Glasgow Centre for Population Health

BRIEFING PAPER 13 CONCEPTS SERIES

Towards asset-based health and care services

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KEY MESSAGES

- The language of 'assets' is being used more widely in health and social care literature as the emphasis shifts towards prevention and the need to work differently to tackle persistent inequalities.
- There is a lack of descriptive evidence about the characteristics of health and care services which take an 'asset-based approach' to their delivery and engagement with patients.
- A number of well-established ways of working and approaches exist, such as co-production, personalisation and strengths-based approaches, which support and are based on underpinning principles and values similar to those of asset-based working, and support a focus on assets.
- Assessing assets alongside needs may give a better understanding of the health and care requirements of individuals, enabling a shift towards more empowering, sustainable and holistic approaches for delivering services.
- New models of leadership are needed to develop, drive and respond to the required changes in power sharing and to provide a renewed focus on frontline relationships.

INTRODUCTION

The language of 'assets' is being used more widely in health and social care literature as increasing emphasis is placed on prevention and the need to work differently to tackle persistent inequalities. New thinking is emerging, as emphasised in recent reports of the Chief Medical Officer[1,2] and the Christie Commission[3]. Health assets and asset-based working have come into sharper focus as being potentially important in improving health and in reducing health inequalities.

Growing interest in and development of asset-based approaches is central to the national agenda of public service reform and the integration of health and social care in Scotland. Policy and legislative developments in Scotland are increasingly placing priority on collaborative working which enables people to exercise choice and exert greater control over the types of support they need for better health and wellbeing outcomes. But what does this mean for the delivery of public services, the public sector workforce and those who engage with and are supported by services?

This paper builds on the evidence and discussion presented in previous Glasgow Centre for Population Health publications:

- *Asset based approaches for health improvement: redressing the balance*[4] which provides an overview of the approach and a synthesis of relevant research.
- *Putting asset based approaches into practice: identification, mobilisation and measurement of assets*[5] which discusses a range of methods and techniques that can be used to identify and mobilise individual and community level assets.
- *Assets in Action: Illustrating asset based approaches for health improvement*[6] which presents an investigation of asset-based working at the community level.

Drawing on the evidence and commentary from a range of sources, this briefing paper discusses current models of public service delivery, why a change to the delivery system is needed if

services are to be fit for the future and what asset-based working may add to the way services are delivered. The first part of the paper discusses the current Scottish health and care policy landscape and how asset-based approaches fit within this. The second part considers alternative examples of service delivery, each of which align closely with the principles of asset-based approaches. Lastly, the paper discusses the value and potential of asset-based service delivery and the implications and opportunities of asset-based working for the health and social care workforce in Scotland.

PUBLIC SERVICES AND THE NEED FOR TRANSFORMATION

Public services are important to us all but are of particular importance in protecting vulnerable and disadvantaged people in society. The quality of those services is part of the foundation on which our society and future prosperity depends. They are central to achieving a fair, equitable and just society[3]. Major progress has been made in improving the performance of NHS Scotland in the last few decades. However, there is growing recognition that the current models of health and social care may not be sustainable in light of resource constraints, the needs of an ageing and increasingly diverse population, the changing burden of disease, and rising patient and public expectations[7]. In addition, inequalities in health are increasing, particularly on those dimensions with a large preventable component. Although many of the determinants of health inequalities lie outwith the service sphere, the current pattern of service delivery is largely failing to make an impact here. For all these reasons, there is recognition that new models of service delivery and population health improvement are needed. It is stated that to maintain quality public services, there is a need *"to do things smarter and better"*[8 (p 2)]. The overarching commitments in the National Performance Framework[9] of early years intervention, tackling poverty, reducing health inequalities and others, challenge current models of service delivery to the extent that there is a need to rethink how services are delivered and what is delivered.

The report from the Commission on the Future Delivery of Public Services[3] (Christie Commission) brings to the fore the need for new ways of working. It clearly states that *"irrespective of the current economic challenges, a radical change in the design and delivery of public services is necessary to tackle the deep-rooted social problems that persist in communities across the country"*[3 (p viii)]. To achieve this goal, a key objective of the reform programme must be to ensure that *"public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience"*[3 (p 26)]. Central to this reform process is the empowerment of individuals and local communities by involving them in designing and delivering the services they use. There is an associated requirement for public services to work in partnership with other organisations and communities to improve outcomes. In seeking this shift, the Christie Commission has offered both a road map, and a substantial challenge.

The Christie Commission report[3] and the aims of public sector reform build on previous legislation (Local Government in Scotland Act 2003)[10] and policy commitments on the public sector engaging with communities across Scotland. Through the Community Empowerment Action Plan 2009[11] the Scottish Government and public services have committed to community empowerment, and promote and support the use of a variety of participatory approaches and engagement techniques. These include the National Standards for Community Engagement[12] which set out best practice guidance for engagement between communities and public agencies and the 'Better Community Engagement' A Framework for Learning[13] publication, which aims to help build the skills and competences needed for effective community engagement.

Through the Public Services Reform (Scotland) Act 2010[14], and in responding to the Commission recommendations, the Scottish Government has committed to reforming and building public services in Scotland so that they build on the assets and potential of individuals, families and communities through: a decisive shift towards **prevention**; greater integration at a local level driven by better **partnership**; **workforce** development; and a sharper, more transparent focus on **performance**[8]. This approach maintains an "*emphasis on achieving the outcomes that matter the most to the people of Scotland and to lead public services into new ways of working and thinking, new understanding of people's needs and innovative ways to meet those needs*"[8 (p 4)]. The aims of the reform programme clearly reflect the principles of an asset-based approach, and recognise the value and importance of achieving a balance between service delivery and community building, as well as meeting people's needs and nurturing their strengths and resources. The integration of health and social care, through the passage of the Public Bodies (Joint Working) (Scotland) Bill[15] will further support the provision of personalised and flexible services, planned and delivered from the perspective of the service user or carer that shifts care from acute services to care provided at home or in the community.

The Scottish Government has also set out its strategic vision for achieving sustainable quality in the delivery of healthcare services across Scotland. The 2020 Vision[16] provides the strategic narrative and context for taking forward the implementation of the NHS Scotland Healthcare Quality Strategy[17], and the required actions to improve efficiency and achieve financial sustainability. The 2020 Vision for Healthcare and the Quality Strategy aim to put people at the heart of NHS Scotland and are committed to providing high quality healthcare. Furthermore, the 2020 Workforce Vision has been developed in recognition of the vital role of the workforce in delivering high quality healthcare, embodied in a commitment to valuing and empowering the workforce and treating people well[18].

The Quality Strategy[17] is set on three clearly articulated and accepted ambitions based on what people have said they want from their NHS – care that is safe, effective and person-centred. The Quality Strategy, a development of Better Health, Better Care[19], builds on the significant achievements in health and healthcare of the last few years and aims to put quality at the heart of NHS Scotland. However, there are a number of different metrics that are used to judge how 'good' services are. These include talking about the effectiveness of services (which focuses on outcomes), their productivity (which focuses on throughput), their cost-effectiveness (which focuses on value for money) and their quality (focusing on issues in relation to the patient experience). Services strive to achieve all of these but there often has to be a compromise. The priority for the Quality Strategy is to embed a recognition that a patient's experience of the NHS is about more than speedy treatment – it is the quality of care they get that matters most to them.

Mainstream service delivery remains largely designed to react to problems rather than to prevent them. Growing acknowledgment of the shortcomings of this 'deficit' or 'treatment' approach to the delivery of public services, coupled with impending cuts to public service provision, have given a renewed impetus to finding better ways of working. In the context of public service reform, services need to achieve the most efficient and effective use of diminishing resources to improve outcomes for individuals, families and communities – they "*need to achieve more with less*"[3 (p vi)]. To do this, public services will have to use the resources that are available in different and innovative ways. A sea change in thinking and action that goes well beyond arguments about how to improve the performance of the existing system is required.

However, in making the case for changes to our health and social care delivery systems, it is important to remember and emphasise the many strengths of these systems, and to continue to build and develop them. Specifically, the commitment to universal access to care, the provision of a comprehensive range of services and the ability to focus on the needs of the whole population are widely acknowledged to be key features that must be protected and, wherever possible, enhanced[7].

Asset-based approaches are ways of working that promote and strengthen health assets. Such assets include the resources that individuals and communities have that help protect against poor health and support the development and maintenance of good health and quality of life. Assessing and building on the strengths of individuals and the assets of a community may open the door to new ways of thinking about health, improving health at individual and population levels, and responding to ill health.

PATIENTS AT THE CENTRE

The design of better services requires a better understanding of people's needs. The people who use services, and the staff who deliver services, generally have a deep knowledge and understanding about how to make them better[20]. In the most basic sense 'patient-centred care' means taking more account of the users of services. In the broadest terms, patient-centred care is care organised around the patient. It is a model in which service providers and other staff create a partnership with patients and families to identify and agree the full range of patient needs and preferences[21]. However, to succeed, a patient-centred approach must also focus on and address the staff experience, as the ability and inclination of staff to care for patients is compromised if they do not feel cared for themselves. Furthermore, patient-centred care is in no sense a substitute for excellent medicine and care – it both complements clinical excellence and contributes to it through effective partnerships and communication. It is about examining all aspects of the patient experience and considering them from the perspective of patients and not the convenience of providers[21]. The NHS Scotland Healthcare Quality Strategy[17] is underpinned by the requirement of person-centred healthcare. The Quality Strategy strives to deliver *"mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision making"*[17 (p 23)].

In Glasgow it is recognised by the local NHS that more needs to be done to support people to manage their health and prevent crisis. It is stated that more than 70% of people are able to manage their own illnesses if given the right support[22]. Improved information on what to expect from their condition(s) and treatment, and more involvement in their care planning, can empower a patient to manage their own health and illness. The settings in which healthcare, treatment and support are provided are important. Although patients need to be able to access hospital care when required, it is also acknowledged that patients value local access to care and being supported at home or in their community where possible[22].

Where services are designed around patients, healthcare delivery and health outcomes are improved, patient engagement is promoted and strengthened and health literacy[a] increased[23]. Where services have listened and responded to user and staff ideas and experiences, outcomes are reported to have improved markedly[20].

[a] Health literacy: the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

ALTERNATIVE WAYS OF WORKING

At present there is an absence of descriptive evidence about the characteristics of asset-based working in health and care services and what is required to deliver it. There are, nevertheless, a number of well-known ways of working, new legislative requirements, complementary approaches and areas of innovation, which have not been developed with an assets perspective in mind but which are based upon similar principles and values[4,6]. These ways of working share the common feature of identifying and mobilising what individuals and communities have to offer that might enhance health and wellbeing. Traditional approaches put professionals and their expertise at the centre of the process; whereas participative approaches emphasise the knowledge and capacities of the service user. One of the best known examples is co-production which clearly takes an asset-based approach.

Co-production and an asset-based approach

The concept of co-production has emerged in recent years as an innovative and valuable approach to the provision and development of public services. Although it is not a new concept[24], and is well-established within the Third Sector, there is renewed interest within the public and private sectors in exploring ways of strengthening the involvement of service users and communities in service design and delivery. The relationship between professional service providers and service users has begun to change as a result, making them more interdependent, and there is a greater degree of professional interest in the implications of co-production for public service delivery[25].

Co-production is both complementary to and dependent upon an asset-based approach[26]. From a health and social care perspective, co-production has been defined as *"the public sector and citizens making better use of each others assets, resources and contributions to achieve better outcomes or improved efficiency"*[27]. Co-production recognises that people have 'assets' such as knowledge, skills, characteristics, experience, enthusiasm, family, friends, colleagues and communities. These assets can be brought to bear to support health and wellbeing.

Co-production stems from recognising that understanding the needs and abilities of people using services and engaging them closely in the design and delivery of those services is a pre-requisite for the delivery of successful services. The theory behind co-production suggests that conventional public service delivery is failing because it has been unable to grasp the fact that professionals need their clients as much as the clients need professionals[28]. In practice, the consumer model of public services, where professional systems deliver services to passive clients, misses out what is most effective about their 'delivery' – the equally important role played by those on the receiving end[28]. The New Economics Foundation (NEF) argues that co-production has the capacity to transform public services by rebuilding the traditions of empathy and mutuality that have dissipated in recent decades[29]. By acknowledging and introducing the resources of interest, experience and motivation that service users may be able to provide, co-produced services are essential for building sustainable public services[29].

This implies a move beyond consultation, user involvement and citizen engagement to equal partnership; a shift from 'doing to' to 'working with', from 'providing' to 'enabling and supporting'. In this way, public service workers become brokers and facilitators, not experts who can fix things, and both professional and experiential knowledge are valued and combined[30]. Real co-production of public services does not mean 'self-help' by individuals or 'self-organising' by communities – it is about the integrated contributions of individuals and the public sector[25]. Co-production occurs in the critical middle ground where user and professional knowledge combine to design and deliver services.

Co-production demands that public service staff behave in an enabling way, focusing on people's abilities. The key is to involve people more in the decisions that affect them and to encourage them to use their skills and experience to help deliver solutions. Public organisations or services that co-produce with their clients, and their families and neighbours, will display a range of different characteristics. They will not necessarily all look the same, but similar processes will be in place, that[31]:

- Provide people with opportunities for personal growth and development, so that they are treated as assets, not burdens on an overstretched system.
- Invest in strategies that develop the emotional intelligence and capacities of individuals and local communities.
- Allow public service agencies to become catalysts and facilitators rather than simply providers.
- Reduce or blur the distinction between producers and consumers of services, by reconfiguring the ways in which services are developed and delivered, recognising that services can be most effective when people get to act in both roles – as providers as well as recipients.
- Devolve real responsibility, leadership and authority to 'users', and encourage self-organisation rather than direction from above.
- Offer participants a range of incentives which help embed the key elements of reciprocity and mutuality.

Evidence also suggests that public services can be more cost-effective when they are built around co-production[32-34]. They will be cost-effective not necessarily because they cost less – though they can do[20] – but because they produce more effective outcomes, they help to insulate people against ill health, or help people to achieve better outcomes than many services currently do[29]. Furthermore, co-produced services can also be more cost-effective because they bring in often ignored, extra resources in the form of help and support and efforts from clients, their families and neighbours.

By shifting professional practice in this way, the basic service delivery objective shifts as well. Delivering public services ceases to be primarily about tackling symptoms and immediate needs. The focus is on sustained change and development, building wellness and quality of life for service users, and deploying professional expertise in support of those longer-term outcomes.

A helpful overview of the concepts of co-production and asset-based approaches in reshaping care within the wider strategic context of Scotland is presented in both *The Role of Co-Production in Health and Social Care – what it is and how to do it*[35] and *Co-production of health and wellbeing in Scotland*[36].

Personalisation and self-directed support

Personalisation is an umbrella term covering a range of approaches to provide individualised services, choice and control[37]. Like co-production, it requires public services and social care to be planned and delivered in a different way – starting with the person and their individual circumstances and putting them at the centre of their own care and support. Co-production is recognised as a core approach to implementing personalisation[38].

In Scotland, self-directed support (SDS) is central to realigning social care along these principles[37]. Personalisation and SDS have grown out of a number of personal and policy developments including the championing of the rights of the individual, the principles of recovery and re-enablement – helping people to gain skills and confidence to move on from their current situation to an independent and fulfilling life – and the drive to ensure services respond to the changing needs and expectations of people. The approach is reflected in a number of Scottish reports and policy initiatives (e.g. *Changing Lives*[39], *Reshaping Care for Older People*[40], *Caring Together*[41], *Shifting the Balance of Care*[42]).

SDS is the person-centred framework through which personalisation is delivered[38]. SDS sits at the centre of the Scottish Government's agenda to promote individualised services and to give people greater control over their care and support[43]. In Scotland, the National Strategy for Self-Directed Support[44] has been developed to help take forward the personalisation of social care services and has been further strengthened by the enactment of the Social Care (Self-directed Support) (Scotland) Act 2013[45]. The Strategy defines SDS as:

"A term that describes the ways in which individuals and families can have informed choice about the way support is provided to them. It includes a range of options for exercising those choices. Through a co-production approach to agreeing individual outcomes, options are considered for ways in which available resources can be used so people can have greater levels of control over how their support needs are met, and by whom."[44 (p 229)]

SDS is being driven forward because it offers choice, flexibility and control for the individual who requires social care, with the advice of professionals. The strategy is based on the rationale that when people have a greater say in, and more control and responsibility over their support planning, they will be able to access the care options that best meet their individual needs, and outcomes should improve[46].

Professionals help an individual assess their need(s) and the person is given an indicative budget which they can use to design the service solutions which make the most sense to them[47]. The Social Care (Self-directed Support) (Scotland) Act requires Scottish local authorities to offer people four choices for accessing their social care:

1. Individuals take a cash payment in place of services that otherwise would have been arranged by the authority. The individual then arranges their own care package (direct payment).
2. Individuals direct their care and support but without actually taking the payment which is held by the authority on their behalf (individual budget or service fund).
3. The local authority continues to arrange an individual's services on their behalf.
4. Individuals choose a mixture of these three options for different types of support.

On local authority approval of an individual's plan, the indicative budget becomes real and flows to the individual and service provider of their choice. Budget holders can spend their whole budget on traditional services or, at the other end of the spectrum, design a bespoke solution, commissioning all services themselves and employing support staff to help them. In between these two extremes lies a range of options to mix in-house and personalised services to suit an individual's needs[47]. Self-directed support is about transforming social care services, taking into account not only health needs, but also housing, benefits, education, leisure, and transport requirements.

Self-directed support is about more than one particular mechanism – it involves the citizen making an informed choice and deciding how much ongoing control they wish to have. It is argued that self-directed support is cheaper than traditional service delivery and top-down approaches, and that it can be more creative and make better use of the money available, enabling an individual to get more for their money[47]. Although the evidence to date is limited, it is reported that SDS will not cost significantly more than conventional social care[37]. In a small cost review of 102 people who moved from a traditional care plan to a personal budget, drawn from ten local authorities in England, it was reported that personal budgets in this sample cost about 10% less than comparable traditional services and generated substantial improvements in outcomes[47]

"Under personal budgets and self-directed services people get higher quality, more personalised services at lower overall cost, which generates savings to other public services and creates wider social benefits as people become more engaged with their communities. Personal budgets can create a more cohesive and integrated community while also allowing people to tailor services to their needs."[47] (p 40)

Personalisation and SDS are consistent with the idea of the 'patient expert'. However, there is a need to balance empowerment and the promotion of independence with protection and safeguarding, particularly in the case of vulnerable adults[48]. How risk is recognised, negotiated, and managed is a key part of changing practice, particularly regarding SDS and the personal budget process. Concerns about risk and personal budgets have been shown to stem from the misconception that personal budgets are cash payments, and that people requiring social support and care will be left to organise their own services[49]. It has been reported that people given the freedom to design their own care packages make sensible and appropriate choices that improve their quality of life and keep them safe[50]. Although the national and international evidence is based on many relatively small-scale examples of SDS, given the right level of support, user views are very positive and report improvements in wellbeing, self-determination, their home situation and community life[45].

Informative reports on personalisation and SDS have been produced by the Social Care Institute for Excellence (*Personalisation: a rough guide*)[38] and Demos (*Making it personal*)[47].

Strengths-based approaches and recovery-orientated practice

Like that of co-production and personalisation, strengths-based practice is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets[51]. The approach concerns itself principally with the quality of the relationship that develops between those providing support and those being supported, and with the personal resources that the person seeking support brings to the process. The goal of strengths-based practice is to minimise the weaknesses and maximise the strengths of the client, whether the client is an individual, group or community. Empowerment is a central theme. The strengths perspective is said to be the social work equivalent of salutogenesis[52] which highlights the factors that create and support human health rather than those that cause disease[51].

A strengths-based approach is based on a perspective for working with individuals, families, groups, organisations and communities[53], which recognises the importance of people's environments and the multiple contexts that influence their lives[54]. This perspective recognises the resilience of individuals and focuses on the potentials, strengths, interests, abilities, knowledge and capacities of individuals, rather than their limits. It is in this way that strengths-based approaches are similar to asset-based approaches and are underpinned by the same fundamental principles.

A strengths-based approach is based on six key principles[54,55]:

1. Every individual, family, group and community has strengths, and the focus is on these strengths rather than on illness.
2. The community is a rich source of resources.
3. Interventions are based on client self-determination.
4. Collaboration is central, with the practitioner-client relationship as primary and essential.
5. Outreach is employed as a preferred mode of intervention.
6. All people have the inherent capacity to learn, grow and change.

Within mental health services, for example, there is a strong focus on recovery and positive psychology, which are inherently strengths-based[56]. Putting recovery-orientated practice into action means focusing care on building the resilience of people with mental health problems, not just on treating or managing their symptoms[57]. Recovery-orientated practice refers to the subjective experience of optimism about outcomes from mental illness (or addiction), a belief in the value of the empowerment of clients, and a focus on services in which decisions are taken collaboratively with the service user[58]. Recovery emphasises that, while people may not have full control over their symptoms, they can have full control over their lives. Recovery is not about 'getting rid' of problems. It is about seeing beyond a person's mental health/addiction problems, recognising and fostering their abilities, interests and hopes[57].

Strengths-based approaches work on a number of different levels, from individuals, associations and organisations to communities[51]. A growing number of methods of social work practice relate to and build upon the philosophy of the strengths-based perspective, including solution-focused therapy (SPT), strengths-based case management, narrative inquiry[5] and family support services. These methods can be used alongside others or in isolation. Much of strengths-based practice has an internal component which is therapeutic in nature and involves locating, articulating and building upon an individual's assets or capabilities. A number of frameworks are also available to support strengths-based practice (e.g. ROPES: Resources, Opportunities, Possibilities, Exceptions, and Solutions[59]). Such frameworks focus on strengths and weaknesses and encourage a holistic and balanced assessment of the strengths and problems of an individual within a specific situation. However, a strengths-based approach is not simply about different tools or methods that are used with people; it is about different concepts, structures and relationships that are built into support services[51]. Ultimately, the strengths-based philosophy seeks to promote self-efficacy, giving individuals belief in their own abilities and competencies.

A useful overview of the literature on strengths-based approaches for working with individuals has been produced by Pattoni[51].

In summary, the three examples of delivering care outlined here, co-production, personalisation and self-directed support and strengths-based approaches, have been referred to as '*public services inside out*' – overturning the conventional passive relationship between the 'users' of services and those who serve them[33]. These examples point to the possibility of a different approach – better, more empowering, more cost-effective services (in the longer term), developed with those who know their care requirements the best.

ASSET-BASED SERVICE DELIVERY - COMPLEMENTING NOT REPLACING

Conventional approaches to the delivery of public services are based on meeting needs, providing care and the treatment of presenting problems[60]. Individuals are frequently labelled by their condition ('diabetic', 'disabled'), their behaviour ('smoker', 'drug-user'), or their personal circumstances or characteristics ('unemployed', 'elderly'). Communities are described in terms of their collective problems and needs. It follows that the role of public services is then seen as being to fix these problems for individuals and communities. In doing so, they tend to make people passive recipients of services[26]. A sense of control over one's life is associated with better health and a greater likelihood of adopting healthy behaviours[61]. Actions and environments that undermine this sense of control, it is argued, increase passive acceptance of risk[60]. On the other hand, actions and environments that accentuate positive capabilities and nurture people's strengths and resources may allow them to activate responses that promote their self-esteem and resilience, leading in the longer term to less reliance on professional services and to improved health outcomes.

Asset-based approaches are concerned with identifying the protective factors that support health and wellbeing. These approaches set out to work with people to make their skills visible and give them confidence that they are valued. This way of working enables people to become better connected with each other and encourages a spirit of co-operation, mutual support and caring for one another. As confidence and self-esteem grow in individuals and neighbours, trust and community cohesion are built. Crucially however, asset-based approaches are not about overlooking structural and material issues or asking vulnerable people to think positively despite their circumstances[62]. Addressing poverty, deprivation and inequality must continue to be the focus of concerted effort as key social determinants of health and wellbeing.

Asset-based working is not a universal panacea. Some public services are evidently better suited to asset-based working than others. At one end of the service delivery spectrum, in intensive care or accident and emergency settings for example, asset-based working is less of a priority than technical excellence, effectiveness and efficiency of care. In many other domains, however, there remains the potential for health and social care services to re-orientate and re-shape care delivery to become more assets-driven and person-centred. Asset-based practice already exists across Scotland in many different contexts, although projects and services may not be using the language of assets to describe how they work[6]. Working in this way promotes the possibility for individuals and communities to be co-producers of health rather than simply consumers of healthcare services. The medium-long term outcomes from these approaches are not yet known. However, theory-based models would suggest that a clear and sustained focus on positive ability, capability and the capacity of individuals, may lead to less reliance on professional services and reductions in the demand for scarce resources in the longer-term.

ASSET-BASED WORKING AND WORKFORCE AND ORGANISATIONAL DEVELOPMENT

The shift from using a deficit-based approach to an asset-based one has far-reaching consequences for organisations and the staff who work in them. Policy documents from across the UK acknowledge that the reform of public services will require a radically altered workforce. Asset-based working, co-production, SDS and other person-centred approaches have implications, not just for roles and skills, but for workforce composition and regulation[37]. These approaches require significant organisational changes in systems, attitudes and ways of working. All systems, processes, staff and services will need to put people at the centre, in order to be asset-based.

Workforce attitudes and skills are critical to the effective adoption and embedding of asset-based values and culture[63]. For many staff, training and skills development will be required to support this new way of working; and within organisations, the prevailing cultures will be required to place increased value on the views of those who use services. Approaches such as Appreciative Inquiry[5] can be powerful in valuing and drawing out the strengths and successes of groups and organisations to build a positive, shared and realistic vision for the future. New models of leadership will also need to be developed to drive and respond to the fundamental changes in power sharing and the renewed focus on flexible, client-centred frontline relationships.

The views and experiences of people using services should be a primary source of evidence for workforce development approaches, as well as for performance monitoring. In accordance with the public sector reform agenda, people experiencing services should be enabled to collaborate with those delivering them to improve design and delivery so that there is greater impact on outcomes.

To explore a number of these issues, the Scottish Social Services Council (SSSC) is leading on a programme of work known as the '***Skilled Workers, Skilled Citizens***' initiative (previously known as 'Community Asset Based Workforce Development' initiative). The programme is engaging with a wide range of staff and organisations from public service organisations from across Scotland to come to an agreed and shared understanding of the skills and knowledge they need to embed and deliver asset-based working, establish a number of pioneer sites to explore and illustrate asset-based working across the public sector, and develop a range of practical tools and resources to support staff and organisations working in this way.

Further information can be found at:
http://www.scottishleadersforum.org/skilled-workers-skilled-citizen[64]

CHALLENGES OF IMPLEMENTATION AND DELIVERY

Although the language of assets and asset-based working permeates much of the current health policy literature, it remains unclear from the evidence available at present how the concept and supporting theory will translate into effective practice and what the likely impacts will be on how services are organised and delivered. Asset-based approaches will challenge the way professionals are expected to work. From the sources of evidence and commentary available, a number of challenges have been identified (presented in brief below) which will need to be taken into account and addressed if asset-based working is to be successfully adopted within Scotland's health and social care services.

Public services, it is said, will stand or fall by the skills and experience of the staff they employ, and the public service ethos that motivates them to make the system work. If staff succeed, services will also succeed. If they fail, no amount of targets or redesign will turn the situation around. It is recognised that staff who are valued and treated well improve patient care and overall performance[65,66]. It is critical that staff are valued as an asset of public services and enabled through their training, development and day-to-day working, to recognise their own personal strengths and the assets of their organisations and use these in the way they work. Staff need to be empowered to make working structures more adaptable, to interact more flexibly with patients/clients, giving them discretionary powers and, where possible, discretionary budgets[67]. Staff should be allowed to consider carefully the circumstances in which an asset-based approach would be appropriate; there should not be the suggestion that this is suitable for every situation. Preparation will be required to support staff to engage with service users, their families and the wider community in a different way. Workforce development processes will need a stronger community-based focus; this will take time to change. The magnitude of the transformational change required in the cultures of large, complex organisations, implies a long-term process, supported by new forms of leadership, changes in organisational systems and values, and also in individual mindsets.

The culture of targets, standards and best practice tends to mitigate against innovation. At the very least, health and social care targets could be simplified and redefined so that they encourage, rather than exclude, participation. Institutions should be given freedom to set locally-agreed health targets in response to local need and circumstances[66].

SUMMARY

It is generally accepted that current patterns of services and spending are unsustainable against future finance and demand. Conventional approaches are said to disempower people, and fail to recognise that they have assets and personal resources which could contribute to solutions. Assessing assets alongside needs may give a better understanding of the health and care requirements of individuals and help to build resilience, increase social capital, and enable a shift towards more empowering, sustainable and holistic approaches to delivering services and to improving Scotland's health. By working with people rather than doing things to them, asset-based working (and other approaches which closely align), arguably presents the potential to transform the way public services are delivered so that they are better positioned to assist people in addressing their problems in effective and sustainable ways. From a services perspective, an asset-based approach fundamentally changes the way organisations and the people within them think about service delivery, work with, and provide support to their patients and patients' families. This change involves the recognition that utilising the 'expertise' of people currently using services (or who may use them in the future) are as important as professional knowledge and experience[46].

To continue tackling the growing health divide, asset-based approaches are required to be embedded alongside, and be complementary to, existing good public service provision, social support and protection, and established interventions to improve health and wellbeing. The adoption of asset-based approaches will not on its own tackle health inequalities. Rather, it should be recognised as one component of a multi-faceted approach – a component which accentuates positive capability and encourages the participation of individuals and communities in the health development and maintenance process. In working to improve health-enhancing assets, we must not only focus on psychosocial assets such as skills, confidence and self-esteem but also on the social, economic, cultural, physical and environmental factors that influence inequalities in health and wellbeing.

To further embed this approach in mainstream service delivery, policy and practice, Scotland must continue to support individuals and communities to have more control over their own circumstances. A number of Scottish policy and strategy documents emphasise the value of working in this way. The challenges therefore lie in changing organisational cultures, enabling professional freedom and new working practices to develop and understand service user expectations. Public services and communities will both need to find a new balance in their relationship if health and wellbeing is to be enhanced in our society.

NEXT STEPS

This briefing paper has presented a discussion of the evidence and current thinking in relation to the re-shaping of health and care services in line with asset-based principles and what this way of working could add to the range of services, approaches and delivery mechanisms already available. It has also explored a range of ways of working and areas of existing innovation that hold the potential for enhancing service quality, the patient experience and health outcomes.

Against the current policy and legislative backdrop discussed in this paper and building on our learning about asset-based working in a community setting, our next steps include research to explore the features, characteristics, challenges and potential of asset-based working within health and care service settings.

In addition, we wish to engage with as wide an audience as possible and to open up an opportunity for feedback, comment and learning from experience and practice. If you would like to contribute to this process please submit comments by email to GCPHmail@glasgow.gov.uk or by post to the Glasgow Centre for Population Health, House 6, 94 Elmbank Street, Glasgow G2 4NE.

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