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This assignment is going to focus on Community Health Care Nursing, primarily being focused on individuals living in the United Kingdom (UK). The responsibility of a community health nurse in society is to focus on the health requirements of their patients outside of the hospital setting (Drennan and Goodman, 2014). Therefore, the nurse's work role is being an advocate, health care provider, educationalist, supporting chronic disease management, mediator for agencies to promote healthy outcomes of the individual and the community, in addition to child and adult protection (Drennan and Goodman, 2014). Furthermore, there are numerous areas in which a registered nurse can specialise within, these include education, district nursing, health visitors, occupational nursing, community paediatric and walk-in centres such as, sexual health and contraception (Drennan and Goodman, 2014). Additionally, community nursing can correspondingly be acknowledged as primary health care which can be demarcated as, a methodology to the development and provision of health services in the community (Blackie *et al.*, 1998). Moreover, Ebrahim and Rankin (1993) argue, methods to community health care highlights extensive health care structures that include the accomplishment of preventing, promoting and healing individuals. Therefore, systems are established and applied with the involvement of individuals, the family or any person in the community attaining care services (Ebrahim and Rankin, 1993). However, due to the vast amount of health care fields a community nurse is responsible for, this essay will concentrate primarily on older patients in addition to, current legislation that protects those 'at risk' within a health and social care setting.

Health and social care have been established historically from an institutional and building-based environment to a more community-based paradigm (Glasby, 2017). Numerous economic difficulties and out-dated requirements were prominent in the development of additional community nurses during the 1980s and 1990s (Glasby, 2017). During the 20<sup>th</sup> century the UKs life expectancy augmented from 45.5 (men) and 49 (female) to 74.4 and 79.7 in the 1990s (Tinker, 1996 *cited in* Glasby, 2017, p. 47). Although, the aging population in current times should be an indication of accomplishment to the welfare state, nevertheless, social change signifies the need for more community health amenities (Glasby, 2017). However, the Office for National Statistics (ONS, 2015) reported, one in twelve individuals will be aged over 80 by 2039, a rise of 89.3 per cent to 9.9 million people, reasons for this may be because of medical

advances in technology. As of 2017, the population of the UK conveyed by ONS surpassed to 66 million people (Ons.gov.uk. 2018a). Additionally, 639 thousand individuals are working as nurses in the UK during 2018, 285 thousand are employed full time and the majority of nurse's work for the National Health Service (NHS) (Statista, 2018). Moreover, all nurses actively working in the UK must be registered with the Nursing and Midwifery Council (NMC) (Statista, 2018). Thus, the NMC is responsible for ascertaining the standard of care, professional code of practice as well as conversant training for nurses and midwives. The Royal College of Nursing (RCN) (2010) argue, nurses and health care assistants make up the majority of those individuals working for the NHS, with over 400,000 staff members working towards providing the health policy goals of all governments across the UK. Due to everchanging governmental and financial priorities, the community health and social care setting are quickly altering throughout the country, each government is authorised to respond exclusively to the health requirements of society and organise the health service suitably (Royal College of Nursing, 2010). In England, there have been challenges to develop primary and community facilities, in the hope of reducing the need for hospital admissions, whilst improving the health of the public (Royal College of Nursing, 2010). Moreover, the White Paper, 'Our health, our care, our say' during 2006, comprised of extensive public discussions and led to the health improvements in England (Royal College of Nursing, 2010). Therefore, Transforming Community Services (TCS) adapted six agendas, endorsing health and wellbeing and equality, closer to home services, children and family amenities, help with long-term health conditions, rehabilitation and long-lasting neurological conditions as well as, end of life care (Royal College of Nursing, 2010). Correspondingly, Wales is working towards intensification to primary and community services and equally reduce the pressure on hospitals, during 2009 The Royal College of Nursing Wales, was represented by the Ministerial Steering Group which helped developed the Primary and Community Services Strategic Delivery Programme, 'Setting the Direction' (Royal College of Nursing, 2010). The main purpose of the plan was to improve the delivery of services in local communities, predominantly those who are vulnerable and have multifaceted requirements (wales.nhs.uk, 2010). However, Wales developed a new law entitled 'The Social Services and Wellbeing (Wales) Act 2014' which came into force in 2016, the main principles of the act is to aid individuals to live independently and have a say on the care they receive (Olderpeoplewales.com, 2016).

Current nursing is multifaceted and demanding, however, historically the purposefulness of nursing has not altered much from the time when Florence Nightingale subsisted, encouraging

health and well-being as well as establishing a safe and caring setting (Selanders and Crane, 2012). Florence Nightingale, use of relational proficiencies such as advocacy, improves the caregiving setting. Therefore, advocacy can be described as a comprehensive term safeguarding a range of proceedings to assist the opinions and feelings of individuals, who use local services, mainly those who are rarely heard in society such as the elderly, people with mental health problems, individuals suffering from HIV/AIDS, young carers, ex-offenders, ethnic groups and people who are homeless (Adams, 2007). Moreover, although Florence Nightingale did not report the concept of advocacy, she did, however, exhibit advocacy in notable ways during her career (Selanders and Crane, 2012). Throughout, Nightingales career she wrote over 13,000 correspondences which explained her actions (Selanders and Crane, 2012). Nevertheless, during Nightingales career she became a healthcare and societal campaigner, advocating for people who were not permitted to receive health care (Selanders and Crane, 2012). Additionally, Nightingale correspondingly turned her attention on the improvement of caring standards and the right to peaceful death for patients as many chronically and mentally ill patients were often disregarded (Selanders and Crane, 2012). One of Nightingale's fundamental issues was the significance of the nursing role in the administration of the patient environment, she alleged 'miasmatism' the conception that foul smells produced illnesses, although this is an erroneous theory, it did emphasise the concept of the environment is comparative towards illnesses (Selanders and Crane, 2012). Consequently, Petiprin (2016) argues, Florence Nightingale environmental theory transformed the aspect of the nursing practice, which is still used in nursing today. The focus of nursing in this model is to modify the person-environment in order to alter their health. Thus, the environmental issues that influence health, as acknowledged in the theory, are fresh air, clean water, adequate food provisions, effective drainage, purity of the environment and the patient, in addition to sufficient sunlight (Petiprin, 2016). However, if the environmental issues are deficient, the patient may endure deteriorated health, therefore the nurse's role in the patient's recovery is to alter the setting, in order to create an optimum environment for the patient's well-being (Petiprin, 2016). To correspond with the Environmental Theory, Maslow states that in order for an individual to have their needs fully met, it must be guided by the five hierarchy of needs, once an individual has these needs met, their requirements are being converged satisfactorily (Maslow, 1987). Maslow (1987) argues, the first tier of the pyramid is the individuals physiological needs, which requires food, water, warmth and rest, second is the individuals needs which include the persons safety and security, third is their love and belongingness having trust, friendships, receiving and giving affection, forth is their esteem needs, achieving

independence and respect from others, fifth is self-actualisation this comprises of the individual attaining self- fulfilment. Therefore, by linking Maslow (1987) and the Environmental Theory (Petiprin, 2016) equally they correlate with each other, with the Environmental Theory the patient requires fresh air, clean water, adequate food provisions, effective drainage, purity of the environment and the patient, as well as sufficient sunlight to allow the patient to recover successfully. Maslow's Hierarchy of needs emphasises, for the person to ascent the pyramid, the needs of the first tier must be met first, by way of connecting these theories collectively, nurses can assist in safeguarding adequate health requirements for the patient.

However, during the 1930s and 1940s an accord was starting to arise that health care conditions were required because health care amenities were not suitable in the UK (Sines *et al.*, 2001). The development of industrialisation had led to the overcapacity in housing and the workplaces, unhygienic settings caused extensive ailments such as typhoid and cholera (Sines *et al.*, 2001). Legislation over the subsequent years was extended to support people in housing and education, William Beveridge set out a plan to challenge the consequences of what he explained as 'the five giants: want, idleness, ignorance, squalor and disease (Sines *et al.*, 2001, p. 16). During 1911, an insurance coverage had been initiated to low pay employees to pay for health services, nevertheless this did not help the unemployed or frail, however, perception was increasing that essential requirements were needed for everyone (Sines *et al.*, 2001). Subsequently, after World War Two a Labour Government was elected under Clement Attlee with the prospect that there would be an extensive social reform (Fatchett, 1998). Although talks of the NHS were developing before the war it was the appearance of Aneurin Bevan at the Ministry of Health that augmented the process (Fatchett, 1998). The development of the NHS in the UK on 5<sup>th</sup> July 1948 had a number of significant goals which included, the whole of the UK would receive free health care and provisions would be made widespread, the attribute of services would be enhanced for all individuals and services would be structured, strategically and disseminated more efficiently (Fatchett, 1998). Although, community health care nursing was established in the ninetieth century by volunteer workers and charitable organisations, the 1946 National Health Service Act had a substantial effect on community nursing as it required local authorities to provide free home nursing provisions and health care centres in the community (Walsh and Gough, 2000 *cited in* Sines *et al.*, 2001, p. 16). Financially, subsidisation towards the NHS is primarily from taxation and National Insurance contributions, however, the amount disbursed by National Insurance, and tax covers approximately 98.8 per cent of NHS funding while 1.2 per cent is funded through patient

charges such as prescriptions, dental and eyeglasses which originated in the 1950s to boost the NHS funding (TheKingsFund, 2017). Moreover, Talcott Parsons was a sociologist and a functionalist, Parsons (1952) argued, good health and successful medical care is vital for society to operate. Thus, ill health weakens our aptitude to accomplish our responsibilities in society. Therefore, poor medical care is destructive for the community (Parsons, 1952). Nevertheless, Parsons (1952) claimed, medical professionals also had a role to play in the running of society, firstly they have to diagnose the individual, treat the illness as well as helping the person to recover. Consequently, Parsons (1952) regarded the professional and the sick person affiliation as hierarchical, the professional gives the instructions, and the sick individual follows the advice. However, Giddens and Sutton (2013) argue, Parsons concept has been significant in the medical setting nonetheless, the concept does not consider individuals with long-term illnesses.

Furthermore, discriminations in society regarding health are preventable, everyone should have the chance to endure a healthy life, regardless of where they live or who they are, inequalities in health can cause inefficient health, decreased quality of life and a premature death (Baker *et al.*, 2017). Despite the fact health inequalities in society are prominent if the individuals' socioeconomic background is deprived, it can have an effect on the person's overall well-being (Drennan and Goodman, 2014). Therefore, Dahlgren and Whitehead's (1991) model, illustrates the foundations of health, our genetics, lifestyle, the health care received and the impact of wider causes such as our physical, social and financial settings including, for example, employment and education can all contribute to our well-being. Hence, the development of the Equality Act 2010 in the UK which protects individuals from discernments in the health care setting (GOV.UK, 2015). However, a statement by Alma-Ata (1978) affirmed, primary health care is central to the interaction between the individual, their family and society, bringing health care close to where the individual resides is fundamental. Correspondingly, The World Health Organisation (WHO) also acknowledged the significance of primary health care with the intention to promote improved well-being for all (Who.int, 2008). Despite these declarations, American citizens are not receiving these provisions as health care is not free like the UK, a charge of \$30,000 to treat cancer can cause bankruptcy for individuals with no health insurance (Amadeo, 2018). Nevertheless, there are up to 50 million American citizens taking dangerous risks with their health as they cannot afford the insurance premiums (Amadeo, 2018). Furthermore, during 1999 the British government sanctioned a new Health Act that outlined new NHS structures, the context was constructed on the ideologies of the Community

Care Act 1990 and expressed the importance of community care and all health and social care provisions (Sines *et al.*, 2001). Although, each local authority was authorised to produce a community care plan, it was revealed that the Community Care Act had been put into place as a cost cutting measure and the Conservatives were criticised of inadequately funding the NHS (BBC News, 1999). Therefore, the development of the Health and Social Care Act 2012 presented lawful obligations regarding inequalities in health to individuals living in England, the Act requires organisations including the Department of Health, Public Health England, Clinical Commissioning Groups, and NHS England towards health equality in all public health settings (England.nhs.uk., 2018).

Additionally, during 2016 11.8 million individuals living in the UK were aged 65 and over (Ons.gov.uk., 2018b). Despite the fact that individuals are living longer, people are in general healthier, many older people are among the multitude of informal carers who, has been projected to save the British economy £57 billion per year (Ons.gov.uk, 2017). The majority of deaths reported in the UK are people aged 65 and over, cancers, cardiovascular disease and respiratory are some of the core reasons (Drennan and Goodman, 2014). An individual who has a continuing or terminal illness can receive palliative care by community nurses that will aid the individual through pain control, delivery of emotional, social and expedient provisions, therefore the significant of the community nurse is essential to the patient well-being (Welsh Government, 2018). Thus, palliative care purposes to improve quality of life for the individual and their families facing life-threatening ailments, through early identification and controlling pain (Welsh Government, 2018). However, there have been many changes in the way community nursing are constructed in present day, one example is 'holism' which can be defined as, treating the individual, in view of mental and social concerns rather than just the signs of an illness (Luker *et al.*, 2000). Thus, palliative care by community nursing is generally valued as it compromises to be a paradigm of otherness in terms of the ability to identify the ethics of nursing today. Ham *et al* (2018) argue, the relationship between staff and the public has been disregarded, the aspiration of individuals being supported in making healthy life choices has not been accomplished and there are apprehensions for the population's health. The emphasis on shared responsibility for the public and patients in order to fully involve the individuals about their health and well-being is fundamental (Ham *et al* 2018). Furthermore, care home closures in the UK have ascended to almost 40 per cent in 2018, producing an increasing crisis in social care (Donnelly, 2018). The strain on the NHS and the resident's relations due to social care cuts is paramount, with over one million people aged over 65 there

has been an escalation of ‘bed blocking’ in hospitals since individuals with no medical complications are placed in hospitals due to no provisions at home (Donnelly, 2018).

The funding of public services (2018) articulate, the Government’s announcement to assign an extra £24 billion per year by 2023 to health care services has consequences to further public services, and additional money will be crucial to save the NHS from further crisis. However, decisions on the extra funding have not yet been decided, and a raise of 2p on tax in National Insurance will not be sufficient to cover the extra subsidy (The funding of public services, 2018). Nevertheless, community nursing amenities play an imperative role in assisting people to sustain independence and the demand for community nursing is growing. Nonetheless, the increasing pressure on nurses has an effect on the services, staffing and the eminence of patient care (Maybin *et al*, 2016). Therefore, in terms of increasing patient numbers the negative effect on the overall well-being of staff has increased which precedents poor morale, anxiety and tiredness, consequently, many nurses are leaving their career because of these pressures (Maybin *et al*, 2016). However, Maybin *et al* (2016) argue, despite policy ambition to offer ‘more care close to home’ the government continues to focus on the hospital setting rather than on community health service, for community services to be effective there must be a progress of new care models and sustainability that alter strategies. As a result of Brexit, there has been numerous disputes about the health care industry and how it will have an effect on global employment since the UK voted out of the referendum in 2016. Thus, Courea (2018) argues, the NHS health structure will worsen after Brexit, with longer waiting times and staff deficiencies.

To conclude, the role of the community nurse in society is fundamental to the health of individuals who need extra support out side of the hospital setting, however, unless policymakers are willing to invest in social care, thousands of individuals face a dismal future. Moreover, Helm (2018) articulates, by 2023/24 the UK taxpayers will be asked to fund the NHS by an extra £20billion to help generate more nurses and doctors. Nevertheless, the Health and Social Care secretary Jeremy Hunt claims that the government wants to ‘show the world what a cutting-edge 21st-century healthcare system can look like’ (Jeremy Hunt *cited in* Helm, 2018). Therefore, the Government declares the extra funding will be created by increasing taxes and with leaving the EU in the Brexit deal will save the UK approximately £600 million per week within six years (Helm, 2018). Additionally, 75 per cent of individuals reporting they would now vote to remain in the EU compared to 66 per cent at the time of voting, the pledge

that Brexit would contribute £350m a week to the NHS was the central focus of the leave campaign (Courea, 2018). Nevertheless, YouGov (*cited in* Courea, 2018) reported, 83 per cent of the medical profession deemed it as a premeditated lie, whereas 10 per cent thought it was a genuine endeavour to assist the NHS. Consequently, with staff shortages, increased waiting times and cuts in funding, 88 per cent of people report that the NHS requires foreign doctors and nurses to keep functioning (Courea, 2018). Nevertheless, the Department of Health (DH) report, by 2026 the NHS will have a deficiency of 42,000 nurses if migration regulations are reformed, since the referendum there has been a 96 per cent drop of nurses registering with the Nursing and Midwifery Council (NMC) (Harrold, 2017). However, in the 2017 conservative party policy, they promised to improve the nursing shortage by making EU NHS staff a precedence during the Brexit deliberations, with 30,000 staff shortages in England alone these negotiations are crucial for the health and well-being of UK residents (Harrold, 2017).

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