



5TH EDITION

Community and Public Health Nursing

EDITED BY

David Sines
Sharon Aldridge-Bent
Agnes Fanning
Penny Farrelly
Kate Potter
Jane Wright

WILEY Blackwell

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The Context of Primary Healthcare Nursing

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The changing context of service provision

The population of the United Kingdom is projected to increase by 4.9 million from an estimated 62.3 million in 2010 to 67.2 million over the 10-year period to 2020. Projected natural increase (more births than deaths) will account for 56% of the projected increase over the next decade, resulting in an overall UK population increase to 73.2 million over the 25-year period to mid-2035. The population is also projected to continue ageing with the average (median) age rising from 39.7 years in 2010 to 39.9 years in 2020 and 42.2 by 2035 (Office for National Statistics 2011).

The key drivers for population growth within the United Kingdom relate to greater life expectancy and migration, particularly from Eastern Europe (migration being expected to account for 68% of population growth during this period). Over the 25-year period to 2035, the number of children aged under 16 is also projected to increase from 11.6 million in 2010 to 13.3 million in 2026 before decreasing slightly to 13.0 million in 2035, whilst the population is projected to become older gradually, with the average (median) age rising from 39.7 years in 2010 to 39.9 years in 2020 and 42.2 years by 2035. As the population ages, the numbers in the oldest age groups will increase the fastest. In 2010, there were 1.4 million people in the United Kingdom aged 85 and over; this number is projected to increase to 1.9 million by 2020 and to 3.5 million by 2035, more than doubling over 25 years (Office for National Statistics 2011). The age of the working population will also increase during this period,

demonstrating unforeseen lifestyle patterns, which in turn will impact on those people of state pensionable age.

According to Mathers and Loncar (2006), the ten leading causes of death by 2030 will be ischaemic heart disease, cerebrovascular disease, upper respiratory tract and lung cancers, diabetes mellitus and chronic obstructive pulmonary disease (COPD). Within the top ten leading causes of death will also rank dementias, unipolar depressive disorders, alcohol use disorders, stomach and colon cancers and osteoarthritis. The combination of longer-term physical disorders and psychosocial challenges will demonstrate the importance of integrated service provision and workforce capability and capacity to respond to presenting co-morbidities. Other worldwide challenges relating to infectious diseases, such as HIV and tuberculosis, will provide additional pressures on our healthcare systems.

So how do society and its associated health and social systems respond to such challenges? In the first place, it can be assumed that societal change moulds the institutions that are created to respond to the needs of the population. Demands change over time, and in so doing, socio-demographic factors drive the process of change that in turn requires the National Health Service (NHS) to adapt its operational base. Examples of such changes relate to the needs of an increasingly demanding and complex population, a reduction in the number of available informal carers, advances in scientific knowledge and technological innovation and a heightened awareness of ethical challenges (such as gene therapy, stem cell research, embryology and euthanasia). In addition, the 2010 Coalition Government's quest to locate healthcare delivery as 'close to home' as possible has placed greater priority on primary and community service developments.

Such changes were enshrined within the context of the Government's inaugural healthcare White Paper 'Equity and Excellence: Liberating the NHS' DH (2010a). The 2010 White Paper placed much emphasis on sharing decision making between clinicians and patients, leading to their empowerment and ultimate engagement in sharing responsibility for their own care:

Too often patients are required to fit around services, rather than services around patients.

This is a key component of the Government's 'Big Society' mandate, encouraging a move to self-care and a reduction in dependency on State-sponsored healthcare delivery.

The resultant 'care closer to home' initiative has been influenced by a range of external forces, driven by government pressure to drive down NHS costs and to reduce dependency on hospital admission (DH 2008a, b). Such changes however come at a price in their own right, and if the NHS is to succeed in responding effectively to the demands of the new community care culture organisation, then it will have to be prepared to face the demands of a changing environment of care practice and delivery (Buchan 2008).

Care closer to home has been defined by Nancarrow *et al.* (2006) as 'shifting all resources and expertise to primary care trusts'. This somewhat simplistic definition

was adopted throughout the NHS 5 years ago and became the foundation for healthcare reform in the United Kingdom (Ham 2011). For example, NHS London announced in September 2008 that it would develop a new community-focused workforce plan for the city by 2013 (Workforce for London – NHS London 2007). The Health Authority advised that it wanted to see a 50% shift of hospital-based activity into community and primary care. This ambitious plan included a 10% reduction in inpatient bed admissions and a 41% increase in outpatient attendances in community healthcare service facilities. In order to achieve this, the workforce was challenged with the need to work more flexibly alongside patients, across care pathways in a variety of settings closer to home (DH 2008a, b). The workforce strategy that accompanied the SHA plan (NHS London 2010) advised that 15 000 healthcare workers would need to be trained or retrained to work in the community. More specifically the community nursing workforce would need to expand from 22% of the total nursing population in London to 40%. This presents a major challenge for the NHS and its educational providers (Buchan 2008) and represents three decades of investment in community-focused health service reform.

Other influencing factors were emphasised by Professor Stephen Field (DH 2012) in his healthcare 'Listening Exercise' for the Coalition Government (as a prelude to the implementation of the 2012 Health and Social Care Act). He identified the importance of promoting self-care and in encouraging patient and user involvement in healthcare prediction and co-treatment and service design. In his report he noted the major challenges facing the health of the population regarding obesity, smoking and alcohol/substance abuse, all of which place a heavy burden on the state healthcare system and contribute to the incidence of dual diagnoses and longer-term, complex healthcare conditions.

The expectations of higher service response from the health service and its professional workforce also continue to rise, particularly as service users engage more fully in the determination of the shape and scope of local healthcare provision. The Government received a final report from Professor Steve Field (DH 2012) that advised the Secretary of State for Health to continue to position care closer to home and to accelerate the transfer of care from large acute hospitals to the community through a new process of 'clinical commissioning', to be led by general practitioners (GPs) (through new Clinical Commissioning Groups). The Government accepted these proposals and has now advised that NHS employees should be involved in the design and commissioning of new services, supported by new workforce training arrangements to prepare them for the transition. These changes will undoubtedly herald the way for a major transformation of the NHS workforce as it prepares to support care closer to home and reduces dependency on secondary care hospital-based services.

There are some risks attached to this shift in emphasis however since the concept of GP-led clinical commissioning (the new vehicle through which services will be commissioned) is untested and untried. Similar issues relate the nature, structure and deployment of the existing non-medical workforce in the NHS (Buchan 2008). Indeed,

many practitioners remain defensive and tribalistic and tend to divide labour on the basis of historical or traditional trend rather than on the basis of actual customer or market need (Cipd 2010). A relationship also exists between professional groups and the State (Nancarrow *et al.* 2006), and in this regard the reshaping of the nursing workforce (with emphasis on community care) might provide an example of how government policy is driving change in how the professionals train and work.

Whatever the rationale for change, the impact of change, stimulated by a growing demand for flexible, high-quality services provided within local communities, will inevitably remould the NHS of the future. Resources are already being moved to the community at a rapid rate, and health service commissioners and providers are now required to demonstrate that the care they purchase and deliver is effective and responsive to consumer need. Field (DH 2012) has also written of the important role that members of the public are now making to the governance of the NHS, mainly through 'Ownership' of NHS Foundation Trusts and through engagement with Expert Patient programmes. NHS Trusts in turn are now responding more purposefully and seriously to user and patient expectations and are required to publish action plans in response to local and national patient satisfaction surveys and to demonstrate compliance with local service user requirements and feedback. Associated with the rise in consumerism and user engagement is a marked improvement in the capacity and capability of the NHS to respond to user complaints and to enhance governance procedures. Even more challenging to the NHS, however, is the increased number of litigation cases presented by patients, seeking recompense for less than satisfactory care experiences. It is perhaps therefore unsurprising that it is in the primary and community care sectors that change has been most rapid, demanding the creation of innovative workforce solutions and service reconfigurations.

The changing face of the community healthcare workforce

In this chapter, we have noted that more healthcare provision needs to be delivered through primary and community-based care with public involvement in health improvement in order to enable a shift away from over-reliance on acute care. This will help the healthcare service to evolve to meet the increasing challenges of an ageing population and an increased need for case management of those with long-term conditions in a way that allows patients to retain and regain an active role in society.

The NHS reviews of the last decade (Wanless 2004), the 'Prime Minister's Commission on Nursing and Midwifery' (DH 2010b) and the Royal College of Nursing (2011) have all recognised the need to upgrade the role of community nursing in order to respond to government policy. The Royal College of Nursing expresses agreement for this view and have advised that '80% of the nursing workforce will be working with local people to improve their health, rather than working in the hospital fixing the preventable, resulting in the safe reduction of a large number of hospital beds'. Changes in

Government policy will enable this to happen over the next decade, providing opportunities for the production of a competent, capable and confident workforce of community nurses and health visitors. Key changes in the new healthcare system [following the enactment of the Health and Social Care Act (Parliament 2012a)] will include:

A shift of power over health budgets to patients and GPs. The Government will allow patients the 'choice of any qualified provider' following a policy of 'no decision about me without me'. Patients will be supported whether they want a service from a hospital, from a GP, from a community health service or from a voluntary provider. This shift in policy towards patient choice has the potential to drive and reward innovation evidenced within community health services.

Promotion of a mixed economy of service provision, including an increased role for local authorities and voluntary and independent sector care provision; social enterprises will also be encouraged, in line with the Government's vision of the 'Big Society'.

Greater opportunity for clinicians and front-line staff to develop, design and deliver services that are responsive to the needs of local people and their GP commissioners.

Freedom for practitioners to innovate and to provide services and outcomes that improve the health and social capital of their local neighbourhoods.

In order to realise these aims, we argue in this book that:

1. There will be a continued demand to expand the community nursing and health visiting workforce and their role in delivering health provision over the coming decade.
2. The nature of community nursing and health visiting will change as a result with community practitioners taking on a greater role as expert clinicians, leaders, innovators and entrepreneurs.
3. There will be a major need to transform the delivery of care so that there is greater emphasis on public health and management of long-term conditions in the community as dependence on the acute sector is reduced.
4. Community practitioners will need to acquire additional skills in evidence-based practice and to create a community service with leadership, innovation and entrepreneurship as central skills. Emphasis will also need to be placed on enhancing patient safety (and safeguarding), on improving clinical effectiveness and on working productively and efficiently. Such skills will be needed to modernise the service.
5. The number of nurses working in the community who have specialist/advanced community nursing qualifications (health visitors and district nurses) will need to increase significantly over the next 5–10 years.
6. Key features of our contemporary society suggest that a much greater focus on health promotion and public health is required since people are living longer and healthier lives and are better informed about their needs and expectations of the health service with particular regard to promoting self-management.

7. Increasing emphasis will be placed on increasing social inclusion and valuing diversity for socially excluded groups, that is, those least likely to access health-care, and on the reduction of health and social care inequalities experienced by significant groups within our population (geographical diversity will also demand local adaptation of national healthcare solutions, particularly within the context of devolved government to the four countries of the United Kingdom).
8. Practitioners will require greater competence and capability to work with assistive technology in areas such as tele-health, tele-care and tele-medicine; consumers and practitioners are also becoming increasingly dependent on e-based information systems and smartphone usage.

In order to ensure that the workforce is appropriately skilled and aligned to the needs of the new healthcare delivery system, the Government produced a consultation paper on education and training in the NHS – ‘Developing the Healthcare Workforce’ (DH 2010a) (The full paper is available at http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122590).

As a result of this paper, a national statutory body was created to determine the nature, structure and focus of the healthcare workforce in England (and its educational commissioning requirements) – Health Education England. This new statutory board will provide national oversight and support to Public Health England and all health-care providers on workforce planning and the commissioning of education and training.

It is intended that the new system will fit with the Government’s requirement to develop care closer to home and will be supported by a series of Local Education and Training Boards, so that employers have greater autonomy and accountability for planning and developing the workforce, alongside greater ownership of the quality of education and training by the professions.

These new arrangements will allow for:

- Robust workforce planning to ensure sufficient numbers of appropriately skilled healthcare staff in the right areas.
- A flexible workforce that can respond to the needs of local demand.
- Continuous improvement in the quality of education and training of staff aspiring for excellence and innovation for high-quality care.
- Transparency across provider funding to ensure value for money and demonstrate the quality of education and training.
- The creation of a diverse workforce that has access to fair education and training as well as opportunities to progress.
- Clearer definition of roles and responsibilities for commissioning and delivery of education.

Government healthcare reform has confirmed the significant role that primary care and health promotion play in the reformed health economy and emphasised that

our focus should be on health outcomes, on user engagement and in the design and implementation of healthy communities and lifestyles at school, at home and at work. These policies have also pledged to 'break down' organisational barriers and to forge stronger links with local authorities, thus placing the needs of the patient/client at the centre of the care process. In so doing, a new foundation has been laid upon which to unite the principles of seamless care delivery and in particular the provision of self-directed care/direct payment packages, based on case management principles (Parliament 2012a). In practice this will require the provision of new inter-sectoral solutions to ensure that care is delivered between health and social service agencies through the development of positive partnerships and integrated case assessments between statutory agencies, consumers, their representatives and the voluntary and independent sectors to provide a positive choice in the provision of services. Emphasis on primary care has been reaffirmed in that, wherever possible, care should be provided as close to the person's home as possible.

In July 2012, the Government published its long-awaited White Paper on Social Care (Parliament 2012b) in which it outlined its vision for the reform of care and social support. Changes heralded in the report include:

- Placing dignity and respect at the heart of a new code of conduct and minimum training standards for social care workers.
- Introducing new social care apprenticeships.
- Legislating to give people the right to a personalised budget and direct payments (in eligible circumstances).
- Applying and embedding the principle of personalised care across all services.
- Placing a duty on local authorities to join up care with health and housing where this delivers better care and promotes people's well-being.
- Developing plans to ensure everyone who has a care plan has a named professional with an overview of their needs and responsibility for responding to their needs.
- Ensuring that partners remove barriers to promote the widespread adoption of integrated care.
- Developing coordinated care for older people and improving access that people living at care homes have to the full range of primary and community health services.
- Enhancing and extending joint funding arrangements between the NHS and social care to support integrated care provision (and to ensure joined-up thinking between housing, social care and healthcare provision).
- The establishment of a new Leadership Forum for social care to lead service transformation (including new standards for registered managers).
- A requirement for local authorities and Clinical Commissioning Groups to work together on Health and Wellbeing Boards to determine how their investment is best used to support and promote innovation and integrated working between health and social care.
- Planning and delivering effective re-ablement services and intermediate care and post-discharge support that enables people to regain their independence.

The primary care vision for the next decade

At the heart of the Government's reformed healthcare strategy is the greater focus placed on the delivery of services in primary care, underpinned by a new relationship between healthcare professionals and patients/clients through the promotion of supported self-care management. Accompanying this philosophy of care is the recognition that many patients present with complex (longer-term) conditions, arising from comorbidity (DH 2011).

Amongst the key reforms resulting from the enactment of the Health and Social Care Act 2012 are:

- The creation of an NHS that 'helps people to stay healthy' and to benefit from more effective treatment, informed by research- and evidence-based practice.
- Requirements for local Clinical Commissioning Groups to commission comprehensive well-being and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations.
- Greater engagement of voluntary organisations and social enterprises between the Government, private and third sector organisations on actions to improve health outcomes.
- The entry of a series of new non-statutory sector healthcare providers (mandated by the NHS Commissioning Board as 'Qualified Providers' of healthcare in England).
- Support for people to stay healthy at work.
- Support for GPs to help individuals and their families stay healthy.
- Extended choice of GP practice.
- Implementation of personal health and social care budgets.
- Care plans to ensure that everyone with a long-term condition has a personalised care plan.
- Introduction of a new right to choice as enshrined in the NHS Constitution.
- Guaranteed patient access to the most clinically and cost-effective drugs and treatments.
- Measures to ensure continuous improvement in the quality of primary and community care.
- The creation of new partnerships between the NHS, universities and industry through the creation of new Academic Health Science Networks.
- The provision of strengthened arrangements to ensure staff have consistent and equitable opportunities to update and develop their skills.

Health service reforms have also been underpinned by the commissioning of new community healthcare facilities and in outcome/standard setting accompanied by matching increased diversity of supply. This will be accompanied by greater ability to respond to the new diversity of demand in preventive and curative medicine – tackling the underlying causes of health inequalities as well as providing the best care.

Decreased tolerance of failing services will also be a core component of the Government's strategic healthcare plan with the NHS Commissioning Board introducing tougher measures to improve standards and to close down services in the case of poor standards. Foundation Trusts will be implemented fully across England by 2014, some of which will also be able to take over failing hospitals to turn around their performance. In the case of primary care, there will be greater diversity of supply and strengthening of the power of Clinical Commissioning Groups to ensure that GP or community healthcare services can be improved or replaced where they fail to respond to local patient/user demand.

Major advances in technology and bioengineering have also brought about significant changes in treatment patterns and modes of delivery. For example, with cutting-edge techniques – ranging from genetics to stem cell therapy – and life-saving drugs to prevent, alleviate or cure conditions like Alzheimer's disease, it is likely that many of today's diseases will succumb to either eradication or amelioration. Investment in the implementation of world-class research programmes will accompany the Government's healthcare investment plan, and new Academic Health Science Networks will be sponsored for implementation across England, working in partnership with Foundation Trusts, Clinical Commissioning Groups, industry and partner universities. These will facilitate the discovery of new technologies, which in turn will enable clinicians the ability to diagnose and intervene at the earliest possible opportunity.

Similarly new alliances will continue to be developed with our emergency care services (e.g. the Ambulance Service) to equip paramedical staff with the requisite skills to treat people suffering from heart attacks with life-saving drugs in their own homes or to provide emergency interventions for longer-term conditions outwith hospital specialist treatment units. For others attendance at specialist treatment centres will become the norm. One such example relates to some stroke patients who now receive immediate treatment with the latest clot-busting drugs in specialist stroke centres, thus extending their lives and enabling many people to lead independent lives. Other patients will benefit from attendance at new trauma centres.

There will also be improvements in the way in which the 16 million people in England who present with longer-term diseases, such as asthma, heart failure, diabetes or psychosocial challenges, manage their care. The people who care for these service users – the 'carers' – also require additional support and 'seamless' access to services. In some cases personal budgets and direct payments will be made available to enable individuals and their families to purchase responsive care packages directly. The use of personal health and social care budgets will underpin reforms of our health/social care system.

Many of the people who will benefit most from new care packages will present with 'lifestyle'-related diseases such as mental health, diabetes, cardiovascular disease, stroke and some cancers. In order to combat the rising trend in such conditions, the health service will work in close partnership with patients and carers to co-design and co-deliver effective preventative and direct treatment services, aimed at encouraging the population to take their own health 'seriously'. In order to achieve this objective,

more patients will become engaged with their care by managing their own conditions, taking advantage of support offered by GPs and nurses in the home or on the high street and by exercising more control over their lives and care. Greater emphasis on what we eat and participation in sports and leisure activities will also be encouraged – presenting a significant challenge for the way in which primary care nurses discharge their role and responsibilities.

There will also be opportunities for the provision of extended screening services, for example, for colon cancer and for breast cancer. An increasing number of patients will also access NHS directly through the internet, smartphones and digital TV to improve their access to evidence-based information about their health. Others, through the use of personalised budgets, will take control of their care packages and manage their care plan directly, rather than having to rely on others. By so doing, a greater range of patients will become increasingly empowered, giving them a greater say in their care, particularly in the later years of their lives.

Such fundamental changes in healthcare policy and process will require primary services to adopt new flexible and responsive approaches and to develop new partnerships with the voluntary and private sectors where they can contribute and innovate. Greater synergy will also be required between acute and primary care and between health and social care. New and dynamic approaches to clinical commissioning will be needed to deliver such changes, focusing on patient choice, direct payments (DH 2011), quality provision and market contestability.

The enactment of this policy shift will reduce patient/client dependency on inpatient or long-stay residential care in favour of seeking the development of a range of options based on local need, which will be flexible enough to meet the demands of service provision required by local people in their neighbourhoods. Clinicians are therefore being encouraged to work in close partnership with their patients and clients with the aim of making them more accountable for their practice and interventions.

At a strategic level, the NHS Commissioning Board now requires all Foundation Trusts and Clinical Commissioning Groups to secure significant improvements in the way in which services are delivered to the population, emphasising the promotion of positive health and safety and the promotion of high-quality care in the community. In order to provide these services, healthcare providers must demonstrate that they offer a range of services for their clients and families as equal participants whenever decisions that will affect their lives are involved. Such principles now underpin the NHS philosophy and form the basis of the Government's 'reformed' health and social care strategy.

NHS providers must also determine the role that they are going to play, with local authority social service departments, in making their contribution to a range of comprehensive service developments for clients. The Health and Social Care Act 2012 also demands that planning agreements should be reached between health and social service departments that identify clearly which services will be provided by each agency and that identify the processes to be adopted in assessing the needs of individuals in their care. The principle of effective alliance building between the NHS and social

services will be further encouraged by the creation and operation of Local Education and Training Boards in England. They (and supporting Government policies) will outline requirements for health and social care services to work together to encourage the joint design, training and education of staff from both agencies in order to provide a workforce with the necessary capacity, skills and diversity to meet the needs of the local population. Alliance building is crucial if user needs are to be met within the context of an increasingly pluralistic health and social care economy, characterised by self-care and user choice and involvement.

The principles outlined in this chapter also require each government department to demonstrate emphasis on public health as a central concept within their business plan – a cornerstone of ‘joined-up government’. For the health service, charged with responsibility to enact national quality standards and health improvement plans for local communities (via the newly established Public Health England Board and by local Health and Wellbeing Boards), a fundamental review is required to assess local public health capacity and capability, across sector boundaries.

In the future, emphasis must also be placed on the promotion of health and alliance building between professionals and users of services. The focus of care is clearly placed within the community with an expectation that resources will be deployed to meet identified health and social care needs through the provision of integrated, peripatetic support from a range of professionals who will include doctors, community healthcare nurses, community specialist public health nurses, social workers, clinical psychologists, physiotherapists, speech therapists, radiographers and occupational therapists (supported by an efficient and appropriately funded intermediate/acute sector, inpatient service). The acute sector will complement the work of local primary healthcare workers who will continue to provide the first point of contact for clients and their families through the provision of effective intermediate and ambulatory treatment/assessment services. In turn such services will be supported by the implementation of primary care-led emergency care walk-in centres, extended GP practices and community-based diagnostic and treatment centres, thus providing a range of ‘seamless’ assessment, diagnostic and treatment services for their local communities.

The next decade will therefore be characterised by the development of highly focused primary care services that will respond to the needs of local practice populations. In this model, much of the activity currently carried out by the local acute hospital will be transferred to general local primary services, some of them provided directly by the NHS, others provided by independent or voluntary sector agencies. New community-based services will also be introduced to provide an integrated, eclectic range of health and social care services, including diagnostic and treatment services for the local population. Such local services will increasingly undertake minor and invasive surgery, routine diagnostic testing, support for cases requiring observation and most outpatient activity. Centralised or specialist hospital facilities will continue to deal with severely ill people with complex therapeutic needs and provide for major surgery. Older people and those with mental health needs or learning disabilities will also continue to be cared for (almost exclusively) in community care settings.

From a practical perspective, the way in which primary care services will be delivered in the future will be determined from both national and local demand perspectives. Nationally, key priorities have been determined annually by the Department of Health and outlined in an operating framework document (see, e.g. the Department of Health's Operating Framework for the NHS in England for 2012/2013, DH 2011). Examples of key operating principles include:

- Listening and responding to patients, the public and staff and improving patient outcomes and experience; making decisions as close to the patient as possible.
- Moving towards clinical ownership and leadership local targets whilst delivering on national priorities.
- Co-production – all parts of the system working together to shape and implement change.
- System alignment – achieving complex cultural changes whilst encouraging different parts of the system to work together in partnership.
- Sustaining a financial regime that supports service reform goals incentivises service improvement.
- An emphasis on partnership working between NHS organisations, local authorities and other partners to ensure local health needs are better understood and addressed.

Other priorities include the need for community services to:

- Build better access for patients, clients and carers and ensure ongoing improvements in patient experience of access by assuring that GP health centres and practices deliver effective and innovative services (including flexible evening and weekend appointments).
- Keep adults and children well with a key focus on heart disease and cancer whilst responding to the needs of children and the newborn (through the 'sure start' and 'healthy child programmes') and by providing excellent maternity services.
- Further reduce health inequalities and deliver evidence-based and cost-effective interventions across all care pathways.
- Ensure more choice in service selection and treatment response; elicit objective feedback on 'the patient experience' and respond accordingly; and encourage active user engagement with all aspects of care design, delivery, and quality measurement.
- Tackle lifestyle issues, such as obesity, teenage pregnancy and problems associated with smoking and alcohol usage.
- Close the gap in life expectancy between affluent and deprived areas of the population by improving the health and well-being of the population (through regular health checks, physical activity programmes and targeted health promotion and public health programmes – sponsored by local, cross-agency Health and Wellbeing Boards).

- Work closely with local authorities to provide integrated and co-located services, including joint commissioning, personalised services, integrated care management and personalised budgets.
- Redesign and implement care pathways that respond effectively to patient and service demand to support patients with longer-term conditions (and to encourage integrated working, self-care and the use of assistive technology).
- Continue to reduce the rate of hospital-acquired infection.
- Strengthen management, leadership and clinical excellence in the workforce to enhance both capacity and capability.
- Put in place and lead local information (e.g. the development and application of the next stage of digital technology) and management and technology plans to improve the health service infrastructure and patient/user experience.

A range of enabling strategies will also be put in place to support the implementation of these delivery plans, including the empowerment of patients, the provision of choice, reduction of service variability, the implementation of a new quality framework, investment in professional training, education and workforce development, commissioning and system reform (including world-class commissioning and clinical commissioning) and estate developments. At the heart of the plan is an explicit requirement to transform community services to drive greater service integration (and in so doing improve patient choice and access whilst also reducing acute admissions and lengths of stay) by 'bringing care closer to home'.

There is little doubt that the introduction of these new service delivery imperatives will provide the primary/community care nursing profession with a range of major challenges that must be addressed if the balance of care is to shift, according to government policy, to the community. One specific question must relate to the future education and training that will be required to equip practitioners with the necessary skills, knowledge and value base to be able to function effectively in the community. In reality, there is also likely to be a reallocation of tasks between nurses and others, including informal carers and other professionals (many of whom work currently in acute hospital settings and who will be required to transfer into new primary care settings as the context of care changes). Primary care nurses must therefore be prepared to develop and change, drawing upon the very best of their past experience and becoming increasingly reliant upon the production of research evidence to inform their future practice.

This section has proposed that the most effective way to meet the health needs of the local population is to focus primary healthcare services within the very heart of naturally occurring communities and neighbourhoods. In so doing (using the general practice population of the focus and locus for care), opportunities for the further improvement of multidisciplinary teamwork and improved communication systems with clients (and others) will be provided. In order to transact effective care, the potential role that primary care nurses can undertake to fulfil the new NHS mandate must be acknowledged.

The impact of primary care policy changes on the role of the primary care nurse

In 2010, the then Prime Minister published a major document entitled 'Front line care – Report by the Prime Minister's Commission of Nursing and Midwifery in England' (DH 2010b). This confirmed the role that community nurses and health visitors are expected to play within the context of a contemporary and 'modernised' healthcare service:

Community Nurses can play a vital role in coordinating services, maximizing continuity of care during the entire care pathway, advising on individual service users' needs and encouraging self-management by helping service users negotiate their way through the sometimes bewildering variety of services and support agencies available (p. 71). Nurses should be supported by a health system that focuses strongly on health promotion for all, while identifying and targeting those most in need...promoting health and preventing illness and reducing health inequalities has long been central to nursing and midwifery roles, and is the foundation of health visiting (p. 66).

The policy drivers outlined in this chapter will have significant impact on the status of the primary care nurse/health visitor as the 'lynchpin' within the context of a multidisciplinary team of specialist healthcare practitioners. Their work has also been directed by the advent of consumerism that has placed new demands for new competencies amongst the workforce with an emphasis on therapeutic skills, case management (this concept will be discussed later in this text), clinical leadership, clinical decision-making and social enterprise skills. Further endorsement of the significance of the role that community and primary care nurses and health visitors will play within the reformed health services has been provided by the Prime Minister's review on Nursing and Midwifery (DH 2010b).

In summary, the community and primary care nurses must be able to respond to the health needs, health gain requirements and expressed demands of their clients and local population groups so as to:

- Stimulate healthy lifestyles and self-care opportunities.
- Design and deliver cost-effective and evidence-based treatment and care responses (including efficient and effective prescribing practice).
- Further educate families, informal carers, the community and other care workers.
- Solve or assist in the solution of both individual and community health problems.
- Orient their own as well as community efforts for health promotion and for the prevention of diseases, unnecessary suffering, disability and death.
- Lead, work within, and with, inter-professional teams and participate in the development and leadership of such teams.
- Participate in the enhancement and delivery of primary healthcare in a multidisciplinary care context.