Well London
A Community Level Asset Based Approach to Health and Wellbeing: :

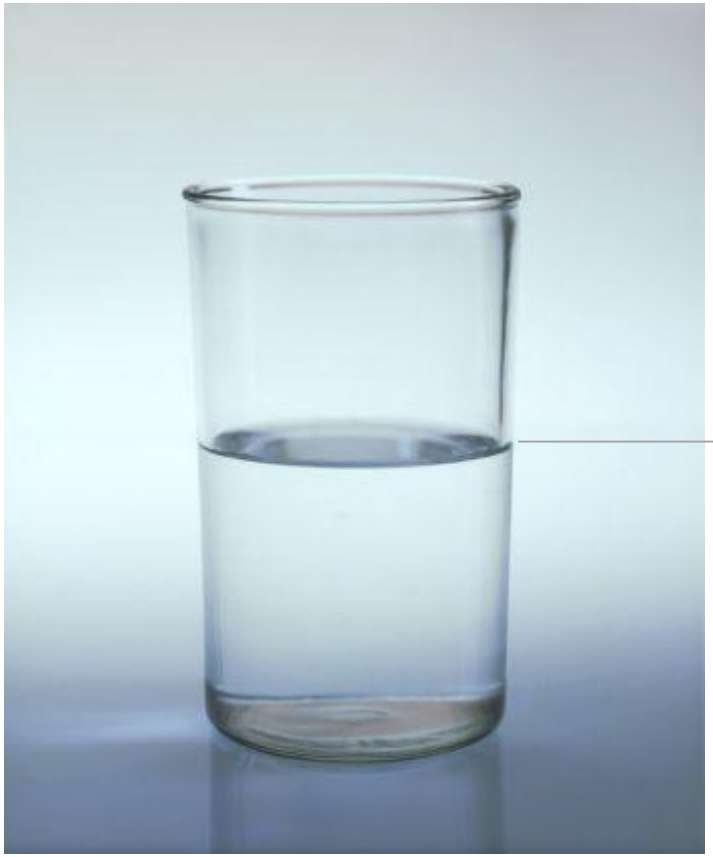
Adrian Renton.

Director Institute for Health and Human Development

Rapid Growth of Interest in “Salutogenesis” and Asset based approaches

- IDEA 2010: Glass half full
- Scotland CMO reports 2009-2012 assets and salutogenesis
- All over NICE public health guidance: Anthony Morgan ed “Health Assets in a Global Context”
- Marmot
- Fits with Big Society/Shrinking Public Sector
- Public Health in Local Authorities and HWB Boards carrying out Asset based JSNAs or JSAAs
- Strategic Health Asset Planning and Evaluation (DH)

A glass half full



UEL University of East London

What is an Asset based approach ?

In essence:

Asset based working seeing service users or communities as having assets as well as needs and therefore being part of the solution to overcoming the needs.

1. Identify the total system of things which can positively influence health and wellbeing

2. Co-produce the organisation of these into an efficient production system for health and wellbeing

What is an Asset based approach ?

Needs and Assets

Asset based approach defined in distinction to Needs based approach in same way that in 1980s Public health defined Needs in distinction to Demands

Deficit/needs approach

- Focuses on needs and deficiencies
- Understands communities by their problems
- Services commissioned to fill gaps and fix problems
- Dependency on professionals
- Individuals/communities passive recipients

Assets approach

- Values skills, knowledge, connections, capacity & potentials of communities
- Positive, aspirational
- What works well
- Active participation in solutions
- Co-production in health & wellbeing

What is an Asset based approach ?

Asset Classes for Health and Wellbeing

Capital	Definition
Financial	Financial capital plays an important role in the economy, enabling other types of capital to be owned and traded
Built	Fixed assets which facilitate the livelihood or well-being of the community
Social	Features of social organisation such as networks, norms of trust that facilitate co-operation for mutual benefit, includes a sub-set of spiritual capital (that form of social capital that links to religion/ spirituality) Bonding, bridging social capital
Human	People's health, knowledge, skills and motivation. Enhancing human capital can be achieved through education and training
Natural	Landscape and any stock or flow of energy and material that produces goods and services. Resources – renewable and non-renewable materials.
Cultural	Shaping how we see the world, what we take for granted and what we value
Political	The ability of a community to influence the distribution and use of resources

So the approach is to

- Identify existing assets (mapping)
- Identify missing assets
- Maintain, enhance, develop assets
- Create/produce assets
- Release and realise assets.
- Co-production of system for their use

UEL University of East London

What would be different ?

Greater emphasis on:

- Investing in strategies that develop the capacity of local communities
- Reducing/blurring distinction between producers and consumers of services, by reconfiguring the ways in which services are developed and delivered
- Allowing public service agencies to become catalysts and facilitators rather than simply providers and use NHS Assets more creatively
- Devolving real responsibility, leadership and authority to citizens and communities, and encouraging self-organisation rather than direction from above
- Using peer networks instead of just professionals as the means of transferring knowledge and capabilities
- Providing opportunities for personal growth and development so that individuals are treated as assets, not burdens

Why are community level interventions important ?

1. In the face of environmental limits to growth and global redistribution of production, there is an imperative to foster communities as empowered, social production processes for wellbeing, by bringing together under- and unused assets - intellectual and creative resources, social networks, time, green and built space - in new ways.

2. Communities and the social, economic, political built and natural environments they comprise **are** the wider determinants of health and wellbeing

3. They provide the networks, settings and systems for the social production of health and wellbeing (the *core economies)* as well as barriers and supports for individual consumption behaviours :

UEL University of East London

How Community Level Interventions work

Old way of seeing

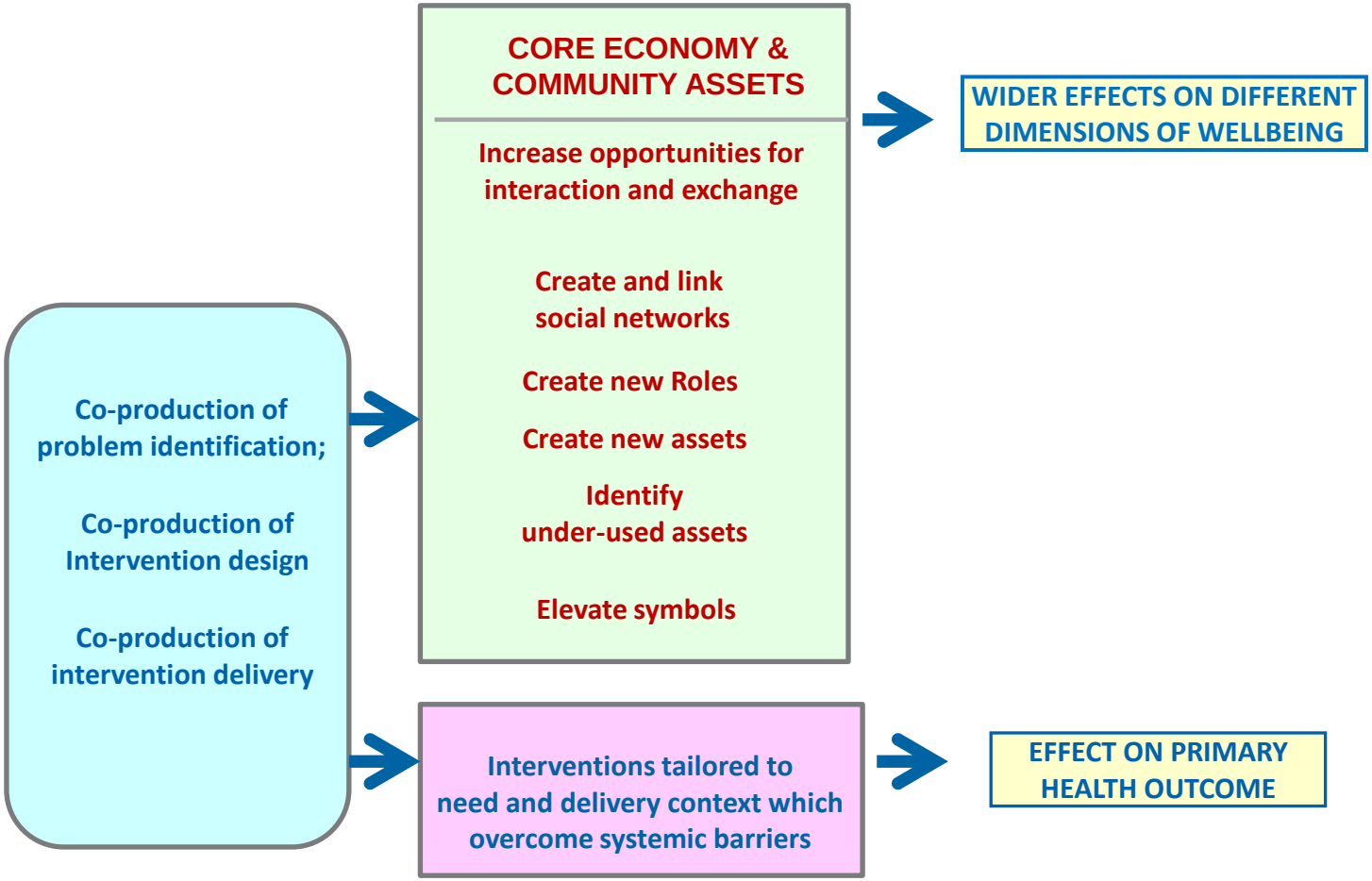
- Communities seen as simple aggregates of individuals: *Population Health Paradigm*
- Community-level interventions seen as acting on large numbers of individuals and delivering effects which are the simple aggregate of individual level effects.

New way of seeing.

- Communities seen as dynamic systems of inter-relationships, networks and assets operating as complex *core* economies for the production of health and wellbeing.
- Community level interventions seen as delivering changes to the ways in which these systems/economies function as well as shifting aggregated individual behavioural norms.

UEL University of East London

How Community Level Interventions work (Health Example)



UEL University of East London

Well London (www.welllondon.org)

- Well London is a continuously developing framework for working with disadvantaged neighbourhoods to improve health and well-being.

- Well London is now in its second phase of development and new strategic partnerships and plans for scaling up in a 3rd phase are being established as part of the development pipeline for the framework.

The Well London Approach

Aim : Improve determinants of chronic disease risk (healthy eating and healthy weight, healthy physical activity) and mental health and wellbeing.

- Work at local level - 20 of most deprived communities: circa £100k per community for 4 years using asset based community development at core.
- Building confidence, self esteem, knowledge and skills in *individuals*
- Community engagement, *co-production*, *co-creation*
- Building and growing social and support *networks*
- *Peer to peer* approaches
- *Collaborative, networked* approach to delivery
- adding value to local work
- Improving local *environments*
- Research and evaluation

UEL University of East London

Portfolio of projects

Heart of the Community:

Key to sustainability

- CADBE (*Community Assessment, Design, Brokerage, Enterprise)*
- Well London Delivery Teams
- Youth.com
- Active Living Map
- Training Communities
- Wellnet

Themed:

- Activate London
- BuyWell
- EatWell
- Changing Minds
- DIY Happiness
- Mental Wellbeing Impact Assessment
- Healthy Spaces
- Be Creative Be Well

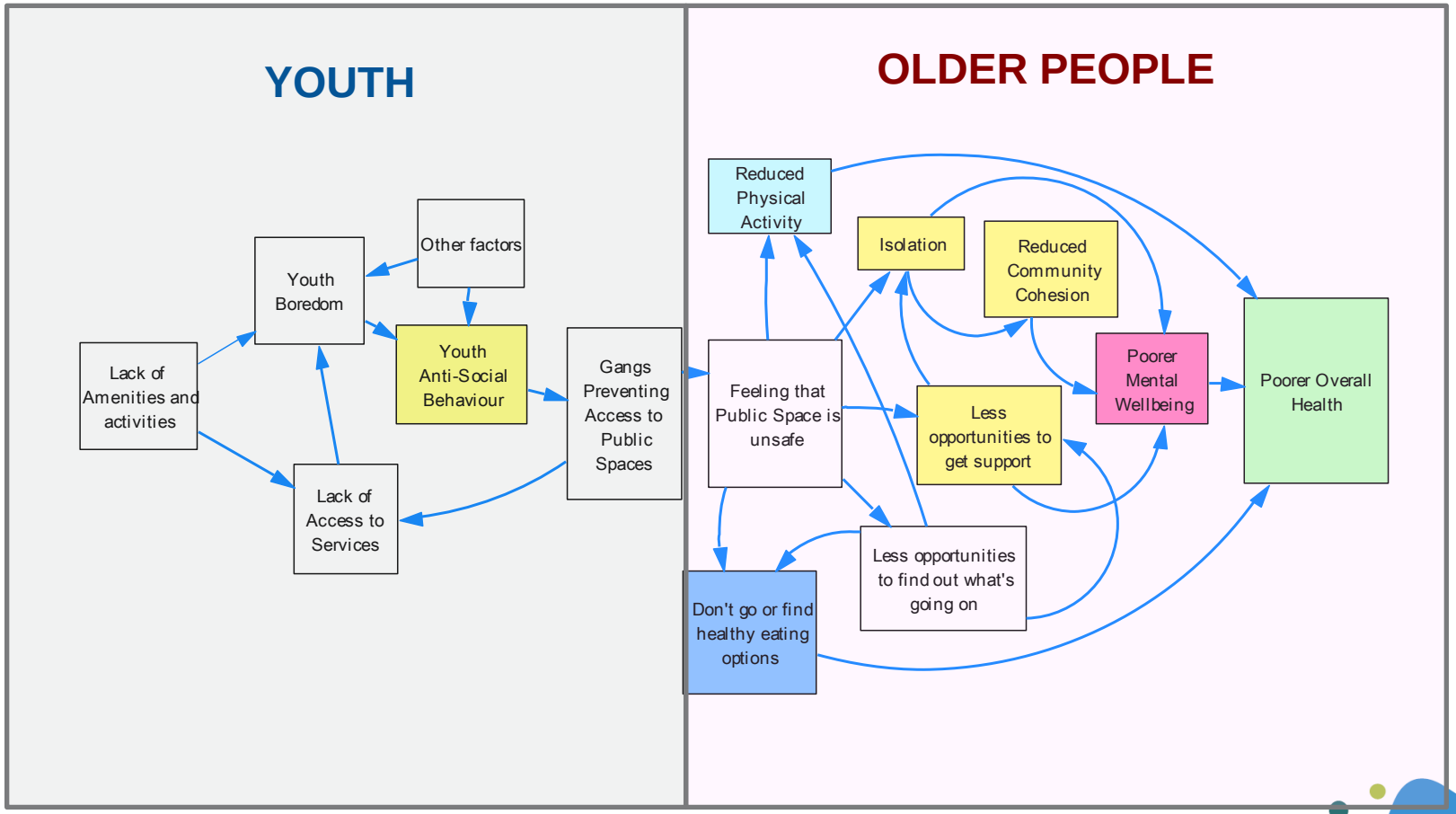
UEL University of East London

Why use community development approach to health improvement

1. Healthy / unhealthy lifestyles often cluster together. Working across the spectrum is CE
2. Local social, economic, physical and cultural environments provide strong barriers or supports for change across a range of health behaviours – wider determinants
3. Need to transform the environments and communities themselves. Set out to build networks and structures of mutual support by helping people organise around common issues which affect their lives.

Well London – interactions and mechanisms

Many examples of complex interactions between domains



Response

What Well London did:

1. Bring young people and old people together through local activities, festivals, projects

2. Work together to develop solutions

Result

Young people become fiercely defensive of “their” older people” there area and help and support them.

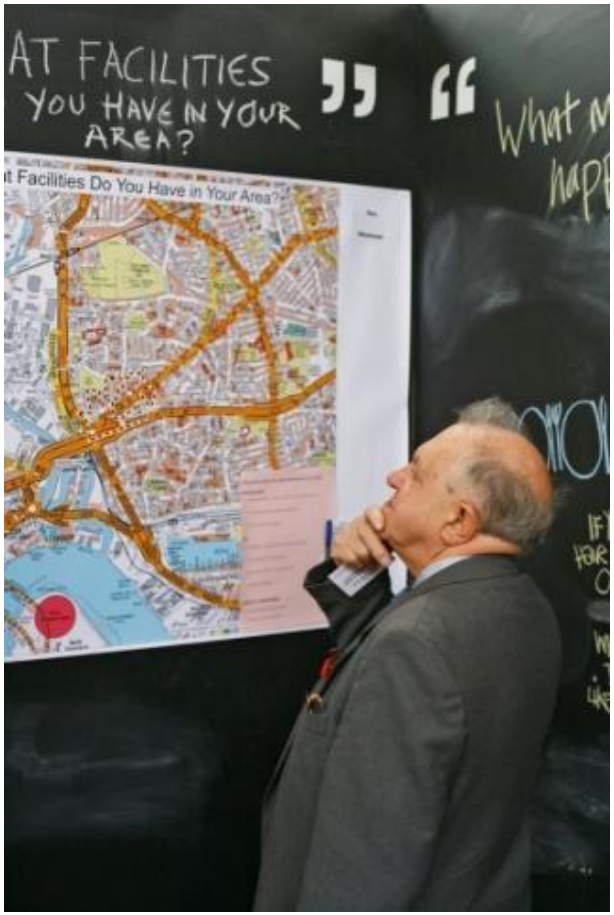
Well London phase 1 evaluation findings (Oct 2007 – March 2011)

- Well London phase 1 evaluation findings (Oct 2007 – March 2011) have now been published and brought together in a synthetic report and considered impact at individual 'participant' level, project level, programme level, community level and whole population wide level.
- There was strong qualitative and some quantitative evidence of important positive impacts for local people who participated directly in the programme activities on a range of health and well-being indicators
- There were also promising findings relating to impact at project, programme and community levels.
- There was little evidence of significant positive impact at the whole population level in phase 1, except for significant positive findings relating to reductions in unhealthy eating and people in the neighbourhood pulling together more (one of the social cohesion measures).
- However areas where there were higher levels of exposure to the intervention showed some significantly better outcomes at the wider population level.

UEL University of East London

A Fundamental Challenge for Innovation in Prevention

- Seen as *soft end* in health
- Usually introduced rapidly and piecemeal
- Little development work / piloting work funded
- Never delivered at scale (space and time)
- Evaluation *post hoc* and inadequately funded
- No infrastructure for evaluation built into delivery agencies



- National Institute for Health Research spends £1bn per year. Around 50% on infrastructure for biomedical research.
- UK Pharmaceutical industry spends £4.5bn per year (about 50% on development of drugs and 50% on clinical testing. These costs are recovered through IP convention protected price based recovery.
- NIHR spends circa £20m (2%) on prevention research (all), < £2m per year on community-level intervention research. Very little on infrastructure for prevention / community level research or on intervention development. No model for cost recovery.

UEL University of East London

Economics of Evidence

UK Private R&D Spend 2008 by sector

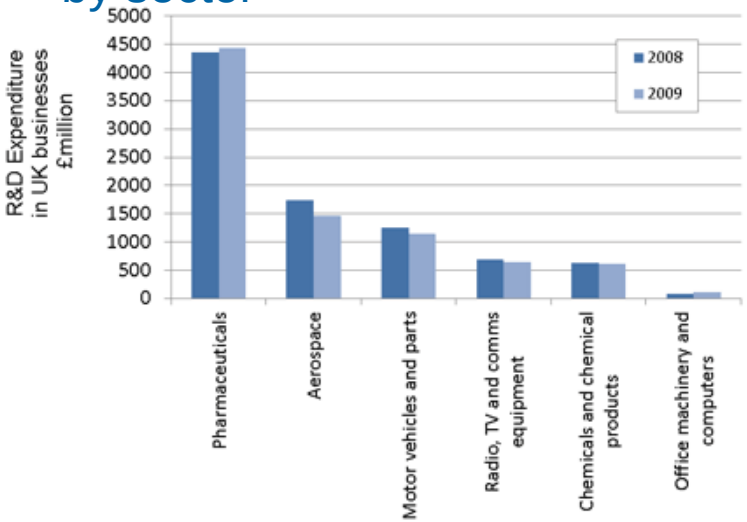
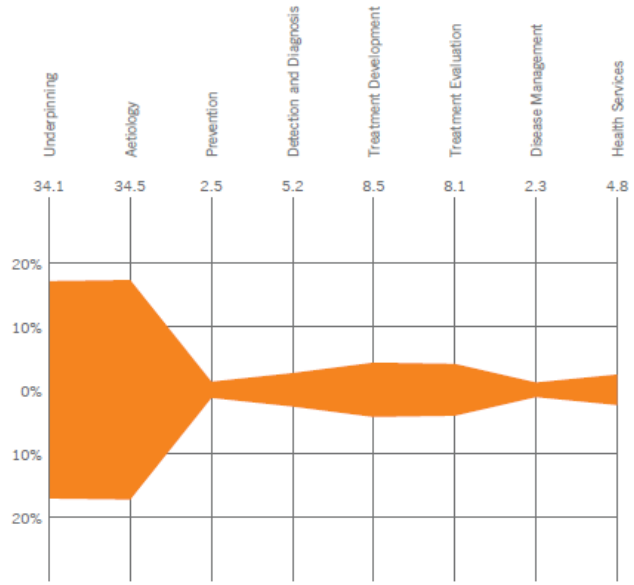


Table 2 | **Estimates of the component costs of drug development**

Component	Pre-approval costs: US $ million (%)	
	Boston Consulting Group (2001)[1]	DiMasi *et al.* (2003)[2]
Biology	370 (42%)	–
Chemistry	160 (18%)	–
Preclinical safety	90 (10%)	–
Overall preclinical	620 (70%)	335 (42%)
Clinical	260 (30%)	467 (58%)
Total	880 (100%)	802 (100%)

UK Public Sector Health R&D Spend 2004/5 by sector by research type (of £950m)

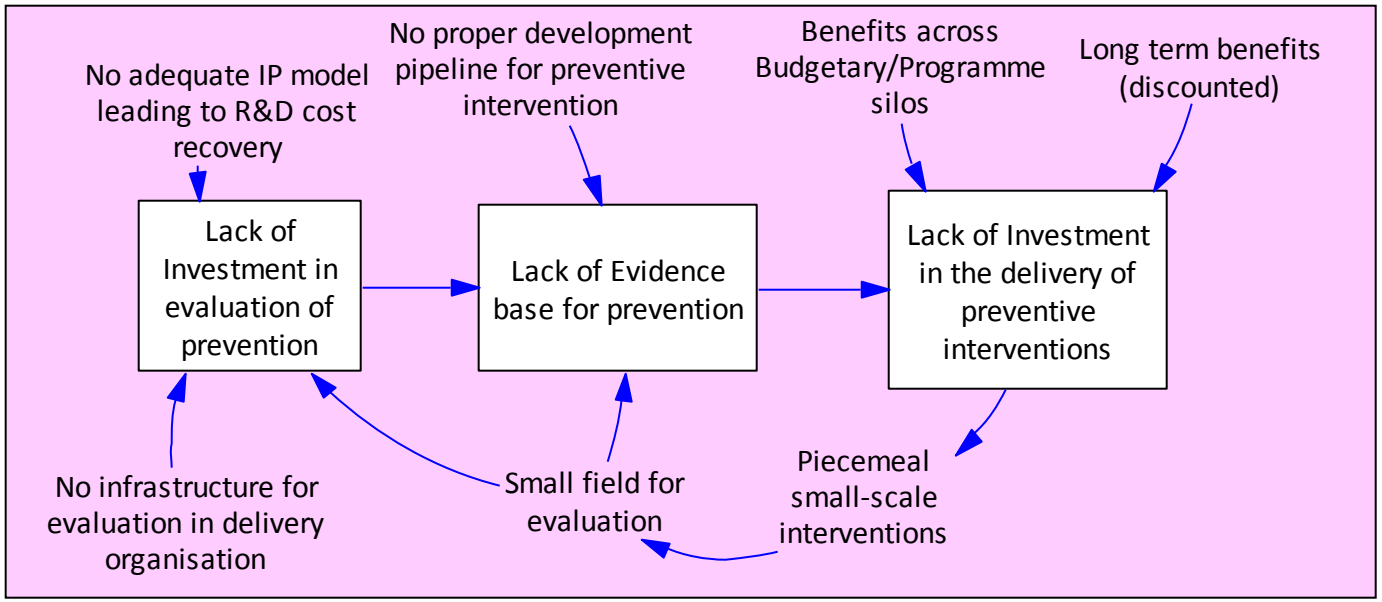
Figure 2 Proportion of Combined Total Spend by Research Activity – Kite Diagram



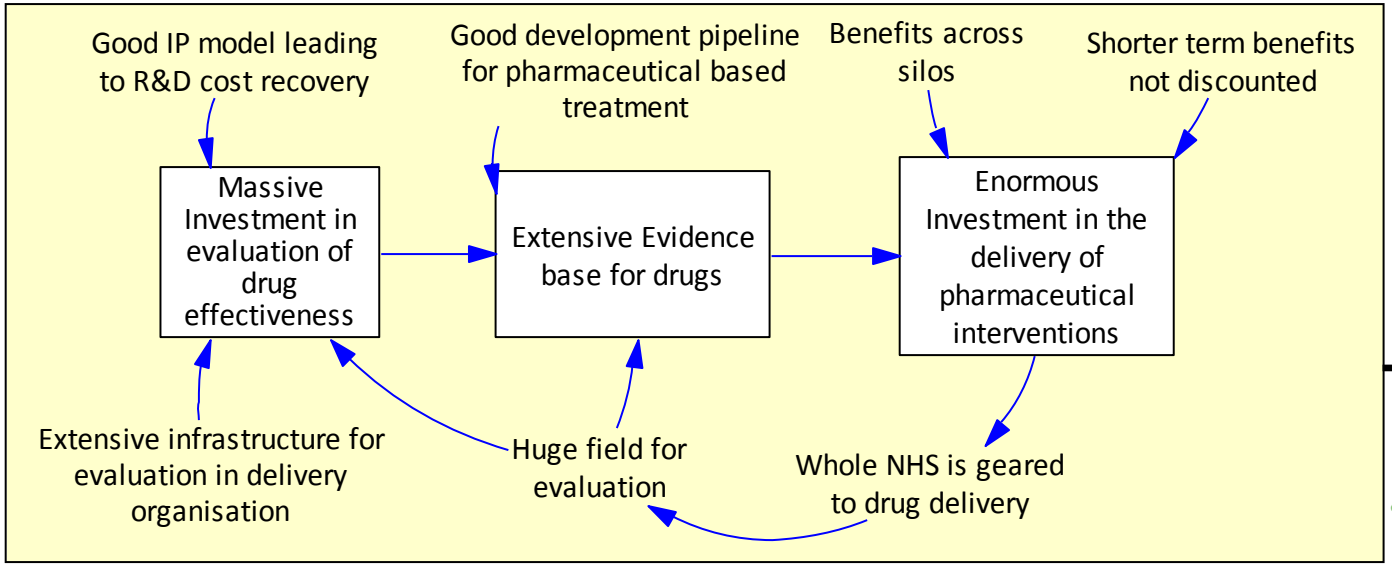
Data excludes R&D support for NHS providers funded by the UK Health Departments, core support costs (e.g. for the Wellcome Trust Sanger Institute) and research taking place outside the UK.

UEL University of East London

Prevention Model



Pharma Model



Massive Imbalances in Health System driven by IP, and NIHR Investment choices

UEL University of East London

Challenges for Asset based working

- we know how to map assets but we don't know much about but how to organise these assets into a lean health and wellbeing production system
- Culture in NHS commissioning structures
- Evidence
- the whole field is almost free of any economic theory or analysis despite the term *"asset"* being primarily economic
- how does asset based approach transform across different scales – estate/town/city/region

A solution to our problems ?

- Part of a solution. Still need deficit/needs approach alongside
- Making better, more intelligent use of our assets must make sense in current economic circumstances.
- But getting it right needs serious investment in innovation, research/evaluation and development. Where is this coming from ?