North of Scotland Public Health Network (NoSPHN
Delivering Asset Based Approaches for Public Health
Responding to the Challenge
27th March 2012, AECC, Aberdeen

Event report

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North of Scotland Public Health Network (NoSPHN)
NETWORKING AND CONTINUING
PROFESSIONAL DEVELOPMENT EVENT 2012
Tuesday 27th March 2012
10.30 am to 4.30pm
AECC, Aberdeen - with remote access

NHS SCOTLAND
NoSPHN

Delivering Asset Based Approaches for Public Health: Responding to the Challenge

This paper has been prepared by Pip Farman, NoSPHN Coordinator in consultation with the key contributors to the day – colleagues are invited to further feedback their views, reflections and narrative of the day for inclusion in this document. Please contact Pip on pip.farman@nhs.net

Delivering Asset Based Approaches for Public Health: Responding to the Challenge

A perspective on the day (what have we heard; what did the feedback say)?

1. Context

On the 27th March 2012 the North of Scotland Public Health Network hosted an event at the Aberdeen Exhibition and Conference Centre (AECC), Aberdeen. 51 colleagues attended the event in Aberdeen and a further 16 participated in the event by videoconference over the day from sites in Inverness and Lochgilphead (NHS Highland), Lerwick (NHS Shetland), Kirkwall (NHS Orkney), and Dundee (NHS Tayside).

The aim of the event was to provide an opportunity for participants to:

- Explore the development and delivery of asset based approaches for public health
- Reflect on the opportunities and challenges to the delivery of asset based approaches
- Focus on North of Scotland issues (with a view to complementing local developments)
- Provide a forum through which to share and discuss issues and practice
- Strengthen participant's capacity to deliver (or support the delivery of) asset based approaches.

The proposal for an event came from discussion between NoSPHN colleagues following the numerous opportunities that Sir Harry Burns (CMO) took at various events the previous year to highlight the need to tackle some of the seemingly intractable health challenges that Scotland faces - exacerbated by factors such as poverty, alcohol, unemployment, and poor physical and social environments. To create and improve health and wellbeing Sir Harry Burns encouraged a move away from a glass half empty model (a deficit model) to a glass half full (an asset model). This culminated for some in a presentation at the Scottish Faculty of Public Health Conference in Aviemore in November 2011 where, whilst recognising that this was a challenging agenda Harry challenged the Public Health community to get on and do it.

Many of us in Health Boards at that time were already moving on the agenda eg with partner organisations; delivering or considering how best to respond to the challenge and importantly considering how best to be able to demonstrate how and what we were doing. A day was suggested to provide us with the opportunity to share practice and access support from others and each other.

An important theme emerging through the planning discussions was that the asset type approach was not new – that many had been working with it for some time – but perhaps what was needed was a way to review the language, find new ways to present what we are already doing and reframe current work – others felt there was much however we still need to do.

It was important in this respect to find out what colleagues wanted from such an event (and to ensure it complemented local and Health Board developments) – and a range of observations were highlighted from "this is not new we have been doing it for a long time", to scepticism and a degree of cynicism and to those who did not know what asset based approaches were. Expectations and needs highlighted in relation to the event included:

- Information and understanding (shared understanding) of what are asset based approaches.
- Evidence of what works (in what contexts), what does not work and how to measure.
- Sharing case studies, practice, experiences and practical applications in Scotland.

- How to incorporate asset based approaches into individuals roles (eg alcohol, health protection, social marketing, communications, early years, Keep Well, health improvement, health intelligence, health services).
- 'Doing' Asset Based work: engaging with communities, facilitating on the ground, identifying community and personal assets, working with other agencies together in communities, putting theory into practice and using asset approaches to support needs assessment.
- What this means in the context of the existing policy context and public health priorities.
- A range of other individual needs were also highlighted.

The day was organised to create an opportunity for colleagues to explore, discuss and find out more. In addition, links to a range of references and materials recommended by colleagues as useful were uploaded in advance of the event onto the NoSPHN website http://www.nosphn.scot.nhs.uk/?page_id=1125 .

The programme for the day is attached as Appendix 1 and a list of participants at the event is noted at Appendix 2.

2. Key narrative and messages heard at the day

The following highlights the key messages from and discussion at the event. All presentations that were made available for the day are uploaded on the NoSPHN website[1].

Introduction to the day – Sir Lewis Ritchie

In welcoming colleagues to the event Sir Lewis reflected that 10-12 years ago he had sat on the Remote and Rural Areas Resource Initiative (RARARI) and had canvassed support in funding to set up NoSPHN so he was delighted to see how NoSPHN had progressed. Summarising the aims of the day Sir Lewis hoped that the day presented an opportunity for colleagues to pull together, share perspectives, practice and experiences and also reflected that whilst assets approaches for him were a great idea there was a need to look at whether and how asset based approaches could effectively be implemented in practice and if and how they would make a difference in public health terms.

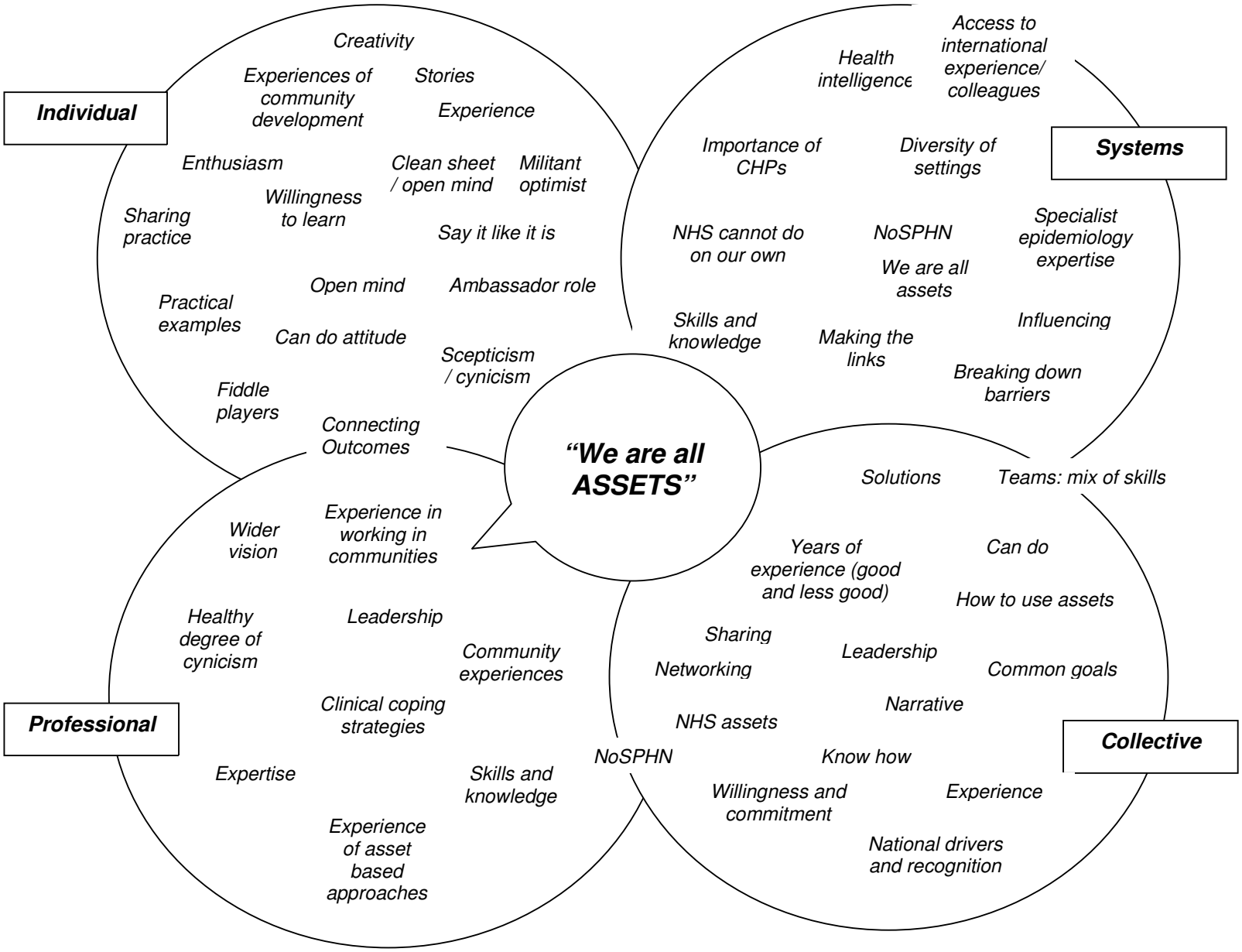
Introduction to the day and each other – Pip Farman

Pip outlined the programme and introduced the range of guests invited to support the event before inviting all the delegates to introduce themselves to each other and to share the assets (individual, professional, systems or collective) they were bringing to the day and the agenda.

These are summarised in the diagram below – the assets sheets were left on the discussion tables during the day and colleagues were invited to add to these over the day.

[1] http://www.nosphn.scot.nhs.uk/?page_id=1125

Assets brought by colleagues to the day and the agenda



How did we get to here? What do we need to think about and do differently? – Trevor Hopkins

Trevor introduced himself describing the asset he bought to the day as one of being a 'militant optimist'. Reflecting on his career Trevor highlighted that he had instinctively been using an asset based approach for a long time but did not have the language to describe it. He noted that an asset based approach has been a recognised way of working, at least on a theoretical basis for 40 years, it had blossomed in the 1970s and therefore predated many existing approaches to improving health and tackling health inequalities eg social marketing and medicalised/reductionist models of Public Health. Trevor contended that social sciences could save Public Health referring to seminal texts such as Ivan Illich, Michel Fouault and Aaron Antonovsky.[2]

Alluding to stories from the holocaust Trevor referred to work by Antonovsky who asked not what made many of the women who had been in the death camps ill but what made some of those women healthy? This was the concept of 'salutogenesis' – the origin of health and not 'pathogenesis' what causes ill health. Antonovsky had recognised a set of qualities or a 'sense of coherence' in those women who were well, that they were optimists, networkers and problem solvers. Trevor also mentioned the work of Jody Kretzman and John McKnight (Asset Based Institute, University of Chicago) that highlighted that being connected, involved and having friends is good for our health.

Key asset based messages that Trevor shared with colleagues at the event included:

- Mapping assets is not just what you do – the benefit is when you connect assets up and the process of connecting communities and resources.
- His contention that the model of health that many are working to at present - at evidence, academic and practitioner levels is based on the deficit, pathogenic or reductionist approaches and not salutogenic. Many of us have diseases in our job titles and he cited Sir Harry Burns movement in thinking recently from a deficits approach focusing on damage to children when born to an asset based way of thinking.
- Asset based approaches have a long pedigree and the research evidence is getting better.
- We have grown pathogenic approaches to Public Health through systems and institutions. He highlighted that we often have health and wellbeing partnerships to create health and wellbeing - but there is very little evidence that working in partnership improves health outcomes.
- Structures (are needed) but an industrialised model by necessity produces lots and lots of the same thing eg flu jag (herd immunity) – this is an intervention that works well but will not work with obesity or for residual smokers. Through intervention generated inequalities we have often made them harder to reach – we need to change the way we work if we are going to get to them.
- Targeting services at specific needs and problems – we need to see people in context as individuals, families and communities – the idea that we should just target 'interventions is erroneous – and the smaller we make the 'target' the harder it will be to hit.
- The asset based approach is by its nature a universal approach - the whole person, the whole family, the whole community.
- What would we see if used the asset based approach more? Perhaps less about servicing need (which is still required and should be used where there is strong evidence that it works) but use the asset based approach where things are not working. Marmot has called for a need to move away from targets to more universal approaches – 'proportionate universalism' – and to redress the balance between needs and assets (not to abandon other approaches). Trevor also highlighted that unless we address material wellbeing, poverty ie the basic determinants of health, asset based approaches will not work – it has to be used alongside other

[2] To access links to references shared in advance of the event - http://www.nosphn.scot.nhs.uk/?page_id=1125
Links to references referred to on the day are available at http://www.nosphn.scot.nhs.uk/?page_id=1413

approaches. There is a need to focus on the causes of the causes of the causes (mental wellbeing) of ill health but also the need to work on all three.

- Evaluation - narrative or story telling can be an effective way of assessing community interventions – Trevor highlighted four questions to use when doing appreciative interviewing (Appendix 3) – and suggested using the questions as a framework for thinking in a more appreciative way, highlighting that appreciative questions form the first phases of an appreciative enquiry.
- In taking work forward Trevor recommended: understanding what is meant by assets; changing perspectives and understanding that maximising and connecting assets have a huge impact on our health – of a similar impact to giving up smoking (and that the evidence base was increasing and becoming more credible to support this).
- Key messages from publications by Trevor and Jane Foot included: the value of mental and social wellbeing (being lonely and ill is bad for you); that the asset based approach needed to be complementary to other approaches; the need to better understand what makes 'better ill people' and recognise that assets can be an input, measure and an outcome.
- We need a new approach to evaluating asset approaches – and need to understand patterns of health in the same way as illness. Traditional evaluation tries to take things out of context (eg RCTs) but this does not help us. In asset working the context is the key, not the intervention – there is a need to understand context more.
- Research needs to be participatory – we will not get at context using traditional evaluation because traditional evaluation removes context – Trevor referred to Prof Huw Davies piece (in 'What makes us Healthy?' by Jane Foot).
- Narrative is important because people create narrative which can be self fulfilling (eg the story of the Angel of the North) and can change the way a place views itself.
- The defining themes of asset based ways of working are that they are place based, relationship based, citizen led and that they promote social justice and equality.
- To finish Trevor emphasised that the asset based approach is not a way of doing things – it's a way of thinking about things (perceiving things), this is not about changing one or two things but changing our perspective on everything.

Discussion following the presentation – summarising key themes and messages

"Targeting – it's a dilemma"?

Discussion noted that Trevor was not endorsing targeting and that this conflicted with others contentions eg who advocated targeting the most deprived areas rather than whole populations and also the challenges of and the need to focus limited resources. "What size of community should we be looking at as we can not afford to focus on all communities"?

Trevor contended that we should target where appropriate, where we know it works and where it is improving health. In terms of targeting deprived communities he asserted that if we do not do the job properly then all will suffer poorer health (all of society suffers as a result of inequalities not just those experiencing inequalities). In terms of developing communities we will need to work in communities but not just deprived (in acknowledgement that wealthy communities also have needs eg alcohol use, but at present we may not be looking at such communities because they are not deprived). We might also work with those communities with the greatest assets (resources) recognising that we do not have the solutions for all communities and we could widen the gap not narrow it if we work inappropriately and should mobilise resources with those who have resources.

Trevor highlighted that communities will self organise – eg in relation to nicotine needs a community will organise to support this (ie it is a functional response to self organise) – we need to understand communities will self organise – and consider how we work with this.

Trevor also asserted that it was a premise to assume we should do work in all communities and that if we require resources we should consider using existing resources in terms of ill health which are not working. Trevor challenged that offering just financial resources or service responses could create dependencies and by definition usually required exit strategies - in this sense we

become part of the problem not the solution and that the side effects of this might be worse than that which the intervention was seeking to address.

"Are community assets the only assets"?
No – individuals, assets of associations, services, cultural, economic, geographical are all assets – however in mapping assets it is important to remember that the asset based approach is not a way of doing but a perspective on people and a place. There are also opportunities to think about online assets eg Facebook where people are already connected – can we afford to miss this as an opportunity?

What will success look like?
"Our concept of evaluation needs to change – resources will be tight – what's the value for money and benefit in the asset based approach?" Trevor referred to his planned evaluation session in the afternoon which would seek to ask does the asset based approach work and is it worth it. He noted that at the moment it is difficult to construct a case about the asset based approach being worth it but the Health Empowerment Leverage Project (HELP) was looking at the financial case for it – evidence was there however for benefits in terms of health and wellbeing.

Thinking and Doing Differently: the practice – an asset based approach case study
Yennie Van Oostende: a story

Yennie introduced her story about a 10 year project called the Bute Healthy Living Initiative (HLI) and how those involved had used an assets based approach to support the project. Using a video clip (available to view on the CHEX website)[3] set in the Green Tree café (a community asset), based in the local community centre.

"Originally it was fully funded by the Bute Healthy Living Initiative and staffed by paid staff. The Bute HLI set up and supported various groups, so that they would develop the potential to run on their own and we also worked with individuals on building life skills, such as cooking, budgeting, confidence and self esteem building programmes etc. When the funding ran out for the Bute HLI, the community was keen to keep the café and community hub going and we developed a sustainability plan, involving as many hopes, dreams and wishes of the community as we could. Now, the hub is an asset that is being run as a social enterprise (another asset) by volunteers, using their interest and talents to put on programmes based in a community café.

One of the regular programmes that was happening was a breakfast club and a supper club for young people. Rachel and Maggie (who you meet in the film) are some of the key people to its success. You might have noticed how Rachael talks about her mobile phone, she's the one who texts people to remind them it's on and Maggie, who now has a young son, has pulled in another 3 young mothers and their babies, who regularly attend the supper club.

The three young men, Ryan, Johnny and Antony are some of the cooks who decide on the menu, go shopping, cook the meal and there is a rota for tidying up. This programme has brought a lot of young people together to sit down for a meal, at a table, like a family. They previously took part in cookery programmes over 2 years as part of a homeless project for young people, where they cooked, videoed and put together a DVD and recipe cards. Over time, they built up their catering skills to cook for bigger groups and are also involved in cooking for a lunch club for older people and other food events. They have felt a great familiarity and confidence when they're in the Green Tree and are always helping other with the Wi-Fi sessions, or serving cups of coffee.

[3] http://www.chex.org.uk/

Other programmes that are happening in the café are:

- Lunch and social club by and for older people (music, stories, flowers on the table)
- Carers support group
- A Film and Animation group
- A Textile Arts group
- WI-FI drop ins etc. All assets of the BHLI were transferred to the social enterprise – including their computers.

Most of the groups were initially run by the Bute HLI, but we always had sustainability in mind, highlighting, appreciating and developing people's own skills, using their talents and now we have these incredible assets in our community. All groups now run themselves and each group takes ownership of the community space during the time that they are there.

I'm hoping that this will have illustrated how the skills and talents of people, whether as staff, a management committee, a volunteer, a participant are fully appreciated and utilised in what we now call an Assets based approach to Community – Led Health".

Discussion: (and colleagues emerging thoughts)
Colleagues were asked to consider whether the story was helpful to visualise an asset based approach (an example of community asset development) and how this perspective might better enable colleagues to take a salutogenic approach.

It was noted that making video probably had a hugely energising effect on the individuals involved (ie demonstrating the power of the narrative).

Should we and how do we ensure we are joining up approaches?
"Are we and how do we ensure that we join up an asset based approach with other work with our partners and for example work on coproduction, that we do not see asset approach in an isolated way?" We should understand what does work and then build on it – work together, having access and listening to what people say and work with that. There is a need to join up things and respond in a way that makes sense for and works for people in communities and strengthening that. David Allan (Scottish Community Development Centre) highlighted that the CHEX website had further evidence of work in practice.[4] "Generic community development reaps benefits across all sectors – let's join it up".

A dilemma
"If our premise is to work on the determinants of health and if we are to build on assets across communities – do we need to recognise that some will be better at building assets because they have better assets – could an assets based approach therefore further contribute to inequalities? Who then decides which communities assets should be built up? What if communities are self organising in the 'wrong' way – are these inherent paradoxes?"

Trevor agreed there was a dilemma – in communities where assets are not as exposed or connected do they need our help most but suggested that we turn around the picture which measured by deficits rather than assets. All communities will have assets – all will self organise (negatively or positively). We need to use our knowledge, professesional skills and engage with politicians to make it work well. Do not work just on assets in the least and best communities. Yennies project has grown as an asset eg the community café. From that, others things have started to grow. Being connected has a huge impact. Public Health colleagues often have a specific target – but any contact that is open and collaborative can have an impact - what would communities like to target – what do people what to change?

[4] http://www.chex.org.uk/

Trevor cautioned seeing the asset based approach only as a community development approach – as to do so would do it a massive disservice for example pharmacists, surgeons, psychologists can (and do) have an asset based focus - it's the way we understand and treat people eg the expert patient programme relies on focusing on assets, connecting people to support – backed up by sound medical knowledge. GPs understand that their surgeries are full of sad and disconnected people who are offered medication – we should be offering alternatives?

"Assets are inputs and outputs" – its good to reflect on child health services and for example child protection services – where we do not want harm to come to a child – our current model is one of a child at centre surrounded by family and community and a flow of assets is part of this – no one process can deliver the right outcome. But should we better ask 'What makes a good childhood'? A new model of health and wellbeing is suggested by McKnight – the concept of a person surrounded by services is not right.

"What happens to those individuals who do not engage and are not seen as part of a community – will it create new inequities leaving some behind?" Put this in a different way – people engage for different reasons – think around natural disasters – most work is done before the emergency services arrive. People who never connect suddenly come to the fore. Rebecca Solnit in her book – 'A Paradise Built in Hell' – produces evidence of why people get involved. Consider also what we mean by community - I am not strongly connected to my geographical community. I am linked in but not connected – but I am connected to other communities of interest (eg hobbies). Our community map is not necessarily the geographical community, Facebook is not geographical, and the mobile phone is a powerful tool to connect to wider communities in particular for young people. We should raise our definition of community to a more embracing one.

Reflective log – colleagues were invited at the end of the session to record their own narrative of the day and share it if they wished.

Reflections on the afternoon workshops

Colleagues were invited to attend two workshops over the afternoon considering a range of perspectives and issues on the asset based approach (see programme – Appendix 1). Where available, copies of the presentations and reference material in relation to the workshops are available through the NoSPHN website.[5]

The following notes summarise key points and messages taken from feedback after the sessions supported by notes taken in the sessions. Where action was suggested in the discussion they are noted in the diagram on page 14 which appeared to fall into: actions for individuals; actions with colleagues and teams; getting on a doing asset based work and the need to influence others.

1. Illustrating asset based approaches in action – initial case study research findings – Jennifer McLean (GCPH) – (presentation available online)

- Emerging cross cutting themes were presented from 19 individual case studies of community projects and initiatives from across Scotland.
- Nothing was surprising for anyone – the key is how we measure the work happening in communities and better support community projects and organisations to better evaluate the work they are doing? Implications for both skills and capacity.
- How do we embed appropriate evaluation systems without losing the creativity and innovative nature of community based work?

[5] http://www.nosphn.scot.nhs.uk/?page_id=1125

- There are recognised funding constraints and limitations of current funding streams (for particular groups) – how could external funding better support community projects to do more of what works for local people?
- The direct health impacts of the projects are hard to assess. Much anecdotal evidence exists of the positive health impacts of projects but there is very limited evaluation data
- Why are communities with these projects in place not healthy? We need to consider the wider context of an individual's life.
- The majority of projects were responding to some form of 'need', projects are responding to need using a different way of working.
- A full write up of case study research is expected shortly (the web link to it will be made available on the NoSPHN website).

2. Tools for building community assets – David Allan (Scottish Community Development Centre)

- Tools and frameworks are available but we need to look at how these can best be applied.
- We need to recognise the complexities of the approach and communities (who are not homogenous).
- Recognise the overall context.
- Need to pay attention to the systems - fundamental change is required to support the asset based approach.
- Build on what we are already doing; there are many good examples of work.
- Challenge colleagues to look at their behaviours.
- Let's share practice.
- Enable networks to develop organically.

3. Developing assets based work in different NHS contexts (planning, services etc) – Chris Littlejohn (NHS Grampian)

- All this feels familiar – we are not reinventing the wheel (and have confirmed wheel is round).
- Need to see healthcare as an asset in its own right (including physical facilities).
- Healthcare is an asset even if targeted at deficits.
- Relationships are important.
- It's legitimate to involve individuals and communities in discussions and decisions about healthcare.
- We need practical asset based approaches.
- Champion and make ourselves opportunities.
- Language is important – particularly how staff communicate with patients and families.
- We should not forget the social context to recovery after ill health.

4. Asset approaches – <u>doing</u> asset based work – Trevor Hopkins (Asset Based Consulting)

- What might be possible if we used an asset based approach?
- See asset approach as part of organisational change eg appreciative enquiry, open space, self improvement models, may have opportunity to use organisational development programmes to develop approaches.
- Asset mapping is not just about mapping, connecting the assets is critical.
- It is a challenge to be with colleagues and in systems that mitigate against taking an asset based approach - how can we in a medically dominated culture champion asset based approaches – can we enable colleagues to start seeing the hooks they have in their own role in organisations and with colleagues and use language that already exists though eg psychology and social care?
- Opportunities to share stories across the Network and share understanding with others.
- "Let's reclaim the story".

5. What does success look like and how might we measure it? – Trevor Hopkins (Asset Based Consulting)

- Evaluation, we cannot solve a dilemma we can only manage it – so lets have the dilemma argument – not the 'can't do' argument.
- Develop ourselves.
- Recognise shortcomings of funding streams and seek to change them.

6. Assets and community resilience – Nick Wilding and Gill Musk (Carnegie UK Trust/ IACD)

- Suspicion – are asset approaches a way of making up for structural / historic inequalities by making poor communities do it for themselves?
- We need to change professionals' attitudes - to challenge our colleagues to take on things / reflect on their deficits approach and to look at our own behaviours and mind sets.
- The power of the narrative / story telling.
- The Mental Health Recovery Network – a great example to look at.
- Policymakers are swamped by reports and statistics: let's source anecdotes and start reporting stories to Government and other professionals and teams etc. In an example from Shetland, it was stories that helped convince policymakers that deprivation exists – the work of capturing older people's stories then inadvertently led to the formation of youth group taking asset approach to their challenges.
- The group talked about how powerful it would be if networks started sharing stories – many other networks are thirsty for stories of work in this area – "let's claim and write our stories – our assets – there is a need to link up existing experiences in the North of Scotland".

7. Asset based approaches for public health – redressing the balance? - Pip Farman (NoSPHN)

- Recognised challenge of target driven environment in both health and Local Authorities – systems are not working in favour of asset approaches and true engagement is currently difficult.
- Cultural change is needed (Government, NHS and in population) – we need to look to others around us eg Harry Burns, DsPH to influence others and lead.
- We need to start applying asset based techniques.
- Let's start with our own organisations recognising staff as assets.
- Healthy Working Lives – has the potential to map assets and workforce – how can the health service be an enabler?
- There is a need for a long term commitment to the agenda.
- Will an asset focus help any better than the deficits approach - we need to make sure it will help us with inequalities?
- What would our work look like if it was asset driven eg Keep Well? But to note that NHSWI Well North was successful in the context of a target driven approach.
- What are the risks of the asset based approach – can it go wrong?
- How do we define our community?
- A lot is going on already eg in health protection, health promoting health services – we need to maximise and build on this.
- Need to recognise that communities are not static and subject to change there is a need for a sustainable approach to this work.
- Loads of examples of how to think about things differently – can we ask ourselves for every piece of work "what would this look like with and without an asset based approach"?

Some final observations / questions

- Power!
- Community fatigue (some of our communities are fed up with being consulted – we need to do it in the right way, be careful how we package and sell eg community consultation).
- What happens if the community come up with something we can not deliver on?
- There has been a lot of discussion about the challenges of dilemmas – you can't solve a dilemma you can only manage it. There is no answer to a dilemma – it's about how you manage and balance the conflicting interests within those dilemmas and at any one time some of these will be in the ascendency and some descending. Meantime see ourselves using an asset based approach and development in terms of managing the dilemmas.
- There is a need for a catalyst to bring conversations together.
- Make asset based approaches part of the corporate culture – make it more explicit in what we are doing.
- Start with what you have got – "make a positive statement".
- Go back to own teams re vision / strategy / changing perspectives.
- If not going to do it properly – do not do it at all.

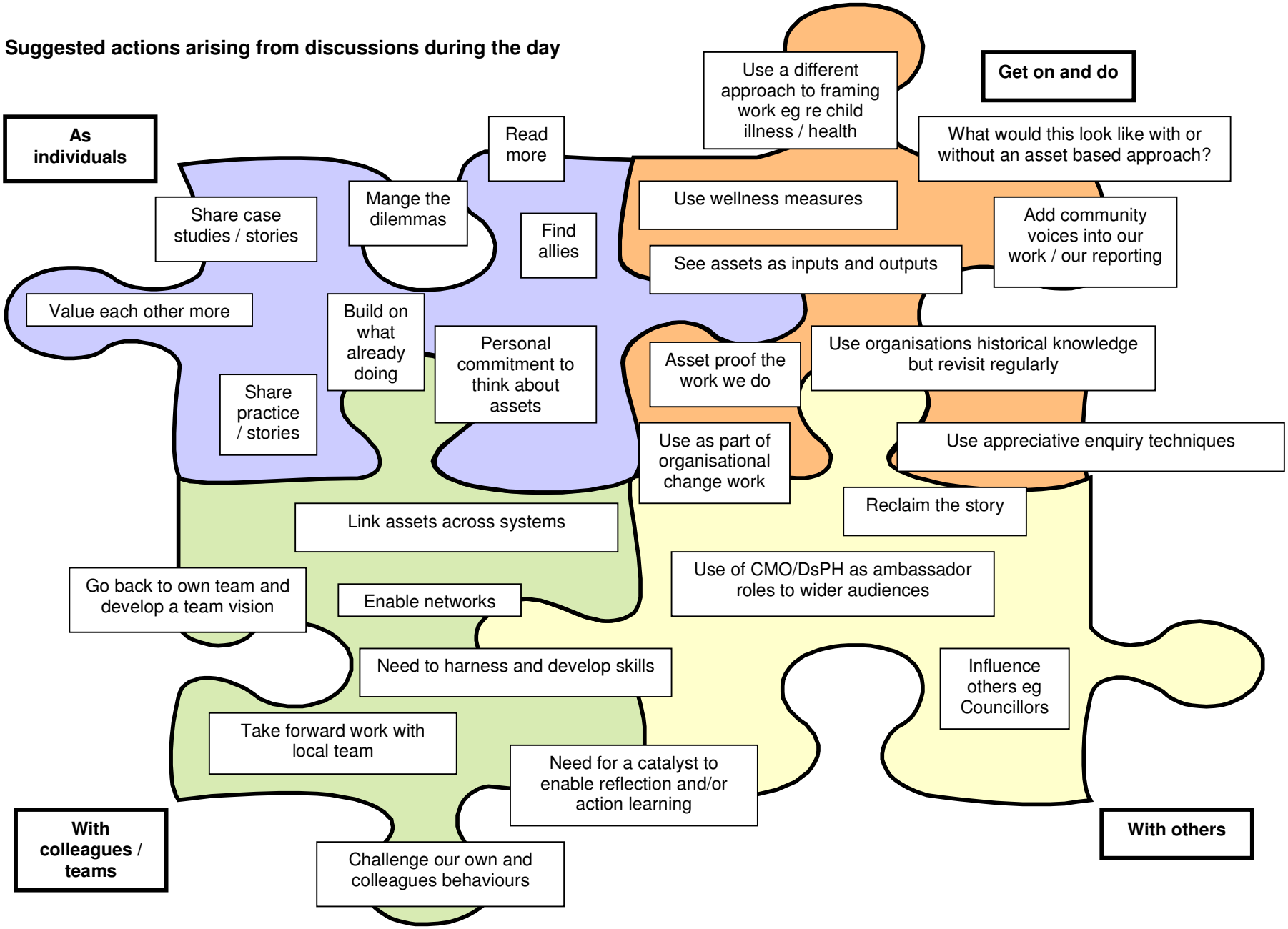
Review of the day and closing comments – Sarah Taylor (NoSPHN Lead)

Sarah reflected on the day and that she had heard some really brilliant things – and that it had been really good to hear about and to share work. Sarah encouraged everyone to recognise that we have strong assets of our own on which to build. There had been a wide range of issues highlighted which left her with lots of threads that she wanted to pursue. Sarah also encouraged members to identify ourselves as a community who might continue the momentum generated from the day and suggested there was the power to achieve this within the room / the North. One way to do this would be to start to share stories with one another which could readily be achieved through the NoSPHN website. Sarah shared her 'aha' moment as reading the Mental Health Recovery Network stories and encouraged colleagues to look at this if they were not familiar with it. Sarah suggested that what was now needed was a commitment to the agenda and that as the Lead for NoSPHN and a Director of Public Health she would commit to take things forward in the North through NoSPHN. Finally Sarah thanked all those that had been involved in organising and contributing to the day and invited members to complete and share their reflective log.

And to conclude with a reflection from Trevor Hopkins:

"There was a huge willingness and enthusiasm to engage with the debate. I think in part because this agenda is being driven by Harry Burns. In comparison with other events I have attended where the approach has been met with a lot of scepticism there was really intelligent debate about the pros and cons and about the dilemmas of the asset based approach which others need to hear, particularly at a national level, for example around targeting".

Suggested actions arising from discussions during the day



Overview of feedback from participants about the event (Appendix 4). A feedback sheet was completed by 60% of those attending the event (thank-you).

There were a wide range of expectations expressed for the event including the need for it to contribute to participant's knowledge and understanding of asset based approaches, putting asset based approaches into practice and sharing of practice. The sense coming through those submitting evaluations were that many felt the event had achieved much of what it had set out to do although more might have been done to support consideration of local issues. The majority of participants felt their expectations had been met, met well or exceeded.

The key insights taken away from the event were numerous but exemplified by comments such as:

"we need to do more of this in our daily work"
"lets start with ourselves"
"we need to look at things in different ways"
"we are already doing this and need to build on it".

Many participants highlighted that they intended to change practice or follow work up as a result of the event and this included: more discussion with others; doing things differently; putting asset based work into practice and further reading.

The feedback highlighted that the organisation of the event had been highly rated and that the event was very positively received and there were a number of welcome comments about how the event might have been improved including the format of the event eg more group work.

The facilities were evaluated well (venue, food and access). The remote access arrangements were well received although there were clearly some challenges with this which will need to be reviewed for future events. However the commitment to ensuring remote access facilities and enabling colleagues to contribute through videoconferencing was well received. Overall the feedback suggests the event was very well received both in its content, delivery and in its prompt to participants to do more[6].

[6] The word cloud that follows was produced using www.wordle.net and the text from the evaluation sheets from the event. Wordle is a tool for generating "word clouds" from text that you provide. The clouds give greater prominence to words that appear more frequently in the source text.


based
asset
approaches
approach
work
need
event
good
practice
delivery
local
health
eg
information
colleagues
Need
examples
Good
well
participants
communities
discussion
opportunities
indication
knowledge
feedback
evaluation
organisation
comments
Excellent
people
way
remote
North
make
better
issues
others
met
links
Well
day
awareness
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debate
Continue
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wide
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Opportunity
improved
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Convenient
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Explore
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Appendix 1

North of Scotland Public Health Network (NoSPHN)
NETWORKING AND CONTINUING
PROFESSIONAL DEVELOPMENT EVENT 2012
Tuesday 27th March 2012
10.30 am to 4.30pm
AECC, Aberdeen - with remote access

NHS SCOTLAND
NoSPHN

Delivering Asset Based Approaches for Public Health:

Responding to the Challenge

The **AIM** of this event is to provide an opportunity for participants to:

- Explore the development and delivery of asset based approaches for public health (in different contexts)
- Reflect on the opportunities and challenges to the delivery of asset based approaches
- Focus on North of Scotland issues (with a view to complementing local developments)
- Provide a forum through which to share and discuss issues and practice
- Strengthen participant's capacity to deliver (or support the delivery of) asset based approaches.

Programme

Links to key reference materials are available at http://www.nosphn.scot.nhs.uk/?page_id=1125. The programme has been planned to be participatory and asset based approaches will be used in the delivery of the event. We have invited a number of guests to be with us on the day to provide a resource for participants to access throughout the day. The event will be facilitated by Jane Groves (NHS Highland).

10:00	Registration and refreshments: How full is your glass? (1)	Forbes
10:30	**Welcome and introductions** Sir Lewis Ritchie - Director of Public Health, NHS Grampian Pip Farman - NoSPHN Coordinator	Forbes
10:45	**How full are our glasses?** (2)	
11:00	**How did we get to here? Why do we need to think about and do differently?** Trevor Hopkins (Asset Based Consulting) Followed by structured questioning as a group	
11:40	**Thinking and Doing Differently: the practice – an asset based approach case study** Yennie Van Oostende (NHS Highland) Discussion in groups	
12.20	Reflections	
12.30	**Lunch**	
1.15	**Unpicking asset based approaches** (themes have been identified in advance and will be reviewed on the day). Facilitators will initiate discussion by sharing their stories / areas of work – participants in the groups will also be asked to share their stories, views and expertise. **Parallel themed discussions 1** (participants will attend/ link to one of the following) 8. Illustrating asset based approaches in action – initial case study research findings – Jennifer McLean (GCPH)	Break out rooms Forbes

	9. Tools for building community assets – David Allan (Scottish Community Development Centre)	Room 10
	10. Developing assets based work in different NHS contexts (planning, services etc) – Chris Littlejohn (NHS Grampian	Room 4
	11. Asset approaches – doing asset based work - Jane Groves (NHS Highland)	Room 3
2:00	**Parallel themed discussions 2** (participants will attend/ link to one of the following)	
	12. What does success look like and how might we measure it? – Trevor Hopkins (Asset Based Consulting)	Forbes
	13. Assets and community resilience – Nick Wilding and Gill Musk (Carnegie UK Trust/ IACD)	Room 10
	14. Asset based approaches for public health – redressing the balance? - Pip Farman	Room 4
	15. To be confirmed on the day in response to issues identified on the day.	Room 3
2:45	**Plenary – what have we heard?**	Forbes
3.15	**Refreshments**	Forbes
3.30	**How full are our glasses (3)? Focussing our assets and determining further needs and next steps**	Forbes
4.15	**Review of the day and closing comments** – Sarah Taylor (NoSPHN Lead)	Forbes
4.30	**Close**	

Appendix 2

Delegate List - NoSPHN CPD Event 27th March 2012

Aberdeen CHP	
Joanne Adamson	Public Health Co-ordinator
Mary Bellizzi	Health Improvement (HEAL)
Jennifer Hall	Public Health Lead
Kim Penman	Senior Health Improvement Officer
Linda Smith	Aberdeen City Public Health Lead
Marlene Westland	Public Health Co-ordinator
Asset Based Consulting	
Trevor Hopkins	Freelance Consultant
Carnegie UK Trust	
Nick Wilding	Development Officer
Fraserburgh Development Trust	
Andrew Mackie	Community Health Development Officer
Glasgow Centre for Population Health	
Jennifer McLean	Public Health Programme Manager
Val McNeice	Public Health Research Specialist
Highland Alcohol & Drugs Partnership	
Debbie Stewart	Co-ordinator / Development officer
Highland Council	
Keith Walker	Health Improvement Officer
International Assoc. for Community Development	
Gill Musk	Development Manager
Moray Community Health and Social Care Partnership (CHSCP)	
Tracey Gervaise	Public Health Lead
Moray Council	
Steven McCluskey	Strategic Manager-Health Improvement
NHS Grampian	
Nicola Beech	Cross System Specialist Analyst
Jenna Bews	Project Support Manager/Hi-Net advisor
Emily Burt	Specialist Trainee in Public Health
Mag Campbell	HIO - Neighbourhoods
Caroline Clark	Public Health Co-ordinator
Leah Dawson	Corporate Communications
Linda Duthie	Special Projects Manager
Caroline Hind	Deputy Director of Pharmacy & Medicines Management
Helen Howie	Consultant in Public Health Medicine
Marjorie Johnston	Public Health Registrar
Nelson Kennedy	Cross-system Specialist Analysts - Public Health,
Chris Littlejohn	Specialty Registrar in Public Health
Sandra MacAllister	Keep Well Project Co-ordinator
Mary McCallum	Health Improvement, Strategy
Elaine McConnachie	Health Improvement Officer
Euan McCormack	Mental Health Improvement Advisor
Naomi Milne	Marketing Assistant
Julie Morrison	Public Health Co-ordinator
Fred Nimmo	Senior Analyst Primary Care and Public Health
Lewis Ritchie	Director of Public Health
Lynn Robertson	ChildSmile Regional Researcher
Marie-Louise Shaw	Health Improvement, Alcohol & Drugs
Dawn Tuckwood	Area Public Health Co-ordinator (Marr)
Susan Webb	Deputy Director of Public Health

Anne Whitcombe	Health Improvement Co-ordinator Knowledge/Learning

NHS Highland

Sally Amor	Child Health Commissioner/PH Specialist
Jane Groves	Public Health Network Co-ordinator
Paddy Luo-Hopkins	Head of Health Intelligence
Alex Medcalf	Public Health Secretary
Julia Nelson	Health Development, Early Years, HC / NHSH
Moira Paton	Head of Community & Health Improvement planning
Sharon Pfleger	Consultant in Pharmaceutical Public Health

NHS Orkney

Ken Black	Consultant in Public Health Medicine

NHS Tayside

Julie Cavanagh	Consultant in Public Health Medicine

NHS Western Isles

Colin Gilmour	Health Improvement Manager

NoSPHN

Pip Farman	NoSPHN Co-ordinator
Sarah Taylor	NoSPHN Lead / Director of Public Health NHSS

Scottish Community Development Centre

David Allan	Head of Programmes

The ARCHIE Foundation

Janine Ewen	Communications Manager

Delegate List - by VC

NHS Highland - Argyll & Bute

Alison Hardman	Senior Health Promotion Specialist
Craig McNally	Senior Health Promotion Specialist
Yennie van Oostende	Senior Health Promotion Specialist-Inequalities

NHS Highland - Inverness

Tara Shivaji	StR Public Health
Margaret Somerville	Director of Public Health
Cathy Steer	Head of Health Improvement
Susan Vaughan	Epidemiologist

NHS Orkney

Suzanne Baird	Health Promotion Officer
Carolyn Chalmers	Civil Contingencies/18 week RTT Programme Manager
Kara Leslie	Health Promotion Officer

NHS Shetland

Elizabeth Clark	Senior Health Improvement Advisor

NHS Tayside

Deborah Gray	Senior Health Promotion/Mental Health Improvement
Mary Quinn	Health Protection Nurse Specialist
Andrew Radley	Consultant in Pharmaceutical Public Health
Drew Walker	Director of Public Health

Appendix 3

Appreciative Conversation – Involving communities as equal partners to improve health & well-being

Question 1 Can you tell a story of a time when you made a positive change to improve your own health and wellbeing? What made this significant for you?
Question 2 What do you believe is now the single most important thing that positively influences your own health and wellbeing? Can you say something about that?
Question 3 Now turning to your work; can you tell a story of how you involved others as equal partners in bringing about real and sustainable change?
Question 4 Imagine your community – your friends, your family, your colleagues and the wider community – telling stories about how you have worked together as equal partners to achieve your dreams of a healthy community. What would these stories be?

Appendix 4

North of Scotland Public Health Network (NoSPHN)
Network and CPD Event, Tuesday 27th March 2012

EVALUATION SUMMARY

Number of people attending: 67 — In person 51; By videoconference 16

Number of evaluations returned 40 (60%)

Although issues have been summarised – it was felt important to leave in much of the narrative to reflect the story of the day. Numbers given in brackets reflect the number of people commenting in a similar way.

	Not at all familiar	Familiar	Very familiar	Total
1. How familiar were you with the NoSPHN prior to this event?	9 (22.5%)	17 (42.5%)	14 (35%)	40 (100%)
	Did not achieve	**Partially achieved**	**Achieved**	**Total**
2. How well did the event achieve its aims to:				
• Explore the development and delivery of asset based approaches for public health (in different contexts)	0 (0%)	19 (47.5%)	21 (52.5%)	40 (100%)
• Reflect on the opportunities and challenges to the delivery of asset based approaches	0 (0%)	13 (32.5%)	27 (67.5%)	40 (100%)
• Focus on North of Scotland issues (with a view to complementing local developments)	7 (18.5%)	24 (63%)	7 (18.5%)	38 (100%) 2 not answered
• Provide a forum through which to share and discuss issues and practice	1 (2.5%)	10 (25%)	29 (72.5%)	40 (100%)
• Strengthen participant's capacity to deliver (or support the delivery of) asset based approaches.	3 (7.5%)	20 (50%)	17 (42.5%)	40 (100%)

3. How did you participate in the event? (1 form - no indication – 3%)	Attendance at the AECC 36 (90%)	By videoconference 4 (10%)
4. Did you access the reference information that was made available on the NoSPHN website prior to the event?	Yes 29 (72.5%)	No 11 (27.5%)

What were your expectations of the event?
Summary (numbers indicate how often reference was made):
Knowledge / understanding (13)
Putting into practice/delivery (6)
Discussion re local impacts (3)
Understanding of what happening elsewhere/ sharing of practice (3)
To raise awareness with others / opportunity to challenge (3)
Evidence/evaluation (2)
Networking (1)

Examples of comments made:

- To further develop knowledge of asset based approaches and their delivery in real-life settings.
- To hear more about taking an asset based approach, to hear Trevor speak (very inspirational) and to have discussions locally about what that means for our service delivery and how we can improve.
- To learn about what else is happening in North of Scotland in terms of asset based approaches. How people in NoS see the asset based approach and does this fit with my views.
- To have the opportunity to reflect on evidence and sharing of good practice.
- Opportunity to challenge / discuss practicalities and 'fit' with present Public Health practice.
- Clarity on how the asset based approach could be used to develop new work and fit with existing work.
- Opportunity to discuss the literature and clarify thinking.

How well were your expectations met?

Summary

- Very well met / exceeded (7)
- Well met (10)
- Met (10)
- Met in part (8)
- No indication (5)

Examples of comments made:

- Good discussions and some practical ideas for taking this forward regionally.
- Local implementation not discussed / local relevance will perhaps continue to emerge / more local examples of asset based approaches would have been useful.
- General scepticism initially, but some real engagement after discussion.
- Now have a clearer understanding / awareness.
- Questions around the reality of how this works in practice and how we can evidence progression.
- Good reflective critical discussion.
- Lot of discussion about examples of asset based working but we did not come up with a shared agreement of what is meant or if there is any difference to what some colleagues are doing already.
- Successful.

What is the key insight you will take away from the event today?

Examples of comments made:

- To take into account asset based approach in daily work.
- We are already doing some of it, but we can do more. Also raising awareness with our colleagues and how we can embed that in our delivery of training and delivery.
- Links to helpful organisations eg Carnegie UK Trust and other areas of policy interest, applying asset based approaches in practice – to use the linkages and knowledge we have in NoSPHN and beyond – supplemented by these other ideas to start to grow our own knowledge and resilience. The power within us!
- Assets are inputs and outputs.
- Need to agree evaluation methods so that evaluation is "accepted".
- Deeper understanding of asset based approaches and issues involved.
- Motivational interviewing as useful tool / example or technique for enhancing individual assets.
- The need to influence colleagues and gain supporters.
- Some of my colleague's embarrassment and discomfort with approaches (eg relationships) really challenged my thinking.
- Value challenges of asset based approaches.
- That asset based approach can be used in all aspects of work and not just in communities, including clinical service delivery.
- This is work in progress.
- Start with ourselves.
- How asset based approaches can be of significant benefit to some people.
- Try to look at things in a different way, eg 60% of people smoke, 40% don't = why don't they smoke?
- That all of the GCPH asset examples were originally started to meet a need – perhaps it is more a way of working once needs have first been considered?
- I have tried to work with communities in this way – it may not have been labelled as an asset based approach! There is evidence that it can work but need to ensure that it doesn't increase inequalities in some communities.

- Moving from a deficit to an asset based approach takes time but may provide better end results and evaluation of this approach is challenging – mental health tools may be a good way forward.
- Might be possible to utilise asset based approaches.
- Focus on: What makes us healthy?
- There is a positive alternative to looking at deprivation.
- Numerous in relation to current work / possible new or different ways of approaching.
- Appreciative questioning – can easily apply this to lots of areas of work.
- Evidence is available on value of this approach which can be shown to policymakers / funders.
- That 'top down' focus on deficits is limiting, but possibilities exist at the local level regardless.
- No answers – manage dilemmas not resolve them.
- There are some philosophical / moral dilemmas which we as an organisation need to debate openly in order to make a collective decision about what we mean. We also need to be having this debate with people in the communities that we want to work with, and then some of the issues pertaining to "how do you monitor / evaluate the impact of this way of working" start to become clearer.
- Increased confidence to deliver – need to be realistic, eg timescales.

Do you intend to change any practice / follow anything up as a result of the event?

Summary
- More discussion / raising with others (14)
- Intend to change practice (9)
- Reading (5)
- Will test methods (eg appreciative enquiry) (5)
- Not sure (2) / No (2)
- Seek higher level support (1)

Examples of comments made:
- Take into account asset based approach in daily work.
- Made links between some local work on poverty and organisations I met at the event – Carnegie UK Trust, and inspired in application within local long term health improvement strategy.
- Re-motivated to take this forward – take enthusiasm and knowledge back to the organisation and influence others.
- Look at opportunities for asset based approaches within work we are doing – need mixed approach.
- Explore programmes and appropriate asset based opportunities in each.
- Need to influence colleagues and gain supporters.
- Looking at evaluation expectations for small projects.
- Discuss with own team, continue to raise locally / assess further steps.
- Consider use of appreciative enquiry.
- Further investigation into the approach and how it can be used will be put into action.
- Needs to be an NHSG Public Health wide conversation and plan.
- Need to find out assets existing in communities and build on this.
- Read more about ABA, find more examples and think about how it can be applied.
- Follow up web links supplied and share information with colleagues.
- Encourage local use through change processes.
- Read more literature, eg Foucault's work on power and health.
- Patience.
- We need to make this practice attractive to everyone – I will spread the word and promote to my health promotion colleagues as the great assets that will give us the answers in tackling poor health and wellbeing.

Any further suggestions or comments about the event?

Summary:
- Positive feedback (7)
- Good use / need better links with remote access participants (5)
- Could have been improved through small group discussion / mini workshops (3)
- Need to do more to communicate approach to others (2)
- More feedback / stories (1)

Examples of comments made:

- Maybe didn't make the best of the remote participants – interested to hear their feedback.
- VC worked very effectively to demonstrate wide interest and input.
- More discussions in small groups would have been useful.
- More needs to be done to communicate the asset based approach.
- More again soon please!
- Need feedback and more stories to keep up the momentum – maybe get an example of how the asset approach could be applied to an existing target driven programme, eg Keep Well, Healthy Working Lives.
- Very good speakers.
- Widen out to other professional groups, eg Early Years Networks.
- Very enjoyable, informative day – well organised. Liked the idea of video link to other venues.

Please comment on the following:

AECC
Facilities Excellent (6), Very good (2), Good (19), OK (2) Just a little cold / temperature fluctuations (2), Convenient, Large room not very congenial for VC breakout
Catering Excellent (3), Very good (8), Good (18) Water jugs could have been replenished more frequently
Access (by road / airport etc) Excellent (2), Very good (1), Good (18) Poor signage, city centre would be a bit easier, convenient, not accessible easily by public transport from airport
Remote Access (remote access participants only)
Pre event information • Fine, adequate information provided • Excellent • Very good / good • Great to be able to read information beforehand
Access to the event on the day (by videoconference or teleconference) • Couldn't teleconference into the breakout groups of my choice, got the wrong room or dialling tone. • VC was ok but need to make sure that presentations sent to participants prior. This was not done for the breakout sessions and we could not see the slides for the two sessions in the Forbes suite. • For one workshop I was on hold on the telephone for 20 minutes and did not get through. • Very good.
How well did you feel you were facilitated to be engaged in the event on the day? • Lot of thought given to including remote participants and I felt that I had the opportunity to ask all my questions and comments • Very well / good (3)

Event organisation
Further comments on the organisation of the event and how it might be improved for another occasion eg programme, administration, management of the event. **Examples of comments** • Great day / well organised / positive comments (12) • The information was good and appreciated the links to papers in advance /online (meant I was better briefed and hopefully able to contribute better) (5) • First class / exceptional (2) • Great speakers, very interesting
Suggestions for further Public Health CPD / networking opportunities in the North. • Another event in 2013 to see what has happened as a result of today / more on assets – especially examples / learning points (3) • Public Health Intelligence – embedding wellbeing • Scottish Effect – high risk vs. whole population approaches • Leadership in times of austerity • Community led health – “Policy into Practice” and how we marry top down targets with bottom up community led health activity