Exploring an asset-based approach to nursing

In this article...

- A discussion of asset-based community development (ABCD)
- Applying ABCD to nursing
- How nurses and managers could form equal partnerships to create solutions

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This article explores a different perspective on perceived “failings” in the nursing profession. It takes learning from an asset-based community development approach called Connecting Communities to find out whether the problems and solutions that we observe in vulnerable communities can help us better understand what might be happening in the nursing community. The ideas presented are evidence-based community development theories that are currently used across the world and are now influencing the commissioning for health improvement/health inequalities.

Today’s nurses are under massive pressure. There is increasing scrutiny following allegations of care failings, they face a rising tide of demand and have more to do with fewer resources. It is no wonder that England’s chief nursing officer Jane Cummings and the Department of Health’s director of nursing Viv Bennett have been tasked with finding solutions – and quickly.

An asset-based approach to nursing might be described simply as a “glass half full” approach. It is concerned with how we can use each other, our talents, skills and experience – often described as the assets of heart, head and hand – to address the perceived ills in nursing. This article aims to start a debate with fellow nurses and nurse leaders to see whether, together, we can develop these ideas further. This is not yet another initiative; rather it is an opportunity to view the world in a different way (paradigm shift) and to give a potential explanation for what might be happening in our profession.

A tale of two health visitors

Back in the 1990s, two health visitors, Hazel Stuteley and Phillip Trenoweth, worked in Cornwall with a vulnerable population called the Beacon Estate, built up the hill from the picturesque seaside town of Falmouth. Beacon residents described the estate as the “Beirut of Cornwall”. It was dominated by drug gangs and crime rates were high. The agencies – housing, council and police – increasingly saw the Beacon as a no-go zone and the police only came onto the estate to arrest people (Jackson, 2000).

One day the health visitors, whose caseload was becoming uncontrollable, reached breaking point. They invited 20 residents from their caseload to a meeting to plan what to do. Of those 20, only five turned up. Together with Ms Stuteley and Mr Trenoweth they knocked on every door on the estate and asked residents to come to a public meeting with Carrick District Council, Carrick Housing Trust and the police.

The residents vented years of anger that night, but at the end of the meeting, it was agreed to try a new approach: to form an
equal partnership between the residents and local agencies to tackle residents’ concerns. Crucially, the residents led the process because they knew what would work – they had the “lived experience”. They started by redesigning a traffic-calming scheme, with the residents undertaking their own traffic survey, then applied for and won a £1.2m housing grant. Beacon residents oversaw the housing improvements themselves, with the backing of Carrick Housing. This transformed the lives of these tenants, and crime, health and education statistics vastly improved. The estate continues to thrive today.

What happened on the Beacon Estate is echoed across the world, where the evidence base for asset-based community development is expanding (Morgan et al, 2010; Foot, 2009; Kretzmann and McKnight, 1993).

Asset-based community development
Ms Stuteley thought long and hard about not only what had happened to transform the Beacon, but also why and how it happened. She now makes regular presentations and her story has been written about extensively (Foot, 2012; NHS Alliance et al, 2011; Jackson, 2000). Researchers at Exeter University Medical School’s Health Complexity Group have put a theory behind the health visitors’ actions. Ms Stuteley and Mr Trenoweth, they said, had created the “enabling conditions for change” by creating a space where those agencies would listen to what the residents said.

The agencies realised that their needs-based, top-down approach to “fixing” the problems in that community had disempowered the residents. The two health visitors, on the other hand, had built upon the community’s lived experience. So for example, the former local drug-dealer set up a plastering business employing local people and began policing the community for drugs rather than selling them. The residents became the solution and not the problem. Capacity was not “built”, it was “released”: the capabilities were already there – they just had to be drawn out. This is the essence of an asset-based approach.

Ms Stuteley explains that at first, residents demonstrated “locked-in behaviour”, which could have been interpreted as apathy. They were so used to being consulted but not listened to that few of them would bother to attend community meetings. However, once they felt they were being heard, they resorted to anger. As one resident of the Beacon said: “If you kick a dog it will turn round and bite you won’t it?” This anger, far from being feared or avoided, can be used as energy for change.

Complexity theory
Exeter University researchers said much of what happened on the Beacon Estate was an example of complexity theory (Health Complexity Group, online resource). In simple terms, when faced with a complex problem, a community can begin to organise itself to meet its own needs in the way it thinks best. This can feel threatening for organisations like the NHS and local councils, which are used to being in control, so it requires a lot of trust and the rebuilding of relationships.

The agencies learnt to share power and decision-making with the residents. The council and its partners formed an equal partnership with community leaders and took action by listening to what most residents said was important – “wants” rather than “needs”. Ms Stuteley took these ideas and formed Connecting Communities, also known as C2 – a seven-step approach that encapsulates this learning. Today the C2 method is being used to transform 20 vulnerable communities across England and Scotland, by permanently changing the culture and relationships between public services and the residents they serve. Asset-based thinking is now influencing commissioning for health improvement and health inequalities (International Association for Community Development and Carnegie Trust, 2011; NHS Alliance, 2011; NHS North West, 2011).

Are nurses becoming “locked in”?
Concerning the debate about the perceived deficits within nursing, a number of parallels can be made between what is happening within our most vulnerable communities and the “community” of nursing. In the media, nurses are portrayed as no longer seeming to care, and predominantly deficit-based language is used to describe the profession. Stories abound of nurses failing to look after patients’ basic needs and maintain their dignity, even though this is only a partial picture and elsewhere there are many excellent examples of skilled and compassionate care. Looking at nursingtimes.net there is a similarity between residents in vulnerable communities and nurses on the frontline in that they display anger at not being respected or listened to:

“Wouldn’t it be good if the trusts cared about their staff instead of turning a blind eye to the rock bottom morale caused by an unappreciated overworked workforce... Never any recognition for hard work only fault finding.” (Anonymous, nursingtimes.net, 25 June 2012)

Recently, hospital nurses were required to implement intentional rounding. Some nurses were indignant at the imposition of a solution, no matter how well-intentioned:

“How is an hourly round going to work? Patients don’t just sit there waiting for us to come along and talk about their needs. Caring for them is an ongoing process, some needing more time than others. Patients should dictate the needs not another chart that needs to be ticked every hour.” (Anonymous, nursingtimes.net, 4 May 2012)

The chief nursing officers’ new nursing strategy, identifying six Cs: care, 

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| **Nurses as assets** | The Energise for Excellence vision is for at least 200,000 nurses, midwives and health visitors to sign up to take action and tell others their quality and cost-saving stories. This initiative encourages nurses and midwives to be proud of many achievements as practitioners, partners and leaders. E4E is a call to action to all nurses and midwives aimed at harnessing our collective energy, commitment and expertise. 
| **Pride in nursing** | The Olympic opening ceremony ignited the debate about pride in nursing and in our health service. For the first time in a long while, nurses began to speak up about what they did, despite some cynicism. Now is not the time to be modest. If we do not speak up for our profession, who will? |

RCN Congress
The 2012 RCN Congress was a good example of how nurses can and do support each other. Debates allowed “listening” and demonstrated self-organising – with the suggested subjects coming from branches across the UK. It highlighted all three of Hothi et al’s (2009) 3Cs: control (of the agenda by members); unparalleled opportunities to contact other members, from student to general secretary; and a huge opportunity to boost one’s confidence.

**Discussion**
compassion, competence, commitment, communication and courage attracted adverse comments from some nurses: “Here’s one C for you: Cobblers.” (@Redpaddys12, Nursing Times, 7 August 2012, page 9).

Are nurses demonstrating the same locked in behaviour as residents in vulnerable communities? Are they, after being kicked like dogs, now biting back? Are nurses in fact becoming alienated from their own leaders because they do not feel that their priorities are listened to and acted upon? Can managers form equal partnerships with nurses to co-create solutions?

**Empowering nurses for change**

Most people agree, however, that these 6Cs are crucial to nursing. But there are three more Cs to add to the list that would support the wellbeing of nurses so they can deliver this new vision. These come from a report published in 2009 by the Young Foundation (Hothi et al, 2009), who looked at the things that improved wellbeing and happiness. They studied findings from three very different communities across England. The key elements that improved wellbeing and happiness were:

- **Control:** by giving people greater opportunities to influence decisions, through participative and direct democracy rather than formal consultation exercises;
- **Contact:** by setting up social networks and regular contact with neighbours;
- **Confidence:** by enabling people to have confidence in their capacity to control their own circumstances.

**Control**

Reflecting on these findings, the debate about how much nurses feel in control of what is happening in their working lives is very moot. (There will be more about control, change or influence in reality. Until that happens, we will continue to pedal round in circles) (Chinn, 2012). This is an example of the C “contact”, with nurses clearly using each other as assets. “Twit-chats” (Twitter discussions organised at a given time around a given subject) are another example of complexity theory’s self-organising principle. New nurse twit-chat opportunities, including #NTTwit, #wnurses, #nurchat and #nurseshift are appearing, around subjects identified by participants themselves.

McCrea (2012) notes, however, in Health Service Journal that, while individuals self-organise and share assets, on the whole, organisations such as the NHS use social media more as a tool to broadcast information than to engage, listen, respond and support. What a fantastic opportunity NHS employers have to become as McCrea calls it “communitarians” and to use social media to harness the views and knowledge of nurses and patients.

**Confidence**

Rarely do we tell each other what we are good at. So one technique I use to boost confidence is talent-spotting. This means approaching nurse colleagues and saying things like: “Hey, you would make a great clinical commissioner. Can I introduce you to the chair of the clinical commissioning group?” At first they tend to demur, but it sets them thinking and if you get it right, it becomes a self-fulfilling prophecy. Bright Diamonds, a podcast of district nurse John Wharton’s commissioning work (available free on iTunes) is an example of an “asset” spotted this way.

**Starting the debate**

As members of the nursing community, our future is in our own hands. We can make a start through discussion on forums and among colleagues. Consider the following questions:

- How can we/will we be directed at the problem and not each other?
- What other mechanisms can we/are we using to put nurses in contact with each other?
- How can we/will we building nurses’ confidence to work in partnership with employers to improve care?
- And remember that anger is good – it is an energy for change, but should always be directed at the problem and not each other. NT

The second article in this series, to be published next week, discusses the importance of feeling in control to support people’s wellbeing.

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**References**


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