Department of Health
Public Health England

Nursing and midwifery actions at the three levels of public health practice

Improving health and wellbeing at individual, community and population levels

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Introduction

This document sets out the actions to be taken by individual nursing and midwifery groups in order to maximise wellbeing and improve health outcomes as part of action area one of the “Compassion in Practice” nursing and midwifery vision and strategy.

Actions are required by nursing and midwifery groups across all levels of practice; at individual, family and population level. This can be achieved by maximising the contribution of nurses, midwives and carers to improving the publics’ health and by ensuring that people get both a positive experience and the best possible outcomes from care.

Currently available metrics within the Public Health Outcomes Framework with available data source and indicator definition against which to measured outcomes of actions are identified for each individual group.

The individual nursing and midwifery groups are identified as follows:

- Practice nursing
- Community nursing
- Occupational health nursing
- Learning Disability nursing
- Mental health nursing
- Sexual health nursing
- Midwifery
- Health visiting
- School nursing
- Paediatric and neonatal nursing
- Acute / general nursing
- Palliative care nursing

It is recognised that this list is not exhaustive and that there are many more individual sub-specialities within these groups who contribute to maximising wellbeing and improving health outcomes through the specific nature of their practice.

Outlined below are core actions to be taken at individual, community and population levels that are common to all nursing and midwifery groups, together with specific actions relevant to each group, some of which are relevant to more than one group.

Core Actions - applicable to all nursing and midwifery groups

Individual Level

- Provide direct health care to individuals across in all settings, taking into account their family, social and environmental links together with consideration of the wider determinants of health
- Adopt an holistic approach to the care of individuals, making “every contact count” to improve health and wellbeing at every opportunity
- Offer and provide up to date evidence based advice and information on health and wellbeing on specific issues to individuals on how to improve health and wellbeing
- Provide advice and support to individuals at risk regarding preventable causes of premature mortality
- Signpost individuals to people and agencies that can help them improve their health and wellbeing
- Agenda match with individuals to identify realistic and achievable goals with regards to improving their health and well-being and the actions they may take to achieve improvement
- Listen to and support individuals to communicate their views of and concerns about health and wellbeing, refer others with consent

Community Level

- Assessment of community needs specific to locality reflected through the planning and provision of specific community focused programmes to meet these needs
- Accessing “hard to reach” groups and those who do not access services through the targeted provision of specific programmes designed to be responsive to local needs
- Plan, implement and review specific aspects of health improvement projects following effective engagement with communities and those responsible for the commissioning and design of services
- Work effectively with public and communities to improve health and well-being and reduce inequalities
- Articulate the health interests and concerns of individuals and communities to relevant people through the utilisation of population level data
- Identify and take advantage of opportunities to improve health and wellbeing and reduce inequalities within communities
- Develop resources for specific audiences to support the improvement of health and wellbeing and the reduction of inequalities within communities
- Provision of evidence based community level health care programmes

Population Level

- Influence and shape the multi-agency political and policy agenda to maximise opportunities for improving population health and wellbeing and reducing inequalities

- Engage with strategic partners in all sectors and the public to establish need and determine goals, priorities, strategies and success criteria for improving population health and wellbeing and reducing inequalities
- Lead on commissioning for improving population health and wellbeing and reducing inequalities
- Lead on the development, implementation and evaluation of health improvement programmes across agencies, partnerships and communities
- Build sustainable capacity and resources for health improvement and the reduction of inequalities
- Ensure infrastructure & processes are in place to support regional & national strategies to improve health & wellbeing & reduce inequalities
- Ensure policy development to support good practice and ensure that effective risk assessment and management processes for nursing & midwifery practices are in place and that lessons are learned and applied from complaints, adverse incidents, “near misses” and reviews
- Ensure nursing and midwifery staff have the appropriate skill set and training to deliver the service required

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to all nursing and midwifery groups

Overarching indicators

0.1i - Healthy life expectancy at birth

0.1ii - Life expectancy at birth

Generic health & wellbeing indicators

1.13 Re-offending levels

1.14 The percentage of the population affected by noise

1.15 Statutory homelessness

1.16 Utilisation of outdoor space for exercise/health reasons

Health protection

3.1 Fraction of mortality attributable to particulate air pollution

3.5 Treatment completion for Tuberculosis (TB)

4.8 Mortality rate from infectious and parasitic diseases

4.15 Excess winter deaths

Specific actions to be taken by nursing and midwifery groups

Practice Nursing

Individual Level

- Working with individual patients to improve health and wellbeing by improving nutrition, smoking cessation, moderating alcohol intake and increasing physical activity
- Supporting individual patients to recover from illness or injury and enhance quality of life for those with long term conditions
- Treating and caring for individuals in a safe environment and protecting them from harm
- Provision of individual immunisation and vaccination procedures
- Provision of individual screening procedures
- Improve outcomes for those with long term conditions reducing co-morbidities

Community Level

- Planning and provision of community level immunisation and vaccination programmes
- Planning and provision of community level screening programmes
- Reduce the causes of premature mortality through targeted health improvement programmes
- Provide specific health and wellbeing advice for “hard to reach” groups
- Address the wider determinants of ill health through routine contact with the wider community
- Provide programmes of support for long term disease management in the wider community

Population Level

- Reduction in preventable and premature mortality through participation in screening programmes e.g. NHS cancer screening programmes, Coronary heart disease screening, Diabetes screening
- Achieve herd immunity through the increased uptake of immunisations and provision of immunisation & vaccination programmes
- Partnership and collaborative working, networking, signposting & actively engaging with primary, secondary and social care and third sector partners
- Achieve interconnectivity between all nursing groups and the wider population to increase basic awareness, reduce stigma and improve the quality of care of those with dementia thus meeting the Dementia Challenge

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to practice nursing

2.4 Under 18 conceptions

2.6 Excess weight in 4-5 and 10-11 year olds

2.9 Smoking prevalence – 15 year olds (Placeholder)

2.13 Proportion of physically active and inactive adults

2.14 Smoking prevalence – adults (over 18s)

2.17 Recorded diabetes

2.19 Cancer diagnosed at stage 1 and 2

2.20 Cancer screening coverage

2.23 Self-reported well-being

2.24 Injuries due to falls in people aged 65 and over

3.2 Chlamydia diagnoses (15-24 year olds)

4.3 Mortality rate from causes considered preventable

4.4 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)

4.5 Under 75 mortality rate from cancer

4.6 Under 75 mortality rate from liver disease

4.7 Under 75 mortality rate from respiratory diseases

4.8 Mortality rate from infectious and parasitic diseases

4.9 Excess under 75 mortality rate in adults with serious mental illness

4.10 Suicide rate

4.12 Preventable sight loss

4.14 Hip fractures in people aged 65 and over

4.15 Excess winter deaths

Community Nursing

Individual Level

- Working with individual patients to improve health and wellbeing by improving nutrition, smoking cessation, moderating alcohol intake and increasing physical activity
- Supporting individual patients to recover from illness or injury and enhance the health and social well-being, independence and quality of life of those with long-term conditions
- Treating and caring for individuals in a safe environment and protecting them from harm
- Enhancing independence by helping and empowering individuals to maintain their functionality and supporting self-management for those with long term conditions

Community Level

- Leading, delivering and evaluating care delivered nearer to home, working with families to deliver co-ordinated care
- Leading and co-ordinating an holistic assessment and whole system approach through key working

- Community level crisis prevention schemes to identify those at risk of serious illness eg diabetes and hypertension – detect chronic disease symptoms before problems become a crisis
- Care provision in any community environment and supporting smooth transitions between primary to secondary care
- Prioritising care and case management according to need and complexity of care

Population Level

- Adopt a 'programme approach' to a specific population group that includes good access to extended primary care services, supporting health promotion and primary prevention, and co-ordinating community based packages for rehabilitation, re-ablement and independent living
- Reduction in premature mortality rates through the provision of services that promote the proactive management of long-term health conditions and acute illness
- Collaborative multi agency working to provide population based nursing interventions, screening and protection to improve community health and wellbeing
- Develop and promote the widespread use of assistive technology to work with patients to help them stay independent
- Partnership and collaborative working, contributing to needs assessment, networking, signposting & actively engaging with primary, secondary and social care and third sector partners
- Achieve interconnectivity between all nursing groups and the wider population to increase basic awareness, reduce stigma and improve the quality of care of those with dementia thus meeting the Dementia Challenge

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to community nursing

2.13 Proportion of physically active and inactive adults

2.14 Smoking prevalence – adults (over 18s)

2.17 Recorded diabetes

2.19 Cancer diagnosed at stage 1 and 2

2.20 Cancer screening coverage

2.23 Self-reported well-being

2.24 Injuries due to falls in people aged 65 and over

4.3 Mortality rate from causes considered preventable

4.4 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)

4.5 Under 75 mortality rate from cancer

4.6 Under 75 mortality rate from liver disease

4.7 Under 75 mortality rate from respiratory diseases

4.11 Emergency readmissions within 30 days of discharge from hospital

4.12 Preventable sight loss

4.14 Hip fractures in people aged 65 and over

4.15 Excess winter deaths

Occupational Health Nursing

Individual Level

- Individualised health screening on commencement of employment including health screening, health needs assessment, risk assessment and health promotion
- The provision of individual counselling and support, identification of stress triggers, sleeping issues, healthy work life balance
- Increasing individual awareness of musculoskeletal disorders in the workplace; correct adjustment of equipment, stretch breaks, VDU management, posture and flexibility
- Individual assessments regarding adjustments required to support the employee in the workplace
- Provision of wider health and wellbeing advice to reduce the risk of causes of preventable mortality and promote wider awareness of the availability of wider support available in the community

Community Level

- The provision of healthy, safe work environments across communities, which leads to high levels of staff engagement and, in the health care sector, positive patient outcomes
- The promotion of healthy living and working conditions within the workplace
- Developing the workplace within the community and improving health and wellbeing through participation in public health programmes e.g. Change for life programme
- Protecting wider community health through increased awareness of health and wellbeing issues and uptake of public health screening programmes particularly with hard to reach groups

Population Level

- Monitoring of the workforce and workplace with regards to health and safety requirements Reduction in work related stress and long term sickness absence levels impacting on short and long term health outcomes, employment levels and wider determinants of health
- Protecting health at population level through the promotion of national screening programmes eg, HIV & Cancer screening in hard to reach groups and the wider population
- Contribute to population level programmes which reduce the impact and prevalence of major causes of premature mortality EG diabetes, cardio-vascular disease

- Achieve interconnectivity between all nursing groups and the wider population to increase basic awareness, reduce stigma and improve the quality of care of those with dementia thus meeting the Dementia Challenge
- Management/advice/prevention of acute seasonal illnesses

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to community nursing

2.13 Proportion of physically active and inactive adults

2.14 Smoking prevalence – adults (over 18s)

2.17 Recorded diabetes

2.19 Cancer diagnosed at stage 1 and 2

2.20 Cancer screening coverage

2.23 Self-reported well-being

4.3 Mortality rate from causes considered preventable

4.4 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)

4.5 Under 75 mortality rate from cancer

4.6 Under 75 mortality rate from liver disease

4.7 Under 75 mortality rate from respiratory diseases

4.8 Mortality rate from infectious and parasitic diseases

4.9 Excess under 75 mortality rate in adults with serious mental illness

4.10 Suicide rate

4.12 Preventable sight loss

Learning Disability Nursing

Individual Level

- Promoting access for individuals to mainstream health services and providing direct specialist support as required, to reduce barriers and support the person to pursue a fulfilling life
- Health interventions provided in the person's everyday environment in the first instance and, where this is not possible, then within the least restrictive setting and as close to home as possible
- Helping to tackle inequalities, both through direct action and through influencing others' views and actions
- Assessing the individuals physical and mental wellbeing at every contact to ensure early identification, assessment and treatment of acute and long term health conditions

Community Level

- Provide a resource in educating, advising and consulting with other health workers, as well as supporting people with learning disabilities in accessing healthcare

- Contribute to the identification, assessment and treatment of mental health problems in a wide range of settings
- Delivery of a full range of primary health care services including health education, promotion and screening to groups of adults with learning disability
- Work in real partnership with people with learning disabilities and their families, as well as with other professionals, organisations and the wider community
- Increase wider community awareness of people with Learning Disabilities and their needs, integrating these within wider community plans

Population Level

- Achieve interconnectivity between all nursing groups and the wider population to increase basic awareness, reduce stigma and improve the quality of care of those with dementia thus meeting the Dementia Challenge
- Reduction in number of people with learning disabilities who die from manageable long-term conditions, through early identification of risk and timely interventions
- Increase uptake of screening amongst those with learning disability through effective communication tools
- Support the development of systems of care for people with learning disabilities who have mental health problems
- Collaborative multi agency working with service users, carers and advocates and development of skills, to reduce risk, improve communication and improve the assessment of mental health needs leading to early intervention and evidence-based treatment plans
- Create a service specification, model of care and outcome measures to meet the health and social care needs of those with learning disabilities

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to learning disability nursing

1.6 Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation

4.3 Mortality rate from causes considered preventable

4.12 Preventable sight loss

Mental Health Nursing

Individual Level

- All mental health nurses maximise their role in health and wellbeing providing advice and support on the preventable causes of long-term conditions. Promote equitable care for all groups and individuals. Help reduce stigma and discrimination
- Working with individuals to achieve the ‘Five ways to wellbeing’; connect, be active, take notice, keep learning and give

- Support services designed for the purposes of independence, wellbeing and dignity provided to individuals given choice and control, regardless of the care setting including those who are socially excluded

Community Level

- Mental health nurses with specific primary and secondary health promotion and ill health prevention roles
- Early intervention & prevention
- Working with families with multiple problems, long term illness & co-morbidities
- Work across communities to improve public attitudes and reducing the institutionalised discrimination inherent in many organisations, including support services
- Recognising the value of service users and carers contribution through involvement in the design of local care provision & develop new approaches to better meet local needs

Population Level

- Achieve interconnectivity between all nursing groups and the wider population to increase basic awareness, reduce stigma and improve the quality of care of those with dementia thus meeting the Dementia Challenge
- Mental health nurses advising, supporting and working in partnership with public health partners to improve health and wellbeing and increase access to screening
- Successful implementation of Individual and group interventions meet national priority of “No health without mental health”
- “Time to change” national campaign strategy to reduce stigma and discrimination
- Collaborative multi agency working with service users, carers and advocates and development of skills, to reduce risk, improve communication and improve the assessment of mental health needs leading to early intervention and evidence-based treatment plans

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to mental health nursing

2.14 Successful completion of drug treatment

4.3 Mortality rate from causes considered preventable

4.9 Excess under 75 mortality rate in adults with serious mental illness

4.10 Suicide rate

4.12 Preventable sight loss

Sexual Health Nursing

Individual Level

- Providing education and information for individuals attending sexual health services

- Encouraging individuals to contribute actively to both the management of their own sexual health and wellbeing, improving the awareness of the risks to long health and wellbeing from high risk sexual behaviours
- Provision of directly accessible, proactive and non-judgmental sexual health and contraceptive care based on individual need
- Provision of sexual health screening, prevention advice and treatment of sexually transmitted infections to sexually active individuals of all ages
- Provision of behavioural counselling interventions to high risk individuals to promote safer sexual behaviour

Community Level

- Education across all settings ensuring that sexually active people of all ages have the information to make positive lifestyle choices
- Open access to sexual health vaccination and screening programmes and to good quality, evidence based sexual health information and advice services
- Work with hard to reach groups to increase screening and treatment of sexually transmitted diseases and HIV
- Ensure sexual health services are delivered in the most cost effective and accessible way that guarantees quality and effectiveness across the health economy better linking them into the heart of community health and primary care services
- Integrating the delivery of sexual health and reproductive healthcare providing access to both services at the same time whilst ensuring separate specialist expertise where necessary

Population Level

- Ensure national public health programmes that influence positive behaviour change
- Ensure the provision of the national chlamydia screening programme to control and prevent chlamydia through the early detection and treatment of asymptomatic infection
- Ensure coordination of integrated commissioning of sexual & reproductive health & HIV services across the NHS CB, GP commissioners and Local Authorities ensuring services are commissioned at the most appropriate level
- Develop integrated models of service delivery to allow easy access to confidential, non-judgemental sexual health services, including for screening, sexually transmitted infections, contraception, abortion, health promotion and prevention

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to sexual health nursing

2.4 Under 18 conceptions

3.2 Chlamydia diagnoses (15-24 year olds)

3.3 People presenting with HIV at a late stage of infection

Midwifery

Individual Level

- Individual obstetric, medical and social risk assessment by 12 completed week's gestation
- Signposting and referral of individual women with medical risk factors and complex social needs to relevant professionals / agencies eg Obstetric care, smoking cessation services, Dietetic services, Safeguarding teams, CAMHs, Drug and alcohol services
- One to one care in labour to support the promotion of normality and reduction in intervention such as caesarean section rates
- Individualised support & encouragement of breastfeeding with referral to breastfeeding support services for those experiencing problems
- Individualised care pathways to ensure improved maternal physical & mental health and wellbeing enabling strong early attachment and maternal and infant wellbeing

Community Level

- Provision of local antenatal and newborn screening programmes meeting key performance indicators
- Smoking cessation CO monitoring
- Healthy start vitamin uptakes
- Provision of specialist care pathways for vulnerable women – in conjunction with family nurse partnerships
- Provision of parent education programmes in preparation for parenthood conveying clear and informative public health messages
- Promotion of breastfeeding in hospitals and at community level: – universal baby friendly standard reached by all care staff and breastfeeding welcome promoted in public places

Population Level

- Provision of high quality , responsive maternity services in which women, their partners and families are supported to maintain & improve health and wellbeing throughout pregnancy, birth, the postnatal period and beyond through the transition to parenthood
- Reduction in maternal and child mortality and morbidity rates resulting from medical, obstetric, social and psychological risk factors
- Provision of regional antenatal & newborn screening programmes leading to early detection and where possible treatment of congenital abnormalities and disease
- Increase in breastfeeding rates at population level, improved short and long term outcomes through improved nutrition leading to improved obesity rates and related illness in later life

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to midwifery

2.1 Low birth weight of term babies

2.2 Breastfeeding

2.4 Under 18 conceptions

2.13 Proportion of physically active and inactive adults

2.14 Smoking prevalence – adults (over 18s)

2.17 Recorded diabetes

4.1 Infant mortality

Health Visiting

Individual Level

- Co-ordination of universal services to all families on individual health visitor caseload within the first year of life improving life chances
- Co-ordination of universal plus services to individuals on health visitor caseload requiring a swift response to specific needs and requiring expert intervention
- Co-ordination of universal partnership plus services to individuals on health visitor caseload requiring ongoing support, from a range of agencies, dealing with complex issues over a period of time
- Agenda match with parents to identify optimum delivery of the healthy child programme for their family
- Provision of family nurse partnership programmes of care to vulnerable first time mothers and their babies in line with the “starting well” life course approach
- Individualised care to ensure improved maternal physical & mental health and wellbeing enabling strong early attachment and maternal infant wellbeing and the development of loving, resilient families
- Support the uptake of individual newborn & child immunisation and vaccination programmes
- Provision of individual newborn & child developmental surveillance screening procedures
- Recognition of safeguarding risks within the individual family and respond appropriately

Community Level

- Provision of universal services to ensure a healthy start for all children through access to a range of community services
- Reduced number of children requiring formal safeguarding arrangements through early identification & intervention ensuring healthy early years development and improved school readiness
- Promotion of breastfeeding at community level: universal baby friendly standard reached by all care staff and breastfeeding welcome promoted in public places
- Provision of parent education programmes in preparation for parenthood conveying clear and informative public health messages and supporting the development of sensitive parenting skills

- Promote healthy lifestyles and work with communities to build and use the strengths within those communities to improve health and wellbeing and reduce inequalities

Population Level

- Provision of the Healthy Child Programme through collaborative working with primary, secondary and social care and third sector colleagues to ensure early identification of need and intervention to meet the needs and aspiration of the family
- Achieve population wide “herd” immunity through the increased uptake of immunisations
- Increase in breastfeeding rates & improved nutrition in the first years of life at population level, improved short and long term outcomes through improved nutrition leading to improved obesity rates and related illness in later life
- Improved outcomes in communication, language, social and emotional development leading to improved school readiness
- Achieve interconnectivity between all nursing groups and the wider population to increase basic awareness, reduce stigma and improve the quality of care of those with dementia thus meeting the Dementia Challenge
- Ensure the Building community capacity programme to support practitioners in revisiting public health practice and re-establishing skills and opportunities that help sustain and build capacity within families, communities and local populations

Outcomes of these actions can be measured via the following currently available metrics within the Public health Outcomes Framework relevant to health visiting

1.1 Children in poverty

1.10 Killed and seriously injured casualties on England’s roads

2.1 Low birth weight of term babies

2.2 Breastfeeding

2.4 Under 18 conceptions

2.8 Emotional well-being of looked after children

2.13 Proportion of physically active and inactive adults

2.14 Smoking prevalence – adults (over 18s)

2.17 Recorded diabetes

2.23 Self-reported well-being

2.24 Injuries due to falls in people aged 65 and over

4.1 Infant mortality

4.3 Mortality rate from causes considered preventable

4.4 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)

4.5 Under 75 mortality rate from cancer

4.6 Under 75 mortality rate from liver disease

4.7 Under 75 mortality rate from respiratory diseases

4.8 Mortality rate from infectious and parasitic diseases

4.9 Excess under 75 mortality rate in adults with serious mental illness

4.10 Suicide rate

4.12 Preventable sight loss

4.14 Hip fractures in people aged 65 and over

School nursing

Individual Level

- Provision of universal access to services for all school aged children
- Leading support for individual children and young people with complex and/or additional health needs including education, training and support for families, carers and school staff
- Identifying individual children and young people in need of early help and where appropriate providing support to improve their life chances and prevent abuse and neglect. This includes working with children and young people at risk of becoming involved in gangs or youth violence
- Provision of individual child immunisation and vaccination procedures
- Provision of individual child developmental surveillance screening procedures

Community Level

- Leading, delivering and evaluating universal Public Health programmes for school-aged children and young people, both within school and community settings
- Reduced numbers of children requiring formal safeguarding arrangements – achieved through early identification and intervention
- Increased uptake of early help and access to evidence based preventative services, which are tailored to meet individual and family needs, including support for parental needs e.g. mental health concerns
- Increased uptake from children, young people and families, of preventative services tailored to their needs and all families access evidence-based programmes including parenting programmes

Population Level

- Leading and promoting national campaigns targeted at school age children to promote health and well-being: eg anti-bullying, drug misuse, anti –smoking, sexual health, contraception impacting on population level improvements in mental and physical health of young people, higher levels of educational achievement and employment and associated impact on the wider determinants of health
- Ensuring the provision of responsive and high quality, youth friendly, school nursing services which meet the You're Welcome quality standard
- Reduced incidences of obesity and positive lifestyle changes through improved coverage of National Child Measuring Programme

- Reduction in prevalence of chlamydia in 15-24 year olds and reduction in under 18 year olds conception rates
- Reduction in proportion of young people who frequently use illicit drugs or alcohol or that smoke
- Ensure processes are in place which prepare young people for the transition from health services designed for children and young people to adult health services particularly those with long-term health needs

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to school nursing

1.1 Children in poverty

1.3 Pupil absence

1.4 First time entrants to the youth justice system

1.5 16-18 year olds not in education, employment or training

2.4 Under 18 conceptions

2.6 Excess weight in 4-5 and 10-11 year olds

2.8 Emotional well-being of looked after children

2.9 Smoking prevalence – 15 year olds (Placeholder)

3.2 Chlamydia diagnoses (15-24 year olds)

4.3 Mortality rate from causes considered preventable

4.5 Under 75 mortality rate from cancer

4.10 Suicide rate

4.12 Preventable sight loss

Paediatric / Neonatal Nursing

Individual Level

- Provision of health and wellbeing advice to children and families in order to reduce the risk of developing long term conditions in later life

- Individualised support & encouragement of breastfeeding with referral to breastfeeding support services for those experiencing problems
- Individualised care to promote early attachment and maternal and infant wellbeing
- Early intervention in parenting and mental health and wellbeing issues providing support
- Supporting children and young people living with complex disabilities and chronic conditions

Community Level

- Reduced number of children requiring formal safeguarding arrangements through early identification & intervention ensuring healthy early years development and improved school readiness
- Leading, delivering and evaluating care delivered nearer to home, working with families to deliver co-ordinated care
- Leading and co-ordinating an holistic assessment and whole system approach through key working
- Developing care provision in community environments and supporting smooth transitions between primary to secondary care

Population Level

- Increase in breastfeeding rates & improved nutrition in the first years of life at population level, improved short and long term outcomes through improved nutrition leading to improved obesity rates and related illness in later life
- Ensure processes that prepare young people for the transition from health services designed for children and young people to adult health services particularly those with long-term health needs
- Take a population level approach to the health and wellbeing of children and families providing opportunities to address the wider determinants of health and health improvement actions

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to paediatric and neonatal nursing

1.1 Children in poverty

2.4 Under 18 conceptions

2.8 Emotional well-being of looked after children

4.1 Infant mortality

Acute / General Nursing

Individual Level

- Provision of individualised, patient centred nursing care during acute illness episodes to promote full recovery and long term health and wellbeing

- Provision of individualised, patient centred nursing care in those with chronic health conditions in order to maximise wellbeing and improve health outcomes
- Compliance with standard principles of infection prevention and control to reduce the risk of health care associated infection
- Encourage individuals to uptake offers of screening and benefits
- Individualised criteria based discharge planning by both acute and community sectors to ensure discharge is timely and appropriate and referrals to appropriate supporting services are made

Community Level

- Identifying and knowing the needs of the local population
- Provision of infection control measures to ensure public protection at community level
- Co-ordination of multi-agency discharge planning processes for those with complex needs to reduce readmission rates and length of stay and improve health outcomes
- Addressing health inequalities through designing and communicating important public health promotion and prevention messages to patients, carers and the multi- disciplinary team
- Engagement with relevant stakeholders to ensure effective policy development and inter-agency working with other statutory, independent, voluntary and community sector organisations

Population Level

- Achieve interconnectivity between all nursing groups and the wider population to increase basic awareness, reduce stigma and improve the quality of care of those with dementia thus meeting the Dementia Challenge
- Tackle the wider determinants of health through every contact ensuring risk factors for causes of premature mortality are addressed
- To ensure a population and pathway approach is taken to address health and wellbeing of the population through targeted action

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to acute / general nursing

1.10 Killed and seriously injured casualties on England's roads

2.13 Proportion of physically active and inactive adults

2.14 Smoking prevalence – adults (over 18s)

2.17 Recorded diabetes

2.19 Cancer diagnosed at stage 1 and 2

2.20 Cancer screening coverage

2.23 Self-reported well-being

2.24 Injuries due to falls in people aged 65 and over

4.3 Mortality rate from causes considered preventable

4.4 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke)

4.5 Under 75 mortality rate from cancer

4.6 Under 75 mortality rate from liver disease

4.7 Under 75 mortality rate from respiratory diseases

4.9 Excess under 75 mortality rate in adults with serious mental illness

4.10 Suicide rate

4.11 Emergency readmissions within 30 days of discharge from hospital

4.12 Preventable sight loss

4.14 Hip fractures in people aged 65 and over

4.15 Excess winter deaths

Palliative Care Nursing

Individual Level

- Maintain and provide and advice and support to ensure that those at the end of life 'live well'
- Identification of those approaching the end of life, assessing needs and preferences agreeing a set of actions reflecting the choices individuals make about their care
- Wherever possible enable individuals nearing the end of their life to choose where they live and die
- Provision of end of life care treating individuals with dignity and respect; aiming to ensure they are without pain and other symptoms; are in familiar surroundings; and in the company of close family and/or friends

Community Level

- Provision of a multidisciplinary approach to support palliative care teams in the provision of support to address physical, emotional, spiritual, and social concerns that arise with advanced illness
- Within each local health economy mechanisms need to be established to ensure that each person approaching the end of life receives coordinated care, in accordance with the care plan, across sectors and at all times of day and night
- Ensure the provision of education programmes for health and social care staff at all levels to have the necessary knowledge, skills and attitudes related to care for the dying

Population Level

- Ensure implementation of the National End of Life Care strategy, through a whole systems pathway approach, improving access to high quality care for all people approaching the end of life
- Ensure a population wide approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable

assessment and treatment of pain and other problems, physical, psychosocial and spiritual"

- Participation in the work of The National End of Life Care Intelligence Network (NEoLCIN) to improve the collection and analysis of information related to the quality, volume and costs of care provided to those approaching the end of life
- Achieve interconnectivity between all nursing groups and the wider population to increase basic awareness, reduce stigma and improve the quality of care of those with dementia thus meeting the Dementia Challenge

Outcomes of these actions can be measured via the following currently available metrics within the Public Health Outcomes Framework relevant to palliative care nursing

2.17 Recorded diabetes

2.19 Cancer diagnosed at stage 1 and 2