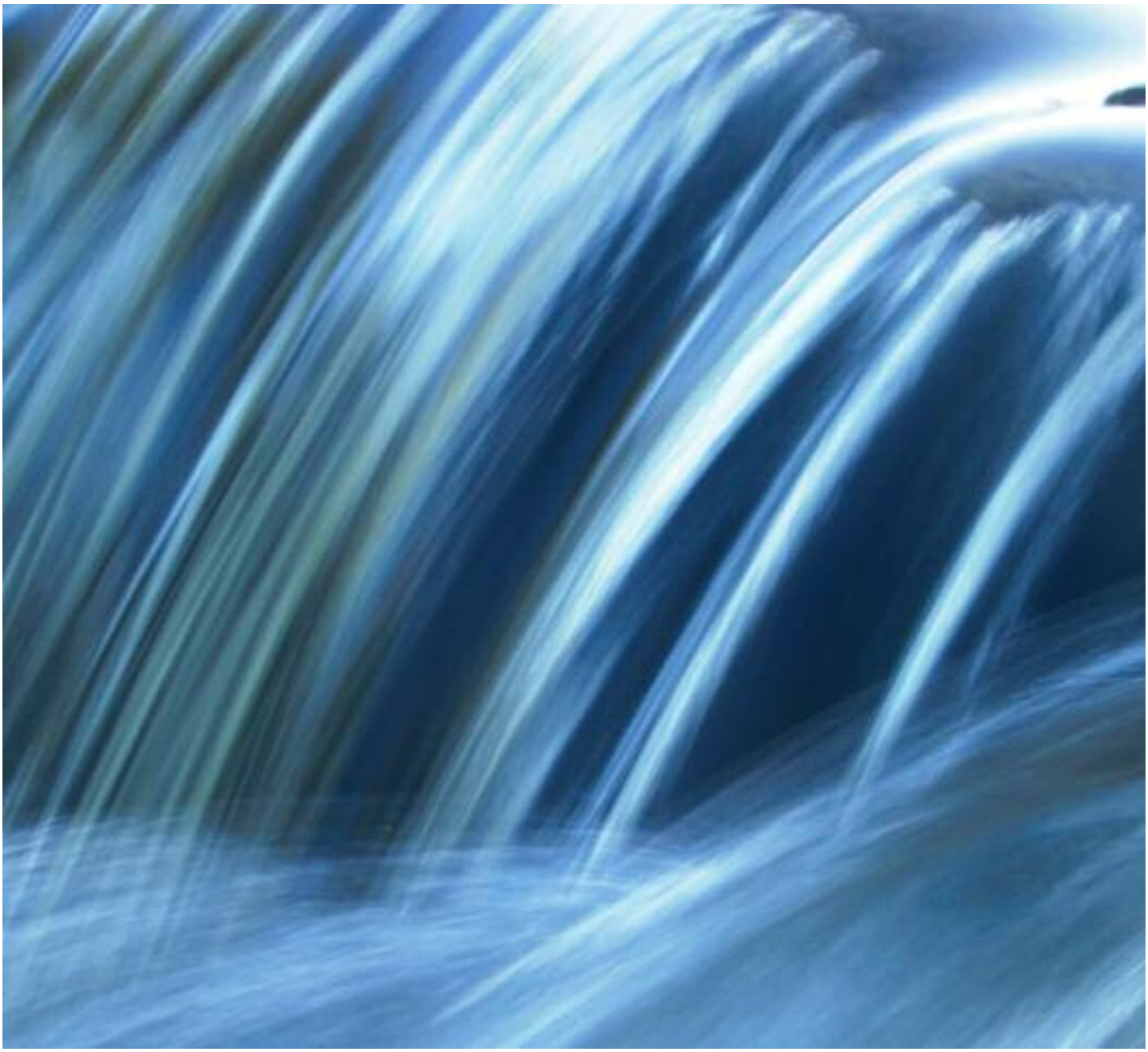
Royal College of Nursing

Going upstream: nursing's contribution to public health

Prevent, promote and protect

RCN guidance for nurses



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Contents

Foreword

I am delighted to endorse this document, which showcases some excellent examples of the nursing contribution to public health. The RCN believes every interaction between members of the public and nurses presents opportunities to deliver messages about healthier living and behaviours.

The RCN works with its members to continually improve the care and outcomes nurses achieve for individuals and communities. We live in an era that poses significant challenges to the public's health; for example, two out of three adults in the UK are overweight and inequalities in health remain widespread. Additional major health threats also remain, including the risk of outbreaks, new pandemics or imported infectious diseases and the potential impact of global terrorism.

An ageing population and increased prevalence of long-term conditions have also had a significant impact on the work of nurses within the UK health care scene. We know that around 1.5 million people have one or more long-term conditions, and the number of people with multiple long-term conditions is predicted to rise by a third over the next 10 years. We also know that people with long-term conditions are the most frequent users of health services.

Nurses are in an ideal position to influence the people they interact with, empowering them to achieve positive public health outcomes. Whether this is by engaging in primary prevention, taking action to reduce the incidence of disease; or through secondary prevention, by systematically detecting the early stages of disease and intervening before full symptoms develop; or through good health teaching and the promotion of self-care management, it is nurses who remain a key influencing contact.

This publication sets out innovative approaches to public health nursing, and provides examples of how nurses are contributing to the public health agenda. We hope these will help to stimulate discussion, dissemination and adaptation.

The RCN urges service planners and commissioners in all four UK countries to take note of the valuable contributions nurses can make to public health, and to ensure these ways and means are reflected in service and commissioning plans.

We want the upstream contribution of nurses to be recognised as a powerful force which ensures the health of the public and the delivery of care that is of the highest quality, safe, efficient and equitable. It is my hope that the principles, frameworks and case studies within this publication assist with navigating the way for nurses, for service planners and commissioners, and for employers of nurses.

Together, we can make upstream nursing come alive and stay alive!

Janet Davies

Director of Nursing and Service Delivery
Royal College of Nursing

February 2012

Executive summary

With more than 410,000 members, the Royal College of Nursing (RCN) is the UK's largest professional association and union for nurses, midwives, health visitors, assistant practitioners and health care assistants. Nurses and health care assistants make up the majority of those working in our health services and their contribution is vital to delivery of the health policy objectives of all governments across the UK.

Since the 1850s, the promotion of good health and prevention of disease has been a feature of public health care. Over the last 30 years, the UK governments have signalled a commitment to address the underlying causes of ill health such as social inequalities and unhealthy lifestyles. The RCN is greatly encouraged and proud of the contribution to public health by its members who have a specific public health remit within their various roles. However, given the significant public health challenges that prevail in the UK, there is now a need to make that contribution more visible and increase the profile of all nurses in tackling the root causes of ill health.

In public health, 'upstream approaches' seek the causes of disease and preventable disability in order to address problems through prevention, rather than treatment. At a time when recent policy imperatives require a greater emphasis on the role and responsibilities of individuals in adopting healthy behaviours and lifestyles, there is much criticism that the NHS offers a 'sickness service' rather than a health service. The RCN believes nurses have a key role to play in 'going upstream' and initiating care to prevent people becoming ill in the first place. Nurses also have a key role in minimising the impact of illness, promoting health and function (capabilities), and helping people maintain their roles at home, at work, at leisure and in their communities. Regardless of the environments nurses work in or their titles or individual roles, all nurses have a part to play in improving the health of local people. This document examines how nurses can help people become healthier and avoid illness and premature death.

This publication draws on and builds further upon several recent RCN reports including *Pillars of the community* (RCN, 2010), *Health visiting and public health nursing* (RCN, 2011), *Health visiting services and public health nursing: a consultation document* (RCN, 2011) and *Nurses as partners in delivering public health* (RCN, 2007). It sets out to signal the way forward to service planners and commissioners, showcasing the innovative methods nurses use to empower and encourage people to live more healthy lives by providing information, treatment and personal support.

This document aims to help RCN members and others working within the health care sector to navigate their way upstream, particularly service planners and commissioners of health services tasked with finding cost effective solutions to the problems caused by unhealthy lifestyles and behaviours.

The RCN believes the strength of this report is that it is enhanced and informed by a collection of case studies which demonstrate how nurses in all four UK countries are actively engaged in upstream public health initiatives. It is encouraging to note that a significant number of the initiatives have been pioneered by individual nurses who have a passion for improving the health of their local population; other examples have been spearheaded and supported by service planners, commissioners and employers/providers of health services.

Service planners and commissioners working collaboratively with GPs and local government in each of the four UK countries are required to set out what 'good care' looks like and use peer influences. The RCN believes the use of case studies, such as those contained within this document, by service planners and commissioners would exploit the power of nursing to help lift overall performance in the NHS in moving away from episodic acute care towards prevention and self-care.

In developing this publication the RCN invited its members to submit examples of nurse-led public health initiatives. The response to this request was overwhelming and of an extremely high quality, and the RCN is very grateful to members who took the time to respond. Many examples were used to inform the publication's discussion on practice, policy, service planning and commissioning, and a cross-section of the submitted examples showcase how nursing interventions are at the heart of promoting the health of the public.

This document is set out in four key sections:

1: Setting the public health scene in the UK offers an introduction to public health in the UK, describes the key public health challenges in the four UK countries and discusses the rationale for why the achievement of public health goals should be the business of every nurse and be integral to their everyday working practice.

2: Celebrating the diversity of approaches briefly introduces and outlines the differing public health challenges, structures and approaches in each of the four UK countries, signposting the reader to more comprehensive guidance and outlining the different terminology used in the four countries in relation to the planning, delivery and procurement of services.

3: A framework for upstream nursing identifies a number of core ingredients/principles that underpin the contribution of nurses to better public health outcomes. These core principles include:

- all nurses, regardless of their work environment, know and understand the health needs of their local population
- identifying defined populations that would enable health care teams to target individuals who would most benefit from upstream approaches
- working in partnership with other members of health and social care organisations to influence the work on tackling the wider determinants of health
- engaging local people and groups, including those who are workless, in upstream awareness and action
- nurses making it their business to be informed, aware and responsive to disease outbreaks and other threats to health
- nurses utilising public health evidence in everyday practice, and not just evidence for treating illness
- nurses working to a public health knowledge and skills framework based on the 'novice to expert' criteria.

The framework also makes links with the key competences required of service planners and commissioners, and offers a diagrammatic view of the contribution of all nurses to working upstream using the key independent yet linked themes: prevention, promotion and protection. These key themes identified by the RCN are also linked with the three domains of public health. These are outlined in the government white paper for England, *Healthy lives, healthy people: our strategy for public health in England* (2010) and build on the work of the Northern Ireland annual report 2010-2011. The strategic direction set by Public Health Wales in its *Public health strategic framework* (2010) and the Scottish Government's commitment to improve the health and wellbeing of its population as a whole, as outlined in its *Behaviour change competency framework* (2010) also address this.

4: Innovation in upstream nursing utilises the 'upstream' concept and the three distinct yet interdependent themes identified to focus on good practice examples received from the RCN membership. These good practice examples are grouped under the following three themes:

Prevention

- Prevention in acute health care
- Keep well for vulnerable groups
- Targeted screening for vulnerable patients
- Helping people work well

Protection

- Protecting health in rural areas
- Safer global travel
- Safety and protection from abuse

Promotion

- Promoting sexual health in prison
- Promoting healthy living in farming communities
- Promoting sexual health in the community
- Promoting health literacy
- Utilising 'health chats'

Note

The terms 'nurse' and 'nursing' used within this publication encompass the full nursing team including nurses, midwives, health visitors, assistant practitioners and health care assistants.

1

Setting the public health scene in the UK

Several reports on health inequalities in the UK, including the Marmot Review (2010), have repeatedly identified the crucial opportunity to counteract health inequalities by ensuring increased health input throughout life, and ensuring all health and social care professionals have an understanding of health and inequality and are able to offer creative solutions.

It is acknowledged that there are three ways in which government regulation can foster health: one is to set standards around basics such as clean water, air, safe food and housing; the second is to legislate, such as the wearing of seat belts or banning smoking in public places; and thirdly by regulating commercial interests that may be detrimental to health, particularly in relation to tobacco, alcohol and food.

A significant proportion of the disease burden currently facing the NHS in the form of illness is caused by unhealthy behaviours. This applies to all four UK countries. In England, for example, the cost of treating obesity is in itself high while the costs of treating diseases caused by obesity (such as coronary heart disease and type 2 diabetes) were estimated to be between £945 million and £1,075 million annually (NHS IC, 2008) at the beginning of the last decade. Further statistical evidence cited by the King's Fund (Kings Fund, 2008), shows us that obesity has been rising sharply since the 1970s and is a dominant public health issue. The 2008 Health Survey for England calculated 38 per cent of adults were now overweight and 24 per cent were obese. The Scottish Health Survey (2010) shows 65.1 per cent of all adults aged 16 and over were overweight or obese (BMI of 25 kg/m^2 and over). Men were more likely than women to be overweight or obese (67.8 per cent versus 62.4 per cent). The Welsh Health Survey (2009) showed 57 per cent of adults were classified as overweight or obese, including 21 per cent obese. In Northern Ireland the 2010/2011 Health Survey shows obesity is more prominent amongst the middle and older age-groups than younger age-groups. A quarter of those aged 35-44 were classified as obese, and around 30 per cent of those in the 45-54, 55-64 and 65-74 age-groups were obese compared with 12 per cent of 16-24 year olds and 16 per cent of 25-34 year olds. The Foresight report *Tackling obesities: future choices* (2007) predicts that, by 2050, if no action is taken, 60 per cent of men, 50 per cent of women and 25 per cent of children will be obese. This would mean steep rises in heart disease, stroke, cancer and diabetes and place a significant financial burden on the NHS as well as the wider economy.

While the number of Scots dying young from heart disease and stroke continues to fall, a further reduction in mortality rates from these diseases remains a top priority for the Scottish Government. The target to reduce premature deaths from heart disease by 60 per cent was achieved between 1995 and 2011 and a 50 per cent reduction in stroke deaths was achieved over the same period. In Northern Ireland during 2008 there were 3,971 deaths from cancer and 2,847 deaths from heart disease (DHSSPS, 2010).

The average annual consumption of alcohol per person doubled between 2000 and 2008, increasing from less than six litres to more than 11.5 litres and the rate of alcohol-related deaths has doubled since 1991. In 2006/7 the annual cost of alcohol-related diseases to the NHS in England was estimated at £2.6 billion, while in 2005 it was estimated that alcohol was 62 percent more affordable than in 1980. In Scotland, as a result of a framework published by the Scottish Government, new Alcohol and Drug Partnerships (ADPs) were established in October 2009 to ensure the effective delivery of drug and alcohol services at a local level. The Alcohol etc. (Scotland) Bill was introduced to the Scottish Parliament in November 2009 and contained a framework that aimed to reduce alcohol consumption and related harm. Meanwhile, the Northern Ireland Health Survey 2010/2011 identified that of all respondents aged 18 and over, 20 per cent reported drinking in excess of the weekly drinking limits (outlined by the Department of Health as 21 units per week for males and 14 units per week for females). Around a quarter of males (27 per cent) drank above weekly limits compared with 16 per cent of females. Alcohol misuse is estimated to cost the NHS in excess of £2.7 billion per year (National Audit Office, 2008).

In 2001 the Department of Health (England) launched a 10-year programme to tackle sexual ill-health and modernise sexual health services. There has been some progress, including an overall drop in teenage pregnancy rates, the introduction of chlamydia

screening, and quicker access to genitourinary and sexual health clinics. But the numbers diagnosed with HIV and STIs continues to rise. Additionally, the number of people living with undiagnosed HIV also continues to rise. In Scotland, HIV remains a major public health challenge and an *Action plan in Scotland*, published in November 2009, signals a commitment to address the challenge. In Northern Ireland 12,000 people were diagnosed with sexually transmitted diseases in 2009; the highest rates were in the 20-24 age group (DHHSPS, 2010).

Scottish legislators were first to show the way in the UK in relation to smoking in public, followed by Wales (2 April 2007) and Northern Ireland (30 April 2007). In July 2007 there was a complete ban on smoking in public places in England, and a greater provision of quit smoking services. Researchers at University of Bath, in a study funded by the Department of Health and published in the British Medical Journal 2010, found that after the smoking ban came into effect there was a drop of 2.4 per cent in the number of emergency admissions for heart attack. The evidence in Scotland has revealed a marked reduction in heart attacks along with improvements in many other health outcomes attributed to shifts in smoking patterns (Sims et al., 2010). Treating smokers costs the NHS in England alone £2.7 billion a year compared to £1.7 billion a decade ago (ASH, 2008).

Dame Carol Black's review *Working for a healthier tomorrow* (2008) suggests that work can be good for health, reversing the harmful effects of long-term unemployment and prolonged sickness absence. Yet much of the current approach to the treatment of people of working age, including the sickness certification process, reflects an assumption that illness is incompatible with being in work. Families without a working member are more likely to suffer persistent low income and poverty. There is also evidence of a correlation between lower parental income and poor health in children. Improving the health of the working-age population is critically important for everyone, in order to secure both higher economic growth and increased social justice. To date occupational health has been restricted in the main to helping those in employment. However, in today's economic and social climate, supporting working-age health also requires us to reach further and be more concerned with helping those who have not yet found work, or have become workless, to enter or return to work.

Sir Derek Wanless warned in 2004 that if action is not taken on these major public health challenges the financial cost to the NHS will grow and make the NHS itself unsustainable. Almost a decade on from the Wanless report there are still many public health issues that require concerted and unified multi agency efforts. The measure of success in public health will ultimately be the impact on closing the gaps in health inequalities across all four countries in UK. For example in Northern Ireland, men living in the 20 per cent least deprived areas live on average eight years longer than men in the 20 per cent most deprived areas. For women in Northern Ireland this gap is five years. These differences are getting worse, widening the gap between those who are affluent and those who are not. Cardiovascular diseases in Northern Ireland are the main contributors to inequalities in mortality (PHA Northern Ireland, 2010).

Since the beginning of the last decade one major theme frequently cited in relation to the health of the Scottish population is the correlation between health and socio-economic status (Scottish Parliament, 2002). The link between deprivation and health is well established. However, recent research has identified the existence of a 'Scottish effect', a term used to describe the higher levels of mortality and poor health experienced in Scotland over and above that explained by socio-economic circumstances. This is well described in a recent paper from the Glasgow Centre for Population Health, *Investigating a 'Glasgow effect'* (2010) which compares Glasgow with similar cities across the UK. *Equally well* (2008), the report of the Scottish Ministerial Task Force on health inequalities, was launched in June 2008. This was followed by a detailed action plan in December 2008. *Equally well* has actions for all, and delivering on these required strong joint working between NHS, local government, the third sector and community planning partnerships.

The chief medical officer for Wales's annual report 2009 confirms that the health of the population of Wales continues to improve overall and the proportion of deaths under the age of 75 continues to decline. However, inequitable gaps in health and wellbeing have also been increasing over the past 20 years and require a sustained commitment to ensure that where a person lives or their social circumstances does not lead to a lesser quality of life and a premature death. Nursing plays an important role in translating these top level commitments into real demographic changes through

the design and delivery of key health care services and through sustained intervention at each point of contact with the public.

Although there has been a decline in infant deaths in Scotland, child health is considered to be a major influence in determining a person's health in adulthood and as such continues to be a focus of Scottish Executive policy as part of its *Early years framework* (2009).

Nurses currently on the third part of the Nursing and Midwifery Council (NMC) register are recognised as public health practitioners and undertake significant activities to promote public health. Health visitors and school nurses focus on children and families as part of their role, while occupational health nurses work in a variety of settings such as industry, health services, commerce, and education and are often employed as independent practitioners or as part of a larger occupational health service team. Occupational health nurses are considered to be leaders in public health in the workplace setting.

The occupational health nurse role includes:

- the prevention of health problems
- promotion of healthy living and working conditions
- understanding the effects of work on health and health at work
- health screening
- workforce and workplace monitoring
- health need assessment and health promotion
- counselling and support
- risk assessment and risk management.

Given the enormity of the key public health challenges in all four UK countries, it is clear we need a more focused and concerted approach by all health care professionals to work towards reducing the effects of unhealthy behaviours and social deprivation. In outlining a vision for the future of working-age-health, Dame Carol Black's review calls for the NHS to adopt a more radical approach to the organisation of its services to support working age health and to ensure work focused outcomes form part of patient care. To this end, the RCN endorses the recent statement made by Lesley Griffiths, Welsh Government Minister for Health and Social Services: "Every encounter between a health care professional and a member of the public should be considered as a public health encounter." Nurses, we believe, can be a powerful force to enable such public health encounters.

2

Celebrating the diversity of approaches

One of the key strengths of the RCN as a UK-wide representative organisation is its ability, via its membership and numerous member groups, to draw on the experience of all four UK countries in developing new and enhanced approaches for nursing.

Public health in each of the four countries faces major challenges including lifestyle choices, emerging infectious diseases, antibiotic resistance and climate change. However, the structures enabling public health and the approaches in each of the four countries are different.

This section of the publication examines some of the similarities and differences, and takes a look at how public health operates in a world of changing structures. It also looks at the different players in public health policy, the increasing financial constraints both nationally and globally, and the recognition by each of the four countries of the growing need for innovation in public health to meet these challenges.

The Coalition Government's white paper for England *Healthy lives, healthy people* proposes the creation of a new public health service to 'integrate and streamline' health improvement bodies and to take responsibility for vaccinations, screening programmes and to manage public health emergencies. Under these proposals responsibility for local health improvement in the main will transfer to local health authorities and Public Health England will be formed.

While public health in England is set to return to its 19th century roots in local government, the experience of Public Health Wales and in Northern Ireland suggest a new unified public health service can ensure a comprehensive set of public health resources, and that expertise can be organised and effectively deployed.

In Wales the health system has been made simpler, with seven health boards across the country. Planning and delivery have replaced internal markets.

The Scottish Government recognises that the shift from acute to a chronic model of health puts human behaviour at the centre of health policy and health care delivery. Health behaviours such as smoking, alcohol consumption, diet and physical activity are acknowledged as making a significant contribution to the health status of individuals, communities and populations in Scotland. *The Healthcare Quality Strategy for NHS Scotland* (2010) and the Patients' Rights (Scotland) Act 2011 are key drivers for person-centered care in NHS Scotland. The quality strategy puts in place the mechanisms for a culture change within the service towards a person-centered focus, while the Patients' Rights (Scotland) Act introduces a new charter of patient rights and responsibilities for individuals accessing NHS Scotland services.

Health inequalities and the social determinants of health are also key issues in relation to person-centred care. This is recognised within the new standards, which state that all nurses must understand public health principles, priorities and practice in order to recognise and respond to the major causes and social determinants of health, illness and health inequalities. Where necessary, they must challenge inequality, discrimination and exclusion from access to care. In Scotland the main government policy in relation to children has been the *Early years framework* (2008). Across Scotland a number of initiatives are being developed to test specific elements of national guidance. These include population based parenting programmes, pilots of the family nurse partnership model, and evaluation of child development contacts focusing on early communication and behaviour.

Dame Carol Black's review of the health of Britain's working-age population *Working for a healthier tomorrow* and the ensuing Department for Work and Pensions' strategy: *Health, work and wellbeing – caring for our future* (2005) are central to the wider welfare reform agenda. 'Health Work Wellbeing' is a cross departmental partnership between the Department for Work and Pensions, the Department of Health, the Health and Safety Executive, the Scottish Executive and the Welsh Assembly Government. The programme aims to help reduce health inequalities and social exclusion by demonstrating clearly that work helps people maintain and possibly improve their overall personal health and wellbeing. The aim is to prevent people becoming injured or ill; keep them healthy in work, and provide accessible support to enable them to remain in or return to work quickly.

The public health white paper for England *Healthy lives, healthy people* responds to the Marmot Report and outlines a new approach that will aim to build self esteem, confidence and resilience from infancy. The RCN welcomes the commitment to increase Sure Start's Children Centre based health visitors to make this aim possible. The challenges in the white paper on public health in England include improving maternal health, giving children a better start, reducing the risk of mental illness, influencing healthier lifestyles, better work place health, changing adults' behaviour to reduce premature deaths and preventing the excess in winter deaths.

In November 2010 the Northern Ireland Public Health Agency highlighted the need for collaborative working to improve the health and social wellbeing of people. In its *Public health director's report Northern Ireland 2010-2011* it outlines how the efforts to reduce health inequalities will be focused on four key work themes; giving every child and young person the best start in life, ensuring a decent standard of living for all, building sustainable communities and making healthy choices easier.

Public Health Wales has developed its own *Public Health Strategic Framework* setting out the services it delivers to local authorities, health boards and NHS trusts. Achieving fairer health outcomes for all is central to the approach outlined in the Welsh Government's document *Our healthy future* (2010) which sees reducing inequalities in health as a key theme and priority action.

In Scotland the government's *Better health, better care action plan* and *Equally well* publications make a series of commitments to improve the health of everyone in Scotland. In May 2010 NHS Scotland published the *Healthcare quality strategy for NHS Scotland,* a further development of *Better health, better care* with a clear focus on 'making measurable improvements in the aspects of quality of care'. The Equality Act 2010 is important in taking forward the patients' rights and person-centred care agendas in Scotland. It establishes a general duty for services in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex (gender) and sexual orientation. Under the act, if a user of NHS services believes they have suffered discrimination (that is, has been treated less favourably than a person who does not share a particular characteristic such as race or gender, or does not have an impairment defined legally as a 'disability'), they may be able to pursue this in law. The Equality Act 2010 offers NHS Scotland new opportunities to eliminate discrimination in service provision and reduce inequalities in health care.

It is the RCN's contention that a new approach should be adopted across the nursing team to ensure all nurses have an increased and more explicit role in public health and sustainable health, not only those on the SCPHN (specialist community public health nursing) register or those nurses working in general practice or in specific health promotion clinics including sexual health, TB and those working with homeless groups across Britain.

In its response to the English public health white paper consultation the RCN supported the government's commitment to put clinicians at the heart of decision-making in the NHS and stated: "we must ensure that the public health nursing workforce is sustainable and fit for purpose. This should include a mechanism for national oversight and integration between medical and non-medical workforce planning."

Alongside the commitment to increasing the numbers of health visitors (HVs) there needs to be an assurance that investment into the recruitment and training of nurses across the lifespan agenda for public health is also made. This needs to be supported by comprehensive workforce plans linked to service plans, which have the support and input of service planners and commissioners, providers and professional groups.

The RCN supports the view that all nurses should be enabled to play a role in and assist the delivery of good public health; in particular, proactively supporting self care and self management by focusing on behaviour change. The RCN believes this will have an impact on clinical outcomes and the long-term dependence on health service provision. Leadership, role modelling and specialist advice for all nurses engaged in public health activities can be sought and enabled via nurses in existing public health roles including but not exclusively, occupational health nurses, health visitors, school nurses and sexual health nurses.

We know, however, that self management support by nurses and other clinicians is still in its infancy. Much more can and should be done by clinicians to explore with patients the best way to make self-care and self-management a part of the routine care we give to patients. In its literature review on clinicians appraising the benefits of self management support, the Health

Foundation (2011) concludes that reducing people's dependence on health professionals and increasing their sense of control and wellbeing is a more intelligent and effective way of working.

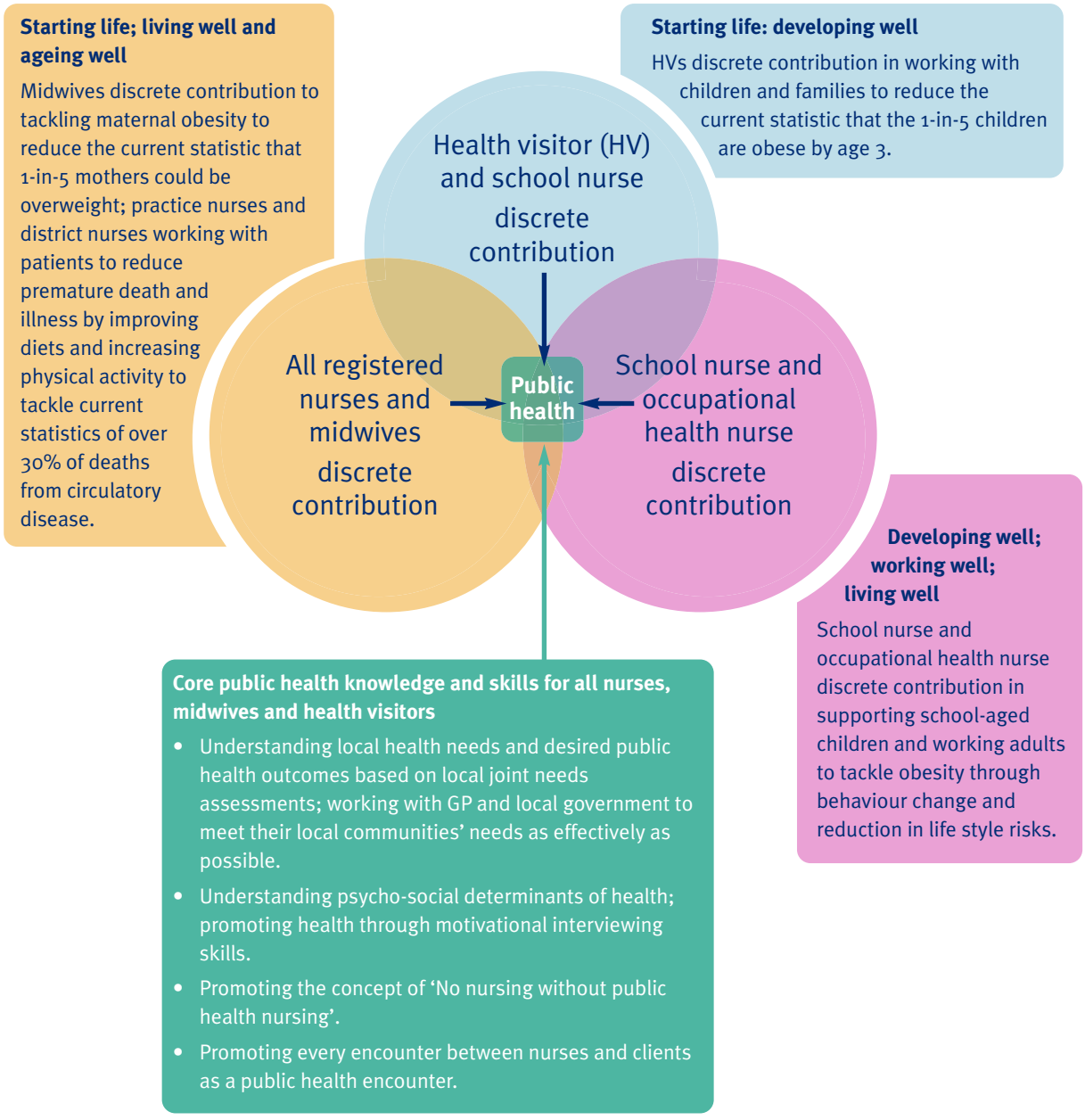
The *No health without public mental health* report published by the Royal College of Psychiatrists (2010) and the England white paper publication on Public Health 2010 clearly herald a new era and new approaches to public health for all health and social care professionals. All nurses have a key part to play in all three domains within the English white paper: health improvement; health protection; and improving health services. These key themes are also echoed and reflected in the strategic documents on public health in Northern Ireland, Wales and Scotland as cited earlier in this publication. To paraphrase the RCP report a focus and action on 'no nursing without public health nursing' could be endorsed.

The challenge for nursing generally is to ensure engagement with key service planning and commissioning bodies in each of the UK countries – for example in England, the local Health and Wellbeing Boards; the Public Health Agency in Northern Ireland; the leaders implementing 'Our healthy future' in Wales and those driving forward the NHS Scotland Healthcare Quality Strategy – so that each nurse understands the key principles of public health, the strategic needs assessments in each of their local areas, and works in new ways to respond to psycho-social determinants of health in addition to disease and disability. Any such change will progress the development of a nursing workforce capable of delivering equitable and sustainable health and wellbeing for all.

The work of the NHS Sustainable Development Unit should also inform and influence the development of the nursing curriculum to demonstrate the complimentary roles of public health and sustainable health. The RCN believes that nurses can make a significant contribution to achieving the balance required between financial, social and environmental factors to ensure future generations do not suffer because of the way we live today.

In its 2011 consultation document on health visiting, the RCN developed a diagrammatic view (see Figure 1) to help visualise how health visitors, other specialist community public health nurses and all other nurses and midwives can contribute to improving public health. The example shown illustrates tackling obesity across the life span, and each example case study depicts the discrete contribution of each nursing group to achieving reduction in the overweight population as a public health outcome. Each example shows the nursing contribution at each life span domain: starting well, developing well, living well, working well, and ageing well.

Figure 1 – Nursing contribution to public health (obesity)



Source: RCN, September 2011 consultation document on health visiting

3

A framework for upstream nursing

There is an opportunity to harness the huge potential of the entire nursing workforce and to supplement and enhance the public health interventions already undertaken by public health nurses. Developing the skills of all nurses to contribute to meeting the key public health challenges through life (*Starting life*; *Developing in life*; Living well; *Working well and Ageing well*) is a way forward worthy of consideration and action.

In this publication the RCN wishes to offer nurses working in all four UK countries a framework to engage actively in 'upstream' public health. The RCN believes a set of core ingredients and principles will help underpin the work of upstream nursing. The principles include:

- all nurses regardless of their work environment knowing and understanding the health needs of their local population
- the identification of defined populations that would enable health care teams to target individuals who would most benefit from upstream approaches
- working in partnership with other members of health and social care organisations, to influence the work on tackling the wider determinants of health
- engaging local people and groups, including those who are not working, in upstream awareness and action
- nurses making it their business to be informed, aware and responsive to disease outbreaks and other threats to health
- nurses utilising public health evidence in everyday practice, not just evidence for treating illness
- nurses working to a public health knowledge and skills framework based on the 'novice to expert' criteria.

Recognition should be given that the delivery of public health is of necessity on a continuum and therefore every nurse has a contribution to make, in whatever role they play, to improve the health of individuals and the communities they interact with; together with specialists in public health nursing and all nurses can navigate client care upstream. Using the principles outlined above will enable all nurses to assess their current approach to nursing practice in regard to whether they are working to influence the causes of ill health, rather than just reacting to the consequences.

Practical approaches for nurses working upstream can be linked to the key priorities facing service planners and commissioners (King's Fund, 2011), as Figure 2 illustrates.

Figure 2 – Key public health priorities

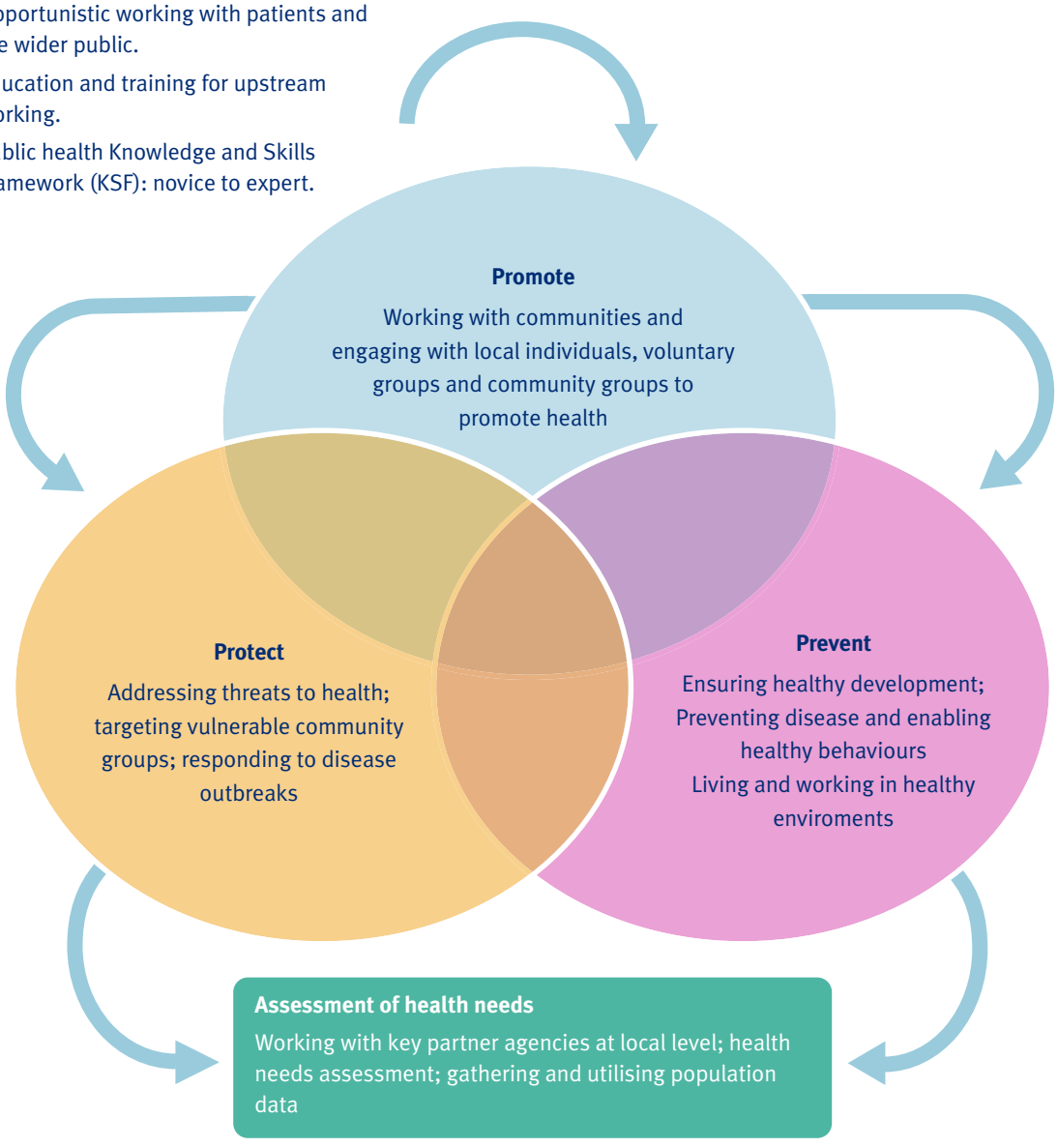
Source: RCN, 2011

A conceptual framework for upstream working by nurses illustrates the collective responsibility. Figure 3 captures the key areas for nurse involvement and accentuates the roles nurses can play in the promotion of health, protection from harm and the prevention of ill-health, underpinned by the assessment of health needs.

Figure 3 – Framework for upstream nursing

Necessary infrastructure

- Service planner/commissioner support.
- Effective nurse leadership.
- Employer encouragement.
- Opportunistic working with patients and the wider public.
- Education and training for upstream working.
- Public health Knowledge and Skills Framework (KSF): novice to expert.



Source: RCN, 2011

4

Innovation in upstream nursing

Prevention case studies

Prevention in acute health care

In 2009 Blackpool Teaching Hospitals NHS Foundation Trust implemented an organisational public health strategy. A key element of this strategy has been the delivery of the stop smoking in secondary care service. The service aimed to embed the assessment of smoking status and offer support to smokers in every clinical contact; to improve uptake to effective forms of support either via referral or medication; and to offer clinical support to smokers who are in hospital and experiencing forced abstinence. It was recognised that patients who smoked spent an average of two days longer in hospital and it was further acknowledged that the hospital setting provided an excellent opportunity to influence the health behaviour of patients as they may be more receptive to health advice and support while in hospital. The scheme included training for all clinical and non-clinical staff across the trust on the 'stop smoking care pathway'; the establishment of a stop smoking specialist adviser post; a publicity campaign under the brand name 'a better tomorrow' with a strapline for stopping smoking entitled: 'stop smoking, start living a better tomorrow'. Over a 12-month period the service has trained 385 staff in brief intervention, encouraged 500 clients to set a quit date and seen 232 proceed to stop smoking. The ward based support received by clients saw an average quit rate of 64 per cent, one of the highest quit rates in the area.

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Targeting screening for vulnerable patients

Inclusion Healthcare is a social enterprise jointly run by a nurse and a doctor. The focus of their work is to deliver a quality service to homeless and other socially excluded people. The enterprise has employed nurses to work in partnership with other agencies (health and non-health) to improve patient pathways for homeless people who become ill, thus avoiding unnecessary hospital admissions for this group of patients. In December 2010 they commenced the delivery of a full range of primary health care services including health education, promotion and screening to a highly vulnerable group of adults with moderate and severe learning disabilities. This is particularly important because the team has identified that people with learning disabilities may die from manageable long-term conditions. The team's aim is to improve health outcomes for this group of patients by ensuring timely interventions and proactive care.

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Helping people work well

A recent company health and safety campaign in EDF Energy focused on raising the awareness of musculoskeletal disorders (MSDs) in the workplace. While incidence of work-related MSDs have decreased to zero, there remains a steady rate of employees presenting with MSDs where their work is impacted or the job is aggravating existing or past MSD problems.

The objective of the programme included providing a central information repository on the prevention of MSDs for managers and employees, increasing the employees' personal responsibility to be aware of hazards in the workplace that may cause MSDs through risk assessment, and to promote the message that early intervention is important in assessment and treatment of developing MSD problems.

The 'Everybody' campaign was co-ordinated by the occupational health (OH) team via a virtual working group which included representatives from across the business. The working group reviewed central and targeted messages for different working environments; for example, issuing business drivers with 'at a glance' information containing ergonomic tips on posture and vehicle ergonomics.

Office 'walk throughs' were organised and provided by the OH advisers and/or occupational physiotherapists to help identify problems with display screen equipment and advise on any postural issues.

A dedicated micro-site was set up on the company intranet introducing a 'body map' with information about common MSDs associated with the main joints of the body. Employees could 'click' on any body part for further information. The site also included information about non-work related MSD risks, such as gardening.

The company's daily safety messages focused on different aspects of the campaign encouraging staff to discuss and think about their musculoskeletal health. Five top prevention tips were also included with useful external links:

1. take time to adjust work equipment (seating positions, vehicle mirrors)

2. organise time to allow for adequate stretch breaks, warm up before starting any physical task

3. make sure you access the display screen equipment training and learn/remind yourself about this information

4. organise activities to avoid repeated motion and vary lighter/heavier activities

5. stay in good physical condition – focus on posture and flexibility.

A comments box for staff was included for feedback and comments about the micro-site or to identify any problem areas in the business.

Some parts of the business also introduced pilates and yoga sessions, fitness challenges and a boot camp to increase general fitness and keep employees further engaged.

Nurse Champion: Linda Maynard – Senior Occupational Health Practitioner to EDF Energy

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Targeting screening for vulnerable patients

Linda, the Regional Nurse Co-ordinator in the screening division of the Public Health Wales Trust, identified that breast and cervical screening can be a daunting experience for women with a learning disability. Using evidence from national guidance and local screening service information, it was further recognised that people with learning disabilities are more likely to have problems but are less likely to access appropriate services. The initiators also found that the most significant barrier for women with a learning disability is communication. Over a 12-month period the project team developed a health promotion and education resource package for use by learning disability teams to support women through the screening process prior to attendance at their screening appointment. The two health education resources *Having a breast test* and *Having a smear test* have also now been made available to local teams and members of the public on the screening division website. The resources have now been developed further to include colcoscopy and breast assessment following abnormal screening results.

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Keep well for vulnerable groups in Scotland

Keep well is the Scottish Government's main anticipatory care and primary prevention initiative. Targeting the most deprived communities, the *Keep well* programme aims to engage with individuals who typically do not make full use of the health care services available to them. Kathy, the primary care support nurse in NHS Greater Glasgow and Clyde, describes how a project run under the *Keep well* banner offers individuals a health check followed by appropriate interventions and services. Patients are invited to attend a consultation which discusses lifestyle, literacy, financial matters, employability, and mental health as well as assessing cardiovascular risk factors. Motivational interviewing techniques are used to facilitate the change of poor lifestyle habits, and partnership working with many other organisations enables effective referral outcomes. Many people do not respond to the initial invitation request, and to address this outreach workers attempt to establish contact resulted in up to 80 per cent uptake from those who did not initially respond. NHS Greater Glasgow and Clyde has actively promoted *Keep well* within socially deprived areas, and the project is currently being rolled out across the health board area. General practice is in an ideal position to reduce health inequalities in partnership with the wider public health workforce and this new style of consultation is an example of practice changing to meet the needs of the population.

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Keeping well in prison

The *Keep well* programme's implementation in Scottish prisons has been facilitated by the *Keep well* project manager in the Scottish Prison Service/NHS. Building on the anticipatory care programme being delivered through *Keep well* in the community, it was recognised that there was a need to broaden the scope of the programme to include other vulnerable groups, such as offenders, who tend to have a high level of illness and incidence of risk factors for heart disease, including smoking, poor diet and physical activity. They also have poor levels of contact with NHS health services on release from prison. The health checks are targeted at prisoners aged 35 years and over who are sentenced to six-months or more. The health checks are provided by two peripatetic teams working across all adult prisons in Scotland. Each team consists of one team leader and two nurses, all of whom are Scottish Prison Service (SPS) staff who have been recruited and seconded onto the *Keep well* project from existing SPS health care teams. The *Keep well* nurses were recruited after they had demonstrated their commitment to health behaviour changes in the prison population. It was important that the nurses were able to show resilience and determination to overcome obstacles. Anticipatory care services are not normally well attended by prisoners either in custody or in the community. The SPS *Keep well* teams had to be creative in ensuring engagement with prisoners. Encouraging health behaviour changes in prisoners and motivating them to maintain the changes they make in the prison requires high levels of input for often small results.

The first SPS *Keep well* clinic took place in May 2010 and is now delivered in every adult prison in Scotland. By 30 September 2011 the *Keep well* programme had invited 5,285 prisoners for a *Keep well* check with 3,170 prisoners having attended for a health assessments. This is a 60 per cent engagement rate.

The success of the project so far can be attributed to several factors. The nurses involved have displayed a high degree of both clinical and interpersonal communication skills, and the combination of these two core skills has been critical in delivering health checks to a very challenging client group in a combination of locations within prisons. The nurses have had to be very flexible in their approach to convince the clients of the benefits of agreeing to complete a health check.

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Protection case studies

Protecting health in rural areas

The NHS Cumbria Health Protection team embarked on an innovation focused on localism which worked successfully in a largely rural county. Cumbria, the second largest county in the UK with a population of approximately half a million, has experienced several significant health protection risks including the propensity for flooding, severe weather, the nuclear industry and zoonotic risks from agriculture. Four senior nurses working within the Cumbria Health Protection team have a range of specialised skills and in recent years have been involved in dealing with foot and mouth outbreaks, severe flooding episodes, serious transport accidents and the west Cumbria shootings.

Their intervention in public health is demonstrated through the significant reduction in health care associated infections and high vaccine and screening uptake rates. They are proud that the team plays a key role in community-based local health protection through inter-agency and partnership working in Cumbria.

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Safer Global Travel Health

Having gained a diploma in travel medicine, Helen is the lead nurse in a private service travel clinic based in a health centre in Lisburn, Northern Ireland. In addition to her clinic responsibilities she also provides an advice and training service for practice nurses and others wishing to deliver travel health medicine. The training she offers is based on the *RCN Travel Health Medicine competences*. The course has been run five times in the last year and includes vaccine and malaria information to assist trainees work through traveller scenarios. Course evaluations have been positive and have inspired the nurse to continue this valued service.

Nurse Champion: Helen E Johnson – Travel Health Nurse Specialist

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James is a specialist travel health nurse who has established an independent travel clinic and consultancy business and wants to ensure people travelling abroad are able to get increased high quality access to advice, vaccinations and medication for the prevention of malaria. He provides a dedicated travel medicine service, offering a range of interventions from off-site services to travel groups with specific needs, through to on-site appointments for individuals. Utilising his skills in education and training, his clinic acts as a resource for local GP surgeries and practice nurses whilst at the same time providing travel medicine study days across the UK. The clinic has gained consistently high reviews from clients via Google and recognition from primary care practitioners. Working with a local general practitioner he has also developed and launched a special expedition and travel medicine study module for medical students at a local medical school.

Nurse Champion: James Moore – Director/Clinical Nurse Specialist

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Safety and protection from abuse

Lucy is a domestic violence risk liaison nurse who acts as a coordinator between the local Multi-Agency Risk Assessment Conference (MARAC) in Bristol and local health care providers. Her role includes flagging up to clinicians those patients receiving support through the MARAC, so that patients who are considered at risk receive an appropriate and sensitive service. The service has been established in recognition of the significant amount of domestic violence experienced by women; the escalating annual domestic violence cost and the significant percentage of children (75 per cent) subject to child protection plans who live in households where domestic violence occurs. The service is aimed at GPs, health visitors and community health professionals who are taught to use recognised risk identification tools to assess clients who may have a high risk of abuse. Nationally, MARACs have been shown to reduce repeat victimisation from 32 per cent to 10 per cent (Source: Cardiff University, 2003).

Nurse Champion: Lucy Muchina

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Promotion case studies

Safer sexual health in prison

The distribution of condoms and disinfectant tablets within prison is a recognised harm and risk minimisation strategy to reduce the transmission of sexually transmitted infections (STIs) and blood borne viruses (BBVs) among men who have sex with men and/or those who inject drugs or use other skin penetrating equipment (such as in home made tatoos).

The Department of Health and the prison service's joint position on the making of condoms and disinfectant tablets available to prisoners was established in 1995. However, there were long standing fears within the Isle of Wight prisons that providing access to condoms and disinfectant tablets would imply that the prison was encouraging or 'endorsing' homosexual activity and illicit injection of drugs among prisoners.

The nurse and head of prison health care outlines how these anxieties and resistance were still present locally some 15 years later in 2010, and his team raised the issue in the light of further recommendations from Her Majesty's Chief Inspector of Prisons that condoms and disinfectant tablets should be made available to prisoners within HMP Isle of Wight.

Supporting evidence (both prison service/offender and public health based) was gathered, and used to work with local prison colleagues to inform the development of the scheme and the prison health care staff decided to develop some promotional information that adopted humorous and easy to understand messages to run alongside the other material. These were designed as leaflets and posters for display in the prison wings and primary health care centres. If prisoners plan to have consensual sexual relationships, condoms, dental dams and lubricants are now available from prison primary health care centre nurses trained as 'condom distribution scheme advisers', to enable prisoners to have sexual intercourse as safely as possible. The provision of disinfectant tablets enables prisoners to clean any equipment used illicitly to either inject drugs or receive tattoos.

The introduction of these schemes does not mean that the prison condones or promotes sexual activity or illicit drug use among prisoners, but is part of promoting and supporting public health by preventing the spread of disease. The scheme aims to encourage prisoners to choose safer lifestyles whilst in custody and also on release. It has enabled nursing staff to move a step closer to the principle of 'equivalence' of health care for prisoners and has brought into open discussion and debate what has traditionally been a taboo subject within the prison.

Prisoners now have the ability to exercise further positive choices in maintaining a healthy lifestyle.

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Safer sexual health

Jenny is Practice Nurse Manager in the East Sussex Downs and Weald, Hastings and Rother area. She was aware of the high teenage pregnancy rate in the area, and worked with local service planners and commissioners to obtain funding to establish a drop-in clinic offering the full range of sexual health services from pregnancy testing and emergency contraception through to the fitting of implants and intra-uterine devices. Jenny is also accredited to train doctors and nurses to fit and remove implants and IUD/IUS. The clinic, which commenced in September 2011 and has secured funding initially for one year, is open to all ages (both male and female clients) and is staffed by the practice nurse manager, a GP and a health care assistant. Flyers publicising the service have been designed and distributed to all local agencies. Surrounding GP surgeries and schools have also been informed of the service and a website has been developed.

Nurse Champion: Jenny Greenfield – Practice Nurse Manager

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Promoting healthy living in the farming community

Heather is a health promotion nurse, based in Lincolnshire, who has established an innovative service providing health checks and health promotion advice to farmers and their families. The scheme is part of a larger service which offers pastoral and practical support to the farming and rural community run by a local Lincolnshire charity.

The nurse, who has a district nursing qualification, runs two clinics in the local livestock markets, weekly in one locality and fortnightly in the other. She provides basic health MOTs which include blood pressure, cholesterol, blood sugar, weight management, hearing, sight and mental health checks. The service is supported by the service planners and commissioners using Choosing health funds.

She says that farmers are well known for putting the health needs of their livestock above their own. Additionally, farmers often find it difficult to keep GP appointments due to the constraints of their working lives. By running the clinic in their workplace, Heather has found a high proportion are living and working with health issues that could be helped and improved with nursing and medical advice and support.

Through the work of her clinic, Heather has detected previously unknown diabetics and ensured these patients receive the necessary medication and dietary advice. She is able to refer on to other services where necessary, including general practice for medication reviews and further checks. The farmers find the service easier to access and therefore the uptake is encouraging.

Nurse Champion: Heather Dawes – Health Promotion Nurse

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Health chats: making every contact count

Amanda has been part of the Essential public health/health chats programme in Stockport, which offers a 2.5 hour training session to improve staff confidence and knowledge in undertaking health chats with clients. The programme teaches nurses and other frontline staff to provide opportunistic health and lifestyle advice, giving staff advice on how to quickly assess patient motivation (as this is key to supporting positive change and compliance). Patients are then signposted to appropriate services. This his patient-centred approach has been evaluated in the Stockport area and rolled out across the health economy, including local authority personnel and hospital staff. The benefits of the service include improved staff knowledge and confidence; increased lifestyle referrals and reduction in patients failing to attend appointments.

Nurse Champion: Amanda Huddleston – QUIPP Nurse Lead

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Health literacy and 'teach back' – a national approach in NHS Scotland

The NHS Healthcare Quality Strategy in Scotland made a commitment to 'improve resources to support better health literacy'. This is being taken forward by the Person-Centred Delivery Group, one of three groups established to implement the quality strategy. The person-centred ambition is to achieve mutually beneficial partnerships between patients, their families and those delivering health care services; partnerships which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making. Actions to achieve this ambition are system wide and will include 'improving communication and effective collaboration between patients and staff'.

As a Public Health Practitioner in Edinburgh Community Health Partnership, Kate has helped implement a programme of health literacy and 'teach back' (a technique that improves communication, patient safety, self-management and health literacy) to promote better understanding and self-management by clients. Teach back in the Edinburgh Community Health Partnership has proved to be a simple but effective way to check not only a patient's understanding of their condition but also to assimilate better the explanation and advice given to them at each interaction with nurses.

Nurse Champion: Kate Burton – Public Health Practitioner

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Conclusions

If we are to close the gap in health inequalities and the burden of avoidable ill health, then we must harness the full potential of the nursing workforce. It is crucial that public health nursing expertise and experience is fully recognised, is appropriately funded and is supported and utilised.

Nurses, midwives and health visitors are in a unique position to contribute to the lifespan approach to health protection and health improvement. This ranges from the midwives, nurses and health visitors who support early years development by providing targeted interventions (for example, through the Family Nurse Partnership programme), to specialist nurses who provide care and early intervention at specific times of need.

In every context and at every level, nursing staff carry out public health activities. They may work in public health departments , have a public health clinical role – such as specialist alcohol nurse, sexual health, occupational health or travel health – or they may deliver public health messages as part of everyday care provision or at 'teachable moments' (when patients are more open to public health messages in light of their present health condition).

The case studies have highlighted a cross-section of innovative public health nursing interventions, but these are only a fraction of the potential waiting to be supported and harnessed. Nurses, commissioners and employers need to work together with their communities to identify and eliminate the root causes of ill health. Every interaction in every location should be seen as an opportunity to promote health and prevent illness.

We hope that this publication will stimulate discussion and action, and that primary prevention and early intervention becomes embedded into all practice. This approach will inevitably provide challenges but it will also provide a great opportunity for nurses to directly influence and address health inequalities and improve the health and wellbeing of all UK citizens.

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