to outwit the system. Community spirit and networks dissolve and the poor health remains.

In contrast, an approach that values assets identifies the skills, strengths, capacity and knowledge of individuals and the social capital of communities. It provides a different story of place that is a positive and outcome focussed picture that values what works well and where health and well-being is thriving. Community pride and spirit is therefore higher and people are engaged in solutions that are more sustainable for that community, with use of outside support where it is needed most.

By acknowledging how individuals and communities are currently contributing to health outcomes, their role as co-producers of health and well-being, as empowered producers and active participants, is enabled. Engagement is meaningful and empowering rather than tokenistic and consultative. People identify their own assets and work collaboratively to develop them. The process itself leads to increased well-being through strengthening control, knowledge, self esteem and social contacts – giving skills for life and work.

---

[5] Department of Health (2010) *Healthy Lives, Healthy People: Our strategy for public health in England,* London: HMG, available at http://tinyurl.com/HealthyLivesHealthyPeople

[6] Holt-Lunstad J, Smith T, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analystic Review. PLoS Med 7(7): e1000316. doi:10.1371/journal.pmed.1000316

[7] DH (2011) No Health without Mental Health, DH (2011) Delivering better mental health outcomes, DH (2011) The economic case for improving efficiency and quality in mental health http://www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm

"Communities have never been built upon their deficiencies. Building communities has always depended upon mobilising the capacities and assets of people and place"[8]

The asset approach is not a new concept – it has become ever more significant as we seek to maximise the social determinants of health and embrace new ways of working to tackle persistent inequalities. For many people and communities the skills and resources of people and places are used and developed naturally and always have been. Fundamental to the asset approach is a (salutogenic[9]) focus on health and well-being and the factors that enable and protect health, rather than on illness and individual risk factors of disease.

"Traditional epidemiological risk factor approaches to health development such as programmes on smoking cessation, healthy eating and physical activity are insufficient on their own to ensure the health and well-being of populations" [1]

The asset approach is not a way of getting communities to provide public services that are being cut. It is a way of valuing the contributions of everyone involved, acknowledging and building what people value most and ensuring that public services are provided where and how they are needed.

The Local Government Improvement and Development organisation (and its predecessor IDEA) has been championing and developing this approach with localities over the last years. See appendix 1 for further information.

In summary, the asset approach could make a significant contribution to:

- Tackling the social determinants of health and reducing health inequalities
- Focusing on health and well-being outcomes
- Strengthening Joint Strategic Needs Assessments
- Fostering co-production of health and the provision of health and social care
- Building the *Big Society* vision of empowered communities
- Supporting the systematic engagement of communities in partnership
- Maximising the role of the voluntary and community sector
- Enabling greater condition management, self care and care closer to home
- Improving individual and community resilience in challenging times
- Improving demand management and service efficiency

[8] Kretzman and McKnight (1993) Building Communities from the inside out
[9] Antonovsky's definition of health as wellness rather than illness (pathogenic)

What is an asset?

"A health asset can be defined as any factor (or resource), which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective (and / or promoting) factors to buffer against life's stresses"[10]

Capacity, competence, capability, 'know–how', aptitude, talent, gift, propensity, faculty, endowment, force, authority, wisdom, enthusiasm, creativity, resourcefulness.[10]

North West Asset approaches

The North West's *Living Well*[2] ambition for asset based working is being developed through a multi-agency group co-ordinating and developing approaches across a range of sectors and settings. This includes initiatives in a number of localities:

- Central and West Lancashire – Senior leadership for asset working, seminars to build consensus and momentum, a funded community and voluntary sector capacity building programme and partnership, asset mapping for social prescribing, Lancashire-wide JSNA guidance on mapping assets and plans for a NW Centre for ABCD and learning.

- Cumbria – Senior leadership for asset working, seminars to build consensus and momentum across the county, community asset mapping within localities, primary care developments and development of a Centre for the Third Age using the assets approach, including an online community asset register.

- Liverpool – appreciate inquiry and community participatory approaches to improve heart health;

- Stockport – Asset assessment to strengthen the JSNA, mapping of physical and service assets, production of an asset directory to support personalisation and health improvement, appreciative inquiry with deprived neighbourhoods;

- Knowsley – community development and co-production work through story analysis and appreciative inquiry (as part of the Connecting Communities programme) resulting in personal improvements, greater community engagement and ownership;

- Blackburn with Darwen – using the asset approach as part of enhancing social value in commissioning and researching and

[10] Harrison et al (2004) Assets for Health and Development European Programme: Developing a conceptual framework, Geneva: World Health Organisation

developing local economic resilience and local resilience to economic challenges.

- Manchester – using asset based approaches, including community development and appreciative inquiry within a '5 ways 2 mental health & well-being network' to strengthen connections between organisations, services, communities and individuals, develop a map of 'resources' and build asset based working.

- Halton & St Helens – Well-being project: social prescribing and redesign of the self help development work using appreciative inquiry and asset based approaches.

- Salford – ongoing use of asset based approaches throughout local public health developments: tackling smoking through focusing on the strengths and resilience of non-smokers in areas with high rates of smoking, a local strategic partnership futuresearch and appreciative inquiry to develop an alcohol strategy,

- Wirral – recovery and peer approaches to reducing substance misuse and its harmful affects. An asset based approach to substance misuse treatment has seen a tenfold increase in the number of Mutual Aid groups (e.g. Narcotics Anonymous) on Merseyside.

The NHS North West is working with some of the above localities to develop a framework for Joint Strategic Asset Assessment (see www.communities.idea.gov.uk/comm/landing-home.do?id=3924714)

The Regional Development Agency has scoped the production of an *Indicator of Health & Well-being,* to complement the Index of Multiple Deprivation, through creating a positive index on the health and well-being of communities. http://www.nwriu.co.uk/research_and_intelligence/society/society_publications/index_of_health_and_wellbeing.aspx

Whole system asset approach

For the asset approach to work effectively it needs to be applied across many parts of the local system(s). Figure 1 and the Ten Key Asks below identify some of things that can be done differently to implement an asset based approach.

Fig 1 Whole System asset approach

Ten Key Asks to creating a whole system asset approach

what can we do differently?

1. **Leadership and Organisational Vision:** Understanding health as wellness, not illness. Providing clarity on the things that promote and protect good health and well-being, rather than only describing health as disease and the risk factors for ill-health.

   Demonstrated through personal commitment and Health & Well-being Strategies.

2. **Joint Strategic Asset Assessment:** Describing the population through the assessment of assets as well as needs e.g. the presence of good health and well-being and indicators on what creates and influences good health, rather than needs assessment that only includes information on disease, death and risk factors for illness.

   Demonstrated through an enhanced Joint Strategic Needs and Asset Assessment.

3. **Map community assets:** Mapping what the community themselves say are the valuable resources and assets that improve their lives; the strengths, knowledge and skills of people and the value of places and facilities. See www.ABCDinstitute.org

   Demonstrated through engagement of the public sector with community-led initiatives, production of community asset maps that inform the JSNA/ JSAA.

4. **Asset Based Community Development infrastructure:** Sustaining community assets through continually empowering citizens and communities and increasing participation in decision making.

   Demonstrated through a local infrastructure for (Asset Based) Community Development.

5. **Individual strengths based working:** Services that assess individual strengths (not just problems) and provide interventions that build on people's strengths and their personal and community resources e.g. social prescribing/ community referral, personalisation.

   Demonstrated through strengths based assessment processes and referral pathways and social interventions.

6. **Neighbourhood Budgets and Commissioning:** based on the JSAA that seek to build on assets and what's working well rather than a sole focus on problems and deficits within communities and families. Empowering people and providing "professionals on tap not on top".

   Demonstrated through use of Community Budgets and Commissioning of solutions that recognise and build on strengths, skills and resources and what's working well for whom, where and how.

7. **Appreciative Inquiry to Organisational Development:** Managing organisational change and service improvement by recognising and building on what's already working well rather than trying to fix what doesn't; involving people in the process of change.

   Demonstrated through use of Appreciative Inquiry in organisational development processes

8. **Organisational asset and skills audit:** Mapping the assets of staff and organisations in order to have a greater understanding of the potential skills, strengths and resources that could be utilised more efficiently within and across organisations; and built upon as part of personal and organisational development and social value.

   Demonstrated through skills audits and personal development plans aligned to emerging organisational priorities to ensure best use of the workforce; And greater sharing of resources within and between organisations;

9. **Time-banking and asset transfer:** Sharing and exchanging assets between public, private and community bodies to improve efficient use of resources and give power to communities.

   Demonstrated through the transfer of physical assets to communities (see www.atu.org.uk) and credit exchange schemes such as time-banking (see www.timebank.org.uk)

10. **Asset based indicators:** Research and monitoring that incorporates the evaluation and development of asset based outcomes, indicators and measures.

    Demonstrated through the use of local asset based outcomes and indicators for monitoring progress.

Jude.stansfield@northwest.nhs.uk
NW Asset Based Working Steering Group
and the NW PH Transition Executive Group

Appendix 1 Key Messages on the Asset Approach
From IDEA, 2009, *A glass half-full: how an asset approach can improve community health and well-being,*

- The asset approach values the capacity, skills, knowledge, connections and potential in a community. In an asset approach, the glass is half-full rather than half-empty.

- The more familiar 'deficit' approach focuses on the problems, needs and deficiencies in a community. It designs services to fill the gaps and fix the problems. As a result, a community can feel disempowered and dependent; people can become passive recipients of expensive services rather than active agents in their own and their families' lives.

- Fundamentally, the shift from using a deficit-based approach to an asset-based one requires a change in attitudes and values.

- Professional staff and councillors have to be willing to share power; instead of doing things for people, they have to help a community to do things for itself.

- Working in this way is community-led, long-term and open-ended. A mobilised and empowered community will not necessarily choose to act on the same issues that health services or councils see as the priorities.

- Place-based partnership working takes on added importance with the asset approach. Silos and agency boundaries get in the way of people-centred outcomes and community building.

- The asset approach does not replace investment in improving services or tackling the structural causes of health inequality. The aim is to achieve a better balance between service delivery and community building.

- One of the key challenges for places and organisations that are using an asset approach is to develop a basis for commissioning that supports community development and community building – not just how activities are commissioned but what activities are commissioned.

- The values and principles of asset working are clearly replicable. Leadership and knowledge transfer are key to embedding these ideas in the mainstream of public services.

- Specific local solutions that come out of this approach may not be transferable without change. They rely on community knowledge, engagement and commitment which are rooted in very specific local circumstances.

Appendix 2 Membership of the North West Asset Based Working Steering Group

Reporting to the NW Public Health Transition Executive Group

Regional:
Department of Health – Jude Stansfield/ Thomas Hennell/ Ruth Passman
Joint Improvement Partnership – David Whyte/ Simon Rippon
NW Development Agency – Yvonne Herbert
GONW – Paul Pinnington
National Treatment Agency – Mark Gilman/ Abbey Jones
NHS NW – Katie Dee
NW Public Health Observatory – Clare Perkins/ Steve Knuckey
Smokefree NW – Andrea Crossfield

Locality Lead Directors:
Maggi Morris, Central Lancashire
John Ashton, Cumbria
Paula Grey/ John Lucy, Liverpool
Steve Watkins, Stockport
Dominic Harrison, Blackburn with Darwen
Mark Woodhead, Wakefield

National:
Local Government Improvement & Development – Trevor Hopkins/ Jane Foot
NICE – Antony Morgan
Department of Health (JSNA)– Mark Gamsu/ Michelle Kane

Community & Voluntary Sector
Diana Forrest, Sale West Partnership
Greg Mitten, West Lancashire CVS

Consultants:
CPC – Brett Nelson
Judith Emmanuel