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3. Partnering and transformation: how to capture systemic change?

Title

Social Prescribing, Assets and Relationships in Communities (SPARC): Co-producing a Social Model of Wellbeing

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Abstract

This position paper sets out the core aims, principles and insights of the Social Prescribing, Assets and Relationships in Communities (SPARC) Network. The SPARC Network offers a collaborative learning space focused on social prescribing (SP), a health care innovation that has been widely adopted across the UK and abroad to address the wider determinants of health by referring people to community-based activities. SP is promoted as a pathway to addressing health inequalities post-pandemic and transforming health and social care systems towards a social model of wellbeing. However, little attention has been paid to how to co-produce SP in partnership with communities and transform underlying system dynamics. We advance our understanding by synthesising practice-based and academic evidence and literature on SP, place-based health and wellbeing inequalities, community co-production, evaluation and asset-based working. We argue that asset-based approaches to SP can enable local communities to coproduce better health and wellbeing outcomes and systems change by creating a shared practice of partnership working and joint inquiry and learning driven by community assets and needs. We present our asset-based action research approach to creating conditions for SP stakeholders to build relationships, shared ownership, and pathways for systems change towards a social model of wellbeing.

Keywords: social prescribing, health and wellbeing, pandemic, action research, asset-based working, collaboration, community power, evaluation, systems change

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Introduction

This position paper sets out the core aims, principles and insights of the Social Prescribing, Assets and Relationships in Communities (SPARC) Network. The SPARC Network is a cross-institutional initiative of academic partners from the University of Birmingham, Bangor University, and the University of Strathclyde and practice partners from The Active Wellbeing Society (TAWS) Birmingham, Wirral ABCD Network, and Gwent Public Health. It developed out of our shared interest in social prescribing (SP), a health care innovation that has been widely adopted across the UK and abroad to address the wider determinants of health by referring people to community-based activities. We were particularly interested in developing our understanding of the changing relationships between individuals, voluntary and community organisations (VCOs), local authorities and NHS as a result of SP, and whether these changes were moving towards the aspired transformation of health and social care systems. Most SP research focuses on evaluating the impact of SP on individual health and its cost-effectiveness for health and social care providers, with less attention paid to its relational nature and transformative dynamics. Since October 2018, we have conducted a scoping study, organised partnership-building workshops, made grant applications, held virtual meetings, and produced an annotated bibliography¹ that have crystallised our focus on asset-based approaches to SP, addressing health inequalities, and coproducing a social model of wellbeing.

SP is a key trend in policy and practice across the UK. The idea is that GPs and other health care professionals 'prescribe' patients to social, cultural, environmental, or economic community-based activities that help to address medical and non-medical issues, including mental health problems, isolation, and deprivation (South 2015; LGA 2016) (Buck and Ewbank 2020). Although varied, most schemes have three key components: referral from a healthcare professional, consultation with 'link workers', and engagement in community-based activities organised by VCOs. While it has been hailed as a welcome intervention to reduce pressure on over-burdened and under-resourced health and social care providers, policy frameworks promote SP as a pathway to transforming health and social care systems that is grounded in a medical model focused on individual health and responsibility towards a new, 'social model of wellbeing' (Welsh Government, 2017; NASP, 2020; Department of Health and Social Care, 2021). SP creates "a new relationship between people, professionals and the health and care system" (NHS England, 2019, 9) through which they can co-produce holistic, person-centred care and share responsibilities for community wellbeing (The King's Fund 2017).

However, SP faces fundamental challenges in implementing and sustaining a social model of wellbeing. While there is a paucity of knowledge about the ways in which SP is enacted and its system dynamics (see Fixsen et al., 2020 for an exception), we know from existing literature on co-production (including partnership working and community engagement), evaluation and systems change in health and wellbeing that it will face a range of structural barriers that will need to be addressed to render SP effective, sustainable and transformative. A fundamental issue is that the medical model underpinning health and social care systems maintains a dominant focus on individual health and responsibility that inhibits systems change to co-producing wellbeing in partnership with communities driven by their assets and needs. The pandemic has highlighted both the urgent need to address the UK's alarming place-based health inequalities and that pandemic responses have been more effective where local authorities and voluntary and community organisations (VCOs) collaborated based on a place-based model driven by community assets and needs. Therefore, we believe that this is an opportune time to explore how stakeholders in SP can co-produce better health and wellbeing outcomes and achieve systems change.

We have adopted Asset-Based Community Development (ABCD) as a conceptual lens to integrate our academic knowledge about community co-production with the approaches to SP that the practice partners have adopted in their respective contexts. ABCD focuses on the assets and strengths, rather than the deficits, of local people and places to create well-connected communities and mobilise them to address structural inequalities (McKnight & Kretzmann, 1993). Each practice partner has adopted an asset-based

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approach in highly disadvantaged communities with some of the highest wellbeing inequalities and Covid-19 impacts in the UK.

- Blaenavon is a relatively small rural area in South Wales. Over the past five years, integrated care and community development has been promoted by Neighbourhood Care Networks (GP Cluster groups), 13 GP surgeries and Torfaen County Borough Council, in liaison with Blaenau Gwent Public Service Board. The newly built Blaenavon Resource Centre offers a public space where link workers and co-located public services can support individuals in addressing the fundamental barriers that hinder their health, wellbeing, and resilience. In addition, the growing 'Healthy Blaenavon' social movement is engaging communities in conversations about health and wellbeing, promoting activity, inclusion, and connection.
- Birmingham is a large city in the West-Midlands of very diverse communities. TAWS has developed an innovative asset-based approach to SP that tackles health inequalities, social division, and isolation through place-making and mobilising urban green space. TAWS is a Community Benefit Society that aims to improve public access to physical and social activities and to enhance active citizenship, autonomy, and capacity of communities. They work closely with Birmingham City Council, health partners (including Birmingham and Solihull CCG, Saheli Hub, GP practices) and community organisations to engage the most deprived and diverse communities in the city who would otherwise not access traditional services.
- The Wirral is a suburban area in Liverpool City Region including some of the most deprived and richest wards in the UK, with a shocking 12-year difference in life expectancy. Over the past decade, Wirral Council, Wirral CCG and Cheshire and Wirral Partnership NHS Foundation Trust have supported the development of an 'ABCD Network' to rebuild collaborative relations and enable asset-based change in disempowered communities. Its 'Community of Practice' meetings include 30+ representatives from community, faith, health, third sector and public service organisations. This has enabled, amongst others, the creation of eighteen Community Connector roles (Involve Northwest) and four Link Worker roles (Citizens Advice Bureau) as well as a community activist organisation (Community Voice).

Despite demonstrable positive impact, our practice partners continue to face considerable relational complexities and transformative challenges. These range from frail and tense relationships between community groups and local authorities, to evaluation and communication of the impact of an asset-based approach to local partners without having to change its mission to suit funding criteria or adopt distorting performance measures.

The SPARC Network aims to be a space for its core partners and wider partners to share experiences, knowledge, and developments, identify opportunities for collaboration, research and change, and engage in ongoing relationship-building and learning. The purpose of this position paper is to lay the foundations for our approach to transitioning to a social model of wellbeing and more sustainable and less unequal health and social care. We are guided by the following questions:

How can asset-based approaches to social prescribing enable local communities to coproduce better health and wellbeing outcomes and transformative and sustainable change?

1. How can asset-based approaches to SP support mutually beneficial and sustainable collaborative relationships between individuals, civil society, and public bodies?
2. How can asset-based approaches to SP strengthen communities' capacities and resources for pursuing collective wellbeing and empowerment?
3. How can devolved governance systems of policy, funding, and commissioning evaluate and support asset-based approaches to SP?
4. How can stakeholders sustain and spread a new social model of wellbeing?

We seek to advance understanding of these questions by synthesising practice-based and academic evidence and literature on SP, place-based health and wellbeing inequalities, evaluation, community co-production and asset-based working. We do so based on recent efforts to combine our resources and literature into a single refined database, currently totalling 302 items. This content includes academic publications, policy and practice reports, best practice guidance, and newspaper articles. We have grouped the items into themes reflecting the above questions and reviewed the content in each grouping, focusing in particular on items that were deemed most relevant to our project – the number of 'starred items'

(N=91) per grouping are indicated in brackets: action research (n=4), asset-based approaches (n=14), collaboration (n=14), community empowerment (n=16), evaluation (n=11), social prescribing (n=16), and systems change (n=16). These items were then extracted and developed into an annotated bibliography with notes, highlights, and key take-aways identified before summaries were created for each theme.

The paper will outline the key contributions, limitations, and opportunities for our asset-based action research approach. We have developed this approach based on three key insights that emerged from the annotated bibliography. First, we observe a notable discrepancy between, on the one hand, growing interest in asset-based and place-based partnership working on health and wellbeing and, on the other hand, a lack of commitment to alternative values and visions that translates into transformative change. Second, we identify three conditions for SP to enable local communities to coproduce better health and wellbeing outcomes and transformative change: a community-driven disposition, a shared practice of partnership working, and joint inquiry and learning through action research. Third, we argue that action research offers an alternative foundation for implementing and sustaining SP that overcomes narrow conceptualisations of evidence, collaboration and power that inhibit systems change. The paper first turns to a discussion of SP and its transformative aspirations for a social model of wellbeing in the context of wider interest in asset- and place-based policy and practice as well as the impacts of the pandemic. Next, we consider the key challenges associated with implementing and sustaining SP, focusing on, respectively, collaboration and community empowerment (or: community co-production) and evaluation. This leads us into an outline of the asset-based action research approach we propose for future research and practice. Finally, we set out our key aims and next steps moving forward.

Social prescribing: towards a social model of wellbeing?

With over 100 initiatives across the UK, SP is now part of policies, strategies and legislation at multiple levels of governance. While interest in SP has increased in the last decade, several localised schemes date back to the 1990s and some even earlier (e.g., the Bromley by Bow Centre which was founded in 1984). Some notable milestones in the emergence of SP include the White Paper 'Our health, our care, our say' (2006), the NHS's Five Year Forward View (2014), the General Practice Forward View (2016) and the creation of the National Academy for Social Prescribing (2020). Interest extends beyond the NHS, with a breadth of independent funding bodies, large third sector organisations, and smaller localised initiatives having developed programmes and/or undertaken research into its viability and impact (Nesta 2013; Dayson and Bashir 2014; LCVS 2015; NASP 2020).

SP is conceived as a key approach to advancing an alternative, 'social model of wellbeing', in which emphasis is placed on preventative practice, the wider determinants of health, patient-centred care, increased service integration, service delivery by third sector and voluntary organisations and reducing pressure on General Practitioners (GPs) and the NHS more generally. It is intended to overcome the limitations of the medical model "founded, organised, and influenced by extreme mind-body dualism" (Kemp and Fisher 2022, p.2) or the materialistic monism of defining 'health' as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO 2022) The contradictions and limitations emergent from these two perspectives underscore the utility of more holistic conceptions of health and wellbeing that embrace an "interactive dualism" (Kemp and Fisher 2022, p.2) and recognise the complex and dynamic interactions between individual wellbeing (micro), community wellbeing (meso) and wider determinants (macro) (Ungar & Theron, 2021). Individual wellbeing includes "objective circumstances, individual attributes, behaviours, functioning, thoughts, or feelings" (Kudrna et al. 2022, p.8), while community wellbeing concerns social, economic, environmental, cultural, or political conditions and dynamics within a given community – be the community place-based, workplaces, educational institutions, or virtual. Echoing Kemp and Fisher's (2022) position of interactive dualism, Atkinson (2021) highlights the 'toxic' risks associated with the dominant 'hyper-individualised' model of health and wellbeing, suggesting "a more wholesome tonic" (p.1) may be found in relational approaches that integrate individual and collective approaches.

SP must be understood as part of wider and longstanding policy agenda focused on asset- and place-based partnership working both in health policy and practice as a primary approach for community-driven collaboration, empowerment, and systems change across the UK (NHS Health Scotland 2016; NIDH 2016; NHS England 2019). Place-based approaches are grounded in the understanding that the health and wellbeing challenges we are contending with are, by their nature, rooted in people, place and circumstance, meaning a model cannot just be taken from one area and simply rolled out in another – transformative and sustainable solutions are necessarily place-based. Health-in-place partnerships were common to UK urban policy pre-pandemic (Judge and Bauld 2006; LGA 2016; PHE 2018) and interest has continued to intensify post-pandemic (McGowan et al. 2021; Pollard et al. 2021; Kudrna et al. 2022). Asset-based working focuses on the assets and strengths present in communities in order to ensure sustainable development and ongoing agency. It continues to capture interest across both policy and practice as a means of focusing on strengths, capacities, and resources rather than deficits and needs, enabling people to identify, strengthen and build on their assets, and engendering system-wide commitment to community-driven collaboration (DHSC 2019; Foot 2020; TLAP 2021). Asset-based and place-based approaches are framed as more transformative models for SP compared to those with a narrow health care delivery focus (Dayson 2017; Dayson et al. 2021).

However, the apparent policy commitment to alternative values and visions does not seem to translate into systems change locally (Chapman 2004; Cretu 2020; Leach 2021). SP faces fundamental challenges in adopting and sustaining a social model of wellbeing. The medical model underpinning health and social care systems maintains a dominant focus on individual health and responsibility that inhibits systems change to co-producing health and wellbeing in partnership with communities driven by their assets and needs (Atkinson 2021). There are underlying tensions between transformative ambitions and a discourse of individualising health and wellbeing, a tendency to reduce health to healthcare, and rationalist assumptions about knowledge, evidence, and engagement (Polley et al. 2017; Fixsen et al. 2020). If these underlying tensions are not recognised and addressed, SP is unlikely to reduce health inequalities and transform relationships towards a social model of wellbeing (Kemp and Fisher 2022).

For instance, due to the relatively recent introduction of SP, limited resourcing, and methodological challenges (Husk et al. 2019), its positive impacts are difficult to capture and prove beyond mostly descriptive statistics and largely anecdotal stories. SP tends to take the form of 'pilots' of "community-based services that complement traditional medical interventions" (Dayson et al. 2013, p.4), which carry the burden to prove their effectiveness and sustainability in competitive struggles for funding and support. Pollard et al. (2021) call this an "evidence paradox", which traps innovative, community-driven initiatives because "they are required to demonstrate their efficacy according to measures not set up to recognise their value" (PP). The future of these pilots therefore remains uncertain and seems unlikely to pave the way for the aspired transformative change in health care systems.

In addition, asset-based approaches to SP continue to face fundamental criticism about the risk for neoliberal co-optation with respect to its being used as a means of furthering individualisation and the privatisation of healthcare systems and the social safety net (Alevizou et al. 2016; de Andrade and Angelova 2020; Duggal et al. 2021). Further risks include asset-based approaches to health risks reinforcing inequality (Friedli 2009; MacLeod and Emejulu 2014), as it may focus on the 'soft assets' (e.g., social networks, skills, and confidence) of individuals and "mask the retreat of the state and the public authorities from responsibilities" (Daly and Westwood 2018). Moreover, there are no examples of asset-based approaches that have managed to resolve structural inequalities in health and wellbeing or transform organisational cultures and professional roles. In a highly competitive funding environment, civil society organisations seeking to fund a clear and effective model to SP can be driven to target communities with already well-developed assets to demonstrate its effectiveness (Taylor 2011). Even where front-line staff may be very supportive of SP, further barriers arise from many community development staff considering the public sector more of a problem than a solution to inequality, and a lack of buy-in by commissioners who are not in touch with local communities (Loeffler and Bovaird 2019).

While the pandemic might have driven SP out of the limelight as the key development in health and wellbeing, it seems to have created new opportunities for advancing SP as a means of addressing health

inequalities through place-based collaboration. First and foremost, the pandemic has painfully reinforced longstanding evidence that the UK's alarming wellbeing inequalities are geographically patterned (Marmot et al. 2020 (Eckersley 2015; Davenport et al. 2020)). Rising levels of social isolation, mental ill-health and vulnerability are predicted to form a significant pandemic legacy (Wallace et al. 2021). Likewise, it has exposed failures in statutory health and social care infrastructures, with local authorities shouldering the burden of ongoing budget shortfalls (Nesta 2020) and disproportionate declines in third sector funding and community assets in the UK's poorest communities (Local Trust 2019; Gilchrist and Taylor 2020; Marmot et al. 2020; Blundell et al. 2021). Addressing health inequalities in connection to these wider political-economic inequalities requires place-based collaboration with communities and VCO in response to local assets and needs (Hambleton 2020).

Indeed, early studies of pandemic responses provide overwhelming evidence that responses have been more effective when local authorities and VCOs collaborated based on a place-based model driven by community assets and needs (Bynner et al. 2021; Dayson et al. 2021; Havers et al. 2021; Macmillan 2021; Moscibrodzki et al. 2021; Paine et al. 2021; Thiery et al. 2021; Wilson et al. 2021). VCOs were widely found to play an essential role based on their unique capacities for responding to specific community needs and assets. Significant differences in the effectiveness and sustainability of these responses were found to "rest on the extent to which community-led infrastructure has been built through investment and support" (McCabe et al. 2020, p.21). Collaborative and mutually supportive relationships between communities, VCOs, local authorities and NHS were crucial to their ability to tailor resources in flexible and creative ways in response to what specific local people and places needed and had to offer.

Hence, the pandemic has created a new context of addressing place-based inequalities, the effectiveness of community-driven and co-produced responses, and the need for ongoing joint learning and change (Cretu 2020). It has given us insight into how innovative approaches to collaboration around wellbeing work and can be effective and begs further action research that explores and sustains these in ways that heal relationships, break systemic patterns, and builds sustainable and resilient ecosystems (McKinley et al. 2020; Involve 2020; Cepiku et al. 2021). Such work could feed into the development of wellbeing 'ecosystems' – i.e., complex environments of a multiplicity of actors, relationships and institutions that support innovation (Domanski et al. 2020) – of communities, VCOs, local authorities and NHS characterised by community-driven collaboration, joint inquiry, and responsive institutional resources.

Yet, despite the fleeting glimmers of possibility for a system-wide 'rethink', it remains debatable whether and how SP might lead to transformative change. A sustained challenge is that the evidence-base for the effectiveness of SP for improving health and addressing health inequalities remains contested and a stronger theoretical underpinning is urgently needed (see Bickerdike et al. 2017; Drinkwater et al. 2019; Husk et al. 2019; Stevenson et al. 2019). The next sections consider the structural challenges that emerge when implementing and sustaining SP in more depth in order to advance a more robust conceptual perspective on how asset-based approaches to SP can enable local communities to coproduce better health and wellbeing outcomes and transformative and sustainable change. By focusing on, respectively, co-producing SP through inter-organisational collaboration and community empowerment, and evaluating SP in ways that can capture and transform the complex dynamics between people, place, and wellbeing, we build our case for adopting an asset-based action research approach that overcomes narrow conceptualisations of evidence, collaboration and power engrained in the dominant medical model.

Co-producing SP

Co-production is a key element of SP (The King's Fund 2017) and fundamental to the social model of wellbeing it aspires. However, developing, implementing and sustaining co-production with individual service users and communities in partnership between VCOs, local authorities and NHS faces a range of inherent challenges. Based on the Four Co's model (Loeffler 2021a), this section explains what we mean by co-production and identify the need to address the complex issues and relational dynamics of place-based health partnerships while moving to community co-production as the central challenge. This will provide stakeholders involved in SP a wider range of roles to make use of the full potential of co-production.

Co-production is at the heart of SP. As a Guide to SP by the University of Westminster (Polley et al. 2017, 13) says, SP can be defined as

a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e., 'co-produce' their 'social prescription'- so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary, community and social enterprise sector.

In other words, SP involves the co-design of a personalised care pathway based on asset-mapping by a link worker or other public service professional (NHS England, 2019). This view of co-production follows the statutory guidance of the Care Act 2014: "Co-production is when you as an individual influence the support and services you receive, or when groups of people get together to influence the way that services are designed, commissioned and delivered". This limited perspective reduces co-production to citizen voice and does not take into account the full range of activities included under the label of user and community co-production (Loeffler and Martin 2016, 302).

While many SP approaches focus primarily on signposting individual users to social activities via social workers, a number of SP approaches take a dedicated community-oriented stance. For example, Local Area Coordination Networks in the UK involve community involvement from the outset – community members even recruit their own Local Area Coordinator to ensure ownership and trust relationships (Sinclair, 2019). This requires a wider definition of co-production which goes beyond the above medical model of user co-design of a non-medical prescription, to include co-design of the system and co-delivery of outcomes (Cepiku et al. 2021). Such a wider definition would be closer to the ambitions of the Integrated Care Act (HM Government, 2021) and in line with widespread commitment to place-based health partnerships that include and are driven by local people and places (South, 2015; LGA, 2016; PHE, 2019; NHS Confederation, 2020; Walker et al., 2020).

Therefore, we adopt a popular definition, developed by one of the authors of this paper, of co-production as "public service organisations and citizens making better use of each other's assets, resources and contributions to achieve better outcomes or improved efficiency" (Loeffler 2021a, 27). By 'public outcomes' we mean not only individual and collective quality-of-life outcomes, such as increased physical and mental health of individuals and individual and collective wellbeing, but also the achievement of key public governance principles, such as social inclusion. Our definition of co-production is asset-based and includes both citizen voice and citizen action. Furthermore, it does not limit co-production to the direct interaction of service users with health services (or other public services) but also accepts that co-production in public health often focusses on preventative activities by individuals and communities, e.g., those which may be triggered by community members acting as role models after receiving training by public services, such as the "Falls Ambassadors" in Aberdeen City. These are community members who had taken part in falls prevention training in the past – these volunteers in turn will then keep the work going by identifying other groups in the community and co-delivering similar sessions (Thompson and McConnachie 2019).

We use the Four Co's framework to demonstrate how user and community co-production may involve both citizen voice and citizen action. This highlights the range of different roles for citizens, as service users and community members, to contribute to reducing health inequities through user and community co-production. According to Bovaird and Loeffler (2013, 5), they include:

- Co-commissioning of outcomes – citizens know best what matters to them.
- Co-design of improved pathways to outcomes – citizens know things professionals do not know.
- Co-delivery of pathways to outcomes – Citizens have capabilities, skills, time and resources to improve public services and public outcomes and can promote behaviour change of other citizens
- Co-assessment of public services, quality-of-life outcomes and governance principles – Citizens often know better than professionals whether a new pathway works for them.

The SPARC Network is particularly interested in SP approaches which pursue a social model of wellbeing by not only focusing on one 'Co' but providing a range of different roles for communities, based on their

assets and needs. While some community members may like to have a say in commissioning boards or the design of services bespoke to their needs, others may prefer to provide some hands-on support through co-delivery of services to fellow citizens, e.g., through peer support. Throughout these different forms of co-producing SP, it is key that it is community-driven rather than institution-led; i.e., “based on the principle that communities have a wealth of knowledge, skills and assets which mean they are well placed to identify and respond to any challenges that they face, and to thrive” (Pollard et al., 2021, PP; see also TLAP, 2016; Locality, 2018, 2020; McKinley et al., 2020).

What we are suggesting here is that co-producing SP is a form of social innovation (Moscibrodzki et al., 2021). Social innovations are new ways of thinking, acting and organising that address unmet societal needs and transform the relationships and values that underpin existing governance systems (Moulaert et al., 2013; Bartels, 2017). Co-producing SP provides a transformative approach to effectively address the needs of disadvantaged communities in ways that distribute power more equally and inclusively across stakeholders (Evert and Ewers 2021). An example is the co-design of a Mental Health and Money toolkit by experts by profession and experts through lived experience. As Hannah Lewis (2020), the project manager, says:

by involving the end-users of the resource in the co-design process we are more likely to develop a product which can effectively meet the needs of both the people using primary care services and the healthcare workers supporting them – leading to people more effectively managing their mental health and financial wellbeing.

These kind of co-production initiatives are clearly a welcome development, yet it is crucial to understand whether it is underpinned by an institution-led or community-driven approach. The former risks placing the focus primarily on more effective service delivery and shifting responsibilities onto individuals to manage their own health and wellbeing better. Instead, the latter is guided by the need to be responsive to the assets and needs of communities and considers how to transform system dynamics that have created the problem that is being addressed in the first place.

The SPARC Network aims at providing a collaborative learning space to enable community co-commissioning and co-design of new services, products or networks, as well as community co-delivery and co-assessment with the eventual aim of re-commissioning existing health and wellbeing services to make these social innovations both effective and sustainable.

Developing, implementing and sustaining new co-production approaches involves several inherent challenges. Drawing on the conceptual framework of barriers to co-production developed by Loeffler (2021, 251), we can distinguish between barriers from service user characteristics, community characteristics, organisational barriers and barriers from the wider context. Given our asset-based approach, we are particularly interested in opportunities and barriers around community co-production. While we believe communities have a wealth of assets, relationships, knowledge and skills to respond to challenges they face and engage in co-production, we also stress the importance of not making any a priori assumptions about the willingness and the ability to co-produce, especially in the case of disadvantaged groups (Loeffler 2021, 254-257). Barriers related to the willingness to co-produce may involve a low perception of the capabilities of one’s own community, lack of self-efficacy or a negative perception of service providers. Barriers to the ability of communities to co-produce may arise from a lack of co-production opportunities. For SP, the most significant barriers may arise from community relationships, including a lack of social connectedness, a lack of active membership in community organisations, a lack of trust within communities and low trust on the part of communities in working with professionals in public services.

The co-production literature points out multiple organisational barriers (Loeffler 2021, 257-259). Interagency collaboration in health and wellbeing, and SP more specifically, tends to face similar issues as partnership working more generally (Fixsen et al., 2020; Johnson et al., 2018; Potluka et al., 2021; Smith & Skivington, 2016; Judge & Bauld, 2006), including the centrality and fragility of relationships, poor communication, silo-working, bureaucratic procedures, the need for both cognitive and emotional buy-in, inadequate evaluation mechanisms, and limited capacity to deliver change and transform systems. Yet, distinct factors to consider include the complexities of adopting a ‘holistic’ approach to health inequalities

and wider determinants of health, the complex and precarious nature of engagement with VCOs, and the temporal impact of the pandemic on the nature and extent of collaboration. For SP, we especially believe that low levels of trust of staff in the capabilities of communities and risk aversion in public sector organisations are likely to be important barriers. Co-production with disadvantaged groups may be perceived to be too risky as this could involve reputational damage for the accountable politicians and service managers. The question is how inter-organisational partnership working could engage several organisations in joint learning and experimentation with new forms of community co-production within SP. This will require a dynamic perspective with a focus on the development of relationships between organisations and people.

Evaluating SP

SP has proven popular with healthcare commissioners, local authorities and VCOs alike because of its practical benefits, holistic approach to the determinants of health, co-designed, personalised services, its integrated and targeted approach to fostering social inclusion and connection, and its potential for cost savings in health and social care services (Drinkwater et al 2019). However, the measurement and monitoring of these benefits of SP are not well-served by traditional clinical data, such as hospital admissions or local authority health data. Many competing primary outcomes measures exist, including mental, subjective or personal wellbeing, health behaviour, anxiety or depression, (subjective) loneliness, (objective) level of social isolation, connectedness, belonging, health related quality of life, or capabilities. Systematic reviews have thus far failed to identify rigorous and standardised evidence for the effectiveness of SP across a range of outcome measures (Bickerdike et al 2021; Costa et al 2021; Reinhardt et al 2021; Vidovic et al 2021), and the longer-term impacts and cost-effectiveness of SP are not yet known.

The personal and community benefits of SP behave us to adopt novel forms of evaluation. Community and individual wellbeing are distinct but interdependent potential outcomes for SP. Yet, evaluation of public health interventions traditionally takes place at an individual or population level. For instance, we might refer to national figures of life expectancy, or the impacts of participation in a smoking cessation programme on a specific person. SP demands a novel appreciation of the dynamic interaction between community and individual wellbeing because it seeks to intervene in the social life and relationships of individuals in their community contexts, or indeed to assess community strengths, infrastructures and assets as manifest in individual experiences. It also asks for working with the fuzzy, complex and multi-dimensional nature of the concept of 'community' in any given spatial area or connoting a particular social or interest group. Finally, it requires identifying how SP outcomes are entwined with place-based health inequalities, which may have a wide range of social, economic and political determinants. New conceptual models and definitions of community are therefore useful in thinking through the noted challenges of evaluating SP, and crucially to identify potential drivers of wellbeing inequalities.

Evaluation on the basis of outcomes for individuals or aggregate populations can miss out on important factors at the level of community and place-person interactions. Key potential outcomes for individuals (mental wellbeing, subjective wellbeing, quality of life) can be associated simultaneously yet in different ways with the characteristics of individuals (demographic variables, sociability - individuals who report talking to neighbours, perceptions of civic pride) as well as with the characteristics of areas (sociability - proportion of people in an area who report talking to neighbours) (p37). For instance, in a recent review, Kudrna et al. (2022: 14-16) found that community participation was correlated with better subjective (community and individual) wellbeing, such that group differences in participation could exacerbate inequalities. They also found that belonging, cohesion, social support, collective control and social networks provided key links between objective community wellbeing (e.g., neighbourhood disadvantage) and individual subjective wellbeing (e.g., community pride) (p15), and that while community boundaries could be fluid and permeable, there could be 'wellbeing spill overs' for groups who are networked with individuals involved in interventions (p16). This confirms established findings that objective variables known to affect subjective wellbeing (e.g., an individual's income, unemployment) can have differential effects depending on the circumstances of those around them. Appreciation of the complex, interactive nature of wellbeing has long been the position of health geographers who have advanced a relational perspective on place, space and health (e.g., Cummins et al 2007; Atkinson 2013; Winterton 2014). In a relational perspective,

public health research “should avoid the false dualism of context and composition by recognising that there is a mutually reinforcing and reciprocal relationship between people and place” (Cummins et al 2007: p?). This is all the more important because the success of SP as a place-based approach to addressing ill-health will depend on its ability to avoid the missteps of longstanding efforts at area-based interventions. As McGowan et al. (2021) highlight, area-based interventions have rarely evaluated impacts on health inequalities. While their extensive review of evidence from 2008-2020 indicated the value of a range of physical, social and economic interventions on health (e.g. housing/home modifications, improving the public realm, parks and playgrounds, supermarkets, transport, cycle lanes, walking routes, and outdoor gyms) (p?), they also warn that targeted interventions which require active behavioural change may in fact increase health inequalities if they are not aimed at addressing the appropriate scale of disadvantage (p?).

Assessments of the overall evidence base for SP suggest there are some clear gaps in understanding the interplay of community and individual health and wellbeing outcomes, the pathways between reducing isolation and improving health, and the possibilities for transformative change in public health provision. It has been noted that evaluations of SP should seek to measure programme effectiveness in terms of systemic and community levels of change (Vidovic et al. 2021: p3) and that the mechanism for improved individual, public health and resilience is that people with higher wellbeing have more capacity, confidence and autonomy in shaping and ‘owning’ their own health care (but cf. responsibilisation). Vidovic et al. (2021:p3) argue that trust, connectedness and social capital are key drivers of community health, community self-help and health service cost savings. One of the few studies to examine the mechanisms between SP, social connectedness and wellbeing – the ‘Social Cure’ perspective – found that participation in social groups could shape social identities and thus mediate the psychological resourcefulness of individuals – giving people feelings of trust, belonging, meaning and purpose, social support through transitions in life and coping with stress (Wakefield et al 2020: 386). Furthermore, the quality of relationships between service delivery agencies, commissioners, healthcare, voluntary and community sector organisations, link workers and patients, and the systems level relationships are rarely evaluated (Polley et al. 2017; Vidovic et al. 2021). Given the stated importance of the quality of relationships as a founding principal of SP, understanding these relationships and the distribution of responsibilities and resources between actors in the SP system are an important set of issues to be assessed.

Alternative perspectives on public health have begun to emerge over the past decade or so which set out to address these issues, frequently building on expertise in community development. Alongside relational concepts of place, ‘relational health’ has developed a distinctive account informed by complexity theory of health as a complex system, in which interventions cannot be evaluated on the basis of inputs and outcomes. Durie and Wyatt (2013: 184) propose focussing on ‘non-linear relationality’ to understand the dynamics of systems change, to account for: “how emergent new relations enable the creation and exploration of ‘adjacent possibles’ which can in turn lead to outcomes that are disproportionate relative to their ‘input’”. Understanding the “sectoral conditions” (Vidovic et al. 2021: p18) and impacts of partnerships are key to this approach, which have been relatively neglected (LGA 2016). These approaches point to another set of issues around governance which are rarely evaluated in SP intervention research. Our proposition arising from this alternative worldview is therefore to approach evaluation through a relational, complexity-oriented and action research lens. Before we turn to our asset-based action research approach in the next section, we first consider a range of other approaches underpinned by similar assumptions.

Realist evaluation methods have proved increasingly popular in medical research to shed light on the potential for systemic change in complex social interventions. This methodology aims to understand why and how an intervention may work in a particular context, time, set of stakeholders. It involves a combination of theoretical development and empirical evidence to ascertain “what is it about this programme that works for whom in what circumstances?” (Pawson et al. 2005, p22). Thus, we would propose that SP evaluations should aim to identify both the mechanisms and contexts that influence how, where and with whom a programme of activities works. This will involve a mixed methods approach involving qualitative interviewing, documentary analysis and observational data across multiple agencies and within communities. This will be useful in tracking the ‘spread’ of a new approach, and to build a theory

of change for the programme. A key point of enquiry is to investigate the necessary competences, characteristics and resources required of institutions, individuals, and groups to ensure tractability and potential longevity of the programme. Existing literature on how to sustain cultural change in complex health organisations is useful here, including: alignment of vision and action, incremental change within a transformative strategy, distributed leadership, staff engagement, collaborative relationships, and collective learning (Willis et al. 2016). Mason et al. (2021) have employed this approach to investigate how Local Area Coordination works for specific people in specific contexts, using Q-method (a ranking exercise) and interviews to discern the key factors needed to make this form of health governance work. And as Cawston's (2011:350) account of how GPs have viewed SP in deprived contexts affirms, this evaluative approach does not shy away from critique of the wider political context in which people are asked to take responsibility for their own health and GP's concerns about their apparent refashioning as "gatekeepers for social resources" in the context of wider declines in state welfare and voluntary services.

A second key aspect of evaluation arising from the relational worldview is developmental or formative process evaluation. While RCTs are aimed at standardisation across contexts, as Durie and Wyatt (2013:184) argue, developmental evaluation is more useful to examine the effectiveness of community health interventions in specific contexts and in which outcomes may not be pre-defined but emergent. They argue that because relational health programmes seek new kinds of more equitable relationships with communities and patients, the aims and findings of research and evaluation should also be co-produced. This can be achieved by regular feedback sessions, input from communities on interim findings and can inform ongoing programme planning and processes. This diverges from the idea of 'piloting', evaluating, and rolling out a health intervention, and instead is based on continually tailoring, improving and sharing ownership with communities. These 'live' evaluation methods can support decision-makers, provide opportunities for learning, and enable adaptations to be made to interventions as necessary, and are opposed to the pursuit of neat, technical solutions. For some this connotes a fundamental shift in understanding the nature of the public to be targeted through public health. Rather than see the public as a barrier to intervention or something to be changed, the term 'healthy publics' has been proposed as a way to acknowledge "the public struggles that are involved in raising health issues, questioning what counts as healthy and unhealthy and assembling the evidence and experience to change practices and outcomes" (Hinchliffe et al. 2018, p?). This novel conception of health aims to be transformative, aware of structural constraints and sensitive to people's ongoing struggles. It calls for "public experiments in building and repairing social and material relations are staged and sustained even if, and especially when, the fates of those publics remain fragile and buffeted by competing and often more powerful public formations."

Established methods of critical systems analysis such as 'boundary critique' to explore the remit of local and systems needs, 'problem mapping' to identify how problems interact, and 'viable systems modelling' to design practical interagency solutions inform this approach (Nicholas et al 2019; Sydelko et al 2021). This can involve participatory co-design workshops across different service departments, alongside community members and community and voluntary sector leaders and intermediaries. Their purpose is often to shift away from delivery and towards a more participatory model of systems intervention and critical reflective practice. Through ethnographic observations and interviews, relationships, decision-making processes, and practices of governance can be brought into the purview of evaluation, helping to identify what matters to individuals involved and what can be changed in terms of current practices or underlying systems. Such evaluation can productively acknowledge power and conflict, the distribution of responsibility and leadership, identify barriers and pressures, and establish a shared sense of purpose and meaning of the SP programme (Fixsen et al. 2020). One example used extensive interviews, observations, and case studies to examine the accountability relationships within 8 Clinical Commissioning Groups, finding conflicting agendas between accountability and autonomy, as well as deficits in how sanctions were applied (Checkland et al. 2013). Another study of the Rotherham SP pilot in North-East England used process evaluation to better understand the core role played by SP co-ordinators, building in regular steering groups to foster action learning and to "respond flexibly to the needs of patients, carers and provider organisations" (Dayson et al. 2013: 3).

Asset-based action research

The challenges we have identified with implementing and sustaining SP reveal that a fundamental shift is needed in how public health and research are understood and practiced. We need to move away from the medical model underpinned by rationalist conceptions of evidence, a narrow focus on individual health, and an apolitical stance to structural inequalities in power and responsibilities. Transitioning to a social model of wellbeing means adopting a relational worldview that understands SP in terms of complex adaptive systems of relationships between interdependent actors, communities and place, and the emergent properties of their dynamic interactions. Concretely, this means co-producing and evaluating SP in a way that creates conditions for health and wellbeing by facilitating joint inquiry into and experiments with building and repairing social and material relations and breaking through systemic patterns that inhibit transformative change (Cropper et al., 2007; Hinchliffe et al., 2018; Kemp & Fisher, 2022). This is what our asset-based action research approach aims to facilitate.

More than a methodology, action research is an established approach to social science research and professional practice grounded in alternative assumptions than conventional approaches (Greenwood & Levin, 2007; Ledwith & Springett, 2010; Bartels & Wittmayer, 2018). It offers a robust and comprehensive framework to guide collaborative inquiry, learning and change in the pursuit of democracy, social justice, and sustainability. Stakeholders and academic researchers collaboratively define problems to address, design and implement the research, and generate ways of relating, acting, and thinking that effectively address the identified problems and transform underpinning system dynamics. Key principles of action research are to create conditions in which all legitimate stakeholders can participate in iterative, self-reflective, and critical cycles of inquiry and action in ways that transform their situation and (power) relationships. In health and wellbeing, action research has been widely adopted to improve health care provision in collaboration with service users (Waterman et al., 2001; Koshy et al., 2011). However, there is a need to extend previous action research addressing health inequalities and pursuing a social model of wellbeing through partnership working with communities (Cropper et al., 2007).

Action research includes a diverse family of approaches, which are combined in response to the challenges, dynamics, and context it addresses and issues that emerge. Based on our diagnosis of SP above and our shared expertise, we have developed an asset-based approach that merges action research approaches with Asset-Based Community Development (ABCD). ABCD was developed in the USA in the 1980s to empower communities facing hardship and structural inequalities (McKnight & Kretzmann 1993; Mathie & Cunningham, 2005; Block, 2008). It counters the deficit-model of community engagement by collaborating with and empowering communities based on the assets, relationships and needs of local people and places. It aims to promote collective action and ownership of local assets by mapping hidden strengths and assets, building local capacities, transforming relationships, and anchoring institutional resources. Due to their shared normative roots in community empowerment, action research and ABCD have often been integrated to identify and strengthen local assets in ways that address community concerns and pursue systems change (Ledwith & Springett, 2010; Alevizou et al., 2016; Ward, 2019; de Andrade & Angelova, 2020; Taliep et al., 2020). Key ingredients of asset-based approaches to action research are:

- a shared commitment to community-driven collaboration and change;
- inclusion of community groups is at the heart of the process;
- asset mapping;
- a common vision of what interventions will achieve and how;
- ongoing engagement with those in positions of power and resource;
- inter-organisational collaboration that positively addresses anxieties and resistances; and
- ongoing joint evaluation, learning and adaptation, including attention to power dynamics.

Our asset-based action research approach aims to sustain SP and transition to a social model of wellbeing by creating conditions in which stakeholders can engage in joint inquiry, practically address health inequalities, and transform systems dynamics. Our guiding theory is that stakeholders need to establish a *shared practice driven by community assets and needs*. As we have shown, all too often, partnership working and community engagement around health fails because it is driven by policy agendas, organisational structures, professional assumptions, and fragmented networks. The result is that much

time, energy and resources is lost on poor communication, while mutual trust and relationships are damaged, community wellbeing deteriorates, and systemic patterns become ever- more engrained. We therefore propose to build Communities of Practice (CoP) in which communities are placed at the heart of joint learning about how to reshape SP around local assets, relationships, and needs, create collaborative and empowering relationships, and evaluate and communicate the impacts of SP interventions on community wellbeing. A CoP is an experiential learning system in which participants critically examine their diverse experiences and change their relationships to create a 'shared practice' that can transform system dynamics (Wenger, 1998; Agranoff, 2008; Bartels, 2018; Woodcock, 2022). Through this shared way of relating, acting, and thinking, stakeholders develop effective practices for dealing with emergent challenges and underlying system dynamics.

The notion CoP was originally developed in the field of organisation studies to counter the conventional idea of learning as an individual process of accumulating and applying knowledge with the view that learning is a social process that takes place in the process of participating in a practice (Wenger, 1998). It is increasingly finding traction as an approach to situations where multiple stakeholders need to collaborate in networks to address a complex problem (Agranoff, 2008; Bartels, 2018; Woodcock, 2022). For such networks to collaborate effectively, they need to build relational capital and a shared vision by developing a self-organising, or non-hierarchical, practice of mutual learning and change. The system needs to be (re)designed around their everyday practices and the challenges that emerge around, for instance, complex organisational procedures, lacking communication between services, or insufficient managerial support for new ways of working. Developing a CoP builds relationships (mutual understanding, trust, commitment), shared ownership (joint vision of the problem, solutions and how to collaborate), and pathways for transformative change (awareness of and interventions into complex interdependencies, diverging perspectives and relational patterns). Following our asset-based approach, we aim to ensure that all these the elements of the CoP are driven by community assets and needs.

"[T]he development [of] communities of practice can be seen as a central component of action research" (Coghlan & Brydon-Miller, 2014, 135). We draw in particular on four approaches to inform our asset-based approach to "co-developing transformative action through relational processes of ... jointly experiencing and critically assessing the situation at hand and considering it ... as a 'reality in process' open to transformation" (Bartels & Wittmayer, 2018, 7). First, we follow Participatory Action Research (Freire, 2000) in placing communities at the heart of the process and creating conditions in which they can understand, extend, and exercise the powers they already possess to transform the issues they face. Going beyond a dichotomous understanding of power, we will engage in inclusive dialogue to co-create critical awareness and spaces for transformation (Ledwith & Springett, 2010). Second, we rely on Pragmatic Action Research (Greenwood & Levin, 2007) to construct 'arenas for dialogue' in which stakeholders engage in ongoing inquiry, visioning, and action planning. We will enable stakeholders to devise a form of joint practice through which they can develop joint understanding of the complexity and uncertainty of situations of mutual concern, their diverging perspectives on these, and their mutual interdependencies for developing workable solutions (West et al., 2019). Third, we extend this process with Systemic Action Research (Burns, 2014) by conducting 'multiple parallel inquiries' that focus attention on underlying system dynamics and pathways for moving a more sustainable system. We will conduct a 'future search' that brings the 'whole system in the room' (Janoff & Weisbord, 2006) to articulate a shared vision on how to move from the system 'as it is' to 'how it could be' (Allan et al., 2021). Finally, we draw on Participatory Evaluation (Guba & Lincoln, 1989) by including the lived experiences and interpretations of diverse stakeholders to come to an understanding of the situation at hand and evaluate the impact of our co-produced interventions. We will engage in 'whole system outside the room' activities to engage with people in local places where they experience community wellbeing (Bartels, 2018).

In concrete terms, in future research, we plan to facilitate CoPs in learning from the other cases, mapping assets, future visioning, experimenting with a local asset-based SP initiative, evaluating, and communicating impact, and leveraging institutional resources and support. In in each case site, we aim to identify 10-15 people in local communities to create a CoP together with existing practice partners in monthly reflective meetings to co-produce the following activities:

1. *Mapping assets.* We will conduct and thematically analyse qualitative interviews and observations and assess any previous asset-mapping. We will also explore the potential of digital technologies to facilitate asset-mapping and identify the 'hidden' assets of 'invisible' citizens through creative ways to meet marginalised groups 'where they are'.
2. *Future visioning.* Based on our asset-mapping, we will organise a future search event to co-produce a future vision and formulate key goals and action plans. We will facilitate participants in identifying their shared values, mutual relationships, individual capacities, community assets, and physical, economic, and environmental resources. The outcome will be a visual roadmap for a joint change process that strengthens relationships, commitment and clarity of purpose and roles.
3. *Leveraging institutional resources and support.* Using the co-produced asset map, vision and action plans, we will negotiate commitment and resources with local, regional and national policy-makers and pioneering individuals and community organisations. This will enable us to facilitate trans-local relationships and trajectories of learning and change. A key limitation of the conventional approach to dissemination and learning from 'local' cases as the final phase of a research project is that it is challenging to create conditions in which wider stakeholders will actually engage in structural transformations of the system. Therefore, we will involve these stakeholders from early on in exploring change as part of the wider system and reconfiguring underlying system dynamics.
4. *Mobilising assets.* Following the future search roadmap, we will experiment with developing a local SP initiative. In this intensive action phase of 100 days, the iterative learning process will be based on small-scale action to sustain momentum and commitment.
5. *Evaluating impact:* After the 100 days experimentation phase, we will analyse lessons learned and assess impact on shared responsibilities and wellbeing. Using established wellbeing and place-based evaluation approaches, we will co-design survey instruments to combine quantification of the impact on attitudes and behaviours of stakeholders with qualitative narratives of what wellbeing means locally and how it has been changing. Through face-to-face questionnaires and interactions with community members and staff at different levels we will identify areas of success, failure and conflicting results, and feed into debates on appropriate remedial action.
6. *Sustaining innovation:* Based on our experiments and impact evaluation, we will meet again with our wider stakeholders to consolidate our learning and change trajectories. This will enable us to identify future pathways for transitioning to a social model of wellbeing and negotiate ways to continue the CoPs and change process after the formal conclusion of the research project.

In addition, we will organise *three cross-case study meetings*. We will bring representatives from the case studies, the academic researchers, Advisory Board members and Network Partners (Social Prescribing Network, Wales Social Prescribing Research Network, Wales Institute of Social & Economic Research, Data & Methods, Local Government Association) together to engage in structured reflection, training and discussion of lessons and models for wider dissemination. Meeting 1 (pre-asset mapping) will focus on operationalising the research design, strengthening relationships, and sharing ambitions. Meeting 2 (pre-asset mobilising) will focus on comparing findings and experiences, sharing plans, and reflecting on emergent issues. Meeting 3 (post-sustaining innovation) will launch the final project reports and focus on sustaining its impacts post-project.

Aims and next steps

In this position paper, we have argued that SP is unlikely to live up to its transformative ambitions without better understanding of how a social model of wellbeing might actually work and what is required for transitioning to it. The pandemic has demonstrated that collaboratively reducing health inequalities and co-producing community wellbeing is no longer just an option and is not simply a matter of bolting new ways of working onto business as usual. It has given us "insight into the bigger question of how and why the wider system had historically become a landscape of silos, guarding resources and 'interrogation of need'" (Cox, 2020) ill-equipped to respond to complex and interconnected challenges of wellbeing. Transitioning to a social model of wellbeing will involve healing fractured relationships, breaking systemic patterns and building sustainable wellbeing ecosystems (Cropper et al. 2007; Cox, 2020, Cretu, 2020). This asks for transformative change based on alternative underpinning assumptions that overcome narrow conceptualisations of evidence, collaboration and power engrained in the dominant medical model.

We have outlined how our asset-based action research approach makes a fundamental shift to co-producing health and wellbeing with stakeholders. It offers a framework for research and practice focused on creating a shared practice driven by community assets and needs. We propose to develop Communities

of Practice that build relationships, shared ownership, and pathways for transformative change towards a social model of wellbeing. By taking this approach, we aspire to foster three conditions – a community-driven disposition, a shared practice of partnership working, and joint inquiry and learning – through which we believe asset-based approaches to SP can enable local communities to coproduce better health and wellbeing outcomes and transformative change.

By articulating our approach in this position paper, we have strengthened the foundations of the SPARC Network for us to move forward with fostering relationships, learning and collaboration between academic and practice partners interested in SP, asset-based working, health inequalities, and a social model of wellbeing. Facilitated by the Centre for Urban Wellbeing at the University of Birmingham, we will start holding regular meetings in which partners can share experiences, knowledge and developments and identify opportunities for mutual support, research, and change. We also plan to apply for a small grant that will allow us to experiment with and refine our approach in a limited number of cases, produce initial outcomes that will feed into a transformative change trajectory in health and wellbeing, and support us in obtaining a large grant that will include a wider range of partners in urban, sub-urban and rural environments across England and Wales. We welcome anyone in the UK and abroad sharing our ambitions and ideas to join the SPARC Network and help to further develop and extend it.

In these ways, we hope to start (1) addressing critical gaps in research, policy and practice about the purpose and impacts of asset-based approaches to SP on health and wellbeing, (2) empowering stakeholders with conditions, capacities, and resources for transformative change, and (3) mobilising an asset-based approach to sustaining and spreading a new and more effective social model of wellbeing. Ultimately, we envisage this to contribute to the development of wellbeing ecosystems, which support SP to become an economically sustainable and collectively supported alternative to an overly individualised approach to health and wellbeing which is inadequate for addressing alarming levels of inequality.

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