A glass half-full:
how an asset approach can improve community health and well-being

Acknowledgements

Healthy Communities Programme

This publication was commissioned by the Improvement and Development Agency's (IDeA) Healthy Communities Programme. The Healthy Communities programme brings together a wide range of programmes and activities with one clear aim – to help local government improve the health of their local communities.

As part of its work the programme also manages a community of practice for all those working to improve health and wellbeing locally, which enables individuals to share successes and collaborate on challenges. To join the community visit www. communities.idea.gov.uk

Foreword

The health and well-being of our communities falls far beyond the scope of the NHS. Local government has risen to the challenge of working with its communities to improve health and plays a leading role in local partnership working.

As councillors we have a vital strategic role in promoting well-being through the provision of services for the areas we represent. In addition, our roles as elected representatives, as scrutineers and as 'place shapers' means we are uniquely placed to address the so-called 'democratic deficit' in local health services.

In the recent report by the Local Government Association's Health Commission 'Who's accountable for health?' (2008) we made the point that, "many of the big public health challenges are linked to gaps in health status and access to services between different groups of the population. Addressing the problems of relatively poor health among deprived sections of society clearly has a local dimension."

Increasingly we are realising that many of the solutions to challenges such as improving public health need to be much more rooted in local circumstances. The 'asset approach' is one of a number of such approaches that can be effective. It builds on the assets and strengths of specific communities and engages citizens in taking action. It is often cost-effective, since it provides a conduit for the resources of citizens, charities or social enterprises to complement the work of local service providers. Given the growing pressure on government finances, these are important benefits.

I'm sure, like me, you will find this publication both stimulating and challenging. Any ideas and approaches that encourage individuals, families and communities to work together and with local government and its partners to take more responsibility for the co-production of good health and well-being are more than welcome, they are essential if we are to deal with the health challenges facing us in the 21st century.

Councillor David Rogers
Chairman, Local Government Association Wellbeing Board.

Introduction

The health of everyone is improving; but the health gap between socio economic groups remains. Improving health requires us to tackle this social injustice and close the gap in health inequalities. This includes the inequalities in life expectancy, in illness and in health and wellbeing. We now have a clearer understanding of the links between mental wellbeing and physical health and the contribution that social determinants make to our health. Sir Michael Marmot's review (Fair Society Healthy Lives, 2010) has re-enforced the links between social conditions and health and the need to create and develop healthy and sustainable communities in order to reduce health inequalities. This will only be achieved through the collaboration of services and communities to create flourishing, connected communities.

Flourishing communities are those where everyone has someone to talk to, neighbours look out for each other, people have pride and satisfaction with where they live and feel able to influence decisions about their area. Residents are able to access green and open space, feel safe going out and there are places and opportunities that bring people together.

A good place to start is looking at where communities are already flourishing. For too long we have concentrated on the deficits and problems within communities and it is time for a different approach. Assessing and building the strengths of individuals and the assets of a community opens the door to new ways of thinking about and improving health and of responding to ill-health. It has the potential to change the way practitioners engage with individuals and the way planners design places and services. It is an opportunity for real dialogue between local people and practitioners on the basis of each having something to offer. It can mobilise social capacity and action and more meaningful and appropriate services.

In the North West, I am prioritising action to develop the assets approach as an important strand of tackling health inequalities. Assessing assets alongside needs will give a better understanding of communities and help to build resilience, increase social capital and develop a better way of providing services.

I commend this guide to others concerned about improving health and wellbeing and reducing inequalities.

Dr Ruth Hussey, OBE
Regional Director of Public Health / Senior Medical Director for NHS North West and DH North West

This publication is aimed at councils and their partners, local authority elected members, community health practitioners, public health professionals and non-executive directors of NHS Trusts. It will be of particular interest to those working with communities to challenge health inequalities, particularly in areas where this gap has widened despite implementing a range of 'evidence based' interventions.

Asset approaches are not new. Local politicians and community activists will recognise many of the features of asset based working. However their methodical use to challenge health inequalities is a relatively recent development in the UK. While we have tried to use a variety of examples of activities from across the country, readers will notice that many of these are in the north of England and London. In some ways this is to be expected as the majority of 'Spearhead' local authorities, those with the poorest health outcomes are in these areas. But health inequalities exist in every community and asset approaches are applicable to all.

Contents

Why read this report

The context for this report is a growing concern over the widening gap in health inequalities across England in 2010. Its publication is timely, just six weeks after *Fair Society, Healthy Lives – The Marmot Review*. One of the Review's key messages on challenging health inequalities is that "Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities". The asset approach provides an ideal way for councils and their partners to respond to this challenge.

The emphasis of community-based working has been changing. Among other aims, asset based working promotes well-being by building social capital, promoting face-to-face community networks, encouraging civic participation and citizen power. High levels of social capital are correlated with positive health outcomes, well-being and resilience.

Local government and health services face cuts in funding. Demographic and social changes such as an ageing population and unemployment mean that more people are going to be in need of help and support. New ways of working will be needed if inequalities in health and well-being are not to get worse.

The first part of this publication aims to make the case that as well as having needs and problems, our most marginalised communities also have social, cultural and material assets. Identifying and mobilising these can help them overcome the health challenges they face. A growing body of evidence shows that when practitioners begin with a focus on what communities have (their assets) as opposed to what they don't have (their needs) a community's efficacy in addressing its own needs increases, as does its capacity to lever in external support. It provides healthy community practitioners with a fresh perspective on building bridges with socially excluded people and marginalised groups.

The second part of this publication offers practitioners and politicians, who want to apply the principles of community-driven development as a means to challenge health inequalities, a set of coherent and structured techniques for putting asset principles and values into practice. These will help practitioners and activists build the agency of communities and ensure that an unhealthy dependency and widening inequalities are not the unintended legacy of development programmes.

Key messages

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.

Part 1: about the asset approach

The asset approach: a glass half-full

"We can't do well serving communities… if we believe that we, the givers, are the only ones that are half-full, and that everybody we're serving is half-empty… there are assets and gifts out there in communities, and our job as good servants and as good leaders… [is] having the ability to recognise those gifts in others, and help them put those gifts into action."

First Lady Michelle Obama
www.abcdinstitute.org/faculty/obama

"Communities have never been built upon their deficiencies. Building communities has always depended on mobilising the capacity and assets of people and place."

Kretzman & McKnight (1993) Building Communities from the Inside Out

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What is an asset?

"A health asset is 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 promoting factors to buffer against life's stresses."

Antony Morgan, associate director, National Institute for Health and Clinical Excellence (NICE), 2009

An asset is any of the following:

- the practical skills, capacity and knowledge of local residents
- the passions and interests of local residents that give them energy for change
- the networks and connections – known as 'social capital' – in a community, including friendships and neighbourliness
- the effectiveness of local community and voluntary associations
- the resources of public, private and third sector organisations that are available to support a community
- the physical and economic resources of a place that enhance well-being.

The asset approach values the capacity, skills, knowledge, connections and potential in a community. It doesn't only see the problems that need fixing and the gaps that need filling. 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 such as deprivation, illness and health-damaging behaviours. 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 services rather than active agents in their own and their families' lives.

The asset approach is a set of values and principles and a way of thinking about the world. It:

- identifies and makes visible the health-enhancing assets in a community
- sees citizens and communities as the co-producers of health and well-being, rather than the recipients of services
- promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment
- values what works well in an area
- identifies what has the potential to improve health and well-being
- supports individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources
- empowers communities to control their futures and create tangible resources such as services, funds and buildings.

While these principles will lead to new kinds of community-based working, they could also be used to refocus many existing council and health service programmes.

An asset approach starts by asking questions and reflecting on what is already present:

• What makes us strong?

• What makes us healthy?

• What factors make us more able to cope in times of stress?

• What makes this a good place to be?

• What does the community do to improve health?

In practice, this means doing the following:

• find out what is already working and generate more of it

• promote the project based on what it is trying to achieve, not what the problems are e.g. 'Salford: a smoke free city' rather than 'reduce the high number of smokers in the city'.

• cherish the assets – as soon as people are talking to each other they are working on the solutions

• actively build capacity and confidence among communities and staff

• involve the 'whole system' from the beginning – those left out will be left behind

• design in what is needed to achieve the desired future

• design out the structures, processes and systems that are stopping this future being achieved

• ensure the long-term sustainability of the solutions and the project.

The asset approach is compatible with the tools and approaches included in Part 2 of this publication, many of which are already in use by local government, health and other practitioners. They can be used as:

• research tools to uncover the assets in a community, to build on the lessons from past successes and to develop a vision for the future – this strengthens local confidence and points to what might work in future

• development and educational tools to build strong communities and civil associations, support social capital networks and sustain local activists who are the catalysts for change

• participatory tools that create shared ambitions, empower local communities and build ownership of improvement and regeneration processes.

Salutogenesis – the sources of health

Since the 1970s, Aaron Antonovsky and others have been developing the theory of salutogenesis which highlights the factors that create and support human health and well-being, rather than those that cause disease. This is a well established concept in public health and health promotion.

A salutogenic model of working focuses on the resources and capacities that people have which positively impact on their health and particularly their mental well-being. The model aims to explain why some people in situations of material hardship and stress stay well and others don't. They have what Antonovsky called a 'sense of coherence'; that is they have the ability to understand the situation they are in, have reasons to improve their health and have the power and resources - material, social or psychological - to cope with stress and challenges.

Salutogenesis (2005) Lindstrom & Eriksson; Journal of Epidemiology and Community Health, 2005: 59:440-442.

The case for an asset approach

Recent studies are helping us to change the way we think about how to improve health and well-being. Current approaches aren't working, or aren't working well enough. This section shows that an asset approach could respond to these new findings by:

• providing new ways of challenging health inequalities

• valuing resilience

• strengthening community networks

• recognising local expertise.

Reducing health inequalities

Current approaches to improving health have not made the impact on health inequalities that had been anticipated. While life expectancy rates are increasing overall, they are rising faster for the affluent than for the most deprived,[1] so the gap between them is getting wider. While there is extensive evidence about which groups and populations suffer worse health and what the risk factors are, there is little definitive information on how best to act to reduce the gap and improve health and well-being.

Improved knowledge alone does not change behaviours, and there is evidence that those with more chaotic and difficult lives are less likely to change as a result of social marketing messages than middle class groups; an over-reliance on social marketing could actually widen inequalities. (Morgan & Ziglio (2007) *Revitalising the evidence base for public health: an assets model*) Some of the most powerful influences on behaviour change are family and neighbours, and a collective sense of self-esteem, helping people believe that it is possible to take actions to improve health and well-being.

The consultation on the joint strategic needs assessment (JSNA) in Barrow-in-Furness in Cumbria concluded that "improving self-worth is at the heart of issues related to healthy lifestyles. If people value themselves, then other behaviours like healthy eating and giving up smoking will follow. Whilst many communities recognise that their health is worse than the average, reinforcing these negative images could have a negative impact on people's self worth."[2]

An asset approach does not automatically tackle inequalities but there are some steps that will help achieve that objective. They include:

• targeting appropriate areas or communities to work in

• allowing enough time for communities to rebuild their confidence and their networks

• using asset or appreciative tools that enable local people to take the lead

• rebuilding trust with local communities by making changes in services.

The experience so far is that practitioners have seen the potential of the approach for working in very deprived neighbourhoods where they have traditionally found it hard to make progress.

"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."
Marmot (2010) Fair Society Healthy Lives Final Report.

Valuing resilience

Studies such as *Spirit Level* (Wilkinson & Pickett 2009) and *Sinking and Swimming: Understanding Britain's Unmet Needs* (Young Foundation 2009)[4] remind us of the interdependence of material needs and inequality with psychosocial impacts such as isolation, low levels of social support, poor social networks, low self-esteem, high self-blame and low perceived power.

Lynne Freidli claims that mental health is significantly socially determined and the identification of social networks and practice that sustains community resilience should be an aim of both local government and health practitioners (Lynne Freidli :WHO 2009).

Work by Freidli and Carlin for the North West NHS[5] examined the role of the public sector in influencing 'resilient relationships': the combination of assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential. The review highlighted the importance of social connections both as a community asset and as a determinant of mental health. It suggests that public sector interventions that sustain resilience are those that:

• strengthen social relationships and opportunities for community connection for individuals and families, especially those in greatest need

• build and enable social support, social networks and social capital within and between communities

• strengthen and/or repair relationships between communities and health and social care agencies

• improve the quality of the social relationships of care between individuals and professionals.

The Marmot Review: Fair Society Healthy Lives. The Strategic Review of Health Inequalities in England post 2010.

"Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age are responsible."

Marmot (2010 Executive Summary)

Professor Sir Michael Marmot[3] has concluded his strategic review to recommend effective strategies for reducing health inequalities in England from 2010, and particularly to reduce the social gradient in health. The findings, set out in his report *Fair Society, Healthy Lives* (2010), are important for councils and health practitioners. For instance, they are advised to:

• move beyond mortality as the main measure of health inequalities, and to focus instead on the inequalities in 'being well' and 'well-being'

• measure impact on 'disability-free life expectancy' instead of mortality: people in lower socio-economic groups not only have shorter lives, they also spend more of their shorter life with a disability that limits their life chances

• concentrate on the 'causes of the causes' – that is, invest more in the material social and psychosocial determinants of health.

• implement 'proportionate universalism'. Health actions must be universal, but with a 'scale and intensity that is proportionate to the disadvantage', rather than focused solely on the most disadvantaged.

• pay attention to the importance of stress and mental health in shaping physical health and life chances, and conversely of the importance of personal and community resilience, people's ability to control their lives and levels of social support

• put empowerment of individuals and communities and reducing social isolation at the heart of action on health inequalities

• prioritise investment to strengthen the role and impact of ill-health prevention, especially health behaviours that follow the social gradient

• create and develop sustainable communities that foster health and well-being, ensure social justice and mitigate climate change.

Taking an asset approach and actively building communities, networks and resilience will be an important element of the response to Marmot.

Improving well-being

Work by the IDeA and the Young Foundation on happiness and well-being[6] demonstrates that community and neighbourhood empowerment has the potential to improve the well-being of individuals and communities in three ways:

1. control: by giving people greater opportunities to influence decisions, through participative and direct democracy rather than formal consultation exercises

2. contact: by facilitating social networks and regular contact with neighbours

3. confidence: by enabling people to have confidence in their capacity to control their own circumstances

But this research also shows that building well-being and improving social capital are rarely articulated as explicit outcomes of neighbourhood working or service design.

The five ways to well-being[7]

New Economics Foundation was commissioned by the Foresight Team[8] to review the evidence about how individuals can improve well-being. They came up with the 'five ways':

• connect: with the people around you

• be active: keep moving

• take notice: environmental and emotional awareness

• keep learning: try something new at any age

• give: help others and build reciprocity and trust.

Strengthening community networks

The National Institute for Health and Clinical Excellence (NICE) *Guidance on Community Engagement to improve health*[9] emphasises how active communities can have a positive impact on health outcomes by improving services and influencing the governance of health services. Recent emphasis has been on personalisation and improved choice[10.]

But the emphasis of community-based working is changing. Among other aims, asset based working promotes well-being by building social capital: that is to promote face to face community networks, encourage civic participation and citizen power, sustain trust and solidarity and encourage trust and reciprocal help. Levels of social capital are correlated with positive health outcomes, well-being and resilience.

The Marmot Review emphasises individual and community empowerment. He comments that this requires mapping community assets, identifying barriers to participation and influencing and building community capacity through systematic and sustained community development.

Supporting local expertise

The Department of Health is already working with an asset approach to developing local expertise in at least three of its community programmes: health trainers, community health champions and cancer champions. These initiatives recognise that local people have knowledge, skills and networks that can be mobilised to improve health.

Health trainers

Recruited where possible from communities who do not normally interact with health agencies and professionals, health trainers are employed, trained and resourced to support people who want to make changes to their lives. Using the techniques of 'motivational conversations' and 'active listening' they support people to overcome their hesitations and start to make the changes that they decide they want to make.

The Yorkshire and Humberside Regional Health Trainers Programme has found that "through the process of becoming more empowered as individuals many health trainer clients become more engaged in their community and build better social networks. This in turn supports them to sustain the lifestyle changes they have made". They have also discovered that this has sometimes led to people acting together to make healthy choices easier, for example, setting up a food co-operative or working with the local council to improve access to the local park.

http://www.yhtphn.co.uk/about-ht.html

Community health champions

These are volunteers who are trained and supported to champion health improvement in their communities. This has a direct impact on their own health and – as their confidence, motivation and knowledge increases – the health and well-being of their neighbourhoods and communities. They might work on a one-to-one basis or set up or support activities such as self-help groups for fathers or health walks.

Altogether Better Programme www.yhpho.org.uk/default. aspx?RID=8462

Cancer champions

One of the major reasons for the variation in survival rates for people with cancer is how early they act on their symptoms and go to their GP. The National Cancer Action Team has been supporting and promoting local schemes to train local people as 'cancer champions'. They are recruited because they care about cancer – perhaps as a result of a personal or family experience – and because they have local networks. Their job is to encourage people to talk openly with their doctor about signs and symptoms, and to help them overcome the fears and myths associated with cancer. The evidence of their impact is impressive.

North East Lincolnshire Community Health Project is a local cancer champion project. It is conceived, planned, tested and carried out entirely by community volunteers, and the results have been impressive. Volunteers have had one-to-one conversations about symptoms with more than 17,000 people and awareness of cancer symptoms has increased by 15 per cent. The number of referrals from GPs has risen: over the first two years of the project, the numbers of two-week wait referrals for gynaecological and bowel cancer increased by 25 and 31 per cent respectively, and by 66 per cent for prostate cancer.

National Cancer Action Team: Prevention, Early Diagnosis and Inequalities.

North East Lincolnshire Care Trust Plus's Promoting Earlier Presentation of Cancer Symptoms Programme

From here to there: What does asset working mean for healthy communities practitioners?

"Targeting resources onto needs directs funding to professionals and to services, not to communities. The system needs needs."

Cormac Russell, ABCD Institute

"What did I not do today that allowed a community to take charge?" A personal appraisal question to Dublin community development workers

The previous section explained what an asset approach is and why it is a powerful tool. This section explores how it can be applied to existing healthy community practitioner roles and the systems in which they work.

Shifting attitudes

This approach requires a shift in attitudes and values and an understanding of the limitations of a 'deficit' way of seeing the world.

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. The timescales are longer than many of the current publicly-funded projects. An asset approach is not the same as community engagement or consultation to improve services – although it will improve both.

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. The Task Group on Social Inclusion and Mobility for the Marmot Review reported that one of the consistent barriers to effective community involvement is frustration and resistance from communities. This is because of past experiences of professionals misusing their power to control the types of issues that they could discuss, which excluded some communities and stereotyped others. They concluded that the practice of empowerment "with its explicit value base of recognising *lay experiential expertise* [their emphasis] and changing power relationships will – if done well and this is key – deliver health benefits at individual and community (interest and place) level"[11]

Moving from a deficit approach to an asset approach	
Where we are now - the deficit approach	**Where an asset way of thinking takes us**
Start with deficiencies and needs in the community	Start with the assets in the community
Respond to problems	Identify opportunities and strengths
Provide services to users	Invest in people as citizens
Emphasise the role of agencies	Emphasise the role of civil society
Focus on individuals	Focus on communities/ neighbourhoods and the common good
See people as clients and consumers receiving services	See people as citizens and co-producers with something to offer
Treat people as passive and done-to	Help people to take control of their lives
'Fix people'	Support people to develop their potential
Implement programmes as the answer	See people as the answer

Complementing, not replacing, good service delivery

The asset approach does not replace investment in improving services or tackling the structural causes of health inequality. While it may help reduce demands on services in the long term and bring about more effective services, it is not a no-cost or a money-saving option. The aim is to achieve a better balance between service delivery and community building. Practitioners and decision-makers need to bear in mind the following:

- Many communities will need an initial investment in community development and to strengthen and support local networks and associations.

- It will take time to build up local confidence and a sense of empowerment.

- Communities must still be involved in improving access to and design of services, and play their part in making choices and improving health knowledge. But using an assets approach can bring more effective involvement in the process.

- Good information about risk, needs and priorities remains important, but this should be complemented with information about assets and opportunities.

- Asset working does not ignore needs. It emphasises psychosocial needs. And it distinguishes between those needs that can best be met by family and friends, those best met through co-operation between services and communities, and those that can only be delivered through services.

- Moving to an asset approach implies significant transformation of services and ways of working – it will take time and money to train staff in this new way of working.

- Community assets can only have a mitigating effect on the structural and social determinants of ill-health and inequality – poor housing, low wages, lack of jobs.

Embed assets in strategic processes

The NHS North West Asset Network of PCTs, local councils and voluntary organisations is working to embed assets alongside needs into strategic planning and performance processes in the following ways.[12]

Aligning strategic priorities

This includes:

- in partnership with the Marmot Review, using an open space event (see Part 2) to plan for the implementation of the review findings, which highlighted the role and contribution of the community, the importance of well-being and prevention as key tenets of the local approach

- designating health as a priority in the single regional strategy

- recognising assets, and the need to build on them, as a key element in the regional strategy.

- driving system-wide change by developing and testing different methodologies and focuses , sharing learning and building leadership.

Augmenting the Joint Strategic Needs Assessment

This includes:

- augmenting the Index of Multiple Deprivation and the joint strategic needs assessment (JSNA) with a 'joint strategic assets assessment' – this will give a fuller picture of the local potential as well as the deficits and gaps

- working on how to measure assets: using the Government's Place Survey of local areas, and the indicators in the National Indicator Set – the single set of 198 performance indicators used for the comprehensive area assessment. There are existing indicators that capture both tangible assets, for example, green space, numbers of community organisations, skill levels, as well as measures of subjective assets such as local people's 'feelings of belonging', or their perception of their 'ability to influence decisions.

- commissioning a mental health well-being survey of 18,000 people in 18 PCT areas. This will improve understanding of the factors that influence well-being and inform commissioning.[13]

Connecting to World Class Commissioning

This includes work to:

- align World Class Commissioning principles with the local strategic partnership priorities of place-shaping and well-being, stronger communities and facilitating community solutions

- support population-level community involvement within the commissioning cycle using innovative approaches to community building

- foster co-production of health and healthcare with the involvement of the third sector and service users

- consider how to invest in long-term outcomes and quantify impact

People-centred partnerships

The need for a people-centred and partnership way of working takes on added importance with the assets approach. This is a locality-based or an outcome-based way of working, where silos and agency boundaries are not helpful – it is a people-centred and citizen-led approach. Joint investment in community building and sustaining social networks will bring benefits to all partner agencies. But it requires the following to succeed at the local level:

- Asset working emphasises prevention and early intervention, so there needs to be cross-agency agreement about how investment and savings are to be balanced.

- Improving outcomes requires co-production with families and communities supported and valued for their participation in health improvement alongside professional services.

- A different model of leadership in partnerships is needed: instead of command and control models leaders have to become orchestrators of place, making connections and sustaining relationships.

- The third sector – voluntary and community organisations, social enterprises and community networks – can lead by shifting their perspective towards community asset building.

- There is a pivotal role for councillors, making visible the assets in their communities, promoting the use of appreciative inquiry and other techniques and supporting communities to develop their resources and thrive.

People-centred scrutiny

Overview and scrutiny committee (OSC) reviews of inequalities in health or other health issues provide an opportunity for a more people-centred way of looking at local services.

The OSC in South Ribble used appreciative inquiry (See Part 2) to review health inequalities and community engagement, and to create a shared vision of a place where people care about each other, and where everyone is involved and takes great pleasure in their environment. One councillor involved said: "It was one of the most positive pieces of work that I have been involved in… and in the poorest part of the borough."

Salford City Council's OSC identified smoking as the greatest cause of deaths associated with health inequalities in their city. Their starting point was the evidence that the overall decrease in the prevalence of smoking was due to the increase in people who have never or only occasionally smoked rather than in the proportion of people who have given up. Even in areas with high numbers of smokers, the overall downward trend means the majority of people are now non-smokers (a big asset) but there is little information about the culture of non-smokers. Using appreciative inquiry the OSC started with the perspectives of local residents rather than with services and involved the whole system; that is, smokers, non-smokers, service providers and partners in one area. The theme was to build on the positive achievements and promote non-smoking rather than focus on the barriers to giving up.

Strategic commissioning

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

Some places are undertaking work on developing commissioning models that have more synergy with an assets approach, for example, that specify co-production and involving users and carers (see 'Co-production' below). As well as being useful for evaluating complex processes, the logic model or the outcomes based accountability (OBA) model can help to scope the specifications for asset-based commissioning (see 'measuring assets').

Mapping individual, family and community assets may lead to a different balance of services and support being commissioned. The experience of direct payments has been that while some people want to purchase existing services, others want to use their budgets to strengthen their own networks and those of families and friends. Instead of having meals delivered at home, they use money to go to the café with their friends. (see www.in-control.org.uk)

Following the New Horizons mental health strategy, Central Lancashire PCT Mental Health Team is using asset mapping to develop 'social prescribing' – health workers prescribe social and community solutions such as befriending schemes, volunteering, access to educational or IT skills, support to make use of the library or local sports facilities and so on. They hope this will improve people's resilience through increasing social connections and sustaining networks that promote self-care and improve health-related behaviours.

"Social prescribing in Central Lancashire will be founded on three principles of identifying the assets of our communities - their knowledge, skills, resources, values and commitment – connecting them for the benefit of the community and its members, and harnessing them to achieve an agreed vision. It is a reciprocal scheme, where people accessing the scheme also contribute their own assets. Social prescribing is not about designing and delivering a specified network of commissioned services for individuals to participate in. It is about identifying, developing and connecting the assets that exist within communities. Once discovered, these capacities can be mobilised"

(Central Lancashire PCT Report to SMT 4/11/2010)

Co-production

"Services do not produce outcomes, people do."

Jude Cummins and Clive Miller[14]

Health outcomes are produced through the combined efforts of citizens and services. While this does happen now, the contribution of citizens is rarely made visible, and rarely included in the planning or actively supported. Their contribution is left to luck. Co–production acknowledges and gives explicit recognition of the role of communities, users and families.

An asset approach combined with co-production methods gives explicit value to the elements on the right-hand side of the diagram. Mapping and assessing the resources and networks of families, friends and communities illustrates how they could or are already contributing to health outcomes. This informs the co-design of both the support needed to sustain those community assets and the specialist health services required to complement them."
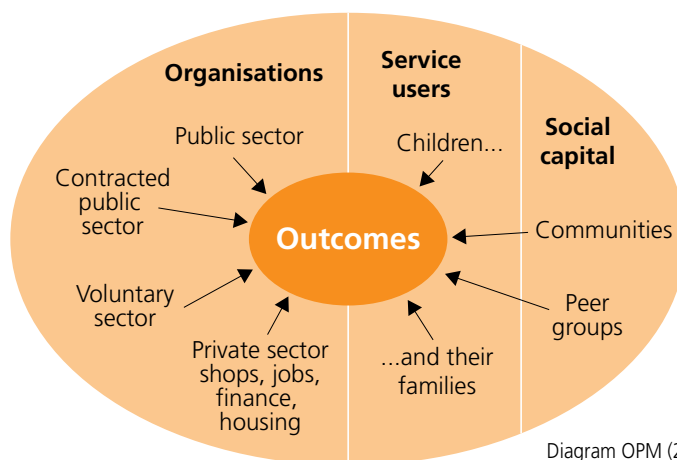

Diagram OPM (2007)

Co-production and an assets approach

Co-production is both complementary to and relies on an assets approach. Frequently the term refers to "delivering *public services* [my emphasis] in an equal and reciprocal relationship between professionals, people using services, their families and neighbourhoods".[15] But by starting with an outcome – such as reduced health inequalities – co-production can also tackle 'whole system change' and mobilise community resources and individuals. It involves citizens and communities, as well as users and their families, as the source of valuable assets and resources.

For example, New Economics Foundation, Camden Council and Camden NHS have created a sustainable commissioning model to deliver wider social, economic and environmental outcomes.[16] Camden mental health services wanted to do more to promote independence and recovery of service users and to involve them more in design and delivery processes. Its mental health services tender specification explicitly included the principles of co-production and stated that the service should be delivered in partnership with service users. The Holy Cross Centre Trust Centre in Camden is part of the consortium that won the tender for mental health services. The centre, which runs projects for people with mental health problems, refugees, asylum seekers and homeless people, has set up a timebanking scheme: members exchange skills with each other and earn credits by helping at the centre. They earn time credits that they can exchange with other members, with Camden services or with local businesses such as cinemas, gyms and theatres. Over 22,000 hours are exchanged in a year.

"By viewing and treating service users and the wider King's Cross community as potential assets, rather than as passive recipients, the consortium delivering Camden's day centres has been able to lever previously invisible or neglected resources: the capacities and knowledge of service users and the wider community itself [...] By seeing service users as passive, and not recognising the assets of the community, we risk limiting the kinds of solutions and strategies that are possible when it comes to achieving outcomes."[17]

Is this approach scaleable and replicable?

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. Collaboration between practitioners – such as the NW Health Network – can develop system changes that support the insights of this approach, and models of support for community led innovation.

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. Bunt & Harris in *Mass Localism* (NESTA 2010) call this "distributed production": instead of assuming that best practice solutions can be prescribed centrally, communities are supported to develop and deliver solutions that reflect local needs and engage citizens, and more effectively tackle national and global concerns

Developing an evidence base for the asset approach

This is early days for asset based working in the UK, and many of the examples quoted are small scale and exploratory. Community health practitioners will have to develop methods of evaluating practice and generating evidence of effectiveness that are robust enough to demonstrate that this approach represents value for money, if it is to be implemented widely, with the organisational and cultural changes it implies.

Assets, such as connectedness and relationships, are not easy to measure. They have an intrinsic value, rather than being of value because they deliver some other benefit. However, there is ongoing work – for instance by the IDEA and Young Foundation's Wellbeing Project – into how to measure such factors as:

• well-being

• resilience

• social capital

• happiness.

Academics are also exploring how to conduct evaluations of similar complex and multi-factored practices[18]. And there are a number of existing evaluation methodologies (see below) which are already in use by practitioners and lend themselves to the task. However none of these models has yet been applied in the context of assets. IDeA is working with colleagues in NICE, the NHS and local government to test these potential methods and would welcome any feedback from practitioners and commissioners.

Developing an evidence base for asset working in a local area throws up two interconnected sets of challenges: methodological and practical.

Methodological challenges

The first challenge is to clarify the goals at the start of the project. Are the objectives to 'increase resilience' and 'build social networks'? Or are they directly health-related, for example, 'reducing depression in women under 50'?

Second, how can we prove that factors such as stronger community networks and social capital have positive impacts on health inequalities and healthy behaviours? While social capital and health are correlated it is hard to say whether one causes the other.

Third, measuring assets in a community, or an asset-based intervention in a community, involves assessing an organic and dynamic system that is responding to different events, circumstances and possibilities. This makes it difficult to replicate the process in another area or with another interest group.

Fourth, most data is collected at population or individual level, not at the level of an interactive and evolving community – whether that is of place, identity or interest. The collection of such data is expensive.

Finally, an asset approach takes time; it is not a quick fix. Savings are often made by other agencies, for example, investments by a social housing provider might reduce the costs for health services. The measurable outcomes may not happen within the project remit or timescales.

Practical challenges

Practitioners need to evaluate what they do to inform future implementation. The questions they are interested in are:

• What does the asset approach achieve?

• Does it achieve health-related goals?

• How does it work: what is the 'theory of change' that explains how the inputs produce the outputs that impact on the defined goals or outcomes?

• In what context does it work?

One potential way to answer these questions is to model the process and show the complex causal relationships between inputs, outputs and outcomes using evidence and other local information. Three examples of these models are described below: the logic model, outcomes based accountability (OBA) and developmental evaluation.

The logic model

This is a systematic and visual representation of a programme. It shows the community and organisational resources that are available; that is, the inputs, the planned activities, the immediate outputs and the longer term outcomes and impact. It provides a 'roadmap' for how they are linked together logically. It can be used to plan and evaluate improvement activities, and is already in use in health promotion. (see W K Kellogg Foundation (2004) Logic Model Development Guide.www.wkkf.org)

By setting out the anticipated 'theory of action'– that is, how the inputs will produce the outputs and how those outputs contribute to the outcomes – it enables the measurement and tracking of those inputs and outputs as intermediate states to the agreed outcome. This can help generate evidence of effectiveness alongside more qualitative work such as personal stories and case studies.

Outcomes based accountability (OBA)

OBA is a widely recommended approach to improving outcomes and accountability (see for instance the Department for Children, Schools and Families' Every Child Matters and IDeA Knowledge). The focus on outcomes, and not just services, means the key steps of the OBA method can be compatible with asset thinking and techniques, and it can provide a visual tool to understand and track the key inputs and outputs.

Tools such as appreciative inquiry, open space and storytelling (see Part 2) can be used to define the positive outcome or question that shapes the OBA improvement process, gain a better understanding of what is working and understand 'the story behind the baselines'. Asset mapping – combined with a co-production plan – will help to make visible the capacities and resources in the whole community that can be mobilised.

Developmental evaluation

Developmental evaluation is an evaluation method designed for social innovation. The developers are actively making links with the ABCD Institute and with appreciative inquiry practitioners. It makes use of data – generated through network mapping, modelling, indicators, appreciative inquiry events – as well as by tracking the emerging process and the decisions taken during the evolution of the project. It is more similar to a structured internal 'action learning' process, designed to cope with uncertainty and emerging practice, rather than an approach that will give project managers an objective judgement about the success or failure of a project, or findings that can be generalised to other circumstances. *A Development Evaluation Primer* (2008) by Jamie AA Gamble[19] is a simple introduction to the principles.

All three models enable a practitioner to 'describe a project' in a flow chart and to measure against process targets and milestones, track what happens and adjust processes or activities while not losing sight of the ultimate outcome.

Even so, innovative community-based projects often do not conform to such linear logic models that move from problem to solution. The goals and processes evolve and there are many influences on the ends and means. Many of the problems associated with evaluating an asset-based intervention are similar to evaluating community development. *Empowering Evaluation*[20] contains an introduction to the issues and some well-used models, including methods of measuring social capital.

Measuring assets

Commissioners need performance measures for monitoring and investment decisions. They need to know:

- what measures to use to establish baselines and track inputs and outputs
- how to measure outcomes in the short and medium term
- how to compare the efficiency and effectiveness of different interventions.

> The National Indicator Set – the single set of 198 performance indicators used for the comprehensive area assessment (CAA) – has several sets of indicators that, when put together, can give a proxy measure of levels of well-being and social capital.
>
> The Place Survey – carried out by every local authority – asks whether people:
>
> - feel they can influence local decisions (NI 4)
> - feel they belong in the neighbourhood (NI 2)
> - feel they get on well together (NI 1)
> - participate in regular volunteering (NI 6).
>
> Other indicators ask about self-reported health and mental well-being (NI 119) and whether people with long-term conditions are supported to be independent and in control of their conditions [NI 124]. Disaggregating this data into small areas and particular population groups makes this information useful for comparison and learning.

The Young Foundation and IDeA's Local Wellbeing Project is testing out practical ways of measuring individual and community well-being and resilience. The partners have published a report from Phase I (*Local Wellbeing: Can We Measure It?* 2008). Phase 2 is examining how data on well-being and resilience can be gathered and used by decision-makers in local areas. The project is:

- developing a model of resilience and well-being, both at the community and individual levels that will aid policy making and local resource prioritisation
- demonstrating how existing data can be used to measure levels of local well-being, placed firmly in the context of the CAA
- demonstrating how measuring well-being and resilience can be targeted towards particular population groups to achieve a range of outcomes.

This work will be developed into a toolkit to assist local partners to follow this approach and to guide decisions on well-being and resilience in local areas. The toolkit will be available in early 2010.

Part 2: the techniques

Introduction

The techniques described in Part 2 are not particular to asset working. But in their principles and objectives, they share the values of discovering and mobilising what people have to offer. Without the changes in attitudes and values set out in Part 1, the tools listed here will not be as effective.

These different working methods are often used in combination with each other. For example:

• asset mapping, story telling and appreciative conversations to inform the 'discover' stage of an appreciative inquiry

• asset mapping and asset based community development as part of the 'design' stage of an appreciative inquiry

• participative appraisal to inform the focus of a world café and an open space

• asset based community development and asset mapping to build community confidence before an open space or world café event.

Asset mapping

What is it?

Participants make a map or inventory of the resources, skills and talents of individuals, associations and organisations. They discover and collate the links between the different parts of the community and the agencies. They use this knowledge to revitalise relationships and mutual support, rebuild communities and neighbourhoods, and rediscover collective power.

Principle

Every community has a tremendous supply of assets and resources that can be used to build the community and solve problems.

"Think of a carpenter who has lost one leg in an accident years ago. Clearly he has a deficiency. However he also has a skill. If we know he has a missing leg, we cannot build our community with that information. If we know he has capacity as a wood worker, that information can literally build our community."

Kretzmann and McKnight (1993) page 14.

Practice

Creating a map or an inventory is more than just gathering data and information. It is a development and empowerment tool. The process of discovering the hidden and potential assets in a community creates new relationships and new possibilities.

Asset mapping categorises assets – actual and potential – in six 'levels':

1. The assets of individuals: these are their skills, knowledge, networks, time, interests and passions. They can be described as skills of the heart, head and hand. Residents are asked what is good about where they live and what they could bring to make life better for their community.

2. The assets of associations: this is not just the formal community organisations or voluntary groups. It includes all the informal networks and ways that people come together: football teams, babysitting circles, pub quiz teams, allotment associations, workplaces and so on. For example, the pub quiz team has members and interest but it could also offer fundraising, networks and people power.

3. The assets of organisations: this is not just the services that organisations deliver locally, but also the other assets they control, for example, parks, community
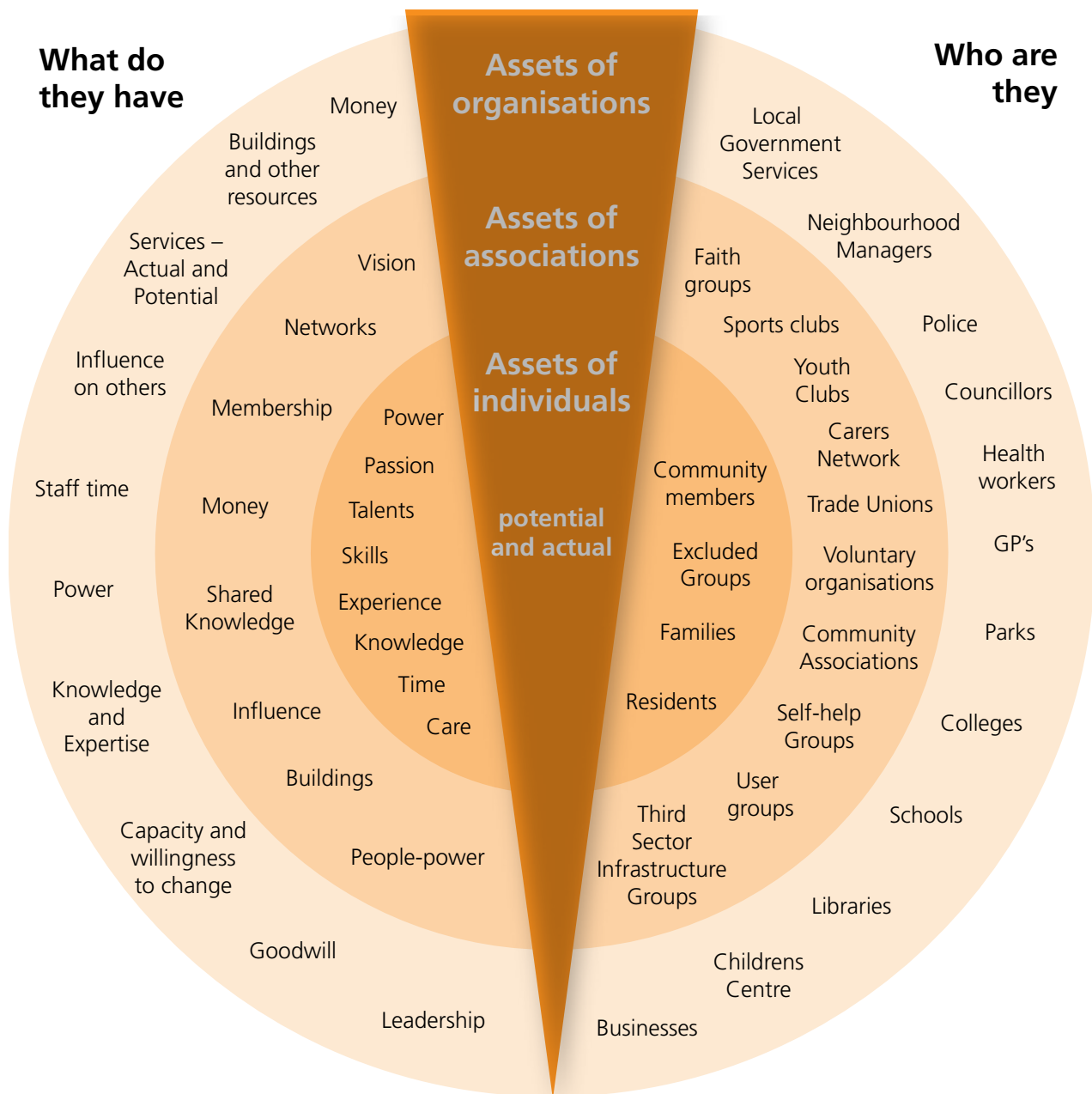
centres, and faith buildings. In fact, it covers anything that could be put to the use of a community to improve its well-being. It includes staff and their influence and expertise, which they can use to support new ideas.

4. The physical assets of an area: what green space, unused land, buildings, streets, markets, transport are in the area? Mapping these assets helps people to appreciate their value and to realise the potential productive uses they could be put to.

5. The economic assets of an area: economic activity is at the heart of rebuilding a community. What skills and talents are not being used in the local economy? How do local associations contribute to the local economy by attracting investment and generating jobs and income? Could public spending in the area be used to employ local people instead of outside professionals? How could the residents spend more of their money in local shops and businesses and increase local economic activity?

6. The cultural assets of an area: everyday life is full of art and culture. This involves mapping the talents for music, drama, art and the opportunities for everyone to express themselves creatively in ways that reflect their values and identities, improves understanding and tackles their lack of a 'voice'.

Ideally, asset mapping starts with volunteers mapping assets of individuals and of the community. Supported by a skilled community organiser they work through the process summarised below. Through this process the community discovers the resources, activities and interests they already have. They learn more about what other members of their community (of place, interest or topic) want to do and change. They find out how to form new and expanding connections to enable them to bring about that change in more inclusive and democratic ways.

Asset mapping is most effective when done by a group with an agreed aim. For example if they want to connect more young girls with non-competitive sport, leisure and fun activities, then associations and other asset-holders can respond clearly. In this way a community can amplify and multiply existing resources and promote better involvement.

Asset mapping

What do they have

Who are they

Assets of organisations

Assets of associations

Assets of individuals

potential and actual

Money
Buildings and other resources
Services – Actual and Potential
Influence on others
Staff time
Power
Knowledge and Expertise
Capacity and willingness to change
Goodwill
Leadership

Vision
Networks
Membership
Money
Shared Knowledge
Influence
Buildings
People-power

Power
Passion
Talents
Skills
Experience
Knowledge
Time
Care

Community members
Excluded Groups
Families
Residents
Third Sector Infrastructure Groups

Faith groups
Sports clubs
Youth Clubs
Carers Network
Trade Unions
Voluntary organisations
Community Associations
Self-help Groups
User groups
Businesses

Local Government Services
Neighbourhood Managers
Police
Councillors
Health workers
GP's
Parks
Colleges
Schools
Libraries
Childrens Centre

There are five steps to conducting a community-led asset mapping exercise:

1. Meet those people who become the core group that will take the lead (also see the next entry – ABCD).

2. Contact the individuals or groups who are active in the community – both formal and informal networks. This will identify the individuals who can do the mapping.

3. Through face-to-face conversations, door knocking and other techniques such as storytelling, these individuals collate the assets and talents of individuals in the community. The residents who get involved recruit more people to help who, in turn, carry on mapping more individuals.

4. Identify the resources and assets of local associations, clubs and volunteers.

5. Map the assets of the agencies including the services they offer, the physical spaces and funding they could provide, and the staff and networks they have. Depending on the local vision, the maps can be extended to include physical, economic and cultural assets.

Those who are doing the asset mapping ask the individuals and the organisations what they do or have now, but also what they would like to do or be prepared to offer with additional support.

In many areas services have started by mapping associations and agencies because it seems easier and quicker. But if so, then it is absolutely essential not to miss out on the face-to-face work of connecting to individuals and communities. Without this knowledge, the asset working will risk being limited to sorting out the issues and opportunities that the services or associations have already thought of. If the mapping of associations is being carried out to see what they could offer individuals in their community –for example, social prescribing – those individuals must also be included in the mapping to discover what they can offer to others.

Mapping is being used for 'whole system change' in which individuals, organisations, agencies and communities all map their respective resources and links. The asset approach means that the community is an equal partner in this 'whole system' and that their resources are given equal value. This information is used to reshape the interactions and interventions, invest in community potential and bring about community and organisational change.

What does asset mapping look like in practice? In Dublin, the city council community worker started doing asset mapping in a few streets, going from door-to-door with a few volunteers. Slowly they built up a core group who organised to get some flower planters in the local parade of shops (something that more prosperous areas in Dublin already had). This success gave them a new profile locally and as they continued their door knocking more people got involved. They are now starting to map the associations and services in the area and suggest changes. For example, health outreach vans now park in the revitalised community centre and many more people are coming for check-ups and advice.

When would you use it?

There are many local circumstances where an asset mapping exercise can help stimulate and motivate change. These include when:

- there are people who are not engaged with their local community and are isolated and cut off from relationships with their neighbours

- a community is fractured, has no sense of its own abilities and no belief that it can change

- there are no community associations or where those that do exist are exhausted, have a low membership and are dominated by public agency agendas

- agencies only see the community as a source of problems and needs and cannot see where solutions can come from

- a group of people who organisations see as dependent – for example, people with learning disabilities – can challenge attitudes and empower themselves

- communities and staff both want to change things and need to see the world differently in order to discover how they could change.

By making visible the things that are undiscovered or unused, the ways people perceive each other can change. Mapping assets balances all the work that is done to collect data about problems and needs.

Learn more

Kretzmann & McKnight "Building Communities from the inside out: a path towards finding and mobilising a community's assets" ABCD Institute 1993. This publication is often referred to as the Green book

Mathie & Cunningham Eds (2008). From Clients To Citizens: Communities Changing The Course Of Their Own Development. Coady Institute Canada

www.coady.stfx.ca/resources/media/From%20Clients%20to%20Citizens.pdf

Mathie & Cunningham (2002) From Clients to Citizens: asset based community development as a strategy for community driven development.

Online: www.caledonia.org.uk/papers/From_Clients_to_Citizens_2002.pdf

Asset based community development (ABCD)

What is it?

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

(Kretzman & McKnight 1993 Introduction)

The purpose is to build up community groups and voluntary organisations and their informal associations and networks, their collaborative relationships, their shared knowledge and their social power (sometimes called social capital and civil society). These are the key to self-directed and sustainable change. By building pride in achievements and a realisation of what they have to contribute, communities create confidence in their ability to be producers not recipients of development. They gain the confidence to engage in collaborative relationships with agencies.

Principles

12 principles are set out by Green, Moore and O'Brien in *When People Care Enough to Act*:

- Everyone has gifts. There are unrecognised capacities and assets in every community. Find them and provide opportunities for people to offer them.

- Relationships build a community. See them, build them and utilise them.

- Citizens are at the centre. It is essential to engage the wider community as actors not just as recipients of services.

- Leaders involve others as active members of the community.

- People care about something. Find out what motivates individuals.

- Identify what motivates people to act. Every community is filled with invisible 'motivations for action'.

- A listening conversation is the way to discover motivation and invite participation.

- Ask, ask and ask. People must be offered an opportunity to act.

- Asking questions rather than giving answers invites stronger participation. A powerful way to engage people is to invite communities to find their own answers – with agencies following to help.

- A citizen-centred 'inside-out' organisation is the key to community engagement.

- Institutions have reached their problem solving limits. They are stretched thin and need more skilful and wider engagement with communities.

- Institutions are servants. Ask people what they need and offer help, step back and create opportunities for people to act together.

Practice

The ABCD Institute (www.abcdinstitute.org) suggests the key stages are:

- mapping or making an inventory of the capacities and assets in the area

- building relationships and connections between residents, and between residents and agencies, to change values and attitudes

- mobilising residents to become self-organising and active by sharing knowledge and resources and identifying common interests

- convening a core group of residents to identify, from the asset mapping and mobilising activities, the key theme or issue that will inspire people to get organised and to create a vision and a plan

- levering in outside resources only to do those things that the residents cannot do for themselves; they need to be in a position of strength in dealing with outside agencies.

The theme or vision for revitalising the community needs to:

- be concrete so that people know what they are aiming at and when they have achieved it

- be achievable with community and other resources

- bring people together and use their skills

- reinforce their strengths and self-confidence.

C2 Connecting communities

While the phrase ABCD is not often used in the UK, the award winning C2 project in The Beacon and Old Hill estate in Falmouth, Cornwall took a very similar approach to the ABCD model and has had remarkable results.

In 1995, the Beacon and Old Hill estate was known as the 'Beirut of Cornwall', blighted by violence, drug dealing and intimidation; it had a reputation as a no-go area with the police and other services. People felt isolated and abandoned by the agencies. There was no community organisation. Two health visitors got to the point where 'something had to be done'. After talking to the other agencies, they agreed that community involvement was an essential part of turning the estate around. They invited 20 residents who they knew could influence their peers to a meeting. Fearing reprisals only 5 volunteered to participate. They drew up a newsletter, delivered it to every house and had one-to-one conversations on people's doorsteps. This approach was fundamental to galvanising the community to articulate and prioritise their concerns.

After a particularly stormy public meeting they set up a multi-agency and resident-controlled partnership. Two early successes – more dog litter bins and a traffic calming scheme – built confidence that things might get done. When the tenants won a Capital Challenge bid to install central heating and insulation, they were given control over how that money was prioritised and set up the Beacon Community Regeneration Partnership (BCRP) as a trust that makes recommendations to full council. The principles of empowering and trusting the residents have created a context in which transformation is possible.

The results of this process have been multi-faceted. From 1996 to 2000:

- the crime rate dropped by 50 per cent
- post-natal depression decreased by 70 per cent
- unemployment plunged by 70 per cent
- child protection registrations dropped by 65 per cent
- SATS results for boys at key stage 1 went up by 100 per cent
- over 900 houses were re-clad and central heating was installed, leading to less asthma and fewer lost schooldays.

By 2004 unintended teenage pregnancies had dropped to nearly zero from 14 per cent in 2002. The estate now has a youth centre, a resource centre offering multiple services for residents, including benefits advice, and a care centre that offers physiotherapy and health checks for people over 65.

Crucially this process has increased trust between residents and with agencies: people began to speak to each other again. Problems have stopped being someone else's and are now the estate's business. Over 100 people are actively involved in the BCRP. There are stronger relationships with local agencies, and these agencies have changed the negative way they used to see the estate and the way they work with residents.

The asset approaches they used include:

- locating the energy for change: through face-to-face conversations, door knocking, meetings with local groups and associations, finding the (small) group of people who could initiate and lead the community
- listening events: co-hosted by the community and the agencies, the professionals listened to what was positive on the estate, what the community thought the priorities were and what needed to change
- creating places and spaces for residents to connect, build relationships, have conversations and share knowledge, and encouraging local activities such as street parties, outings, raffles and so on
- co-learning: through conversations and open discussions communities and staff came to realise that they both have the same aims and they need each other if they are to realise those aims
- learning from similar areas that have been successful: residents and agency staff visited other estates to see what could be done and to be inspired by the possibilities – they now host many visits from developing communities
- challenging the negative image of the estate, held by both residents and staff, so that they all believed they could make changes
- supporting the community to lead the partnership and to determine what the priorities were and what would work.

http://www.healthcomplexity.net/content.php?s=c2&c=c2_main.php

Manton: Social capital model

Manton is an estate in Nottinghamshire that is rebuilding itself in the wake of pit closures. The Manton Community Alliance has adopted a social capital model of neighbourhood renewal. Its focus is on changing behaviour and relationships rather than pump-priming projects that are not sustainable and do not lead to long-term changes. Their belief is that increased participation, building social cohesion, mutual respect and confidence leads to sustainable change. A critical outcome is "to move away from a culture of dependency to one of collective action and from blame to mutual awareness". (Fuller)

The differences between traditional area-based initiatives based on projects and Manton Community Alliance's social capital model are illustrated in the table below.

Project model	Social capital model
• emphasis on money	• less dependency
• short-term solutions, not long-term change	• long-term change
• limited influence beyond the project	• influence with responsibility
• not sustainable	• collective action
• can create dependency	• more social cohesion
	• customer service approach
	• community leadership

This approach appears to be working:

• 41 per cent of residents surveyed in Manton said that they influence what is happening compared with 30 per cent nationally and 25 per cent in the district.

• Crime is down by 18.9 per cent, which bucks the national trend, and fear of crime is down.

• Levels of trust with the police are the highest in generations, according to local surveys.

• 55 per cent of residents surveyed said that the estate was better because of the community alliance.

The evaluation commented that: "This approach is not just one of engagement, but empowerment. In this process it is important to make people see that change is possible, and raise their sense of worth and aspiration, particularly by highlighting the positives in the area and celebration of the good things." (Fuller)

Learn more

ABCD Institute: www.abcdinstitute.org

Coady Institute: http://coady.stfx.ca/work/abcd/

Green,Moore & O'Brien *When People Care enough to Act* http://inclusion.com/bkwhenpeople.html

Cunningham & Mathie (2002) Asset based community development – an overview. Coady International Institute:www.synergos.org/knowledge/02/abcdoverview.htm

ed Mathie & Cunningham (2008) From Clients to Citizens: Communities changing the course of their own development. http://coady.stfx.ca/work/abcd/cases/

Kretzman & McKnight (1993) Building Communities fro the inside out. A path towards finding and mobilising a community's assets. Evanston IL: Institute for Policy Research. This is often referred to as the Green Book.

Manton Community Alliance Annual Report 2008/9 and personal correspondence

Neighbourhood Management Pathfinders National Evaluation Manton Community Alliance 2007 Year 3 Evaluation Report, Dr C Fuller, Warwick University.

Appreciative inquiry (AI)

"Appreciative inquiry is a new method of consulting the community which is based on the asset model where what is good about something is considered as opposed to what is bad. Problems tend to receive attention and resources so people tend to focus on solving the problems sometimes at the cost of losing what is good. This method is the opposite of that and the positivity it generates can be very energising as it can create its own solutions."

South Ribble Borough Council report on its Scrutiny: Broadfield You Matter. August 2009.

What is it?

Appreciative inquiry (AI) is a process for valuing and drawing out the strengths and successes in the history of a group, a community or an organisation. These are used to develop a realistic and realisable vision for the future and a commitment to take sustainable action. AI is not an uncritical or naïve approach; it creates a positive mindset by talking about success rather than being defined by past failures. The inquiry starts with appreciating the best of what is, thinking about what might be and should be, and ends with a shared commitment to a vision and how to achieve it.

Principle

Learn from successes: look for what works well and do more of it.

Practice

The AI process is commonly described as having five stages:

1. Define: the key stakeholders agree the positive focus of the inquiry. For example, 'how do we make this a smoke-free town', rather than 'how do we stop people smoking'? This stage might start with a problem but transforms it into a positive vision.
2. Discover: through storytelling, or a group inquiry process using appreciative interviewing and conversations, the group draws out positive experiences and gifts, and collectively discovers the common themes about what works and what they can build on.
3. Dream: what might be? From the 'discovery', the group develops a dream or shared vision of the future. This is presented in a series of 'provocative propositions' that sum up how that group would like to work in the future. The propositions have to be affirmative, challenging, innovative and based on real experiences.
4. Design: from their collective experience, what would they have to do to create the ideal vision of the future? What innovative ways can they find to do this?
5. Delivery: plan the actions to deliver the dream. How can the group ensure the sustainability of these changes in conversation as well as structures? How can it empower, learn, adjust and improvise?

AI can be used in the following situations:

- In conjunction with asset mapping, a new community group can use AI to develop its vision and its plan for locally-defined improvements.
- People in organisations can come together with users or residents to share their knowledge, and redesign their relationships and ways of working together.
- A group – be it a partnership, a group of work colleagues or a mixed group of residents and professionals – agrees that they want to change in a positive direction.
- There is no pre-determined solution and any agreed and realistic change is possible or permitted.

In 2008, Gateshead Council conducted an overview and scrutiny review of health inequalities. One of the recommendations was the need to find more effective ways of involving and engaging with communities to tackle health inequalities, and to explore different approaches in each of the five neighbourhoods. The Bensham and Saltwell neighbourhood decided to pilot the asset approach using asset mapping and appreciative conversations in the following way:

- A small group of people were given some awareness training on the use of AI and the benefits of asset mapping. They then identified an initial group of individuals and groups within Bensham and Saltwell with whom to have a 'Bensham and Saltwell Alive!' conversation.
- From those conversations, information will start to come forward and be shared with the neighbourhood, probably via a dedicated website, so that residents can start to see how the 'Alive!' conversation is growing.
- Assets from individuals will be gathered as the conversation grows. A simple tick list will be completed, and the results shared online so that new connections can be made between people.
- The library service and the children's centre are supporting the project and this is helping to catalyse interest.

Participants describe the process as a way of making good neighbours and stimulating over-the-garden-wall conversations.

Stockport's OSC undertook a review of health inequalities in Brinnington, its most deprived ward. They used the appreciative inquiry technique. People in Brinnington had felt they had been 'consulted to death', but were attracted to appreciative inquiry because the starting point was what worked in the area rather than what was wrong with it. The inquiry brought together local people, service providers and decision-makers who all shared stories about what was working in relation to health in the area, possible solutions and potential resources.

Learn more

The Thin Book of Appreciative Inquiry 1998 Sue Annis Hammond Thin Book Publishing Co ISBN 0-9665373-1-9) or www.thinbook.com

Storytelling

Storytelling is an informal and appreciative way of collecting information about people's own experience of successful projects or activities, their own skills and achievements and what they hope for. Sharing and valuing different stories of past achievements is engaging and energising. People gain confidence: what we did once we can do again. They learn what they already know and see how they could apply it to their current situation.

"Through the stories we are building up a picture of Broadfield. Mostly how beautiful it is with the trees, the green areas, and how much warmth and happiness there is, how much people matter to one another."

Report by South Ribble Borough Council on its Scrutiny: Broadfield You Matter. August 2009

World Café

World Café is a way to engage large numbers of people in a conversation about a compelling question or questions on an issue that matters to all of them. It is especially useful way for communities, councillors and service providers to talk to each other productively, share their knowledge and collaborate on ideas for change. "The café is built on the assumption that people already have within them the wisdom and creativity to confront even the most difficult of challenges"

In the Café, about 5 or 6 people sit round each of the tables and talk to each other, with one person acting as the host. After about 20 minutes, they move on to another table and the host stays to tell the new people about the previous discussions. At the end the emerging themes and ideas are collected and distilled by the whole group.

"The opportunity to move between tables, meet new people, actively contribute your thinking, and link the essence of your discoveries to ever-widening circles of thought is one of the distinguishing characteristics of the Café. As participants carry key ideas or themes to new tables, they exchange perspectives, greatly enriching the possibility for surprising new insights"

Learn more: http://www.theworldcafe.com/articles/cafetogo.pdf

Participatory appraisal (PA)

What is it?

Local community members are trained to research the views, knowledge and experience of their neighbourhood to inform the assessment of needs and priorities for future plans.

Principles

Local people are experts in their own lives and where they live. They are part of creating a shared future.

Practice

Local people are trained to collect and analyse, in as accessible a way as possible, information about the needs and priorities in their community, including the diversity of views, knowledge and experience. The aim is to describe not only what the situation is, but also why and how it came to be that way. They collect this information by talking to people on the street, going to meetings and organising events.

The framework of the research and what information local people gather is decided by a steering group of local people, not by outsiders: they start with a blank sheet. The information they collect is verified by corroborating it with other sources of statistical or survey data.

A range of visual, creative and participative methods are used to enable individuals and groups to be involved in collating, analysing and communicating the information in transparent and inclusive ways.

Participatory appraisal emphasises that 'the community' is not a homogenous group and that there are many diverse perspectives that should be actively sought out and taken into account. Although this method is used mainly to research needs and priorities, the remit could be extended to collect information about local skills, talents and resources – in line with the asset model.

This method of research engages meaningfully with residents, ensures they are listened to and prioritises their views – it is designed to 'speak their language'. It fits alongside other capacity building work by increasing skills and knowledge as well as building trust and confidence in the community.

The PA approach should not only be applied to the research phase of a development project; it is important to use the same principles and approach to designing any implementation that comes from the research.

Learn more

Annett, H., Rifkin, S. (1995), *Improving Urban Health*, WHO, Geneva. http://whqlibdoc.who.int/hq/1995/WHO_SHS_DHS_95.8.pdf

No more sticky dots: making progress with Participatory Appraisal in Salford. www.oxfam.org.uk/resources/ukpoverty/downloads/nomorestickydots.pdf

Open space technology (OST)

What is it?

Open space technology is a way of organising a meeting that allows a diverse group of participants to work on a complex and real issue. Participants decide the agenda and what is to be discussed rather than having a fixed agenda or speakers in advance. The process works best if representatives from 'the whole system' are in the same room; that is, all the different professional, political and community stakeholders.

Principles

The inventor of Open Space Harrison Owen set out these fundamental principles:

• Whoever comes are the right people – those who care will get involved.

• Whatever happens is the only thing that could happen, let go of expectations and pay attention to what is happening here and now.

• Whenever it starts is the right time – be creative about how to organise the sessions.

• When it's over it's over – finish when you finish rather than following a set timetable.

Practice

In an OST session, there are no speakers or presentations, no set agenda and only loose timings. The convenors set a central and open-ended question, which should be something the participants are passionate about, and say enough to attract attention without limiting the discussion. This provides the framework for the event.

In the context of that question individuals use a 'market place' to propose a topic or idea that they are passionate about and want to discuss. They then recruit participants and take responsibility for organising a discussion on the topic and the actions that emerge.

Participants sign up only to those discussions they want to take part in. If participants feel they are not learning from or contributing to a discussion they have a responsibility to go to another session. This is known as the Law of Two Feet.

The learning from these sessions will answer the initial question as well as commit people to action. It does not create a wish list for someone else to do. It must be clear how the recommendations and action plans will be taken forward, and by whom.

OST is a useful tool to consider when:

• existing processes aren't working and nobody knows the answer – OS can help to harness creativity and create a forum to hear all the different points of view

• it is necessary to create different working relationships for collaboration, networking, conflict resolution or strategy development

• it is important that participants take responsibility for implementing the results of the event

This process should not be used if the sponsors can't or won't cede control of the process, if there is already a pre-determined outcome, or if those involved will not be in a position to implement the results.

Hackney PCT is using OST events with different population groups to consult on this question: "How can Hackney become a great place to grow old in?"

Staff say that the process:

• gets people involved right at the beginning in an open-ended way, rather than starting with the organisation's agenda

• produces ideas and issues they would never have thought of – for example, isolation is the biggest issue rather than a desire for more services

• gets residents thinking about what their contribution could be to making Hackney better.

• changes the way residents relate to professionals – people are thinking about how they can work together.

• does not create expectations that the PCT can't meet

• distilled all the different things that had been talked about into a few really important things to do.

The Marmot Review has been supporting the development of a regional health inequalities strategy in the North West of England. This included an open space event with over 200 stakeholders, including workers, volunteers and the public. Key priorities emerging included building the asset approach within the region and strengthening community development approaches.

Learn more

Harrison Owen (2008) *Open Space Technology. A Users Guide*. San Francisco Berrett-Kohler Publishers. Harrison Owen is the originator of Open Space Technology: www.openspaceworld.com/users_guide.htm

References

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2   Cumbria JSNA 2009. Chapters 6 & 7

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4   *Spirit Level* (Wilkinson & Pickett Allen Lane 2009) *Sinking and Swimming: understanding Britain's unmet needs* (Young Foundation 2009)

5   Friedli L (2009a) *Mental health, resilience and inequalities*, WHO and Friedli L (2009b) *Resilient relationships in the North West: what can the public sector contribute?*, NWPHO

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15 Boyle and Harris (2009) *The Challenge of Co-Production*, NEF and NESTA

16 www.neweconomicsfoundation.org

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18 see for instance Ray Pawson & Nick Tilley. An example is Tilley (2000) Realistic Evaluation An Overview. Presented to the Founding Conference of Danish Evaluation Society.

19 http://www.mcconnellfoundation.ca/assets/Media%20Library/Publications/A%20Developmental%20Evaluation%20Primer%20-%20EN.pdf

20 *Empowering Evaluation: Evaluating Empowerment. A practice sharing report from CDX* (www.cdx.org.uk).

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