ScotPHN report

Scottish Community Development Centre (SCDC)

Developing a culture of thoughtfulness around assets based approaches to health improvement

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Contents

1 Introduction

1.1 This paper sets out the findings of a series of seminars on assets based approaches to health improvement, which took place with Scottish Directors of Public Health (SDsPH) and their teams, in February and March 2013. The first half of the paper starts by setting out the context for assets based approaches, outlines definitions for commonly used terms, and summarises the learning from the seminars.

1.2 The second half of the report examines in more detail a particular theme, which emerged during the seminars; the potential and purpose of developing a strategy or framework to further this work. The paper ends with a series of questions for SDsPH, their teams and their partners to consider.

2 Background

2.1 The Scottish Directors of Public Health contributed to a discussion paper on assets approaches, written by Jo Kennedy of Scottish Community Development Centre (SCDC), and presented to their meeting in May 2012. In subsequent discussions, SDsPH agreed on the need both for a more systemic approach to assets based ways of working, and for more evidence on the effectiveness of these approaches. A New Ways of Working group was established, chaired by Drew Walker, Director of Public Health for NHS Tayside, and including Phil Mackie, Lead for the Scottish Public Health Network (ScotPHN) and Jo Kennedy of SCDC. The group agreed that, in order to tackle the issue in a meaningful way, SDsPH needed to be given a facilitated space in which to think about how to move forward alongside others who were also interested in the assets approach from a community development perspective. It also resolved to create an effective collaboration between SDsPH, SCDC and NHS Health Scotland (mediated by ScotPHN) to help and sustain development.

2.2 In February and March 2013, ScotPHN, in partnership with the New Ways of Working Group, commissioned SCDC to conduct 4 seminars with Scottish Directors of Public Health and their teams across Scotland. The purpose of the seminars was to support the development of a ‘culture of thoughtfulness around assets based approaches to health improvement’ in each participating area. In particular, the seminars focused on how to build on, and promote, an assets based approach to tackling an identified health issue, and how to evaluate the impact of this approach.

2.3 Each seminar followed the same format. SCDC delivered a presentation on the assets approach. Participants discussed the issues, and mapped

assets activity in relation to their chosen topic. The seminars concluded by developing a set of actions, which were intended to extend the assets approach.

2.4 The particular health topics included: smoking cessation, diabetes reduction and supporting older people. At each seminar the following key questions were examined;

- how the locally identified issue is currently being addressed and to what extent an assets based or co-production approach is featured;
- how the issue or topic area may be tackled differently, what assets we may assume exist and how they can be tapped, mobilised and used to achieve positive outcomes;
- how this new intervention might be designed and what its key features would be; and
- how impact will be measured and what will be the indicators of success.

2.5 The seminars were designed to give SDsPH, their local teams and external partners time to consider the implications of adopting an assets approach to health improvement in their areas, focusing specifically on how they move from a project based approach to an underpinning strategy across the whole. The seminars stimulated debate designed to identify how evidence can be collected to support a move towards a systemic approach to assets based work.

2.6 During the seminars several SDsPH debated the benefits of developing a strategy or a framework. As it seemed likely that other SDsPH would also be interested, ScotPHN and SCDC decided to examine this issue in more depth.

2.7 Telephone interviews with the people listed below, took place in May 2013. The list includes representatives from each of the seminars plus 2 of those who have been heavily involved in the implementation of the strategy in Tayside, and a senior manager from NHS Ayrshire and Arran who is promoting an assets approach:

- Paul Ballard, Deputy Director of Health, NHS Tayside;
- Jane Bray, Speciality Registrar in Public Health, NHS Forth Valley (tasked by the DPH with putting together outline assets strategy);
- Anne Clarke, Senior Manager, Public Health Dept, NHS Ayrshire & Arran;
- Derek Cox, Director of Public Health, NHS Dumfries & Galloway;
- Gabe Docherty, Health Promotion Manager, NHS Lanarkshire;
- Chris Littlejohn, Speciality Registrar in Public Health, NHS Grampian;

- Catriona Ness, Organisational Development Consultant, NHS Tayside; and
- Susan Webb, Deputy Director of Public Health, NHS Grampian.

2.8 After the interviews a findings discussion took place between Jo Kennedy, Fiona Garven, and Phil Mackie, Lead Consultant for ScotPHN, which enabled questions for further consideration to be identified.

3 Definitions

3.1 One of the key features of all the seminars and of the subsequent discussions on strategy was a desire to agree definitions, both of what it means to adopt an assets approach and of what co-production is, as well as how the two are linked.

3.2 Sir Harry Burns, the Chief Medical Officer defines assets approaches in the following way:

"*Asset models tend to accentuate positive capability within individuals and support them to identify problems and activate their own solutions to problems, which they themselves identify. They focus on promoting health generating resources that promote the self-esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services. In effect, by concentrating on the strengths of individuals and communities, their sense of control over their lives is enhanced and they experience less of the chronic stress, which leads to a range of health consequences."*

(CMO 2009 report based on Morgan & Ziglio 2007)

3.3 The Glasgow Centre for Population Health outlines the features of asset based activities as being:

- making individual issues community ones, building around needs and aspirations, building supportive groups and networks, developing opportunities for meaningful engagement;
- identifying, building on and mobilising personal, local assets and resources – people, time, skills, experience – mapping the capacities and assets of individuals, associations and local institutions;
- building and using local knowledge and experience to influence change, engaging people in decision making and local governance, building a community vision and plan, and defining local priorities;
- empowering the workforce, changing the relationships between users and providers and across providers to share and liberate resources;
- focusing on facilitating, enabling and empowering rather than

delivering; and
- leveraging activities, investments and resources from outside the community, mobilising and linking assets for economic development.

3.4 The New Economics Foundation uses this definition of co-production:

"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change."

3.5 It can be argued that the assets approach is a set of values and beliefs where as co-production is a methodology. However in practice, particularly in the current context for public health, the distinction is less clear. We found that an assets approach is being used to describe the process of liberating the potential of people and organisations who can work together (or co-produce) improved health in our communities.

4 The Areas

4.1 The half-day seminars took place in Forth Valley, Lanarkshire, Grampian and Dumfries and Galloway and were facilitated by Jo Kennedy and Fiona Garven. The invitation was sent out to SDsPH and areas were selected on a first come, first served basis.

4.2 The topic of the seminar in **Forth Valley** was diabetes reduction. There were 14 participants including: the DPH, consultants in public health and diabetes, health improvement specialists, community learning and development practitioners and service user representatives. The action planning focused on a co-production approach to reducing diabetes in Langlees, which has both high levels of community engagement and high levels of health inequalities. Specific actions included: engaging the local GP practice in the approach and working with a group of local practitioners and community members to agree a plan for change, which includes health outcomes and indicators.

4.3 In **Lanarkshire** the focus was on smoking cessation, particularly in those areas where there has been little success. There were 15 participants, including the DPH, a consultant in public health and health improvement and health promotion practitioners. The action plan included using different approaches to engage with communities such as friendship groups in bingo halls, nurseries and pubs; recruiting individuals from target communities who have stopped smoking to act as peer mentors; working

with staff from across sectors who are already connected into communities and using social media and other forms of communication more effectively.

4.4 **Grampian** is developing an assets based approach to working with older people in Banff. There were 10 people at the seminar including the Deputy DPH, consultants in public health, the public health leads from the CHP, a representative from the modernisation directorate and other health improvement and promotion practitioners. The action plan focused on further developing the assets approach to the work in Banff, gaining support from across sectors, and developing ways to evaluate the impact of the work against health outcomes. A specific approach to the Community Planning Partnership was agreed and a budget allocated to the employment of a community development worker to take the assets approach forward within the different agencies and with communities involved.

4.5 **Dumfries and Galloway** has been adopting an assets approach to working in Annan, as part of a wider programme called Putting You First. They too wanted to focus on supporting the older people within Annan to stay well at home. The participants in the seminar included the DPH and practitioners from across sectors including the private sector. The action plan outlined a number of activities: changing professional mindsets, changing community mindsets and developing the infrastructure, including scheduling meetings with partner agencies, making the links with the Single Outcomes Agreement and further engagement with GPs.

5 Key points arising out of the seminars

5.1 The seminars were opportunities for Scottish Directors of Public Health to reflect on the meaning and implications of the assets approach alongside the senior teams and, in some cases, practitioners working on the ground. Each seminar began with a presentation defining the assets approach and outlining some key issues. These were discussed and debated by participants who very much appreciated the time given to think together. It was clear that these opportunities are hard to come by but enabled a deeper level of thought, debate and cross-fertilisation of ideas.

5.2 Creative thinking was very evident in the seminars, sparked by the opportunity to take time out with a mixed group. In Lanarkshire participants came up with a host of innovative ideas to tackle smoking cessation working with communities, in Forth Valley creative partnerships were formed in the room and in both Dumfries and Galloway and Grampian, the

vision outlined for older people was an inspiring and creative one.

5.3 Participants in the seminars did not, in general, have a lot of knowledge about how the assets approach was being developed in other parts of Scotland. But they were interested in finding out and learning from each other's experiences.

5.4 Co-production was a key theme in all the seminars. It was clear that achieving health outcomes, particularly with an emphasis on health inequalities, was not something that health practitioners could do on their own. They talked not only of the importance of working with the community, but also of working with Community Planning and voluntary sector partners. In Lanarkshire the local community health initiative, HealthynHappy was mentioned several times as a key partner. In Forth Valley, Community Learning and Development (CLD) partners as participants in the seminar, were able to explain the efficacy of their approach to clinicians and took a key role in developing the action plan for Langlees. The Grampian assets based initiative is being delivered through the Community Planning Partnership and Dumfries and Galloway are working with a range of partners including the private sector.

5.5 "*We want to start off with what matters to people in that community and work out the outcomes they are looking for so we can see where our agendas match*" (Lanarkshire participant).

This approach was mirrored in other seminars and it was acknowledged that they might need to take some time and work with through the tension associated with matching differing agendas. In some cases it was clear there was a match. For instance in Langlees (Forth Valley) where diabetes rates are high, the CLD worker was already working with a group of women who were swimming regularly in an effort to lose weight.

5.6 Taking an assets approach does not mean that everyone has to become community development workers. Instead it requires health practitioners to keep their focus as always, on health outcomes. But the way in which they achieve these outcomes will change, as they work with and alongside, the community and partner agencies. For instance, clinicians in the seminars in both Lanarkshire and Forth Valley had strong, effective programmes for managing diabetes and smoking cessation. However they were concerned that there were geographical communities and communities of interest where they were having very little impact, and were interested in working alongside community learning and development or voluntary sector partners to reach these communities.

5.7 Although their clinical knowledge and experience remain a highly valuable contribution, there is a risk of health practitioners feeling deskilled, in a

context in which outcomes might be less predictable, and we saw some evidence of this in the seminars. Training both on the assets approach and on their new role was seen as important and was part of several action plans. At the same time it was thought that a wider range of staff, including CLD and youth workers, would need their awareness raised on subjects such as smoking cessation and managing diabetes.

5.8 Participants in the seminars agreed that an assets approach needs to be integral to co-production. This includes building on the assets inherent within organisations as well as in the community. Assets identified around smoking cessation ranged from people who had given up smoking themselves, to a 24 hour phone line and the pharmacy service.

5.9 Strategies have been used as a way of both enlisting and indicating high level support for the approach. This was acknowledged as extremely important. In Dumfries and Galloway. Participants in the seminar were keen to see Putting You First endorsed by Chief Executives of both the Council and the Health Board, convinced that that would lead to more 'buy in' at all levels.

5.10 Leadership and commitment was demonstrated by the participation of Scottish Directors of Public Health and senior members of their teams. The importance of leadership and 'champions' at all levels was highlighted in different ways in all the seminars and, in particular, in Dumfries and Galloway. It was felt that high level endorsement from across sectors would enable 'champions' at lower levels to convince sceptics and release or divert resources.

5.11 Every seminar included an evaluation specialist. There was a lot of discussion about how to measure the outcomes of an assets approach. The importance of measuring health outcomes (and linking to HEAT targets) to gain credibility and buy from clinical staff was well recognised. Attention will need to be paid both to intermediate as well as long term outcomes and to developing proxy indicators when it can't be proved that it is the approach that has led to making the difference. Participants agreed that a range of health and wellbeing outcomes might be tracked for instance: reduction in falls, lower hospital admission rates, reduction in incidence of diabetes and greater evidence of successful self-management of long term conditions. Dumfries and Galloway already has a 3 year evaluation in place which is measuring both clinical and social outcomes. All areas acknowledged a lack of evidence to show the effectiveness of the approach and were keen to be part of the wider national study being developed by GCPH and SCDC.

5.12 The crucial role of GPs in developing the assets approach was highlighted. Several action plans included collaboration with GPs.

Dumfries and Galloway was the only area where a GP attended the seminar. She found it very useful and agreed to take her new understanding of the approach and the Putting You First vision, back to her colleagues. The action plan included exploring the option of funding longer consultations for GPs, an approach which has been used in the 'Deep End' practices.

5.13 The NHS improvement methodology was mentioned in two of the seminars. In Grampian the Deputy Director of Public Health had been inspired by her engagement with the Early Years Collaborative, and in Dumfries and Galloway the Plan, Do Study, Act methodology was being adopted as a way of supporting both learning and the spread of the approach.

6 Strategy Development for an Assets Approach

6.1 The issue of how to embed an assets approach, whilst simultaneously avoiding the imposing of agency-led solutions, was discussed in all the seminars. Several Scottish Directors of Public Health mentioned beginning to draw together frameworks or strategies designed to address this issue. They were particularly interested in how to make these strategies bottom up and how to link them clearly to other initiatives within the NHS and other frameworks used by partner agencies, for example, Single Outcome Agreements.

6.2 In 2010, NHS Tayside developed their Health Equity Strategy: Communities in Control, which outlined an assets approach to reducing health inequalities within a generation. The strategy was signed off by the Health Board, promoted widely both within and outside the area, and supported by a large scale training initiative which encouraged staff to explore the implications of really working **with** communities. It acts as a framework, which holds together a number of related initiatives including: time-banking, the Healthy Communities Collaborative, Dundee Healthy Living Initiative, Stobswell Equally Well test site and, crucially, a £2m Cash for Communities Innovation Fund.

6.3 According to those leading it, the strategy has enabled Tayside to promote an assets approach as part of co-production, to staff within the Health Board. It was, and is, seen as radical and has helped Tayside develop a reputation for innovation, helpful in bidding for new pilots such as the Family Nurse Partnership, funded by Scottish Government.

6.4 The impact of the Strategy so far is currently being evaluated using the New Economics Foundation's 10 Measures of Co-production. The areas

which are already under development include: strengthening partnership both through the Community Planning Partnership and the Community Health Partnerships and convincing clinicians. Asked about learning from the development of the strategy, one participant responded:

"It would need to be a health and social care strategy now. We would start collectively". (Organisational Development representative)

6.5 The progress of the Health Equity Strategy (HES) in Tayside has been followed with great interest both within Scotland and further afield. However at the time, none of the other health boards followed suit, and some scepticism remains about the value of a strategy;

"*I am not hot on strategies – they don't make stuff happen". (DPH)*

6.6 However, even the most sceptical SDsPH were considering the possibility that now might be the right time to develop a strategy. There was unanimous agreement that such a framework or strategy should be developed by partners in the public, private, voluntary and community sectors and serve several key purposes, outlined below.

7 The purpose of strategies

7.1 A strategy was seen as a way of pulling together several policy and practice objectives, which are influencing public health currently including: the person-centred approach, co-production, the integration of health and social care and reshaping care of older people. SDsPH were concerned to ensure that people are aware of the benefits of an integrated approach to these issues rather than a series of parallel processes. A strategy was seen as a way of ensuring the adoption of an integrated approach;

"*I am struggling to make sure others understand the links". (DPH).*

7.2 Another approach to this could be an 'assets audit', like an Equalities Impact Assessment, of existing strategies and policies locally.

7.3 For some health boards, the development of the strategy itself was viewed as an opportunity to use an assets-based approach and a process of co-production. In practice this meant involving communities and key partners in defining both what should be in the strategy and what should be part of the implementation plan. NHS Grampian is adopting this approach in developing its 20/20 Vision over the next few months and NHS Tayside is updating the 2010 Health Equity Strategy on this basis.

7.4 For some interviewees, a key purpose of the strategy was to come to a common understanding of what is meant by an assets approach to health improvement. NHS Forth Valley has been developing its thinking around this. Their paper considering strategy development contains a list of key principles:

- start with engagement – requires time;
- flexibility of approach;
- minimal critical specification – less 'how to do things', trust the individual/community to develop a 'how to' most suited to them;
- value the assets of individuals, community, workforce;
- increase the numbers of small starts (asset approach by bottom up nature involves starting small, important to remember this and not revert to top down approach);
- timescale needs to be long-term;
- co-production between the community and professionals; and
- person-centred – led by the individual not the professional.

NHS Forth Valley also listed the initiatives it is currently supporting which could be defined as using an assets approach.

7.5 In order to assist change at a grassroots level, the importance of high level endorsement from across sectors was emphasised. Again the development of a strategy signed off by senior management and the board supported by the leadership within partner organisations was seen as a strong driver in giving the approach both credibility and impetus:

"*There was a strong emphasis on partnership working to achieve strategy with a number of interviewees noting the relatively minimal role the NHS had in changing health inequalities. This reflects the clearly documented wider determinants of health. However there was recognition that partners, including communities, should be much more involved. Local ownership of the agenda was noted as a significant gap". (CHP Representative)*

7.6 Workforce development across the sector was identified as a key part of implementing an assets approach to health improvement. It has been a substantial part of the approach adopted by NHS Tayside and was highlighted as a need in all the seminars. It included both training for health professionals in community development/assets approaches and training for community workers in basic health promotion work.

7.7 The continuing need to produce strong evidence which shows the impact of an assets approach both on reducing health inequalities on improving health particularly in relation to issues such as tobacco cessation, obesity, teenage pregnancy and care for older people, was highlighted. Strategies could assist this through the inclusion of an implementation plan with clear

outcomes, which could be tracked over time:
"*The HES was seen as a "vision" of what needed to be achieved, and was seen by some as a useful framework, but very few of those interviewed appeared to have a sense of what specifically needed to be done next, and there was a significant gap in knowing what success was, or how to measure it". (CHP Representative)*

7.8 Ultimately a strategy was seen as a way of getting resources aligned to the approach. These resources could include staff time, but also financial resources from a variety of partners. One interviewee felt that the development of the strategy had given NHS Tayside an advantage when seeking funding from the Scottish Government for new initiatives such as the Family Nurse Partnership.

7.9 NHS Tayside has already put £2m of endowment money to be given out directly to community projects; NHS Ayrshire & Arran is considering using endowment money to employ up to 30 community based staff working with partners and in communities, to take forward the approach. NHS Grampian has given £30,000 towards the employment of a community development worker to support older people improve their health in Banff. The post holder will be accountable to the Community Planning Partnership.

7.10 However, as yet, there is little evidence of a serious co-production approach to improving health and wellbeing across areas and in communities, particularly those affected by health inequalities. The evidence for this would be some jointly funded initiatives, which collectively, would form part of a strategy with clear and measurable outcomes.

8 Conclusions – are we on the right track?

Becoming thoughtful

8.1 Experience has shown that new approaches provide an opportunity for existing practice to be rebranded. This is particularly true when there is a lack of clarity about what the new approach really entails. So there is a real and well-founded fear that adopting an assets approach might in some cases merely be a vehicle for re-presenting existing practice, some of which is a long way from ideal.

8.2 To counter this tendency, further clarity is needed about what adopting an assets approach really means. It is not possible to be definitive about this in every case, by its nature an assets approach depends on local circumstances and environments, but there is a need to learn more about

it what it looks like by testing out assets approaches in action.

8.3 From this work with Scottish Directors of Public Health and their teams, and, in related work undertaken by SCDC and others, including Glasgow Centre for Population Health, it is clear that real assets based practice raises some significant challenges. These are outlined below. Each challenge ends with a question – many of which were posed during the seminars themselves.

8.4 There are no 'one size fits all' solutions, but individual areas are finding ways both to deepen their understanding of the underlying issues and to move forward.

The challenge of both defining and mobilising assets

8.5 Within current Scottish policy there is a renewed emphasis on working with communities and service users in the recognition that locally defined and delivered solutions often lead to a better and more sustainable impact. As we operate in an increasingly challenging fiscal environment, there is a need to better understand how to tap into and mobilise the physical, social and human assets that lie within our local communities.

8.6 In the context of communities, assets mean the wide range of material and human resources that may be available. These include peoples' skills, interests and energies; community infrastructure in the form of networks, groups and organisations; the physical assets of land and buildings; and political assets and the ability to influence and shape decisions. It can be argued that, when those assets are tapped and mobilised, communities develop the capacity to assert more control, to initiate and develop local activities and services, and generally improve the quality of life for residents.

8.7 How do we collectively identify what individual and community assets are available to us and identify what actions we need to take to make best use of those assets and to build assets where there are gaps?

The challenge of collaborating to make sure that preventative action becomes a reality

8.8 Following the Christie Commission Report and as set out in the Scottish Government's response, *Renewing Scotland's Public Services*, preventative action is at the core of Public Services Reform and actors across public services are now required to work together through Community Planning mechanisms to integrate services and thematic activity around communities and to establish co-productive relationships with communities.

8.9 Each agency and partner should be asking about their own role in this collaboration. In this case the role of Public Health in creating the conditions in which assets based approaches can be applied at individual and community level has been the subject of research, generating questions about what actions SDsPH can take now and in the longer term.

8.10 How can we meet the continuing challenge of real partnership working with Community Planning Partnerships and the new Health and Social Care Partnerships but also with the third sector and communities which would include joint commissioning and sharing of resources? Is there a need to legislate for and incentivise this to make sure it really happens?

Real co-production – what does it mean and how do we do it?

8.11 Asset based approaches are an integral part of community development and community-led health interventions. They facilitate people and communities to come together to achieve positive change using their own knowledge, skills and lived experience. Empowering individuals and mobilising the expertise of local communities are central to public service reform: community members working alongside public services and third sector agencies to co-design and deliver services, improve outcomes and achieve meaningful social change. A 'co-production' approach values professional expertise alongside the knowledge that comes from personal experience and recognises that real transformative change comes from a combination of the two.

8.12 There is a requirement for public agencies to help set the foundations for reconfiguring the relationship between communities and public services through co-production. How can agencies and communities work together to achieve a set of 'intermediate' outcomes, the characteristics of which include;

- increased trust and confidence between agencies and communities;
- positive relationships and improved partnership working between agencies and between agencies and communities;
- increased ownership of local issues by communities themselves and the development of locally led responses and solutions;
- increased community cohesion; and
- increased community empowerment through the ability of communities to influence change at a local level.

The challenge of developing a sustainable base for assets approaches

8.13 It should be recognised that the ability to implement assets based approaches will be affected by the level of existing community infrastructure and the availability of groups to engage and work with. Even where there is an element of community infrastructure in place, positive

outcomes will be affected by the community groups' ability to engage with the wider community and a diverse range of interests. It can be argued that, sometimes, pre-existing community structures can be a barrier to wider involvement rather than an enabler, if those existing structures are exclusive and non-participatory.

8.14 In areas of extreme deprivation and low community infrastructure, there is a need for community capacity building support to enable assets based work to be productive and inclusive and for communities to be able to begin to lead, or act as co-producers of, locally led solutions to local issues. In the briefing paper 'Community Empowerment in Action'[1], SCDC noted that 'Preventative spend, the asset-based approach, co-production and community engagement – all increasingly recognised as important in good governance and public service delivery - can only succeed if the communities involved are properly equipped to participate and take advantage of any opportunity that may be available.

8.15 Community capacity building demonstrates that some investment in community infrastructure can pay rich dividends in the success of any policy initiative'. In this context, the term community capacity building encompasses the areas of skills development, establishing effective governance models and processes, addressing equality issues, increasing local involvement, extending the scale of activity at a local level and increasing the influence of local people and local groups or organisations.

8.16 But, who are the capacity builders? And how can we make sure they get the support they need at a community level?

Investing in communities: how do we do it, how does it justify the cost?

8.17 Assets based approaches support the potential for increased involvement in community life, which often provides people with a sense of purpose and self-worth, a wider network of support and social interaction, and feelings of greater control over their own life circumstances. All of these dimensions have an important role in improving and enhancing individual and collective health and wellbeing and overall life chances. Beyond its value to people as individuals, investing in a community development, or assets based, approach will ultimately alleviate impact on public services as communities are more able to participate as equal contributors in achieving health, regeneration, community safety and other outcomes.

8.18 But how much does it really cost? How can we develop clearer

[1] http://www.scdc.org.uk/media/resources/policy-and-practice/FINAL%20SCDC%20Community%20Empowerment%20in%20Action%20Briefing%20April%2012.pdf

intelligence about the economic benefits of an assets approach versus traditional service delivery models?

Prioritising workforce development

8.19 Delivering on preventative action involves investment in workforce development to ensure that public service staff develop and enhance their skills in community involvement and person centred approaches, that decentralisation of power to citizens and communities takes place and that all forms of inequality are tackled as a core principle. It also involves ensuring that leadership is distributed and developed at all levels.

8.20 How do we manage the double demands of supporting our workforce to increase their knowledge, develop new skills and work in new ways at the same time as ensuring quality of current services?

National health targets versus community priorities

8.21 National targets are often monitored on an annual basis. How can we manage the tension between honouring a bottom up approach to health improvement and working with the priorities identified by communities, and the imperative to meet health targets, such as smokefree by 2034?

What are the limits of an assets approach?

8.22 The question of how far an assets based co-production approach can extend commonly arises as health improvement practitioners attempt to engage with clinicians, working in acute and secondary care. The efforts to reduce smoking in a particular deprived area might be ideal territory for an assets based approach, but how does the same approach apply to medical interventions? How do we make the connections between co-production with communities and the kind of person centred co-productive approach taken by a clinician to his/her patient, exemplified by the Esther approach to person centred care being pioneered in Southern Sweden[2]?

What is real and meaningful evaluation?

8.23 How can we meet the challenge of both a comparative and a collective evaluation of a whole range of different initiatives delivered by different partners, which are needed to form part of a bottom up strategy? Should a set of standardised clinical and qualitative indicators be developed? Can we apply 'Improvement Science' to this kind of work, and if so what would this look like?

[2] http://www.govint.org/good-practice/case-studies/the-esther-approach-to-healthcare-in-sweden-a-business-case-for-radical-improvement/

9. What next?

9.1 These questions do not have simple answers. They will need to be considered and worked with by Scottish Directors of Public Health, their teams, and their partners (which includes communities) over the next few months and years as we move forward with an assets approach to health improvement.

9.2 There was some call during the seminars and subsequent research for a stronger endorsement from government for the approach which could include a national strategy to which SDsPH are held accountable, even if this does not include extra resources.

ScotPHN report

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