Half-full or half-hearted? How can asset-based approaches to Joint Strategic Needs Assessment be implemented more effectively?

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Abstract

This public health report addresses the question of how asset-based approaches to Joint Strategic Needs Assessment (JSNA) can be implemented more effectively. Its starting point is the burden of responsibility on local Health and Wellbeing Boards to undertake and utilise JSNA to inform their Joint Health and Wellbeing Strategic priorities. This is explored in the context of the political, economic and organisational drivers for asset based approaches.

The three core concepts of health assets, asset based community development (ABCD) and salutogenesis (health creation) emerging from the literature on asset based approaches are used as a framework for a qualitative content analysis of a sample of twenty five published JSNAs. The results reveal a number of important themes and categories including overall assets-needs balance; place-based approach; outcomes and indicators (pathogenic vs salutogenic); wider determinants; data development agenda; inequalities and inequities; and citizen voice, engagement and collaboration. Presenting the themes and categories on a needs-based to asset-based continuum serves to illustrate the complexity and inter-dependency of the various elements of JSNA products and processes.

A number of important implications and considerations for the development of asset based JSNA are elicited from a critical reflection on the results. These are described under the headlines of moving from asset-based rhetoric to reality; the meanings and visibility of health assets; asset mapping as a tool for change; ABCD, wider transformation and place-based approaches; shifting to a salutogenic epidemiology; and JSNA on the ladder of co-production.

The report concludes with ten recommendations for Health and Wellbeing Boards, JSNA leads, strategic leads and systems leaders to enable a more effective implementation of asset based JSNA within a wider transformation to asset-based and place-based approaches. These include using an Asset Based Checklist (ABC) toolkit, which has been developed as a standalone ‘end product’.

Declaration

This dissertation is the student’s original work unless referenced clearly to the contrary. No portion of the work referred to in the dissertation has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Half-full or half-hearted? How can asset-based approaches to Joint Strategic Needs Assessment be implemented more effectively?

> *"The defining themes of asset based ways of working are that they are place-based, relationship-based, citizen-led and they promote social justice and equality"*(Foot 2012)

Chapter 1: Burden

"*Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), through the health and wellbeing board.*"(Department of Health 2013) The policy intention is for health and wellbeing boards (HWBBs) to also consider wider factors that impact on their communities' health and wellbeing; and local assets that can help to improve outcomes and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory data set to be included. This freedom provides a perfect opportunity for local areas to be creative, innovative and distinctive in shaping their own approaches to JSNA and has "*allowed many places to give serious consideration to how they use a range of intelligence to inform commissioning and to manage this in a dynamic and inclusive manner.*"(Gamsu & Abbas 2012) The same freedom can of course result in local areas adopting minimalist, risk-averse and 'business as usual' approaches which equate a lack of mandate with lack of obligation.

Nationally, the seeds for sharing and enabling good practice in JSNA development and design have been sown very effectively by the 'Springboard to action' toolkit (Local Government Improvement and Development Healthy Communities Programme 2011). This clearly illustrates the factors that delineate between good and poor quality JSNAs and incorporates seven quality themes to "*assist emerging health and wellbeing boards in deciding on their JSNA approach*" (Local Government Improvement and Development Healthy Communities Programme 2011). These can be summarised as: *take stock* (learn from the past and review); *ask big questions* (agree the scope and mandate for the JSNA process; know your audience; build trust and agree a shared process of strategic priority setting); *go into further detail* (match form to function and specify JSNA products; secure capacity, skills, data and

knowledge); and *consolidate* (agree governance and consolidate vision into a clear specification). The toolkit claims to present "*opportunities for local areas to consider how to bring together both needs and assets within the JSNA process to achieve a more comprehensive understanding of what promotes good health*."(Local Government Improvement and Development Healthy Communities Programme 2011) It highlights asset-mapping as an important skill for quality JSNA, citing work in the North West region and elsewhere on developing "*an asset approach in JSNA (or rather, Joint Strategic Asset Assessment, or 'JSAA') that identifies the skills, strengths, social capital, capacity and knowledge of communities as well as its deficits*."(Local Government Improvement and Development Healthy Communities Programme 2011) However, there are no tangible examples of what asset-based JSNA might actually look like or how asset-based approaches can be embedded systematically in the product and process of JSNA.

Regionally, in Yorkshire and Humber in 2012 it was reported that "*intelligence leads continue to struggle to capture data on community assets in a meaningful way that will be helpful to commissioners*."(Gamsu & Abbas 2012) This was referring specifically to the lack of systematic approaches to capture levels of volunteering, the diversity of grass-roots community organisations and the contribution of the voluntary and community sector (VCS) to health and social care outcomes. Most involvement with the VCS in relation to JSNA was assessed as being in the middle of Arnstein's Ladder of participation (informing, consultation and placation). Whilst this does at least allow citizens "*to hear and be heard*," at this level of participation there is "*no follow-through, no 'muscle', hence no assurance of changing the status quo*."(Arnstein 1969) It remains, therefore, a form of 'tokenism.' At a regional level it has at least been acknowledged that there is "*a need for more work at a system level to develop and embed innovative ways of developing greater co-production in JSNA production*".(Gamsu & Abbas 2012) How this is achieved locally will depend to a large extent on local leadership and priorities but "*the current economic and social context mean that the need to present an accessible, public and shared narrative that describes local health challenges has never been greater*."(Gamsu & Abbas 2012)

Arguably, co-production in JSNA production, however innovative or well embedded, if focused solely on the description of health challenges, does not constitute an

asset-based approach which, put simply, is a "*way of helping people by looking at what they have, rather than what they lack. [It] helps people make use of their existing skills, knowledge and relationships. It is also called a 'strengths-based approach', and can be used as a way of improving local areas, by promoting what is good about an area rather than focusing on problems*" (Think Local Act Personal n.d.) The economic, organisational and political drive for asset-based approaches is changeable, multifaceted and often contentious. Whilst a detailed exploration of all these key drivers is beyond the scope of this public health report, a critical overview is necessary to understand why and how asset-based approaches to JSNA should be undertaken and the benefits (and risks) to the local health economy and local communities of adopting this approach.

From a community development viewpoint, Kretzmann and Knight have argued powerfully that a deficiency orientated needs assessment approach can have devastating consequences for local communities.(Kretzmann & McKnight 1993) Firstly, communities themselves begin to think of themselves as deficient and disempowered. Secondly, a community portrayed as a list of problems and needs results in fragmented attempts to find solutions and denies the existence of problem-solving capacities inherent in communities themselves. Finally, when resources are targeted towards needs they end up in the hands of service providers rather than communities themselves. In addition, community leaders are effectively coerced into highlighting community deficiencies in order to attract resources and this underlines the perception that the only real help for communities comes from outside 'experts'. This further weakens "*the glue that binds communities together*"(Kretzmann & McKnight 1993) and perpetuates a cycle of dependence on worsening problems for renewed funding. There is therefore an imperative for an alternative asset-based community development (ABCD) approach which can enable the development of policies and activities rooted in "*the capacities, skills and assets*"(Kretzmann & McKnight 1993) of communities. ABCD can connect these assets; build strong relationships and reciprocal social networks. The ultimate aim of ABCD is to "*mobilise local people to act on the things they care about and want to change*"(Hopkins & Rippon 2015) and we know from historic evidence "*that significant community development takes place only when local community people*

are committed to investing themselves and their resources in the effort."(Kretzmann & McKnight 1993)

At an organisational level, 'A Glass Half Full'(Foot & Hopkins 2010) provided a timely catalyst for JSNAs to shift from a traditional deficits approach, focusing on problems and deficiencies in communities, to one based on community assets and strengths. Its publication came just six weeks after The Marmot Review (Marmot et al. 2010) in which it was argued that effective local delivery to tackle health inequalities required effective participatory decision-making at local level. "*This can only happen by empowering individuals and local communities.*"(Marmot et al. 2010) The asset approach provides an ideal way for councils and their partners to respond to this challenge by valuing the capacity, skills, knowledge, connections and potential in a community rather than focusing on its problems, needs and deficiencies.

It is essential to acknowledge the change in attitudes and values required to shift to an asset-based approach. "*Fundamentally, the shift from using a deficit-based approach to an asset-based co-production model requires a change in attitudes and values. Professional staff and councillors have to be willing to share power … A mobilised and empowered community will not necessarily choose to act on the same issues that health services or councils see as the priorities.*" (Foot & Hopkins 2010) Another key consideration is that place-based partnership working takes on more importance than organisational boundaries with an asset-based approach. In Kirklees the recent commitment to producing a Sustainability and Transformation Plan (STP) on a Kirklees 'footprint' which brings together two CCGs and the local authority; together with a long-standing commitment to locality working (most recently demonstrated by the emerging 'Plans of Place' for the four District Committees within Kirklees), suggests that Kirklees is well positioned to make the shift to a place based and an asset based approach.

Finally, an asset based approach is entirely congruent with tackling the structural causes of inequality and improving services. "*The aim is to achieve a better balance between service delivery and community building*".(Foot & Hopkins 2010) In Kirklees, as in many other areas, the combination of public sector funding cuts and demographic and social changes such as an ageing and ethnically diverse population and a low wage economy mean that a growing number of people will need help and support. To avoid widening inequalities, a radically new way of

working is required. "*Asset based working is not an alternative to properly funded public services. It challenges how those services are designed and delivered and requires a recasting of the relationship between commissioners, providers, service users and communities.*"(Foot 2012)

Prompted by 'A Glass Half Full'(Foot & Hopkins 2010) a number of pilot projects trialling 'enhanced' and asset-based approaches to JSNAs have subsequently been undertaken and evaluated and the findings have highlighted some of the key enablers and barriers to success and sustainability. A trial project in Wakefield, for example, focussed on two priority neighbourhoods, describing in detail what lessons were learnt in relation to the planning and delivery of the asset-based approach itself and recommending key ways forward to develop and embed this approach to JSNA development. A key lesson from the Wakefield pilot was that both needs and assets need to be understood. "T*he JSNA and the Asset Based Co-Production approach should not be seen as separate entities but complementary processes that enable a richer more intelligent and better informed picture in turning around health inequalities and their effect on individuals and local communities.*"(Wakefield District NHS et al. 2012) Likewise, an exploration of pilot approaches to Joint Strategic Assets Assessment (JSAA) in the North West of England concluded that "*by having both a JSNA and a JSAA (or, more importantly, having the strengths and assets built into a JSNA) it is anticipated that it will be easier to see the whole picture rather than just one facet of the problem or issue, thus highlighting the activity and capacity within both the public sector and the community to respond to health inequalities and provide increased equity".*(NHS North West & Department of Health 2011)

The Kirklees Joint Health and Wellbeing Board (HWBB) recently endorsed an asset-based approach to JSNA development which included a commitment to 'whole system' changes to achieve the outcomes of greater understanding and generation of what is already working; and increased capacity and confidence among communities and staff. Arguably, there is a significant risk to the credibility of Kirklees HWBB if local intelligence about needs is not balanced with assets information and, more importantly, if asset-based JSNA is not framed within a system-wide strengths-based approach to achieving the best possible outcomes for people. If this fails to happen, local people, partner organisations and local Healthwatch can hold the HWBB to account. In Kirklees, locality based working is

being embraced and there is a strong commitment to the development of District Committee level 'Plans of Place' informed by the JSNA and other local intelligence and assessments. This may well be the most appropriate starting point for engaging with councillors and communities and instigating a new way of working.

Chapter 3 will examine the evidence that JSNAs are beginning to reflect a system-wide shift to asset based working and the extent to which the learning from the various pilot studies has been embedded. To provide a theoretical framework for this more hands-on analysis the next chapter will explore the wider strategic, political and economic context and evidence base for asset based working. In the current climate of public sector budget cuts alongside a growing and ageing population and increasing inequalities, it is increasingly important to understand this wider context to reduce the risk of presenting and promoting asset-based approaches merely as a way to "*reduce 'unaffordable demand', to achieve public spending cuts and to promote a DIY response to loss of services and loss of benefits.*"(Friedli 2011) At the same time, we must acknowledge that the moral and value-based imperatives for asset-based approaches in the UK emerged from a very different time and place and it is vital to understand the financial and political risks and benefits of embedding this approach.

Chapter 2: Context

As a strategic intelligence product, the JSNA should underpin the priorities of the health and wellbeing board. Whilst an asset based JSNA is an important and necessary component of an asset based approach to the commissioning cycle it is best understood in the context of a whole system change.(NHS North West & Department of Health 2011) This chapter will frame the issue of asset-based approaches to JSNA in a wider strategic and theoretical context by critically appraising the three core elements of asset based approaches - the concept of 'salutogenesis', health assets, and asset based community development (ABCD), alongside the key political and economic drivers.

In Kirklees and elsewhere there is a responsibility on the HWBB to adopt an asset-based approach to JSNA, not simply to retain local credibility and accountability but, more critically, because local commissioners and organisations "*cannot know what [they] need until they first know what they have.*"(Johnstone 2015) Asset-based practitioners fundamentally "*ask the question 'what makes us healthy?' rather than 'what makes us ill?'*"(Hopkins & Rippon 2015) There is a wide range of approaches that can be described as asset based but essentially these are underpinned by the following three interrelated elements of theory and practice:

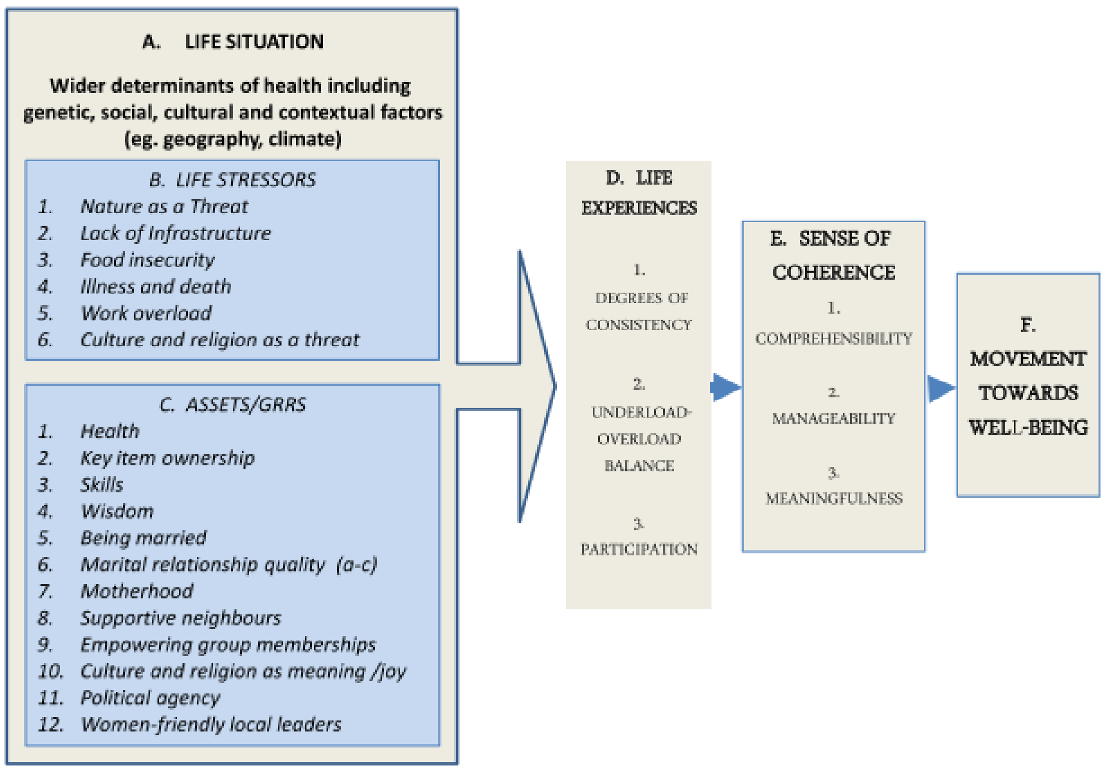
(i) Salutogenic theory and the concept of positive health and wellbeing

Originating from Antonovski's salutogenic framework, 'salutogenesis' is about using resources and capacity to create and maintain health.(Lindstrom & Eriksson 2005) It explains why people manage to stay well despite hardships and stressful situations. Salutogenesis contrasts with the more familiar pathogenic model of health which focuses on obstacles and deficits. "*It emphasizes the success and not the failure of the individual and it searches for the foundations of positive patterns of health rather the foundation of negative outcomes.*"(Morgan & Ziglio 2007) Antonovski used the term Generalised Resistance Resources (GRR) to refer to properties of individuals or collectives which enabled them to cope with the 'stressors' of everyday life. He went on further to theorise that what all GRRs have in common is that they contribute to a 'sense of coherence' (SOC) and that "*the strength of one's SOC… was a significant factor in facilitating the movement toward health.*"(Antonovsky 1996) SOC uniquely combines cognitive, behavioural and

motivational dimensions. As Antonovsky explains, confronted with a stressor, the person "*with a strong SOC will wish to, be motivated to, cope (meaningfulness); believe that the challenge is understood (comprehensibility); [and] believe that resources to cope are available (manageability).*" (Antonovsky 1996) The strength of one's SOC is shaped by various life experiences which are themselves moulded by one's position in the social structure and one's culture. A version of Antonovsky's salutogenic model is shown in Figure 1.

Figure 1: Antonovsky's (1996) Salutogenic Model as visualised by Bull *et al.* (Bull et al. 2013)

The authors inserted codes (e.g. B1) for the purpose of their analysis. GRR = Generalised Resistance Resources



Salutogenesis is one of the underpinning elements of the asset based model of public health proposed by Morgan and Ziglio.(Morgan & Ziglio 2010) They suggest that the central questions posed using a salutogenic approach are: "*What external factors contribute to health and development? What factors make us more resilient (more able to cope in times of stress)? What opens us to more fully experience life? What produces overall levels of wellbeing?*" (Morgan & Ziglio 2010) The authors go

on to suggest that this concept demands a reconsideration of conventional approaches to epidemiology and the public health evidence base. A salutogenic epidemiology would ask: "*What are key assets for health and development at each of the key life stages? What are the links between these assets and a range of health outcomes? How do these assets work in combination to bring about the best health and wellbeing outcomes? How may these factors be used to contribute to reductions in health inequities?*" (Morgan & Ziglio 2010). Arguably, JSNAs adopting a more asset-based approach might reflect this shift in epidemiological approach by analysing and exploring the patterns and relationships between assets and outcomes alongside traditional needs analysis.

(ii) The concept of health assets

A health asset is any factor or resource which enhances the ability of individuals and communities to maintain and sustain health and wellbeing.(Foot & Hopkins 2010) Assets can exist at an individual, community or organisational/ institutional level. One useful framework to help categorise assets and make intangible assets more visible is ' the seven capitals framework'.(McDonald 2002) 'Capitals' is a term often used interchangeably with assets and simply means those assets that are available for use as building blocks in the creation of further assets. Every community, however rural, isolated, or poor, has resources within it. When those resources, or assets, are invested to create new resources, they become capital. The Seven Capitals framework helps identify the role that intangible assets such as human and social capital can play in turning buildings and financial capital into assets that the community can build upon. The seven capitals are financial, built, social, human, natural, cultural and political.

Assets are therefore much more than individual or community skills and resilience. Social or material assets such as income level, housing, and educational attainment also determine health and wellbeing. When the distribution of material assets is unequal this affects not only individual health and wellbeing but also community wellbeing and cohesion.(Foot 2012) Arguably, JSNAs adopting a more asset-based approach will demonstrate local understanding about health assets, 'capitals' and how these are distributed across the local area.

(iii) Asset-Based Community Development and related approaches

Asset-Based Community Development (ABCD) originates from an approach to community development 'from the inside out' cultivated in Chicago by Kretzmann and McKnight.(Caan et al. 2015) ABCD is a method of community and network building that starts by locating the assets, skills and capacities of citizens and local organisations, rather than focusing on their needs and deficits. The aim is to help people to improve their resilience, independence and wellbeing by focusing on what can be done through communities working together.

The roles of health professionals (and allied professions) may be fundamentally challenged by an approach to ABCD in which the skills and capacities of 'communities' are the focal point. Whilst it is vital not to overlook the dimensions (and inequalities) of status, power and authority within and between organisations and sectors, the skills and capacities of professionals and public sector organisations must also be re-examined and understood in the context of local priorities. If we acknowledge that individuals working in provider and commissioner roles do not have the monopoly of 'expertise' in local communities then we should give equal credence to the notion that some of these same individuals also care about and want to change things. A successful local health economy is unlikely to be the outcome from an approach that simply tips the balance between organisations and communities from 'them versus us' to 'us versus them'.

A fundamental tool for ABCD work is asset mapping which is basically *"a process of learning what resources are available in your community."* (Green & Haines 2002) Several tools and methods are available to ABCD practitioners to produce a picture of local assets, to consider their roles and relevance and to identify where more in-depth assessment will be helpful.(Allen 2005)(McKnight & Kretzman 1996) The mapping process alone, however, will not identify local priorities so dynamic asset based approaches such as participatory appraisal and appreciative inquiry are often used to complement asset mapping and define how people will work with the assets they identify. (Emery et al. 2006) Evidence within JSNAs of a local commitment to asset mapping, community-led approaches and methods and tools for local information gathering (the 'what' and the 'how' of ABCD) may therefore indicate a shift towards a more asset based approach.

Political, economic and organisational drivers

In the United Kingdom, asset based approaches have been endorsed by a number of key institutions. For example, the National Institute for Health and Care Excellence (NICE) has recently published guidelines on 'Community engagement: improving health and wellbeing and reducing health inequalities'(National Institute for Health and Care Excellence 2016) which make a clear recommendation to directors of public health and other strategic leads for asset-based approaches "*to build on the strengths and capabilities of local communities*" as an effective method of collaboration and partnerships on local needs and priorities. NICE goes on to make a number of key recommendations as part of a "*local approach to making community engagement an integral part of health and wellbeing initiatives*."(National Institute for Health and Care Excellence 2016) These include using the JSNA to understand the local demographic profile; planning ways to enable people to participate; "*identify the 'assets' (skills, knowledge, networks and relationships) and facilities available locally; [and] plan how to build on and develop these assets as part of the joint strategic needs assessment.*"(National Institute for Health and Care Excellence 2016)

The much heralded NHS Five Year Forward View outlines how health services need to change and argues for *"a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health".* (NHS England 2014) Whilst this change in direction should be welcomed there is an implicit 'them and us' dichotomy in the proposed models of working that does not fundamentally change the existing relationship between citizens and service providers and, whilst there is a strong emphasis on the role of 'volunteers', the wider contribution of community skills, knowledge and networks is less clearly defined.

In contrast, a recent Public Health England (PHE) report, which makes reference to the Five Year Forward View, explicitly refers to these assets within communities as the "*building blocks for good health*"(Public Health England & NHS England 2015) and defines participation as "*representation, community leadership and activism*" as well as volunteering. The report recommends community-*centred* rather than community-*based* approaches which involve "*mobilising assets within communities, promoting equity and increasing people's control over their health and lives*" (Public Health England & NHS England 2015). The report outlines 'a new family of community-centred approaches' in four key groupings; *strengthening communities*

(involving building on community capacities to take collective action); *volunteer and peer roles* (which focus on developing individuals' skills to provide guidance, information and help or organise community activities); *collaborations and partnerships* (where communities and local services work together at any stage of the commissioning cycle); and *access to community resources* (involving connecting people to resources and opportunities to meet needs and improve social participation.

The motivation for asset-based approaches can also be examined through an 'ecological' lens. Several commentators(Hanlon et al. 2011)(Hanlon & Carlisle 2010)(Lyon 2003) have suggested that we are entering a 'fifth wave' in public health. With its roots in an ecological public health discourse(Hanlon & Carlisle 2010) this presents us with a series of population, energy, environmental, climate and economic challenges that demand a new approach because the "*accumulated traditions of previous waves… are inadequate in the face of current and emerging challenges.*"(Hanlon et al. 2011) One of the emergent qualities of this fifth wave is a rebalanced mind-set from 'anti' to 'pro' and "from dominion and independence… to greater interdependence and cooperation."(Hanlon et al. 2011) With a 'glass half full' mind-set, proponents of a fifth wave in public health argue that "*an ever-expanding health care budget is not the answer*" to improved health status. Rather, we need to look "*in the fabric of our everyday lives… where wellbeing is the outcome of our relationships and actions towards each other - person to person, organisation to organisation, sector to sector.*"(Lyon 2003) The main proposition of a pivotal 'fifth wave' report is that "*mobilising the energy within ourselves and others will provide a basis for positive change.*"(Lyon 2003)

Interestingly, the literature on assets approaches appears to be overwhelmingly positive although evidence on the perceived benefits of such approaches in public health is often anecdotal and measures of outcomes and effectiveness for different projects are seldom directly comparable.(Baker 2014) Arguably, the relative paucity of evidence on the benefits of asset based approaches requires a shift in emphasis from understanding 'what works' to prevent disease or reduce risk factors to 'what works' to create and sustain health and wellbeing. This requires a conversion from a 'pathogenic' to a 'salutogenic' evidence base which needs to retain methodological rigour but will necessitate a re-thinking of the conventional hierarchy of evidence.

A worthy but far less widely discussed critique of the increasing interest in salutogenetic and asset based approaches is that this in effect extracts psycho-social factors from the substantial realities of people's lives and diverts attention from "*addressing questions of economic power and privilege and their relationship to the distribution of health.*"(Friedli 2013) Some authors have argued that the assets movement is actually part of a more wide-scale attack on public sector provision because it emphasises how public services generate need and produce dependency rather than addressing the health impact of corporate power or the consequences of the free market.(Friedli 2013)

From a critical public health perspective it should be acknowledged that 'societal determinants' of health – "*how health is shaped by the political and economic interests of those with power and privilege*"(Birn 2009) are often noticeable by their absence from assets discourse. Similarly, political struggle, trades unions and street protests are missing from the plethora of asset approaches discussed in the public health literature. Friedli argues that asset based approaches used in Scotland to support a shift from 'welfare to wellbeing' and 'dependency to self-determination' are morally flawed because they convey poverty as individual misfortune and dependency as moral failing. Her conclusion that framing problems in terms of a 'deficit approach' of professionals and a 'culture of dependency' among the poor avoids hard questions about corporate power, undermines collective responsibility and blames the public sector - which is simultaneously "*picking up the pieces and picking up the tab… [Furthermore] it… appears to be unsupported by the evidence. OECD figures show that public services reduce inequalities in the UK more than almost anywhere else.*"(Friedli 2013) Elsewhere, Friedli argues that asset-based rhetoric shifts the focus onto a "'*radical change in the design and delivery of public services', rather than on a radical change in economic and fiscal policies that … 'sanction gross inequalities and obscene greed*."(Friedli 2011)

In its defence, whilst an assets approach to community development does not claim to single-handedly solve inequality within and between communities, it can help communities to develop greater confidence and a stronger political voice with which to engage the political system in addressing structural causes of injustice and their roots in an unfair and unsustainable global economic system.(McDonald 2002) Ultimately perhaps, focusing solely on the presence of resources of people living in

poverty (or 'gilding the ghetto') at the cost of resource distribution would be unethical. However, focusing on the assets of such communities does not mean that additional resources from outside are not needed, rather that they will be "*much more effectively used if the local community is itself fully mobilized and invested, and if it can define the agendas.*"(Kretzmann & McKnight 1993) Arguably it would also be unethical "*to overlook the presence of resources*" in the poorest communities.(Bull et al. 2013)

Finally, it is useful and timely to consider asset based approaches in the context of a concurrent growing interest in place-based approaches. A recent New Local Government Network (NLGN) report (New Local Government Network (NLGN) & Collaborate 2016) argued that "*place matters – and if we are really serious about reorienting our health and care model around the grain of people's lives, assets and ambitions, then we need to take it seriously as a starting point for reform.*" (New Local Government Network (NLGN) & Collaborate 2016) The authors suggest that the policy and practice around diverse delivery models and the centrality of citizen voice and experience (as espoused in the NHS Five Year Forward View(NHS England 2014)) is disconnected and that what is needed is a system for health and wellbeing that starts with the question "*what would help you to enjoy life more?" rather than "what health services do you want?*"(New Local Government Network (NLGN) & Collaborate 2016) Implicitly asset based, the approach they propose is 'place-based health' and involves bringing expertise from all sectors together and integrating services across a geographic area to "*secure better outcomes and become sustainable for the future*".(New Local Government Network (NLGN) & Collaborate 2016)

One of the conclusions from the NLGN research was that structural, top-down reform had been rolled out in a way that was detached from the experience of local practitioners so they opted instead to "*look between the lines and concentrate on the enablers and relationships that could help a place-based health system to work on the ground.*"(NLGN & Collaborate 2016) Their findings concluded that three interconnected factors were holding back reform: First, the 'evidence paradox' means that if we never try to deliver place-based health we can never demonstrate that it works. Councils and the NHS must be open to experimentation and local variation and committed to rigorous evaluation. Second, the organisational and

financial incentives of councils and health commissioners and providers are poorly aligned. New ways of working need to be created which incentivise a different collection of behaviours. Third, national regulation is often heavy and rigid and tends to inhibit local flexibility and change.

In summary, asset based approaches are dynamic and multi-faceted and there is a strong case for saying that their current resurgence has been propelled by the need to respond to the local and national organisational, political and economic challenges of increasing inequalities, a growing and ageing population and a squeeze on public sector funding. Nevertheless, the concepts of salutogenesis, health assets and ABCD remain central to asset based approaches and these are therefore proposed as three overarching ‘indicators’ to provide evidence of a shift to asset based JSNA. The extent to which JSNAs currently demonstrate these three core elements (which may or may not be aligned with any economic, organisational or political context as discussed above) may be indicative of a more system-wide shift to asset based approaches. These themes therefore provide the starting point for the analytical framework and deductive methodological approach described in the next chapter.

Chapter 3: Methodology

3.1 JSNA sample selection

A purposive sample of twenty five JSNAs was selected for analysis. Seven of the sample had been cited in the literature review(Foot & Hopkins 2010)(Foot 2012) as demonstrating or piloting some aspect of asset-based approaches. Nine JSNAs had been identified in the Springboard to Action JSNA Guide(Local Government Improvement and Development Healthy Communities Programme 2011) as exemplifying good practice for particular elements of JSNA development. The remaining nine were randomly selected with no prior knowledge of their format, approach or assets/ needs balance. The JSNAs in the sample are identified in Table 1. The reference numbers (in brackets) allocated to each JSNA are used to identify them throughout the analysis and subsequent narrative to ensure that there are clear links between results and the 'data'.

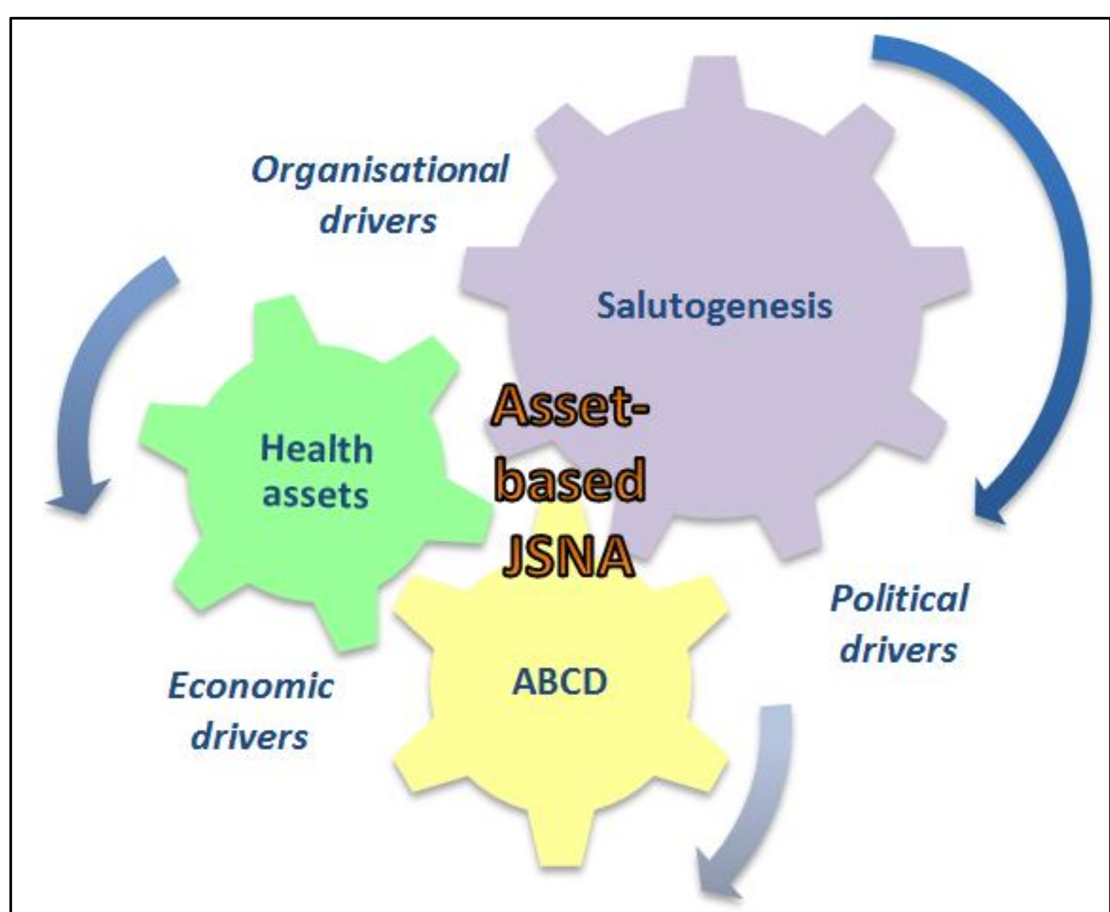
Table 1: Sample of JSNAs selected for analysis

JSNAs identified from the literature as piloting asset-based approaches	JSNAs identified in the Springboard to Action Guide as good practice	Randomly selected JSNAs
Cumbria (3)	Cambridgeshire (12)	Birmingham (1)
Gateshead (4)	Cheshire East (13)	Blackburn with Darwen (2)
Knowsley (5)	Lancashire (16)	Bristol (24)
Manchester (7)	Newcastle (11)	Cheshire West (14)
Salford (8)	Nottingham (18)	Halton (15)
Stockport (10)	Portsmouth (19)	Hull(25)
Wakefield (9)	South Staffordshire (21)	Liverpool (6)
	Westminster (23)	Newham (17)
	West Sussex (22)	Richmond (20)

3.2 Analytical framework

The framework for my analysis of JSNAs was hinged on the three core elements of 'salutogenesis', health assets and asset based community development (ABCD) discussed in the previous chapters with an acknowledgement that these are shaped by political, economic and organisational drivers. This framework is represented diagrammatically in Figure 2.

Figure 2: Diagram illustrating core elements of analytical framework



The key themes and concepts summarised in Table 2 present more comprehensively the theories and constructs emerging from the literature that have shaped the analytical framework. Whilst these are aligned with each of the three core elements, they are not mutually exclusive and the interdependencies between them shaped both the analysis and the interpretation of the findings from the sample of JSNAs.

Table 2: Analytical framework themes and concepts

Themes and concepts relating to *salutogenesis*
Focus on factors that generate health and wellbeing which traditional epidemiological approaches have failed to do(Brooks & Kendall 2013)
Community perspectives - views, expectations, perceptions and experiences of service users and local communities about what contributes to good health(Local Government Improvement and Development Healthy Communities Programme 2011)
Concept of salutogenesis (Morgan & Ziglio 2007),(Brooks & Kendall 2013); salutogenic approach to public health (Morgan & Ziglio 2007); salutogenesis has currency even in areas of severe deprivation(Bull et al. 2013)
Generalised Resistance Resources (GRR) (Antonovsky 1996),(Bull et al. 2013)
Sense of Coherence(Antonovsky 1996) - Enables development initiatives to make sense logically (comprehensibility), perceived to be practically realistic (manageability), motivating because meaningful & based on involvement in decision-making (meaningful) (Bull et al. 2013)
Activities which focus on protective factors which build resilience to inhibit high-risk behaviours (NHS North West & Department of Health 2011),(Kelly 2010),(Morgan & Ziglio 2007),(Marmot et al. 2010)
Themes and concepts relating to *health assets*
Positivist rather than deprivation(Baker 2014)
Part of a larger ‘capabilities approach’ (Baker 2014)
Social, physical and support networks(Foot & Hopkins 2010),(Baker 2014)
Capacity, skills, knowledge, connections, potential(Morgan & Ziglio 2007)(Foot & Hopkins 2010),(Bull et al. 2013),(Foot 2012),(Hopkins & Rippon 2015)
Social capital (Foot & Hopkins 2010),(Brooks & Kendall 2013),(Kelly 2010)

The seven capitals framework for developing assets - financial, built, social, human, natural, cultural and political(Emery et al. 2006)
Identifying local strengths(Foot & Hopkins 2010),(Baker 2014),(Emery et al. 2006),(Health 2011)
Assets as protective factors(Morgan & Ziglio 2010),(Brooks & Kendall 2013)
Resilience(Morgan & Ziglio 2010),(Baker 2014),(Brooks & Kendall 2013),(Kelly 2010)
Individual, community and organisational/ institutional level assets(Morgan & Ziglio 2010)
Themes and concepts relating to *asset based community development (ABCD)*
Community resilience and cohesion, communities thriving in in the face of change or adversity (Foot & Hopkins 2010),(Baker 2014),(Friedli 2013)
ABCD approach which enables the development of policies and activities rooted in capacities, skills and assets of communities(Kretzmann & McKnight 1993)
People as active agents rather than passive recipients of services (Foot 2012),(Brooks & Kendall 2013)
Community-led, mobilised and empowered communities(Foot 2012)
People-centred outcomes (Foot 2012)
Themes and concepts relating to contextual *economic, organisational and political drivers*
Part of 'ecological' public health mind set - wellbeing seen as the outcome of relationships and actions (person to person, organisation to organisation, sector to sector)(Lyon 2003)
Place-based working more important than organisational boundaries(Foot 2012),(New Local Government Network (NLGN) & Collaborate 2016)

Systematic approach to capturing volunteering, grass roots community organisations and VCS(Gamsu & Abbas 2012)
Political struggle, street protests, trades unions (Friedli 2011),(Baker 2014),(Friedli 2013)
Acknowledging societal determinants of health(Friedli 2011),(Friedli 2013)- how health is shaped by the political and economic interests of those with power and privilege

Section 3.3 Approach to analysis

For the purposes of this study, qualitative content analysis was selected as the most appropriate approach to analysing the content of JSNAs. Hsieh and Shannon define qualitative content analysis as "*a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns.*"(Hsieh & Shannon 2005) They argue that it is important to delineate one's specific approach to content analysis before beginning data analysis because "*creating and adhering to an analytic procedure or a coding scheme will increase trustworthiness or validity of the study.*"(Hsieh & Shannon 2005)

My approach to the qualitative content analysis of a sample of JSNAs was informed by the work of Elo and Kingas (Elo & Kyngas 2008) who represent inductive and deductive analysis processes as three main phases: preparation, organizing and reporting. They summarise their approach diagrammatically to illustrate the key steps in the process of qualitative content analysis. Figure 3 shows an annotated version of their diagram (with my annotations in yellow and red) to dissect my analysis process and clarify how each step of this approach was applied to the analysis of JSNAs.

It is important to note the distinction between *inductive* content analysis, in which the concepts are derived from the data, and *deductive* content analysis in which the analysis is framed by previous knowledge. My approach to analysis, framed by the key themes and concepts pertinent to asset based approaches illustrated in Figure 2, was a predominantly deductive approach.

The preparation phase, guided by my literature review and additional insights gleaned from my involvement in the Kirklees JSNA development process, started with selecting the 'unit of analysis.' It has been suggested that the most suitable unit of analysis "*needs to be large enough to be considered as a whole and small enough to be kept in mind as a context for meaning unit during the analysis process.*"(Graneheim & Lundman 2004) At the outset of this study, my unit of analysis was tentatively defined as the 'JSNA summary' but after a preliminary review of the sample this was extended to include JSNA landing pages, introductory and overview sections in order to accommodate the more interactive nature of web-based JSNAs which generally incorporate dynamic functionality and/or links to additional on-line information or downloadable documents.

The next step in the analysis was to make sense of the data and "*understand the whole*".(Elo & Kyngas 2008) In deductive content analysis the organizing phase involves developing a categorization matrix and coding the data according to the categories. This part of the process was a useful way of 'testing' categories or concepts that had emerged from the literature review and involved selecting attributes from the data that fitted the matrix of analysis. For example, whilst a search for the key themes and concepts identified in Table 2 such as 'asset(s)', 'strength(s)', 'protective factors', 'wellbeing' and 'resilience' was a useful way to identify relevant sections of text, further reading 'around' the words would reveal a variety of meanings, interpretations and applications that would generate different coding categories. These would prompt further searches for a new set of themes or concepts which would create additional coding categories. Appendix 1 shows the complete categorization matrix and how the data was coded to the emerging categories. For example, one key theme from the analysis was 'overall needs/assets balance' and this had several categories to which the data was coded including 'needs emphasis', 'assets and needs balance,' 'assets highlighted' and 'asset mapping'. Sub-categories of 'assets highlighted' emerged as 'cites ABCD activities'; 'buildings, spaces, infrastructure'; 'stakeholders, services, organisations'; 'social capital'; and 'examples of things that improve wellbeing'. The categorisation matrix included references to specific JSNAs (listed at the end of the categorisation matrix) where these categories and sub-categories had been identified and coded to these categories.

After the first ‘round’ of analysis, each JSNA was analysed a second time to ensure that the emerging coding and categorisation was applied consistently across the total sample and that insights from the analysis were revisited, reconsidered and refined. Figure 3 dissects this analytical process and provides an overview of the steps involved. Depicting the process in this way is intended to bring the analysis to life and provide a clear chain of events between formulating hypotheses, analysing data and presenting and interpreting results. The combination of the annotated diagram in Figure 3 and the categorisation matrix in Appendix 1 should provide the reader with a clearer understanding of “*how the analysis was carried out and its strengths and limitations*”(Elo & Kyngas 2008) thereby improving its reliability and trustworthiness. The reliability of this study is increased further by the inclusion of references (with hyperlinks to the sources) to those JSNAs which exemplify particular coding categories, demonstrating clear links between results and the ‘data.’(Elo & Kyngäs 2008)

In the reporting phase of the analysis I decided to incorporate my thoughts, interpretations and ‘insights’ within the categorisation matrix itself (see Appendix 1) rather than confine these to a separate reflexive research diary. This reflective approach provides “*an interpretation of interpretation*”(Cassell 2006) and is intended to enable the reader to more fully understand the chain of ‘analytical events’ that underpinned how my results, discussion and recommendations were developed and presented. A detailed discussion of reflexive research practice and the benefits of using a reflexive research diary (Cassell 2006),(DeVault 1997) is beyond the scope of this report. However, it is worth noting that the decision to use qualitative content analysis methods resulted from my reflections on how to refine my research question at the start of the research process. Likewise, the way I have chosen to describe and present the methods, results and recommendations has been shaped largely by reflections on my progress and of my interpretations at each stage of the research process. In other words, the use of a research diary, which provided the space to be reflexive, “*impacted both directly upon methodological and analytical decisions made during the research process as well as influencing the theoretical conclusions reached*”.(Cassell 2006) Overall my approach to analysis meets Tracy’s ‘big tent’ criterion of being ‘meaningfully coherent’(Tracy 2016) because it “*uses methods and*

procedures that fit its stated goals", is clear about what I have analysed, how and why and "*has lived up to what was promised.*"(Tracy 2016)

Section 3.4 Limitations of analytical approach

One obvious limitation of the approach to analysis described above is the selection of the JSNA landing page, introduction, overview and summary as the 'unit of analysis.' Given that web-based products are by nature, interactive, dynamic and 'dispersed' it was often difficult to navigate through, understand and assess the 'whole' JSNA within these parameters. Perhaps more important is the assumption that, in any given JSNA, these components accurately reflect and represent the approach and content of the entire 'product'. Whilst it was beyond the scope of this study to assess every JSNA in its entirety, where information was *not* found 'easily', this was a notable finding in itself, having important implications for JSNA design and development which will be discussed later in the report.

A second limitation is that the sample of JSNAs may not reflect the diversity of approaches to JSNA across the country. "*There are more than 130 health and wellbeing boards run by local authorities with their health partners*" in England (The King's Fund 2016), so it is likely that many examples of good practice have been excluded from this study. However, given that the purposive sample included JSNAs that had been cited in the literature as demonstrating some aspect of 'asset based approaches' or 'good practice' as well as randomly selected JSNAs it was hypothesised that a sample of twenty five out of 130 (approximately 1 in 5) would provide a reasonably representative cross-section of current approaches to JSNA.

A third limitation is the underlying assumption that a JSNA can realistically reflect a system-wide shift to a more asset-based approach, particularly an emphasis on ABCD and community-driven change. Lack of 'evidence' from a JSNA that these changes are being embedded may simply reflect the difficulty in capturing something that is, by definition, fluid, complex, multi-layered and does not easily align with the priorities prescribed by Joint Health and Wellbeing Strategies and Boards which often provide the foundations on which a JSNA is built.

Figure 3: Annotated diagram to dissect the analytical process with sample of JSNAs

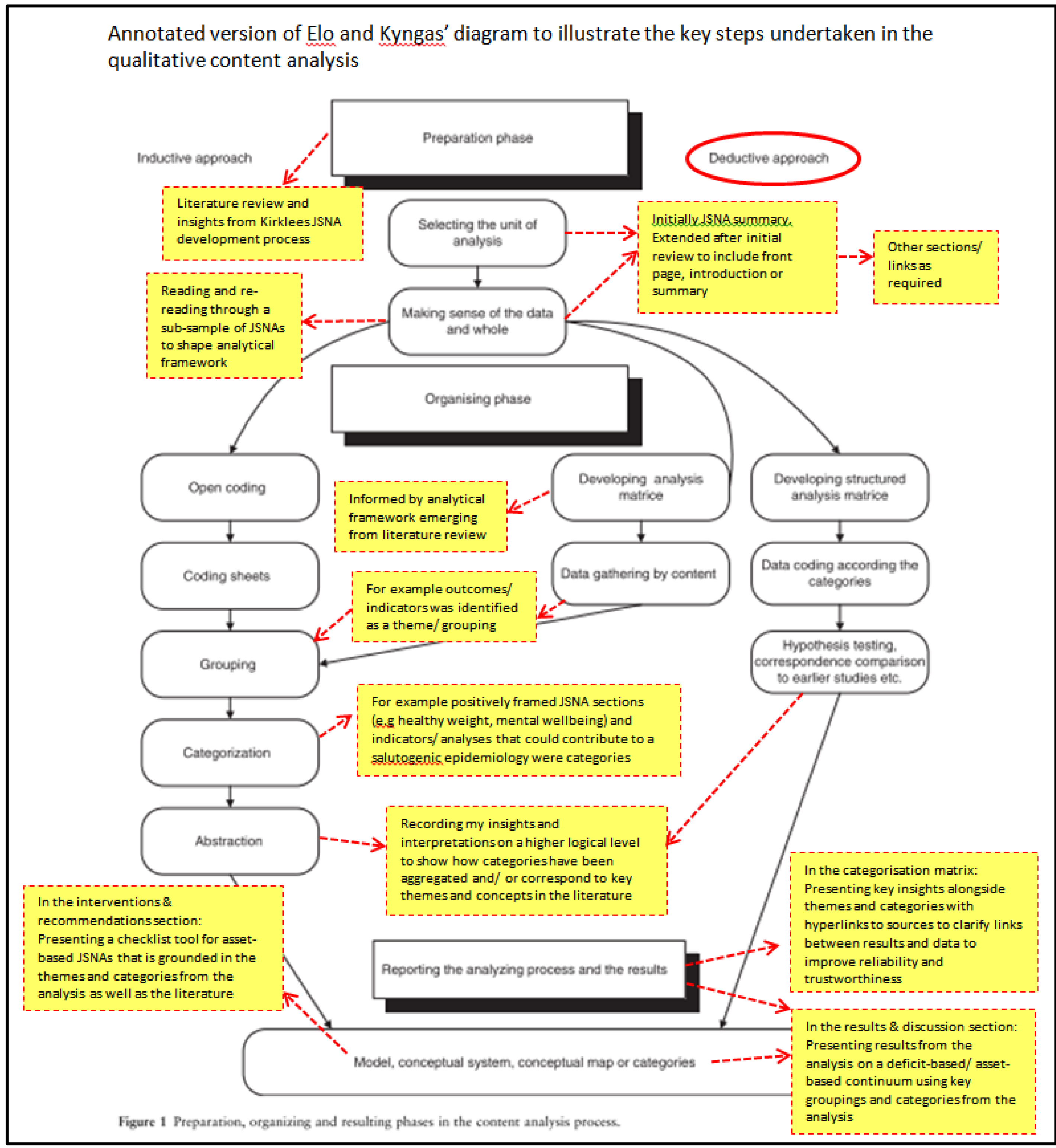


Figure 1 Preparation, organizing and resulting phases in the content analysis process.

Chapter 4: Results

The categorisation matrix and emergent insights have been included in full as Appendix 1. Headline findings from the analysis are summarised below for the most notable themes and categories (numbers in italics refer to the JSNAs listed in Table 1 which provide illustrative examples).

Overall assets-needs balance

- The categories identified under this theme were (i) needs emphasis (i.e. a manifest needs focus), (ii) assets and needs balance (where clear reference was made to including both strengths and needs), (iii) assets highlighted (with sub-categories of types of assets that were included); (iv) asset mapping (with examples of types of asset mapping that were in evidence); and (v) place-based strengths/ assets.
- Based on their introductory or 'landing pages', the majority of JSNAs (approximately 19 out of 25) indicated a needs-based approach, including many of the JSNAs that had been cited in the literature as having piloted asset-based approaches. The other JSNAs professed 'up front' to incorporate a balance of needs and assets. However, on closer inspection, an asset-based 'style' was commonly not supported by asset-based 'substance'.
- Various types of assets were highlighted in both the manifestly needs-based and the more 'balanced' JSNAs. Around half of all the JSNAs referred to stakeholders, services or organisations as assets; around half referred to physical assets such as buildings, spaces and infrastructure; and around half referred to social/ human capitals such as culture, people, volunteers, social connections and skills as assets.
- One JSNA referred to the role of ABCD in building community resilience but gave no examples of where this had taken place.
- Evidence that asset-mapping (arguably a core component of ABCD) had been undertaken was identified in eight JSNAs. Some of these (but not all) were JSNAs that had declared a more asset-based approach from the outset. Some asset-mapping examples stemmed from neighbourhood ABCD projects (presented as

'case studies') and although extremely informative this information was often extremely difficult to locate within the JSNAs.

- Only four examples of attempts to map (or describe) assets across the whole district/ borough/ city were identified (*8b, 9c,16d and 21d*). In the two 'descriptive' examples (*9c* and *16d*) the information on assets was generally either missing, 'work in progress' or only available on request. In the 'mapping' examples, one method (*8b*) was to map 'assets' (somewhat narrowly defined as community groups and buildings) alongside needs ('types of problem') to identify a surplus or deficit of assets. Another method employed (*21d*) was to map and highlight examples of local facilities, walks, schools, clubs, etc. alongside local 'economic assets' nominated by elected members.
- Clear examples of things that improve wellbeing were found in only two JSNAs (*2, 13*).
- A judicious discussion of the above issues will be included in the next section because they embody all three of the pivotal elements of asset-based approaches (salutogenesis, health assets and ABCD) and thus have important implications for what and how assets are defined, understood and represented in JSNAs.

Place-based approach

- The categories identified under this theme were (i) breakdown to smaller localities; (ii) stories of place; and (iii) place based commissioning/ collaboration.
- The majority of JSNAs included a breakdown of information at lower geographical level such localities or wards. Some JSNAs also included CCG-level information. The format and content of lower level summaries or profiles was as varied as the JSNAs themselves although whilst some profiles/ reports were bespoke, several used 'off the shelf' profiles from external sites such as the PHE Local Health tool (Public Health England 2014a).
- One clearly identifiable 'story of place' (*2*) was found as was one clear example of place-based commissioning/ collaboration (*7*). Interestingly the first example evidenced a shift to balancing needs and assets whereas the second did not. Overall, a shift to 'place-based approaches' was not in evidence.

Outcomes and indicators (pathogenic vs salutogenic)

- The categories identified under this theme were (i) deficit-based outcomes/ indicators; (ii) positively framed themes/ sections; (iii) positive outcomes; (iv) successes and challenges; (v) salutogenic approach; and (vi) action focus.
- Several JSNAs used 'traditional' deficit- based outcomes and indicators although positively framed themes and issues such as 'healthy weight', 'emotional wellbeing' were apparent in greater numbers. However, the vast majority of positively themed sections went on to present a selection of deficit-based indicators as supporting evidence, reflecting a somewhat shallow interpretation of asset-based approaches. For example, one JSNA (*25*) included a link to a social capital map but virtually all of the 'social capital' indicators listed were deficits (e.g. lack of trust, rarely talks to neighbours, dissatisfied with local area, etc.)
- A small number of JSNAs presented clear examples of 'success stories' or 'opportunities' (*16, 21*) alongside 'challenges' (*2, 15*) reflecting an attempt to strike a balance of positive and negative messages. However, on closer inspection, challenges were more likely to be framed as reducing something negative than increasing something positive.
- Very few examples of JSNAs describing 'things that improve wellbeing' (potential salutogenic indicators) were uncovered. The notable exceptions were examples of positive wellbeing measures(*18*); things that improve children's wellbeing (*2*); and measuring trends in friendships and neighbourliness (*11*).

Wider determinants

- The categories identified under this theme were (i) overarching; (ii) economic; (iii) crime; (iv) housing; (v) environment; and (vi) work and skills.
- More than half of the sample of JSNAs included a manifest acknowledgement of wider/ social determinants, some referring directly to the Marmot Review(Marmot et al. 2010) and associated reports. Whilst all JSNAs included detailed focus on one or more wider determinants, some did not define them as such, often categorising them under 'life course' headings (for example including work/

employment issues within a ‘living well/ working well’ theme (*7*).

- Whilst poverty, housing (and homelessness) and work/ employment were commonly included, environmental factors such as transport, green infrastructure and air quality were less frequently included. In general, those JSNAs which included environmental factors also presented a clear overarching description or explanation of social determinants of health. The absence of environmental factors in many JSNAs may reflect the relative paucity of local ‘measures’ (either deficit or asset-based) around these issues or be related to the fact that these issues are often tackled on a regional footprint and may be seen as ‘out of scope’ for JSNAs.

Data development agenda

- This phrase is intrinsic to an Outcome Based Accountability (David Burnby and Associates 2016) framework and is used to clarify gaps in data or intelligence, data collection issues, problems of data definition or interpretation and gaps in ‘evidence’ identified during the process of selecting appropriate outcome indicators or performance measures. The categories identified under this theme were (i) data/ intelligence/ knowledge gaps; (ii) data quality; and (iii) broader evidence gaps.
- A small number of JSNAs highlighted gaps in local intelligence although not specifically in relation to local assets, what helps to improve wellbeing or the connections between these (arguably the foundations of a salutogenic epidemiology). Interestingly, one JSNA wellbeing section (*18*) described “the impact on wellbeing of commissioned services… not routinely being measured” as a service gap rather than a knowledge gap. This illustrates what can be overlooked if a service-orientated rather than an outcomes-focused approach is adopted.

Inequalities and inequities

- The categories identified under this theme were (i) highlights key inequalities; (ii) protected characteristics/ communities of interest; (iii) vulnerable/ at risk groups; (iv) inequity of provision; (v) implicit in data/ intelligence gaps; (vi) process rather

than content.

- Most JSNAs highlighted key inequalities, describing and explaining them in a variety of ways. Most JSNAs also included a focus on specific ‘vulnerable’ or ‘at risk’ groups such as victims of domestic abuse, homeless people, travellers/ migrants, disabled people and carers.
- In some JSNAs vulnerable groups were also assessed under the heading of wider determinants (for example (victims of) domestic abuse and homeless(ness)) whereas in other JSNAs they were incorporated into either one section or the other but not both. Whilst there is no right or wrong way to handle this, it is important to acknowledge and understand the interdependencies between wider determinants, inequalities, inequities and ‘vulnerable groups’. Interestingly, many of the JSNAs with a strong emphasis on wider social determinants were also those with a clearer focus on inequalities.
- There were no examples of JSNAs in which intelligence about current or changing inequalities was mapped or explored alongside intelligence about local assets. Again, aligned with the issues highlighted under the ‘data development agenda’ theme described above, it is possible that a less compartmentalised and more holistic approach to exploring and understanding local patterns of inequalities, assets and wellbeing could form the basis of a salutogenic epidemiology.

Model of health/ life course approach

- The categories identified under this theme were (i) asset based/ positively framed; (ii) age group based; (iii) within conditions; and (iv) within interventions.
- Around half of the JSNAs reflected a life course approach with most of these using the ‘asset-based’ stages (starting well, living well, ageing well) adopted by Public Health England in their current marketing strategy (Public Health England 2014b) and others using more traditional groupings (children, adults, older people).
- Intuitively, a life course approach may lend itself to an asset-based approach because it provides an opportunity to focus on people, families and communities

rather than conditions or problems. However, there were many examples of JSNAs using positively defined life course headings to frame a predominantly deficit-based narrative. Likewise, there were several examples of condition/ needs focused sections which incorporated information about assets (for example, self-help groups).

Citizen voice, engagement, collaboration

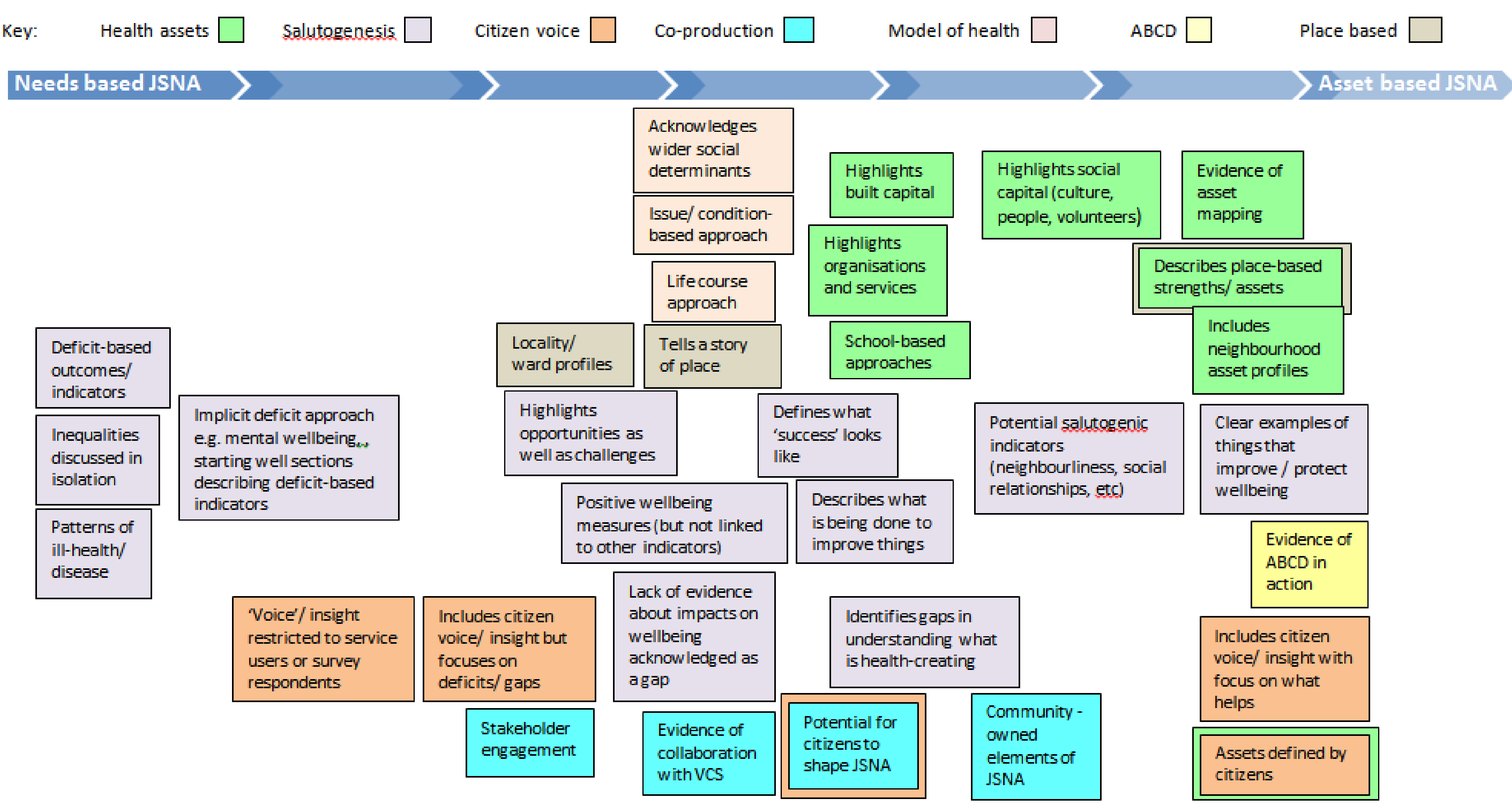
- The categories brought together under this theme were originally considered separately but were then merged because they were intrinsically linked. These were (i) 'citizen voice'; (ii) active agents vs passive recipients (including a sub-category of citizen defined assets); (iii) citizen ownership; (iv) councillor ownership; (v) and voluntary and community sector (VCS) collaboration.
- Clear examples of citizen stories, experience or insight were identified in around half of the JSNAs although these terms were, on occasion, found to be attributed to survey responses rather than any qualitative exploration. Several examples of deficit focussed citizen 'voice' were found (for example, experiences of depression, views on what was wrong with local services), suggesting that an amplification of 'citizen voice' in JSNAs is not necessarily associated with a shift to an asset-based approach.
- Whilst in some JSNAs citizen voice was 'passive' (restricted to service users), there were a small number of JSNAs which included 'active voice' such as information about assets defined by local people (*2, 19, 21*) and one JSNA described assets defined by local citizens alongside those defined by local councillors (*21*) illustrating both commonalities and differences in perceptions. One example of people (children) being asked what helped to improve/ protect their emotional wellbeing was identified (*2*) in an emotional wellbeing section. Unfortunately a search of all equivalent sections in the sample of JSNAs was beyond the scope of this study.
- In terms of ownership and collaboration, there were some examples of stakeholder engagement processes and plans although it was generally unclear to what extent citizens were included in these. A few examples of open invitations to contribute or 'get involved' in the JSNA were found (*6, 7, 13*).

Genuine collaboration (as opposed to 'engagement') with the voluntary and community sector (VCS) was rarely evident. One notable exception was a 'compact' between a Health and Wellbeing Board and the VCS (7) which also incorporated a regular 'call for evidence' for the JSNA to local communities. Two JSNAs were found which included a 'VCS owned' JSNA linked to the main JSNA (*7, 13*).

In summary the analysis revealed a number of examples of JSNAs which demonstrated an understanding or acknowledgement of the key concepts underpinning asset-based approaches – health assets, ABCD and, to a lesser extent, salutogenesis. Some JSNAs demonstrated an understanding of the broader economic and organisational context and how these influence not only health and wellbeing inequalities per se but also how local organisations and places respond to these.

Given the range of inter-dependent themes and categories that emerged from the analysis and the diverse mix and quality of styles and approaches that were demonstrated in JSNAs, it was not possible either to compare one JSNA directly with another or to position individual JSNAs on a continuum of 'needs-based' to 'asset-based' JSNAs. However, as a preface to a more detailed discussion of the findings and the implications for theory and practice, it is useful to consider where the emergent themes and categories themselves might be positioned on such a continuum. Figure 4 illustrates the key findings using this approach.

Figure 4: An illustration of the key themes and categories from the analysis presented on a needs/ assets continuum



Chapter 5: Discussion and implications

Whilst some of the results described above are self-explanatory, it is necessary to critically appraise the key findings and consider the implications for the theory and practice of asset-based approaches in order to respond to the original research question: 'How can asset-based approaches to Joint Strategic Needs Assessment (JSNA) be implemented more effectively?' The needs-assets continuum in Figure 4 provides a starting point for considering the typical 'features' of asset-based JSNA but in itself does not provide a way forward that is clear, practical and systematic. It is also necessary to reflect on the extent to which the triad of health assets, ABCD and salutogenesis underpinning the analysis provide an appropriate theoretical framework for future study and a possible basis for monitoring and evaluating the shift to asset-based JSNA. In order to reflect the inter-dependencies between health assets, ABCD and salutogenesis that emerged from the results, the three concepts are discussed concurrently under six key headings with a consideration of the implications for theory and practice. As in the previous section, numbers in italics refer to the JSNAs listed in Table 1 from which quotations or illustrative examples are cited.

Moving from asset based rhetoric to reality

Overall the findings suggest that, whilst the rhetoric of asset-based JSNA is becoming more widespread, this is not being matched by a comprehensive and systematic shift to an asset-based process or product. One JSNA (*25b*) opens with the following line about its local area:

> *"We believe our citizens and our communities are its greatest asset."* (JSNA *25b*)

However, there is very little coverage of assets elsewhere in this JSNA beyond the opening paragraph. This typifies several examples found in the study and it is clearly important that a JSNA does not claim to include a balance of assets and needs information unless it actually 'does what it says on the tin'. Arguably, 'hidden assets' within JSNAs are equally misleading (although perhaps more morally defensible) and a number of good examples of asset mapping were only located by means of

convoluted routes through JSNA webpages. For example, one good example of ward-level asset mapping profiles (*1a*) was found within a standalone case study report linked to the local Health and Wellbeing Board webpages. However, the front pages of this JSNA gave no indication of the value of asset-based approaches or the inclusion of asset-based content. In another example (*24b*) the JSNA introduction was manifestly needs-focused but evidence of local asset mapping was identified (not without difficulty) within a section on social determinants. Had it not been for the fact that particular JSNAs had been highlighted in the literature for demonstrating aspects of good practice, much of the asset-based content would have been left undiscovered.

The meanings and visibility of health assets

The classification and meaning of 'assets' found in the sample of JSNAs was extremely varied and lacked a consistent framework. The classification of assets ranged from extremely narrow, such as services and organisations, to much broader definitions such as social capital. In addition, the source of definitions was largely unspecified. Unless explicitly described as community-defined assets or, in one case, local councillor defined assets (*21d*) the assumption was that assets were defined by JSNA authors. Finding a common perception of what is meant by 'assets' is a significant challenge and it "*is often important to move beyond identifying assets to assessing the meanings assigned to them and their roles in everyday social interaction*."(Visram 2013) This is particularly important for JSNA because with narrow or 'top-down' definitions there is a risk of misunderstanding or ignoring what is available or appropriate for whom as well as overlooking unmet need. One JSNA example (*8b*) had attempted to map both needs and assets systematically 'across the patch'. The approach compared community groups and buildings (designated as 'assets') with 'types' of problems in order to classify localities as having either a 'surplus' or 'deficit' of assets. Whilst a commitment to methodical asset mapping is commendable, the example cited is problematic. Not only is the notion of asset 'surplus' at best surprising and at worst damaging, but a rudimentary method such as this undermines the diversity of local assets and local communities. It is also premised on the assumptions that there is consensus on what constitutes local assets and that all groups and buildings actually meet the needs of local people.

Whilst beyond the scope of this analysis, it is important to consider those things that are *not* defined or framed as assets or strengths but have a good evidence base for contributing to the prevention of problems or acting as ‘protective factors’ for positive wellbeing. For example, support groups for parents might be identified and mapped as local assets because they are tangible groups, networks or organisations but ‘positive parenting’ (which may or not depend on ‘support groups) is unlikely to be defined or mapped as an ‘asset’, most likely because it is too difficult to measure. There is an inherent risk in asset mapping (as in many other areas of public health) that we only count or map what is quantifiable and thus overlook the building blocks of what makes a positive difference to people’s lives. It is therefore crucial to understand and commit to asset mapping and asset based JSNA in the context of a broader theory of change and a whole system approach.

Asset mapping as a tool for change

The results reveal that beneath the veneer of credible sounding asset-based concepts a conventional, deficit focused approach to analysis and understanding persists. One JSNA example (*25c*) included a link to a ‘social capital Atlas’ which mapped a large selection of indicators of which the vast majority were arguably the ‘polar opposite’ of social capital indicators (for example lack of trust, rarely talks to neighbours, dissatisfied with local area). Arguably, had the ‘flip side’ asset-based indicators been used, this example would have represented a potential starting point for a salutogenic epidemiology (discussed in more detail below). This example also illustrates the multi-dimensional nature of needs, deficits and assets because needs and deficits are not synonymous and, likewise, a deficit does not necessarily equate to a gap in assets. Local context, knowledge, definitions and priorities are vital.

In view of the fundamental importance of JSNA to commissioning, service re-design and delivery and funding decisions, the visibility, accessibility and clarity of assets information should be a key priority when considering JSNA development and design. Furthermore, given that asset mapping and knowledge may be undertaken or ‘owned’ by any number of stakeholder organisations across a given locality, the organisational and political context is hugely important. Without a wider shift to integration, collaboration and asset-based models, asset-based content in JSNA is

mere window dressing. More critically perhaps, whilst comprehensive asset mapping "*could provide a framework for asking new questions about equitable access to valued resources… in the end it still comes down to who actually owns the assets… Who owns the means of production?*"(Friedli 2011) Shifting to an asset based approach should not reduce the imperative to tackle the social determinants of health, reduce inequalities and understand the relationship between the distribution of resources, equity of access and health outcomes. In the right hands, asset mapping could be a powerful tool with which to challenge the status quo.

ABCD, wider transformation and place-based approaches

One of the difficulties of embedding asset mapping into JSNA (and asset based approaches more broadly) is that assets are not fixed or stable either geographically or over time. Any picture of local assets, however well undertaken or presented, is only a 'snapshot.' Capturing both temporal and spatial changes in assets is a significant challenge for JSNA and requires dedicated and ongoing commitment and capacity. "*For the process to evolve with the community and its goals, efforts have to be made to consistently update asset maps [and] continually build relationships among identified social capacities*."(McKnight & Kretzman 1996) Ironically it is this very challenge that underpins the rationale for ongoing needs assessment and the centrality of JSNA to the work of Health and Wellbeing Boards. Arguably, the resources employed across local authorities and clinical commissioning groups to collect, analyse, interpret and present local intelligence about needs would also support an asset based approach. Whilst these are not inherently incompatible with the tools and techniques utilised in ABCD such as participatory appraisal and appreciative enquiry,(Emery et al. 2006) workforce development and significant organisational changes may be necessary to facilitate more effective integration of 'intelligence' and community development functions.

More importantly, for asset based approaches to be fully embedded across organisations a wider programme of transformation will be required. The scale of this change should not be underestimated given that the shift to an asset-based or strengths-based approach is undoubtedly a 'threshold concept'(Cousin 2006) - the equivalent of passing through a 'conceptual gateway,' that "*opens up previously*

inaccessible way(s) of thinking about something." (Flanagan 2016) Threshold concepts are transformative, troublesome, irreversible, integrative and their mastery "*often involves messy journeys back, forth and across conceptual terrain*".(Cousin 2006) The challenge for organisations is to acknowledge this messiness, appreciate the different levels at which change needs to take place and use a 'theory of change' for asset based working to understand the "*key stages local systems should consider and progress when making a shift toward asset-based working.*"(Hopkins & Rippon 2015)

Whilst this study suggests that a shift to place-based approaches was not evidenced in the majority of JSNAs, several examples of asset profiles were identified for small areas or neighbourhoods within a local authority. This indicates that the building blocks for both place-based and asset-based working are intrinsically linked and it is perhaps no coincidence that the clearest example of a 'place-based' JSNA (*2b, 2d*) included a clear focus on assets in its narrative. However, although there may be a natural juxtaposition between place-based and asset-based approaches, telling a 'story of place' does not a guarantee an embedded asset-based method. Any system wide shift to place-based approaches should thus be considered in conjunction with a shift to asset-based working and vice versa.

Shifting to a salutogenic epidemiology

The extent to which assets and needs are understood and interpreted in isolation or alongside each other has important implications for a shift to a salutogenic epidemiology. In relation to the example of the social capital atlas (*25c*) cited above it is worth considering whether analysing the 'flip side' (arguably the correct one) of these indicators (good levels of trust, often talks to neighbours, satisfied with local area, etc.) would represent a salutogenic approach given that we know these factors are associated with positive health outcomes (Marmot et al. 2010)(What Works Centre for Wellbeing 2016). The fact that these indicators are intrinsically salutogenic is pivotal because exploring the 'flip side' of inherently 'pathogenic' indicators such as smoking, violent crime, falls, etc. would not result in an understanding of 'assets' because the absence (or reduction) in something negative is not synonymous with the presence (or increase) in something positive. However, it is likely that analysing

or mapping non-smoking, low crime and low falls rates alongside local assets could provide some useful insights into what 'protective factors' are at work.

Another JSNA (*11a*) described trends in (ward level) social relations, friendships, neighbourliness with an explanation of 'why this matters.' However, presented in isolation from each other and from any analysis of other assets or health and wellbeing indicators it was not possible to explore these connections and to hypothesise which social capital indicators were associated with other factors and the presence or absence of community assets. It is postulated that mapping 'gaps' in social capital overlaid with community defined assets in a given locality could serve to identify areas where support groups, networks or community-based interventions could be (i) established and (ii) targeted and tailored more effectively. A creative, flexible and open-minded approach to exploring and understanding patterns of health, wellbeing, needs, assets and outcomes is therefore required.

Two examples of 'community JSNA' (*7b*, *13b*) owned by the local VCS were found in the study. Whilst these may demonstrate a positive shift towards community collaboration and citizen voice, they also created a partition between the 'community' and the 'official' JSNA, in effect, presenting two different 'stories of place'. Whilst the combined intelligence is likely to be comprehensive and informative it is unlikely that a coherent understanding of the links between community assets, VCS activities, needs and inequalities would emerge from a JSNA that is fundamentally divided in this way. This suggests that a shift to producing separate JSNA and JSAA may actually undermine a salutogenic epidemiology by preventing the holistic exploration of patterns of inequalities, needs, assets and outcomes and essentially severing evidence of 'the problem' from evidence of 'what works.'

JSNA on the ladder of co-production

Although the results revealed some positive examples of the inclusion of active (as opposed to passive service user) citizen 'voice', voluntary and community sector (VCS) and citizen involvement and collaboration in the JSNA process, there was no obvious correlation between these and more asset based approaches. The clearest example of a JSNA inviting citizen involvement was illustrated by the following statement:

"You can tell us about what's working well and about gaps in services by completing our online Community JSNA form" (JSNA *13b*)

Unfortunately there was no evidence of what intelligence (if any) had been produced from the information received and what had happened as a result.

Whilst it was beyond the scope of this study to identify and understand the various governance frameworks in place for JSNA, these have important repercussions for asset based approaches. The example of an official 'compact' (*7b*) between a Health and Wellbeing Board and the local VCS appears commendable in its equitable approach to 'calls for evidence' and 'calls for topics' for JSNA development. However, the compact does not appear to have resulted in an asset based JSNA illustrating that collaboration per se does not represent a shift to asset based working. This has important implications for proponents of Arnstein's ladder of participation(Arnstein 1969) which does not explicitly capture an assets dimension. In the ladder of co-production (New Economics Foundation 2014), however, one of the defining characteristics of co-production is that it sees people as assets and thus one of the key drivers for asset-based JSNA is likely to be a wider organisational shift to co-production. This underlines the previous assertion that a shift to asset based working, as a 'threshold concept', demands change at several levels and should be framed within an appropriate theory of change.

To summarise, a number of important implications for both the theory and practice of asset based JSNA have been discussed under the six key headings of moving from asset based rhetoric to reality; the meanings and visibility of health assets; asset mapping as a tool for change; ABCD, wider transformation and place based approaches; shifting to a salutogenic epidemiology; and JSNA on the ladder of co-production. In the next and final chapter of this report these will provide a framework for a set of recommendations and interventions to enable a more effective implementation of asset based JSNA.

Chapter 6: Recommendations and interventions

To conclude this public health report the key issues discussed in the previous chapters will be consolidated into a set of recommendations and interventions to support the theory and practice of asset based JSNA. This connection between theory and practice is crucial because, as the concept of 'praxis' ("*theory in action*" or "*putting theory in practice*"(nymph 2007)) emphasises "*theory is not an end in itself to the problems it analyses*".(Hooks n.d.) Fundamentally important to feminist theory, praxis describes the feminist commitment to a political position in which 'knowledge' is not just 'knowledge *what'* but 'knowledge *for*'. "*Succinctly the point is to change the world, not simply study it.*"(Stanley 1990) To enable a more effective implementation of asset based JSNA, arguably a core component of asset based praxis, the following ten recommendations are proposed. To be pragmatic, the first three recommendations should be considered as a priority:

1. Health and Wellbeing Boards and those people with designated responsibility for JSNA development should **use the checklists in the Springboard to action toolkit** (Local Government Improvement and Development Healthy Communities Programme 2011) to help them to clarify their approach to JSNA.

2. Health and wellbeing boards and those people with designated responsibility for JSNA development should supplement the Springboard to action toolkit with the **Asset Based Checklist (ABC) for JSNA toolkit shown as Table 3**. The five quality themes in the ABC tool are the overall assets/ needs balance; embedded assets based approach; place based asset mapping and ABCD; shifting to a salutogenic approach; and organisational context and change. These will help the consideration of how asset based approaches might be more effectively embedded in the process and the product of JSNA.

3. Health and wellbeing boards, those people with designated responsibility for JSNA development and strategic leads across all health and social care organisations should consider the ABC toolkit in the context of a **wider transformation to asset based approaches**. The **recommendations set out**

in the Head, Hands and Heart (Hopkins & Rippon 2015) report are strongly endorsed to support this transformation. These are briefly summarised as:

a. **Develop a working model for health assets** based on salutogenic theory, health assets research evidence and learning from asset-based practice (see Figure B in the ABC toolkit).

b. **Continue to tackle health inequalities**. Focus on 'what makes us well' rather than 'what makes us ill' (linked to recommendation 5).

c. **Plan to incorporate asset-based approaches into mainstream public health activity**.

d. **Plan to integrate health assets and interventions that promote assets into health and wellbeing strategies**. These strategies should reflect the association between levels of good health and wellbeing and the strength of local assets.

e. Ensure that local system leaders **champion asset-based approaches**.

f. Prioritise NHS and local authority **investment into asset-based community development (ABCD)** for health and wellbeing.

g. **Develop workforce and community capacity** for asset based approaches with individuals, families or approaches.

h. Create **'place-based outcomes'** (linked to recommendation 6)

i. Commit to a **theory of asset based changed** (see Figures C and D in the ABC toolkit) to think about how and why change happens and what stages are involved in a shift to asset-based working.

4. Local system leaders, commissioners and service providers should respond to the recent national call to action to *"**consider how community-centred approaches that build on individual and community assets can become an essential part of local health plans**"* (Public Health England & NHS England 2015).

5. Local system leaders should **commit to co-production** as the 'end goal' of asset based organisational re-design. A co-produced JSNA is neither achievable nor sustainable in the absence of this wider transformation. Co-production means *"delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours"* (Scottish Co-production Network n.d.) and entails a shift from 'commissioning for' to 'commissioning with' communities, building on assets, capacity, networks, shared roles and collaboration (Boyle & Harris 2009).

6. Health and wellbeing boards, those people with designated responsibility for JSNA development and strategic leads across all health and social care organisations should maintain a focus on **understanding and tackling the societal determinants of health and wellbeing**. It is vital that re-shaping the design and delivery of public services in line with an asset based model and a better understanding of 'what makes us well' is accompanied by policies and strategies which address inequalities and the root causes of 'what makes us ill'.

7. Health and wellbeing boards, those people with designated responsibility for JSNA development and strategic leads across all health and social care organisations should build on local asset mapping and knowledge to develop a **place based approach** in line with the **recommendations in the recent Place-based Commission for Health Report**.(New Local Government Network (NLGN) & Collaborate 2016) In essence these consist of three major 'shifts' for place-based health, namely; from institutions to people and places; from service silos to system outcomes; and enabling change from national to local. They also highlight five enablers for place-based health, namely; embed long-term planning; an explicit focus on breaking through the evidence paradox; a renewed push towards integrated local commissioning; a route map towards place-based health (incorporating a *"relentless focus on citizen outcomes"*); and a systematic approach to building readiness for change.

8. Strategic leads and system leaders should use an outcomes based approach such as '**Outcomes Based Accountability**'(OBA) (David Burnby and Associates 2016) across the system to monitor outcomes and performance at place, organisation and service levels. This includes ensuring that a balance of

‘heartening’ and ‘troublesome’ indicators is selected to reflect a balance of assets and needs. An example template is shown as Appendix 2. Asset based approaches can also be embedded into the OBA process when considering what works and action plans. The first two of the three key questions used in the ‘People, Power, Change game developed by Cormac Russell “*can be a good source of no-cost/ low-cost ideas.*”(Friedman 2015) These are “*what can only citizens do?*” and “*what can only people do together with government and professionals?*” (Friedman 2015)

9. System leaders should maximise the potential to **learn from the national ‘What Works’ network**,(Cabinet Office 2013) particularly the What Works Centre for Wellbeing(What Works Centre for Wellbeing 2016) which provides a wealth of evidence based information to increase understanding of what government, business, communities & individuals can do to improve wellbeing. Implementing and evaluating these things locally and mapping them alongside other assets, resources and inequalities will contribute to an improved local evidence base.

10. Public Health England should **review the Public Health Outcomes Framework indicator set** to identify opportunities for shifting the balance from predominantly deficit-based indicators to asset-based indicators. An OBA framework will help to clarify any ‘data development agendas’ and support a shift to a salutogenic epidemiology. A change in how outcomes are measured and monitored nationally should be accompanied by efforts to encourage and support equivalent changes at regional and local level.

Ultimately, the approach to JSNA must be agreed locally and will both shape and be shaped by a local ‘story of place.’ The recommendations above, underpinned by the ‘intervention’ of the ABC toolkit for JSNA (Table 3) are intended to support the transition to a more effective, and sustainable approach to asset-based JSNA in the context of a system-wide shift to asset-based working.

From an academic and theoretical perspective, there is potential for a much more detailed exploration of the extent to which JSNA does and should reflect a shift to

asset-based approaches and a more in-depth critical analysis of the three core concepts of health assets, ABCD and salutogenesis. This report has merely scratched the surface of JSNA products and processes but has nevertheless provided some useful insights into how we might re-think and re-frame our approaches to needs assessment, epidemiology, public health outcomes and, ultimately the commissioning and delivery of health and social care.

Table 3: Asset Based Checklist (ABC) for JSNA Toolkit

The following checklist should be used in conjunction with the worksheets included in the Springboard to action JSNA Toolkit (Local Government Improvement and Development Healthy Communities Programme 2011)

	Question	Note your thoughts and comments here
1	**Overall assets/ needs balance**	
1a	Is the JSNA presented primarily as a needs assessment or is there a clear attempt to balance needs and assets?	
1b	Is there a clear reference to asset- or strength-based approaches in the JSNA introduction, summary or overview (with an explanation of what this means)?	
1c	Is this consistent throughout the JSNA? Which parts could be improved?	
1d	Does the JSNA demonstrate a clear understanding of the social determinants of health and structural causes of injustice and inequalities?	
2	**Embedded assets based approach**	
2a	Is there a clear reference to assets, strengths, social capital or protective factors in different parts of the JSNA? Is there a clear demonstration of asset-based approaches being used to improve health and wellbeing or reduce health inequalities?	
2b	How easy is it to navigate to this information from the JSNA introductory or	

	Question	Note your thoughts and comments here
	summary pages?	
2c	Does the JSNA present information on assets/ strengths separately to information on needs and inequalities or is there an attempt to bring/ understand these elements together?	
2d	If the JSNA lacks information on assets is this clearly identified as a gap in local intelligence/ knowledge? Is there a process in place to plug these gaps?	
3	**Place based asset mapping and ABCD**	
3a	Does the JSNA include descriptions or links to information about local assets (places to do things, community groups/ networks/ activities/ skills) and where they are?	
3b	Has there been an attempt to ‘map’ assets at a neighbourhood, locality, CCG or local authority level? What sorts of assets does this include? Who has defined them as assets?	
3c	Is asset mapping being undertaken consistently across the local area or are there gaps in local knowledge? If there are gaps, are the reasons for these clear and is there a process in	

	Question	Note your thoughts and comments here
	place to do something about it?	
3d	How well does the JSNA reflect the current range of asset-based community development (ABCD) activities and community-led activities/ events/ networks in your local area? How do you know? How often and how effectively is this updated?	
4	**Shifting to a salutogenic approach**	
4a	Does the JSNA describe clear ambitions to achieve positive health outcomes for population groups, communities or places?	
4b	Does the JSNA contain a balance of positive (asset-based) and negative (deficit-based) health and wellbeing indicators? (e.g. healthy weight vs obesity/ overweight, emotional wellbeing vs mental illness)	
4c	In the JSNA, are outcomes measured by ‘heartening’ (positive) indicators or by a reduction in ‘troublesome’ (negative/ deficit) indicators?	
4d	Does the JSNA include clear examples of things that are being done locally *across all sectors* to improve wellbeing? If there are gaps in some sectors, is there a process in place to do something about this?	

	Question	Note your thoughts and comments here
4e	Does the JSNA include any evidence about the contribution of local assets to improved health and wellbeing?	
4f	Does the JSNA explore local patterns/ distribution of assets alongside the distribution of resources, inequalities?	
4g	Does the JSNA explore the relationship between assets, what works to improve wellbeing and positive outcomes or are these considered in isolation?	
5	**Organisational context and change**	
5a	Is the voluntary and community sector actively involved in the development of the JSNA? If so, is this asset based or is it mainly focused on unmet needs or gaps in service provision?	
5b	Are the necessary data collection, analysis, interpretation and visualisation skills being resourced and used effectively for the JSNA? Are the necessary ABCD skills and techniques being resourced and used effectively for the JSNA? How well joined up are these two areas of work? What are the workforce development needs to support asset based JSNA?	

	Question	Note your thoughts and comments here
5c	Whereabouts on the co-production ladder does your JSNA production stand? *[See Figure A]*	
5d	Is an asset-based approach clearly embedded in the governance of the JSNA? e.g. is there an explicit commitment to this approach by the HWBB or is it defined in the terms of reference of the JSNA steering group?	
5e	Is there a commitment to a system-wide shift to asset-based approaches? Is there a shift to an asset model of public health? *[See Figure B]* Has the JSNA been considered in the context of a theory of change for asset based working? *[See Figures C and D]*	

Figure A: The ladder of co-production(New Economics Foundation 2014)

Co-production
Co-design
Engagement
Consultation
Informing
Educating
Coercion

Doing with
in an equal and
reciprocial partnership

Doing for
engaging and
involving people

Doing to
trying to fix people
who are passive
recipients of service

Figure B: Morgan & Ziglio's asset model for public health(Morgan & Ziglio 2007)

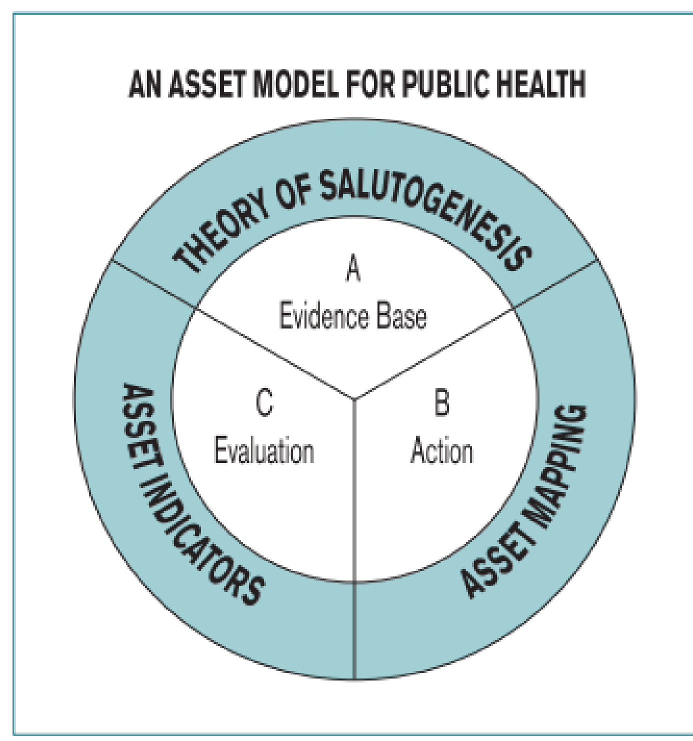
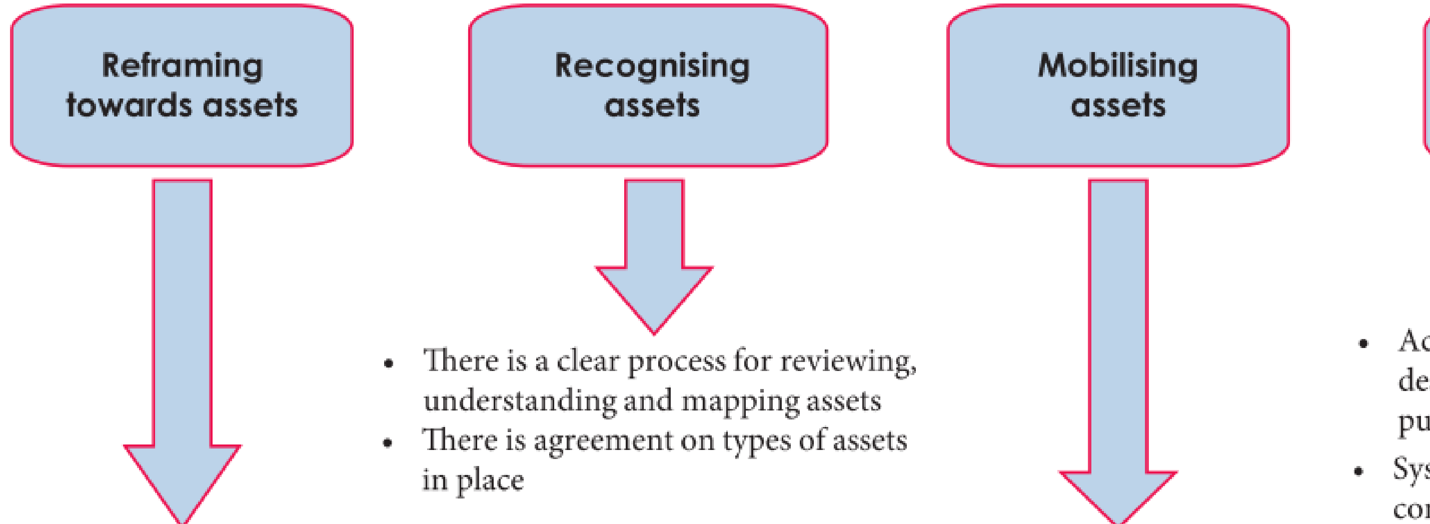


Figure C: The four elements in a theory of change approach for asset-based working (Hopkins & Rippon 2015)



Reframing towards assets

- Identify champions
- Increase asset-based dialogue
- Exposure to knowledge, theory concepts and evidence

Recognising assets

- There is a clear process for reviewing, understanding and mapping assets
- There is agreement on types of assets in place

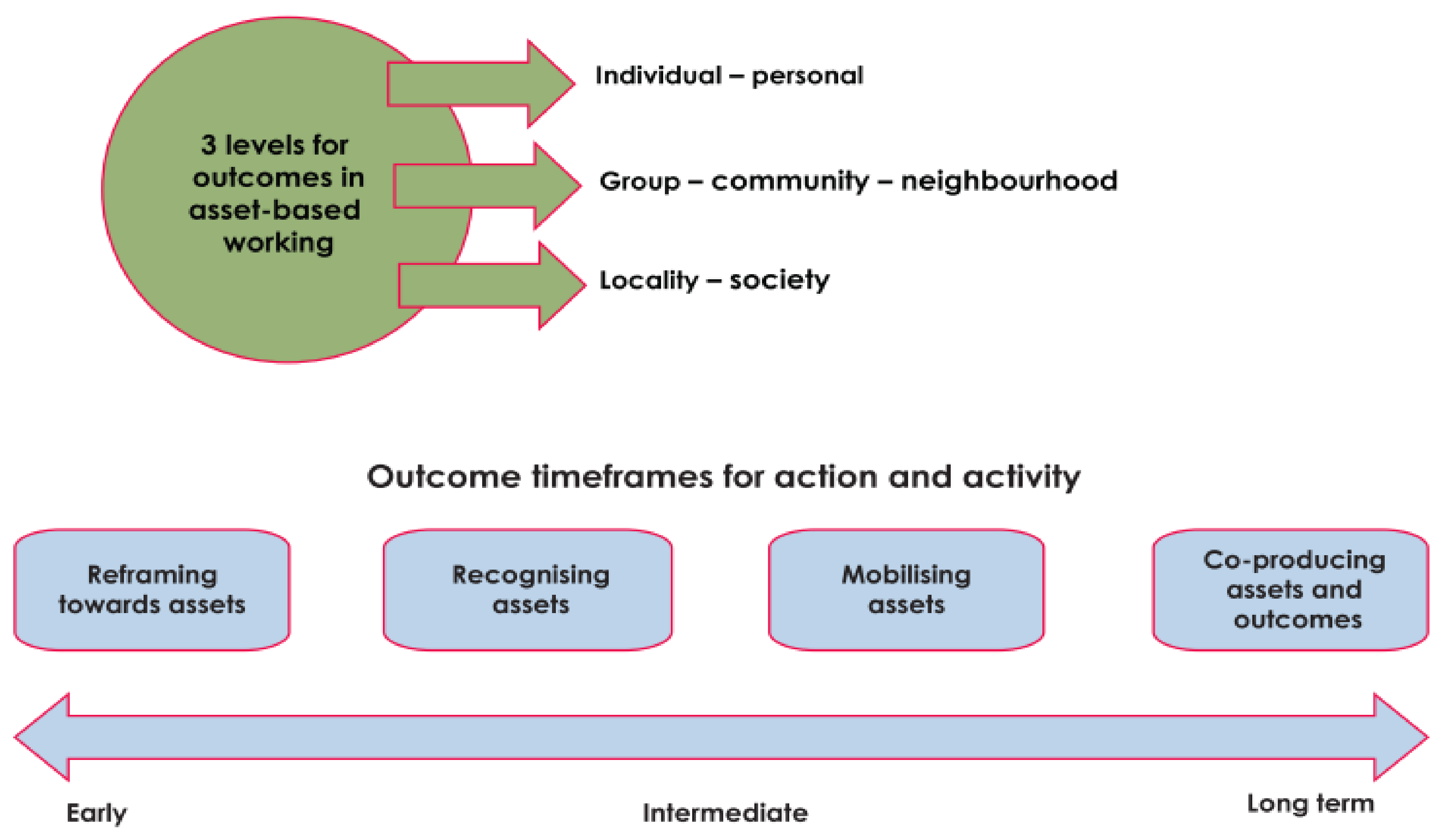
Mobilising assets

- Action and activity designed to use assets for agreed purpose
- System leaders create climate, context and rationale for asset-based change

Co-producing assets and outcomes

- Activity and action by local actors designed to use assets for agreed purpose
- System leaders create and enable context, rationale and climate

Figure D: A theory of change for asset-based working – key elements and stages (Hopkins & Rippon 2015)



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Appendix 1

Categorisation matrix and codes (showing illustrative JSNA examples) with emergent insights from analysis

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
Overall assets/ needs balance	**Needs emphasis**	**Assets & needs balance**	**Assets highlighted**	**Asset mapping**	**Place-based strengths/ assets**	**Reference to national guidance re inclusion of community assets**
[Look for 7 capitals = financial, built, social, human, natural, cultural and political]	Manifest needs focus e.g. 1a, 1b, 3a, 4a, 5b, 7a, 7b, 9a, 10a, 11a, 12a, 14a, 15a, 16a, 17a, 18a, 19a, 22a, 23a, 24a, 25a	Refers to an assets/ strengths & needs approach e.g. 1e, 2a, 3b, 5b, 8a, 9a, 9c, 13a, 16d, 21a, 25b	Cites ABCD activities as building community resilience e.g. 3b [but no examples]	Evidence that asset-mapping has been undertaken e.g. 1a, 1c, 1d, 1e, 8b, 9c, 13c, 16d, 19b, 21d, 24b	e.g. 2b, 2d, 7a, 8b, 9a, 11a, 13c, 16d, 21b, 21d	e.g. 12c, 1d not a relevant category?
			Buildings/ spaces/ infrastructure e.g. 1c, 1d, 2b, 8b, 11a, 13c, 16d, 19b, 20b, 21b, 21d, 25b	Neighbourhood asset profiles e.g. 1c, 1d, 8a/b, 9c, 16d, 21d	School-based approaches (positive) e.g. 1b, 5b	
			Stakeholders/ services/ organisations e.g. 1c, 1d, 3b, 4a, 5a, 6a, 8b, 9b, 13c, 16d, 18b, 19b, 21d, 23b	Neighbourhood asset profiles compare needs with assets to identify surplus/ deficit e.g. 8b		
			Social capital - culture/ people/ volunteers, social connections, skills e.g. 2b, 4a, 8b, 11a, 13c, 16d, 19b, 20b, 21b, 21d, 24b, 25b	Across the district/ borough e.g. 8b,		
			Examples of things that improve			

Appendix 1

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
			wellbeing e.g. 2c, 13c			

Insights on overall assets/ needs balance theme…

Don't judge a book by its cover! Declaring the JSNA as balancing needs and assets does not necessarily mean that it does!
Likewise a manifest needs focus on the front page does not mean that assets are not understood!
e.g. first line of Hull JSNA (25b): "Hull is an amazing City. We believe our citizens and our communities are its greatest asset." [however there is scant reference to assets beyond the opening paragraph of the report]. Hull also refers to 'asset approaches' in the 'social capital' section of its JSNA. *"This approach is based on strengths, abilities and capacities of the community rather than weaknesses and disability, and 'active participant in solution' approach rather than a 'passive victim of problems' approach which involves collaboration rather than silo provision. It is hoped that improving and maintaining high levels of positive social capital can help this approach"*. Assumption that social capital will itself generate an asset based approach?

There is no clear cut flip side to assets, strengths, deficits and needs.
Needs and deficits not synonymous. There will always be needs and assets can help to meet these needs. Are gaps in assets the same as deficits?

Asset mapping – Salford example (8b) – attempts to look at needs and assets at local level but assets narrowly defined (community groups and buildings). 'Type' of organisation/ groups compared with 'type' of problem used to identify surplus or deficit of assets. (Can there be a surplus of assets?!) Fairly rudimentary approach – how do we know an organisation/ group actually meets the needs of people with needs? How do we understand equity of access, reasons for uptake/ lack of uptake, etc.?

Good examples of asset-mapping (although still distinct from other wellbeing indicators) from South Staffs (21d) and Birmingham ward case studies (1c, 1d, 1e). Birmingham asset mapping very difficult to find – no evidence from the front pages of the JSNA that this ward level case study has been more widely implemented across the city or embedded into the JSNA approach.

South Staffs (21d) Asset profile for district and localities x 5 (mapped and described e.g. outdoor facilities, walks, schools, clubs, etc. but not clear re the selection criteria for assets). Also includes 'economic assets' nominated by elected members (21d) which demonstrates subjective nature of assets and political undercurrents likely to surface when mapping local assets with different stakeholders.

Place-based asset mapping (see place-based approaches theme below) Anecdotally, asset mapping can be challenged because things change all the time. How do we ensure asset mapping is flexible, has wide/ community ownership and can be updated on an ad hoc basis? Do we need to explore IT-enabled solutions?

Is asset-mapping vital to understanding the 'pattern' of assets and therefore necessary for a salutogenic epidemiology?

Wakefield (9a/c) – quite a disappointment after all the pilot work. Assets hidden in the 'strategy' summary and also captured in sub-district profiles – although much of the assets information missing and not mapped against needs, etc. Is the asset work being captured elsewhere? Is the JSNA the best 'way in' to this information/ intelligence? To what extent should the JSNA include this information or simply signpost elsewhere? Separating intelligence about assets from the rest of the JSNA is not conducive to a salutogenic epidemiology

"Overall, Richmond is healthy, safe and rich in assets… Life expectancy is high and mortality is low. Levels of crime and accidents remain low compared to the rest of London. We have many green spaces, high educational attainment and high levels of volunteering." (20b)

Narrowly defined assets?
"Therefore the health and wellbeing system has services and assets that are far reaching across Cumbria and span all health and wellbeing issues. In future topics services and assets should not be limited to considering the well-recognised stakeholders"(3b). Refreshed sections in Cumbria JSNA include 'assets' information which extends to the VCS but still limited to services and organisations.

Hidden assets (i) Key issue is accessibility of assets info on JSNA websites?! Where there is reference to assets in JSNA homepage/overview the evidence of embedded assets is scant. BUT where there are some good examples of asset mapping, attempts to develop asset profiles, etc. these are generally difficult to find and not signposted clearly from JSNA e.g. Lancashire Assets page (16d) is virtually impossible to find from current JSNA homepage but includes some good examples of assets mapping work (although no direct links to information for much of this so not being made accessible). Birmingham (1a) ward level asset mapping/ profiles 'hidden' as a separate report linked to an 'asset based' link via HWBB pages. These are not referred to in the JSNA front page which has a manifest 'needs' focus as does the JSNA summary! Bristol (24b) – needs focussed introduction but some attempt to map assets hidden within the social determinants section. Why this discrepancy?

Where assets are VCS 'owned' (e.g. 7b, 13b) – are there clear links between this and what is in the main body of the JSNA? How are these brought together to understand the whole place?

Hidden assets (ii) Some actions/ outcomes not defined/ framed as assets but arguably are things that contribute to the upstream prevention of problems, e.g. support for parents might be 'mapped' as a group/ network, etc. but positive parenting (which may or not depend on these support groups) itself contributes to improved HWB of children but not necessarily defined/ mapped as an 'asset' (is this because it is too difficult to measure?)

Note re asset mapping – is it actually assets that are being mapped (see example 25c in outcomes theme re deficit indicators used to map social capital)

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
Place-based approach	Breakdown to smaller localities e.g. 1b, 2b, 2d, 3b, 4a, 5a, 7a, 8a, 9a, 10b, 11a, 13a, 14a, 15a, 15b, 19b, 21b,	'Story of place(s)' e.g. 2b, 2d	Place-based commissioning/ collaboration e.g. 7a, 7b	*Obesogenic environment e.g. 1b*		

Appendix 1

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
	24b, 25b					

Insights on place-based theme…

Telling a 'story of place' is not necessarily asset based!
Refer to report/ reference re why place based commissioning is important and more likely to be asset based?

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
Outcomes/ indicators (e.g. pathogenic vs salutogenic)	**Deficit-based outcomes/ indicators**	**Positively framed themes/ sections**	**Positive outcomes**	**Successes & challenges**	**Salutogenic approach?**	**Action focus?**
	e.g. 1b, 2b, 3b, 4a, 5b, 11a/b	healthy weight, economic wellbeing, mental wellbeing, etc. e.g. 2b, 6a, 7b, 10a, 11a, 14a, 15a, 18b, 20a, 25b	'What would success look like?' e.g. 4a, 6a Positive messages (re inequalities) e.g. 16b	Successes and challenges (e.g. decreasing infant mortality, increased inequalities 15b) Both big challenges and big opportunities e.g. 2b 'Success stories' e.g. 21a (EoL and Health checks)	e.g. trends in social relations, friendships, neighbourliness in 'community' section of JSNA with a pre-amble of 'why this matters' (11a) Examples of things that improve/ protect CYP wellbeing e.g. 2c Positive wellbeing measures e.g. 18b	What are we doing about it e.g. 4a, 6a, 10b, 21b Issue & response summary e.g. 9a Clear links to local priorities and JHWS outcome measures e.g. 19a

Insights on outcomes/ indicators theme…

What is the relationship between positive/ heartening outcome indicators and the data and intelligence that sits underneath it? E.g. what do we actually learn about 'healthy weight' in CYP by only focusing on obese/ overweight CYP?

E.g. in Newcastle (11a) 'environmentally friendly lifestyles' section focuses on litter, graffiti, fly tipping, etc. These are reducing but this is not portrayed as an assets/ strength. Should a reduction in something 'troublesome' be a positive/ asset? How do we understand 'protective' factors if we only look at risk factors and factors

associated with poor outcomes? Implications for what we analyse and how we interpret local survey data….

Mental wellbeing often the title of a needs assessment or section but focus predominantly on mental illness/ suicide, admission rates, etc. e.g. 13a, 14a

Lots of examples of JSNAs that have positively framed titles (healthy weight, ageing well, mental wellbeing) but predominantly focused on deficit indicators (check for examples/ exceptions). So – 'gloss/ veneer' rather than substance! Similar examples in relation to asset mapping – e.g. Hull JSNA includes a link to a social capital Atlas (25c) but virtually all of the long list of 'social capital' indicators are deficits (e.g. lack of trust, rarely talks to neighbours, dissatisfied with local area, etc.)

What would salutogenic epidemiology/ intelligence look like?
e.g. are the trends in ward level social relations, friendships, neighbourliness in 'community' section of 11a – with a pre-amble of 'why this matters' a potential starting point for a salutogenic epidemiology? But if these indicators viewed in isolation from each other and from other health and wellbeing indicators it is not possible to make the connections. Do we need clear messages to say in place X, these indicators of social capital are improving and we know that these are associated with improved QoL and HWB etc.? Where social capital indicators are poor (gaps in assets but not necessarily identified as 'needs') there is potential for asset mapping to be utilised to see whether appropriate support groups/ networks/ befriending schemes, etc. could target these places more effectively?

e.g. 'school readiness' readiness is (arguably) a useful indicator of 'every child has the best start in life' and is likely to be an intermediate outcome of good pre-school support from 'services' but more so of positive parenting which may (or not) depend on strong family and social support networks.
Do we need to map support for parents in the community alongside 'school readiness' (and other indicators) to better understand what actually makes a difference?

Is lack of local knowledge about assets identified as an intelligence gap, part of a data development agenda?

Outcomes Based Accountability (OBA) may be useful for these last two points? E.g. Kirklees population accountability report card template to illustrate? BUT needs to be system-wide not just within an organisation so that the interdependencies and relative contribution of different organisations is understood.

Re **action focus** category….
Demonstration of improved health outcomes from interventions (whether they are NHS, LA or VCS) is key!
How can JSNAs contribute more effectively to our local evidence base?
Do we need a clearer distinction in JSNAs between evidence of problems/ needs and evidence of 'what works'?

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
Wider determinants of health	**Overarching**	**Economic**	**Crime**	**Housing**	**Environment**	**Work and skills**
	Manifest acknowledgement of wider/ social determinants e.g. 1b, 2b, 3b, 4a, 5b,	Poverty e.g. 1b, 2b, 3b, 4a, 6a, 6b, 9a,13a, 14a, 16c, 19a, 24b, 25b,	Crime e.g. 2b, 4a, 5a, 6b, 9a, 15b, 16c, 22a, 25b Domestic abuse	Housing e.g. 2b, 4a, 5a, 6a, 6b, 7a, 9a, 14a, 15b, 16c, 18a, 22a, 23b, 24b, 25b	Environment/ climate change e.g. 4a, 6b, 14a, 22a, 25b Air quality e.g. 6b,	Work/(un)employment e.g. 2b, 3b, 5a, 6a, 6b, 7a, 9a, 15b, 16c, 19a 22a, 24b, 25b

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Question/ concept/ theme	Category	Category	Category	Category	Category	Category
	6b, 11a, 12c, 14a, 15b, 17b, 20a, 24b, 25b Causes of causes clear e.g. 16b	Welfare reforms e.g. 2b, 4a, 6a, 6b, 16c, 25b Fuel poverty e.g.1b, 2b, 3b, 4a, 6a, 16c, 25b Gambling e.g. 15a	e.g. 1b, 6b, 8a, 9b, 16c, 18a, 23b, 25b	Homelessness e.g. 1b, 4a, 6a, 6b, 9b, 13a, 18a, 20a, 22a, 23b, 25b	13a, 14a, 16c, 18a, 22a, 25b Transport e.g. 2b, 3b, 4a, 5a, 6a, 7a, 15b, 16c Green infrastructure e.g. 2b, 6b, 25b	Education e.g. 6a, 13a, 16c, 24b, 25b

Insights on wider determinants theme…

In discussion section give a few examples of what is included with generic commentary on wider determinants and how this is framed in JSNAs e.g. any reference to causes of causes?

9a includes fuel poverty, education and skills, employment and worklessness, housing, crime under ‘quality of life’??? Is this side-stepping wider determinants or turning them into something more person-centred?!

May not be worth exploring in detail in JSNA analysis but still relevant to critiques of asset-based approaches –something to include in JSNA checklist?
e.g. risk of an asset-based approach is that the focus shifts so much to what individuals and communities are doing that it diminishes the importance of wider determinants/ the causes of the causes? Links to the criticism (Friedli et al) that asset-based approaches don’t acknowledge political protest/ action, etc. as ‘assets’?

Note – fewer JSNAs include ‘environmental’ factors – is this due to relative paucity of ‘measures’? Is this due to this being more likely to be tackled on a regional footprint? But how do we link up with this?

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
Prevention agenda	**Initiatives**	**Priorities**				
	Ref to early intervention initiatives e.g. 1b, 4a, 5a, 12c, 19b	Prev and early intervent’ identif as priorities e.g. 9a, 19a				

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Insights on prevention theme…
Not directly relevant to the analysis? Are these assets as upstream contribution to improved health and wellbeing? Are they only assets if they are co-produced (because this approach fundamentally sees people as assets)? May be noteworthy in discussion re using the JSNA to identify community asset contribution to the prevention agenda e.g. support for parents as a community asset contributes to upstream prevention of risky behaviours in CYP

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
Data development agenda	**Data/ intelligence gaps**	**Quality**	**Broader evidence gaps**			
	Identifies gaps in data/ intelligence e.g. 1b, 3b, 5b, 7b, 15b, 19b Knowledge gaps e.g. 18b	Data quality issues highlighted e.g. 5a	Any gaps in understanding what is health-creating? i.e. acknowledges salutogenic approach?			

Insights on data development agenda theme…
See outcomes/ indicators theme re salutogenic approaches… The distinction between service gaps vs knowledge gaps has important implications for commissioners re what they build into commissioning contracts with providers. If we don't all monitor impacts of services/ interventions on wellbeing this is ultimately a knowledge gap for the whole system! *In Nottingham JSNA wellbeing section (18b) "The impact on wellbeing of commissioned services is not routinely being measured" is identified as a service gap rather than a knowledge gap

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
	Highlights key inequalities	**Protected characteristics/ comm's of interest**	**Vulnerable groups/ at risk groups**	**Inequity of provision**	**Implicit in data/ intelligence gaps**	**Process rather than content**
Inequalities and	e.g. 1b, 2b, 3b, 4a, 5b, 5a, 8a, 9a, 10a,	e.g. 2b, 4a, 5a, 8a, 9b, 10b, 16a, 20a,	e.g. 1b, 2b, 3b, 4a, 5a, 6a, 8a, 9a, 9b,	Sexual health e.g. 1b	e.g. 1b, 2b	e.g. link to equity audit toolkit e.g. 16a

Appendix 1

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
inequities	11a, 12a, 13a, 14a, 16b, 16c, 24b, 25b	24b	10b, 13a, 20a, 23b, 24b, 25b Victims of domestic abuse 1b, 4a, 5a, 8a Homeless 1b, 4a Carers e.g. 2b, 4a, 5a, 8a, 9b, 25b Troubled Families (2b) Disabilities e.g. 4a, 5a, 8a, 9b Travellers/ migrants/ homeless e.g. 4a, 8a, 9b, 25b	Inequity of accessibility (rural areas/ travel time) e.g. 3b		

Insights on the equalities theme…
Is this relevant to this dissertation if no assets evident?? Worth noting that inequalities explored in detail but always devoid of assets context. If we brought together analyses of changing health inequalities with analyses of assets would this provide the basis for a salutogenic epidemiology?

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
Model of health/	**Asset-based/ positively framed**	**Age group based**	**Within conditions**	**Within interventions**		

Appendix 1

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
life course approach	Start well, live well age well (or equivalent) themes e.g. 2b, 4a, 6b, 10b, 11a, 13a, 14a, 22a, 25b Locality based life course approach - e.g. 15b, 21b	Children, adults, older people e.g. 8a, 10b, 10c, 15a, 17b, 18a	Long-term conditions e.g. 12b	Early intervention e.g. 1b		

Insights on model of health/ life course approach theme…

Is this relevant to analysis?
JSNA structure potentially influenced by PHE life course approach… Does this lose the focus on wider determinants?

Intuitively a life course approach should lend itself to an asset-based approach as potentially more opportunity to look at the people/ families/ communities and highlight strengths (protective factors) as well as deficits? But there are many examples of life course narrative that is needs focused (e.g. 'starting well' sections focus on infant mortality, low birth weight, childhood obesity, etc.). Likewise many examples of condition/ issue focused JSNA sections that capture assets (e.g. condition-focused community self-help groups) although these usually presented as 'add-ons' to largely needs-based content.

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
Collaboration e.g. transcends organisational boundaries	Manifest integration e.g. 2b, 7b	Disease-specific service integration e.g. 1b	Range of organisations included in actions e.g. 6a, 7b	VCS included in actions e.g. 6a	Explicit agreement between HWBB and VCS/ Healthwatch e.g. 7b, 10a, 13a	

Insights on collaboration theme…

Governance/ processes for JSNA production/ development/ownership, etc. are vital. Springboard for action highlights key elements of this. The commitment to an asset-based approach must be embedded in this or collaborative/ integrated approaches will continue to be deficit focused (e.g. Manchester 'compact' is commendable but not asset based?)

Appendix 1

Beyond scope of this study to explore various governance processes in place (described in detail in some JSNAs and not at all in others) but it will be important to capture in the checklist/ appraisal tool to ensure asset-based approaches are reflected in the governance process. What is the evidence that JSNA production is shifting to co-production?

Manchester 'compact' - 'Calls for evidence' plus 'calls for topics' – still needs focused?

Question/ concept/ theme	Category	Category	Category	Category	Category	Category
Citizen voice, ownership & collaboration	**Citizen 'voice'**	**active agents vs passive recipients**	**Citizen ownership**	**Councillor ownership**	**VCS collaboration**	
	Inclusion of stories/ experiences/ insight e.g. 2b, 2c, 5a, 6a, 8a, 10b, 11a, 13b, 14a, 19b, 20a, 21b, 21c, 24b	**active** CYP engaged re what helps to protect/ improve emotional wellbeing e.g. 2c **Citizen defined assets** e.g. 2d, 19b, 21b, 21d **passive** Service users focus E.g. 11, 18b, 24b Views/ experiences limited to survey respondents e.g. 22b	Manifest commitment to being citizen-centred e.g. 11c Annual engagement plan e.g. 9a Stakeholder engagement or consultation e.g. 5b, 7b, 11b, 12b, 19b, 20a, 23b, 24b **Inviting contributions to/ involvement in JSNA e.g. 6a, 7b, 13b	What Cllrs define as local assets e.g. 21d	HWBB and VCS compact (7b)* & 'call for evidence' to VCS/ communities VCS assets starting point for asset profile (21d) 'Community JSNA' linked to JSNA but VCS 'owned' e.g. 7b, 13b	

Insights on citizen voice, ownership & collaboration theme…

Thinking about the ladder of participation in relation to JSNAs: Quite a few examples of 'voice' etc. being incorporated but framed in needs/ deficits context (e.g. what service users told us about their experiences of depression, etc.) and potential quite tokenistic? Who sets the agenda? Do citizens want to talk about what's bad/ not

working more than they do about what's good/ working or is it just that this is what is asked?

Is there evidence that those JSNAs with strong element of citizen 'voice' are also more asset-based?
Things not always what they say on the tin – 'customer insight – getting to know our residents' ((21c) = Mosaic profiles of localities/ wards

Newcastle – explicit commitment to being citizen-centred and asset based but this is hidden in a separate 'process' report. On the surface Newcastle looks like it has embedded community insight but this is not available for all issues and isn't necessarily asset-based. E.g. Newcastle report on disabled people list lots of VCS groups, etc. but focus is more on needs and what is lacking from service provision rather than how many people are being supported and what difference this is making, etc. Likewise some misleading headings on Newcastle site e.g. 'what people say about their wellbeing' sounds like 'voice' but is simply self-reported wellbeing scores/ responses from a survey.

Are there any examples of citizen-defined outcomes?

Inviting involvement – best example = 13b – *"You can tell us about what's working well and about gaps in services by completing our online Community JSNA form"*

Is there evidence that those JSNAs with strong element of VCS engagement/ citizen involvement are also more asset-based?

Manchester 'compact' - 'Calls for evidence' plus 'calls for topics' – still needs focused?

Manchester (7b) and Cheshire East (13b) - VCS 'owns' the 'community' JSNA webpages (theme/ group based but VCS needs/ assets) info. How is this joined up with what is in the other sections of the JSNA?

Links to the collaboration theme….
Ladder of participation does not capture the assets dimension. Ladder of co-production (ref) clearly based on Arnstein's ladder but brings in the assets dimension (i.e. one of the defining characteristics of co-production is that it sees people as assets). So – is the ultimate asset-based JSNA one that is co-produced?

Governance/ processes for JSNA production/ development/ownership, etc. are vital. Springboard for action highlights key elements of this. The commitment to an asset-based approach must be embedded in this or collaborative/ integrated approaches will continue to be deficit focused (e.g. Manchester 'compact' is commendable but not asset based?)

Beyond scope of this study to explore various governance processes in place (described in detail in some JSNAs and not at all in others) but it will be important to capture in the checklist/ appraisal tool to ensure asset-based approaches are reflected in the governance process. What is the evidence that JSNA production is shifting to co-production?

Appendix 1

Key to sources cited in categorisation matrix:			
1a	Birmingham JSNA home page	13a	Cheshire East JSNA homepage
1b	Birmingham JSNA summary	13b	Cheshire East Community JSNA
1c	Birmingham asset mapping case studies	13c	Cheshire East Community JSNA Mental Health (includes mapping)
1d	Birmingham asset mapping conceptual framework	14a	Cheshire West and Chester JSNA homepage
1e	Birmingham HWBB asset based approach	15a	Halton JSNA homepage
2a	Blackburn with Darwen ISNA home page	15b	Halton JSNA Summary
2b	Blackburn with Darwen ISNA story	16a	Lancashire JSNA homepage
2c	Blackburn with Darwen CYP EWB summary	16b	Lancashire JSNA Health Inequalities Report
2d	Blackburn with Darwen locality stories	16c	Lancashire JSNA Annual Commentary 2014
3a	Cumbria JSNA home page	16d	Lancashire JSNA Assets
3b	Cumbria JSNA overview and introduction	17a	Newham JSNA homepage
4a	Gateshead JSNA home page (plus issue/ group specific sections)	17b	Newham JSNA 2012
5a	Knowsley JSNA home page (plus topic specific sections)	18a	Nottingham JSNA homepage
5b	Knowsley JSNA background info	18b	Nottingham JSNA Wellbeing section
6a	Liverpool JSNA home page	19a	Portsmouth JSNA Homepage
6b	Liverpool JSNA statement of need	19b	Portsmouth JSNA Summary
7a	Manchester JSNA home page	20a	Richmond JSNA Homepage
7b	Manchester About the JSNA and other sections	20b	Richmond JSNA – The Richmond Story
8a	Salford JSNA home page	21a	South Staffordshire JSNA Homepage
8b	Salford neighbourhood asset profiles	21b	South Staffordshire Enhanced JSNA
9a	Wakefield JSNA homepage	21c	South Staffs E-JSNA Customer Insight- Getting to know our residents
9b	Wakefield topic based needs assessments	21d	South Staffordshire E-JSNA – Assets in South Staffordshire
9c	Wakefield sub-district profiles	22a	West Sussex JSNA Homepage
10a	Stockport JSNA home page	22b	West Sussex summary 2014
10b	Stockport JSNA key summary & topic based needs assessments	23a	Westminster JSNA Homepage
10c	Stockport At a Glance summaries	23b	Westminster JSNA background
11a	Newcastle ('Know Newcastle') home page and Know your City sections	24a	Bristol JSNA homepage
11b	Newcastle Know Your City – What people are living with (includes MH)	24b	Bristol JSNA 2015
11c	Newcastle report on developing Future Needs Assessment	25a	Hull JSNA homepage
12a	Cambridgeshire JSNA home page	25b	Hull JSNA 2016
12b	Cambridgeshire JSNA summary report	25c	Social Capital JSNA Hull Atlas
12c	Cambridgeshire What is the JSNA		
12d	Cambridgeshire JSNA overview		

Appendix 2

Example of an Outcomes Based Accountability (OBA) template used to support population or place based outcomes in Kirklees

OUTCOME 1: *A condition of well-being for people in a place…*

Turning the Curve Report Card
Population Accountability

POPULATION: *e.g. adults, school-aged children, disabled people, carers*

HEADLINE INDICATORS *Measures that help quantify the achievement of an outcome*

Heartening indicators:
*Choose **heartening** (positive, asset/ strength-based) indicators that have high…*
*… **communication power** (common sense and compelling);*
*… **proxy power** (say something important about the outcome and bring along the data herd);*
*… **data power** (quality data available on a timely basis).*

Troublesome indicators:
*Choose **troublesome** (negative, needs/ deficit-based) indicators that have high…*
*… **communication power** (common sense and compelling);*
*… **proxy power** (say something important about the outcome and bring along the data herd);*
*… **data power** (quality data available on a timely basis).*

Data development agenda:
- *Do you have everything you need to understand the story behind the headlines?*
- *Do you have sufficient evidence of 'the problem' ?*
- *Is there a genuine intelligence gap?*
- *Have you asked the right questions/ looked in the right places?*
- *Do you need more/ better data to inform your indicators?*

**Do you have evidence of 'what works'?*

STORY BEHIND THE BASELINES:
- *What's going on here?*
- *What is our 'curve to turn'?*
- *What are the key inequalities?*
- *What do we know from national/ local intelligence insight and community 'voice'?*
- *What are our target populations, segments?*

WHAT ARE WE GOING TO DO* TO MAKE THINGS BETTER AND WHO CAN HELP US?
- *Is our plan specific enough? How much **difference** will it make? Is it consistent with our personal and community values? Is it **feasible** and **affordable**?*
- *What is the **workforce development** agenda?*
- *Does our stakeholder map need reviewing? Who are the key influencers on our target audience?*

HOW ARE WE DOING?
- *Report on the above indicators at appropriate intervals*
- *Are you turning the curve?*
- *Have you responded to the data and workforce development agendas?*
- *Are you keeping an eye on emerging new intelligence, evidence and partners?*