4th edition

A Handbook for Student Nurses

Introducing Key Issues Relevant for Practice

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Student Nurses

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PREFACE TO THE FOURTH EDITION

The Nursing and Midwifery Council (NMC) is the regulatory body for nurses and midwives whose professional register people undertaking nursing or midwifery education programmes aim to join on graduation or to re-join if returning to the profession. The NMC sets *Standards of Proficiency* and professional standards of practice and behaviour for nurses, midwives and nursing associates (*The Code*) and this *Handbook for Student Nurses* enables learners to explore key components of these standards. It is designed so that each individual chapter can be utilised as a quick source of reference; it also contains activities and further reading to enhance understanding, knowledge and analysis. This new edition has incorporated contemporary issues such as the latest principles of nursing and the NHS Long Term Workforce Plan, which is designed to meet the challenges of the next fifteen years.

Sara White
January 2024

ACTIVITIES AND QR CODES

In some of the Activities in this book we have used QR codes to enable you to reach websites quickly and easily. Download a QR reader/scanner onto your smartphone, scan the code and it will take you instantly to the relevant website.

PREFACE TO THE THIRD EDITION

The Nursing and Midwifery Council (NMC) is the regulatory body for nurses, midwives and nursing associates and is responsible for setting standards of proficiency. The standards of proficiency define the overarching principles of being able to practise as a nurse, and must be achieved before students are eligible to join the register. The aim of this handbook is to highlight and address many of the key issues which surround these standards of proficiency and relate them to not only the working knowledge you require in the practice setting but also to *The Code: professional standards of practice and behaviour for nurses, midwives and nursing associates*.

This handbook has been written, and updated, for student nurses, return to practice nurses and those who trained overseas, students undertaking Further Education Access courses or BTEC (Business and Technology Education Council) qualifications, and Nursing Associates. The content is also relevant for healthcare assistants and assistant practitioners, as many of the principles are relevant to all those working in care settings. It is designed so that each individual chapter can be utilised as a quick source of reference, although together with the activities and further reading, it may serve as a starting point for more in-depth study.

Anneyce Knight and Sara White
February 2021

ABOUT THE AUTHORS

Wendy Benbow: Following qualification as a registered nurse in 1969, Wendy worked for two years in genito-urinary surgery and major spinal injuries before moving into community nursing. Over a fourteen-year period Wendy was involved in a variety of roles that included community nursing sister, practice work teacher and nurse manager, as well as time seconded for research and coordinating pre-registration student placements for the local acute hospital. After a year out to complete her teaching qualification, Wendy began working full-time in education in 1985. She was involved in both teaching on and managing a range of pre- and post-registration courses, programme development, regionally funded research and national project development. Wendy has now retired from working in healthcare.

Gill Jordan: On qualifying as a registered nurse in 1978, Gill completed her Orthopaedic Nursing Certificate and moved to New Zealand where she worked in a large orthopaedic teaching hospital, ultimately as a ward sister of a trauma orthopaedic ward. On her return to the UK in 1988, Gill moved into nurse education. Since then, she has been involved in a variety of courses and professional development programmes, as both a teacher and programme leader. These have included courses leading to professional registration, Return to Practice, Overseas Nurses Programme, conversion courses and various post-registration undergraduate and postgraduate programmes. Gill has now retired from working in healthcare.

Anneyce Knight: The late Anneyce Knight, who died in 2021, had retired earlier that year from her role as Associate Dean for Global Engagement and Senior Lecturer in Adult Nursing at Bournemouth University, where she was also the Programme Leader for the Return to Nursing Practice course. She qualified as a registered nurse in 1982 and worked in orthopaedics and oncology, then trained as a midwife. She continued to practise in a variety of nursing and midwifery

clinical settings before moving into Higher Education in 2000. Prior to taking up her role at Bournemouth University in 2015, Anneyce was the Course Lead for the innovative Foundation Degree in Health and Social Care (clinical) for Associate Practitioners, a joint NHS and Southampton Solent University collaboration. Previously she was at the University of Greenwich, where she held a number of positions. She was passionate about the need for compassionate care, thereby enhancing the quality of patient care, particularly at the end of life. Her primary research interests focused on public health and wellbeing, areas in which she published and presented nationally and internationally.

Sara White: Sara qualified as a registered nurse in 1986, after which she worked in Acute Trauma and Orthopaedics before moving to Intensive care (ICU) and Coronary care. She worked in a number of ICUs in London and the south of England and gained multiple qualifications (including General Intensive Care Nursing, Principles of Intensive Care (Paediatrics), BSc (Hons) Nursing Studies and Diploma in Health Service Management). Having spent ten years as an ICU Sister she moved into Higher Education (HEI) where she has been for twenty years. During her time in HEI she has facilitated the learning of many thousands of students at both undergraduate level and postgraduate level, whilst at the same time continuing her own education to Doctorate level. She believes that as a nurse educator she should strive to enable students to fuse their learning and integrate education, professional practice and research in order to develop as future nurses and enhance the care they offer patients.

11 PUBLIC HEALTH AND PROMOTING HEALTH AND WELLBEING

The aim of this chapter is to raise your awareness about public health and promoting health and wellbeing, which are an integral part of every nursing student's and registered nurse's roles.

LEARNING OUTCOMES

On completion of this chapter you should be able to:

- define public health and health promotion
- appreciate the contested nature of wellbeing
- identify the wider determinants of health and health inequalities
- explain public health priorities
- describe the importance of empowerment in order to change behaviour
- understand the nurse's role in promoting health

» Why is public health and promoting health and wellbeing relevant to nursing?

"Failing to meet the fundamental human needs of autonomy, empowerment and human freedom is a potent cause of ill health."

(Marmot, 2006, p. 2081)

The NMC (2018a) standards state that "Registered nurses play a key role in improving and maintaining the mental, physical and behavioural health and well-being of people, families, communities and populations. They support and enable people at all stages of life and in all care settings to make informed choices about how to manage health challenges in order to maximise their quality of life and improve health outcomes. They are actively involved in the prevention of and protection against disease and ill health and engage in public health, community development and global health agendas, and in the reduction of health inequalities" (ibid., p. 10).

Within the wider context of health and social policy, all four countries of the UK seek to improve the public health of their populations (NHS Scotland, 2012; NHS England, 2014; Public Health Agency [NI], 2015 and Public Health Wales, 2015). This is increasingly important as there is a growing and ageing population with many people living with more than one long-term condition (co-morbidities). In addition, with the requirement for clinical and cost-effectiveness there is an emphasis on being, and remaining, healthy as well as reducing health inequalities. Notwithstanding the political, epidemiological and demographic factors that impact on health, it is the responsibility of all registered nurses to promote the health and wellbeing of the patients/service users with whom they come into contact. This is embedded not only in the NMC *Code* (2018b) but also, as we have seen, in the NMC standards (2018a) which require the registered nurse to have "the underpinning knowledge and skills required for their role in health promotion and protection and prevention of ill health" (ibid., p. 11).

» It is the responsibility of all registered nurses to promote the health and wellbeing of their patients.

Nurses are well placed to promote health and use a range of public health interventions, as they are at the forefront of delivering face-to-face person-centred care in a variety of acute and community settings. The RCN's (2016) survey *'The Value and Contribution of Nursing to Public Health in the UK'* endorses this by stating that "nurses have the skills and are best placed to provide meaningful public health interventions across all health and social care settings as part of holistic patient-centred care" (ibid., p. 28) and that "nursing staff are an integral and fundamental part of the public health workforce" (ibid., p. 29).

This chapter will define public health, health promotion and wellbeing. It will provide an overview of the context of public health, outline the public health priorities, and summarise the wider determinants of health and health inequalities. Following on from this there is a discussion of the term 'wellbeing'. The chapter will conclude with consideration of health promotion, including a discussion on individual and community empowerment.

» The context of public health

Definition

Wanless (2004) provided what is now an accepted definition. Public health is:

> *"the science and art of preventing disease, prolonging life and promoting health, through organised efforts and informed choices of society, organisations, public and private, communities and individuals."*

This definition makes it explicit that public health is everybody's business and that it is an overarching term that includes many differing health promotion approaches and interventions at individual, family and community levels.

Historical context

The roots of public health can be traced back to Edwin Chadwick (1800–90), a social reformer who sought to have the English Poor Laws of 1601 and 1834 amended and who reported on *The Sanitary Conditions of the Labouring Population* in 1842. He believed science could improve health.

Other studies followed, such as Charles Booth's *Life and Labour of the Working Class in England* in 1903, documenting poverty in London, and Seebohm Rowntree's *Poverty: a study of town life*, which explored poverty in York. Both studies highlighted the inequalities within society and established a link between poverty and poor health. Indeed, Rowntree developed the first measurement for poverty (Moreno-Leguizamon and Spigner, 2009). The work of John Snow (1854), mapping outbreaks of cholera and tracing the disease back to one water pump, contributed to the understanding of how disease was spread and his work was the beginning of modern epidemiology. Legislation has also played an important role in improving the health of the UK, with the first parliamentary Public Health Acts in 1848. The first Sanitary Act of 1866 made local authorities responsible for sewers, water and clearing streets, and developments such as Joseph Bazalgette's sewerage system for London contributed to reducing the spread of diseases such as cholera.

During the Second World War, William Beveridge's Report on *Social Insurance and Allied Services* was published (Parliament UK, 2019). Within this report he set out his vision to eradicate what he saw as the 'five evils' – want, disease, idleness, ignorance and squalor – by the development of the welfare state as we know it today. From this, the NHS (1948) emerged to provide free healthcare to all from the 'cradle to the grave' with a focus on eliminating disease. The Town and Country Planning Act (1947) led to slum housing being cleared and new homes being built and the Education Act (1944) ensured all children had free education until they were aged 15.

All of these social changes also contributed to improving the health of the UK's population and are now seen as the wider, or social, determinants of health. More recently, developments in genetics, as well as improved medicines and treatments of diseases, together with further parliamentary Acts, such as the Health Act (2006) which banned smoking in public places, have all contributed to an overall improvement in the health of the UK's population and to our understanding of what public health is today.

Public health priorities

Each of the four nations of the UK has a public health organisation to oversee their health and wellbeing and reduce health inequalities. These organisations are the Office for Health Improvement and Disparities (OHID), which took over the health improvement and public health work of Public Health England (PHE) in 2021, Public Health Scotland, Public Health Wales and the Public Health Agency in Northern Ireland. Each nation has its own strategy and priorities.

In addition, the UK Health Security Agency (UKHSA) has health protection responsibilities for England and liaises with the other nations' public health bodies on issues affecting the UK. In 2023 the UKHSA launched its 3-year strategy to combat both new and re-emerging threats and to protect health security, and set out its vision and goals for the next three years. Its six strategic priorities are:

1. Be ready to respond to all hazards to health
2. Improve health outcomes through vaccines
3. Reduce the impact of infectious diseases and antimicrobial resistance
4. Protect health from threats in the environment
5. Improve action on health security through data and insight
6. Develop UKHSA as a high-performing agency.

(UKHSA, 2023)

An overarching approach to public health practice is defined by the UK's Faculty of Public Health (FPH) which states that it:

- is population based
- emphasises collective responsibility for health, its protection and disease prevention
- recognises the key role of the state, linked to a concern for the underlying socio-economic and wider determinants of health, as well as disease
- emphasises partnerships with all those who contribute to the health of the population.

(FPH, 2016a)

According to the FPH (2016a), there are three overarching public health domains:

1. Health Improvement
2. Health Protection
3. Healthcare Public Health.

Improving the health of the population has a focus on individuals' health behaviours, together with individual risk factors associated with poor health outcomes. These include the wider determinants of health (see below) as well as the principal preventative factors to ill health, mortality and morbidity. The NMC (2018a) recognises that a registered nurse should identify and use all appropriate

opportunities, making reasonable adjustments when required, to discuss preventative factors. These are "the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people's individual circumstances" (ibid., p. 11). Therefore discussions may focus on key public health priorities:

- smoking cessation
- reducing obesity
- healthy eating
- reducing alcohol consumption
- improving mental health (including patients with dementia)
- tackling solvent abuse
- promoting physical activity
- improving sexual health
- tackling recreational drug abuse.

The COVID-19 pandemic illustrated how public health approaches seek to protect the health of individuals and society as a whole (for example, Hands, Face, Space; Test and Trace and the search for a vaccine). Indeed the provision of the UK-wide, free immunisation and vaccination programmes have reduced the number of deaths and morbidities from diseases such as measles, rubella and polio and led to the elimination of what were common communicable diseases such as smallpox. Vaccinations aim to provide immunity for diseases for the person they are administered to. However, those who have been vaccinated are less likely to infect others who have not been vaccinated for medical reasons or by parental choice. This is referred to as 'herd immunity' (Public Health England, 2013). For this to be achieved, 90–95% of the population needs to be vaccinated (Oxford Vaccines Group, 2016). Nurses are expected to have knowledge and understanding of "the principles of pathogenesis [the biology of a disease], immunology [the immune system] and the evidence-base for immunisation, vaccination and herd immunity" (NMC, 2018a, Clause 2.11).

» **To achieve herd immunity, 90–95% of the population needs to be vaccinated.**

Protecting health also includes assessing the health effects in relation to being exposed to environmental factors such as biological or chemical agents, radiation or polluted water (FPH, 2010). On a day-to-day basis, nurses protect health through "understanding and applying the principles of infection prevention and control" (NMC, 2018a, Clause 2.12).

Healthcare Public Health (HCPH) focuses on the strategic areas of planning, procuring and monitoring of healthcare services. The FPH (2016b, p. 1) defines HCPH as "concerned with maximising the population benefits of healthcare while meeting the needs of individuals and groups, by prioritising available resources, by preventing diseases and by improving health-related outcomes

through design, access utilisation and evaluation of effective and efficient healthcare interventions and pathways of care". Therefore, implementing evidence-based practice, clinical effectiveness and clinical governance (see also *Chapter 6*) all contribute to this, as well as the use of evaluation and audit.

Global health issues

Globalisation is a contemporary issue which Walsh (2018, p. 78) states "refers to a range of processes that have the effect of bringing dispersed populations into closer contact, creating a single, integrated community of interest or independent society". Orme *et al.* (2007, p. 205) put it more simply by stating that it is "the growing interdependence between different peoples, religions and countries". In addition, there is economic interdependency between countries and the ease of international travel which means that we live in a world where public health issues have the potential to impact worldwide, including the UK population. This is illustrated by the worldwide COVID-19 pandemic. Other situations include, but are not limited to, communicable diseases such as Ebola, tuberculosis and SARS; environmental factors such as diseases from mosquito bites, including Zika virus and malaria; natural disasters (e.g. flooding) and industrial disasters (e.g. nuclear accidents). The WHO (2007) report entitled *The World Health Report 2007 – A Safer Future: global public health security in the 21st century* identifies the need for global health security and for individual countries to work together to identify risks to health and seek ways to address these within the International Health Regulations of 2005.

The Institute for Health Metrics and Evaluation (IHME) aims to provide an evidence-based picture of global health trends in order to inform the work of policymakers, researchers and funders. Each year its experts outline global health issues for the following year. These are available on the IHME website: www.healthdata.org/news-events/insights-blog/acting-on-data.

» Determinants of health and health inequalities

For nurses to deliver holistic person-centred care or family-centred care, it is essential to be aware that our patients/service users/families are more than their diagnosis. They live within families and communities and there are many wider 'social' factors that impact on health. These are known as the social determinants of health which can impact on health outcomes (such as life expectancy) and diseases (for example, lung diseases which can be caused by living in damp housing). Overall, the health of the nation has continued to improve in the UK thanks to improved medical and healthcare and social conditions.

However, these improvements hide a widening gap between the health outcomes of the wealthiest and the most deprived people and communities. This is known

as health inequality. Consequently, to improve these inequalities the NHS cannot work alone to prevent disease, as there are many other contributing factors that are local, national and international. Indeed, the NHS *Long Term Plan* (2019) identifies that prevention involves individuals, communities, local authorities, national government and business and voluntary sectors.

These wider determinants of health are presented in Dahlgren and Whitehead's (1991) model which places individuals and their unique factors that influence their health at the centre (e.g. age, sex and genes). This is then encompassed in several layers, as in a rainbow, of other factors that determine health which includes lifestyle (alcohol, obesity, smoking), social and community networks, living and working conditions and the socio-economic, cultural and environmental factors (see *Figure 11.1* and www.pslhub.org/learn/improving-patient-safety/health-inequalities/the-dahlgren-whitehead-rainbow-1991-r5870).

The reality of health inequalities means that "a boy born in one of the most advantaged 20% of neighbourhoods in 2015 can now expect to outlive his counterpart, born in one of the least advantaged 20% of neighbourhoods, by 8.4 years. In 2001, that gap was 7.2 years. For girls, the difference has risen from 5 years to 5.8 years over the same period" (Longevity Science Panel, 2018). This is because those in poverty have poorer living standards; for example, inadequate

» **People living in poverty have poorer standards of living, poorer health and shorter life expectancy.**

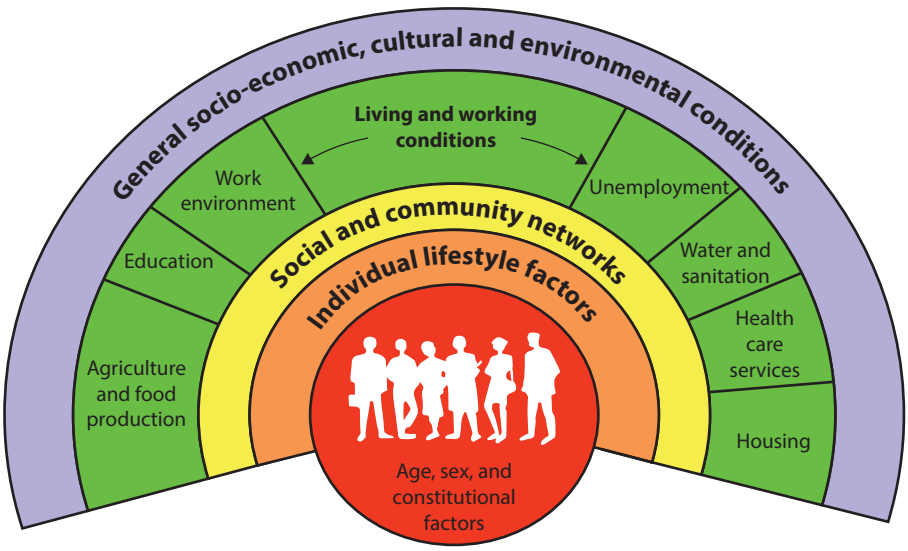

Figure 11.1: *The Dahlgren–Whitehead rainbow. Reproduced with permission from Institute for Futures Studies.*

housing and diet. The Marmot Review (2010) highlighted a social gradient in health, where the less affluent a person's position, the worse their health. This review also described the importance of measures to address the wider determinants of health as well as interventions to prevent ill health by improving health behaviours, thereby reducing health inequalities and promoting health.

The report identified recommendations for six priority areas:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention.

The follow-up to the 2010 Review, *Health Equity in England: the Marmot Review 10 years on* (Marmot *et al.*, 2020) identified a slowdown in life expectancy, a rise in the inequalities related to life expectancy and overall that the health of the population had declined. The 2020 Review also stated that there continues to be a strong correlation between a shorter life expectancy and the level of deprivation in geographical areas, including regional differences, which the COVID-19 pandemic has highlighted further. It sets out actions and policies that the government needs to lead on to reduce health inequalities.

As identified, childhood has an influence on longevity and physical and mental health and wellbeing, as well as potential life choices. For example, studies such as those of Thacher *et al.* (2018) explore the relationship between parental smoking and asthma. Children living in poverty are more likely to "die in the first year of life, be born small, be bottle fed, breathe second-hand smoke, become overweight, suffer from asthma, have tooth decay, perform poorly at school [and] die in an accident" (Wickham *et al.*, 2016, p. 760).

Poverty, a wider determinant of health, is defined as having an income that is 60% of the median income in a year, measured after household costs are removed (McGuinness, 2018). Every year the End Child Poverty Coalition publishes data on the number of children living in poverty. The 2023 report found that the total number of children experiencing poverty in 2021/2022 was 4.2 million, an increase on the 3.6 million recorded the previous year, with the highest child poverty being in the North-west and the West Midlands. The figures show a strong correlation between family size and poverty. In 2021/22, the UK poverty rate among children with two or more siblings was 42%, compared with 23% and 22% among children in families with one or two children (End Child Poverty Coalition, 2023). This can lead to poorer health outcomes and reduced educational attainment which in turn impacts on the choice and range

of employment opportunities and less job security (Naidoo and Wills, 2016). Hence, health promotion interventions and public health initiatives are needed at individual, family and community levels.

FURTHER READING

Health inequalities have been well documented since the *Report of the Working Group on Inequalities in Health* (the Black Report) of 1980 which was assessed by Townsend and Davidson (1990) and in *The Health Divide* in 1987 (Whitehead, 1990). Further reports include those by Acheson (1988), Wanless (2004) and Marmot (2010, 2020) (focusing on England).

» Local public health

The responsibility for local public health has resided with the relevant local government administration since 1 April 2013 when it moved from NHS provision. These local government administrations include organisations such as county councils, unitary authorities, London and Metropolitan boroughs. They are well placed to be responsible for public health as they already hold the portfolios for local education, housing, social care and economic development (all wider social determinants of health).

Each organisation's Public Health Department, led by their respective Directors of Public Health, commission public health services and work in partnership to promote health in all local policies to improve the health of the population and reduce health inequalities. This includes working with the NHS, non-governmental organisations and local communities.

Joint Strategic Needs Assessment (JSNA)

The Local Government and Public Involvement in Health Act of 2007 has required localities to produce a Joint Strategic Needs Assessment (JSNA) which seeks to inform the commissioning of health and social services, as well as the development of appropriate and effective services (Department of Communities and Local Government, 2005). This involves both statutory and non-statutory organisations such as the Local Authority (including Public Health which sits within Local Authorities), local NHS organisations, service users, community and non-governmental organisations (voluntary sector) all working together to assess the local population needs and plan the current and future health and social care requirements in order to reduce health inequalities and improve health outcomes.

Therefore, this is a significant document when planning public health interventions and health promotion activities as it is important to address what the real need in a locality is, rather than the need a nurse or other practitioner

thinks needs to be met; for example, an area with a high number of older people may have different priorities than an area with a high number of children. As such, the JSNA is a *top-down* approach to improving health; that is to say, the power for change and decision-making comes from these organisations.

RECAP

- Public health is the science and art of preventing disease, prolonging life and promoting health.
- Nurses have a responsibility to promote the health and wellbeing of their patients and to have the underpinning knowledge and skills required for this role.
- Factors such as lifestyle, social and community networks, living and working conditions and socio-economic, cultural and environmental conditions are all determinants of health.

ACTIVITY 11.1

Find the JSNA for your local area online. What are the needs identified and how are these needs being met? How can you as a nurse contribute to this?

» Wellbeing

Today, the term wellbeing is part of our everyday vocabulary and is often linked with health and sometimes used synonymously. However, the WHO (1948) definition of health, "a complete physical, mental and social wellbeing and not merely the absence of disease", suggests wellbeing is an aspect of health. Hence wellbeing "incorporates subjective (self-perceived) feelings of happiness and contentment with spiritual and socio-economic factors" (Knight and McNaught, 2011, p. 1) and there is no commonly agreed definition.

The Department for Environment, Food and Rural Affairs (DEFRA) began measuring wellbeing in 2005 and the Office for National Statistics provides data on national and personal wellbeing. Subjective wellbeing can be researched using measurements of how happy people, or societies, feel and is often seen within psychological literature in terms of quality of life. However, this suggests that the quality of our lives is only determined by ourselves. As we have already noted, many factors impact adversely on health, and similarly on wellbeing.

McNaught (2011) sought to provide a definitional framework which illustrates the micro and the macro elements associated with wellbeing. Furthermore, he

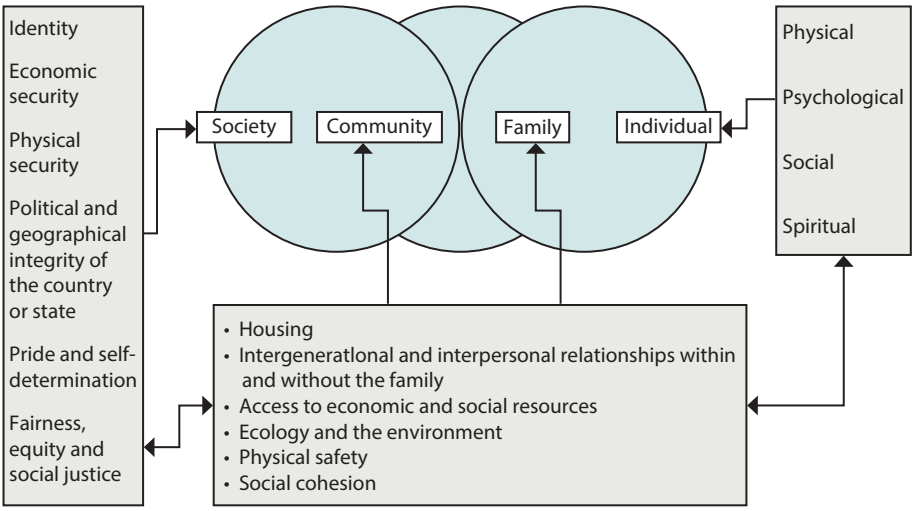

Figure 11.2: *A structured framework for defining wellbeing (McNaught, 2011, p. 11).*

presents visually the notion that wellbeing is wider than the individual and encompasses family, community and society as a whole (see *Figure 11.2*).

It can be seen, using this definitional framework, that there is interlinking between an individual and their place within their family, their community (e.g. geographical or religious community) and society (job, influence of social policies, e.g. housing) as a whole. So the influences on wellbeing can be seen as multifactorial. Thus, individual wellbeing needs to be seen within this wider context as each individual's circumstances are unique to them. This is an important consideration for nurses when undertaking health promotion and forms the basis for person-centred approaches.

» Health promotion

The Ottawa Charter (WHO, 1986) states that:

> *"Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being."*

The WHO definition of health promotion is an important one as it acknowledges that individuals need to be healthy in order to live their daily lives; for example,

participate in communities, families, work and so on. It recognises the wider determinants that impact on health, as discussed earlier in this chapter, and also makes it clear that the empowerment of individuals and communities is fundamental to health. Subsequently the WHO (1998) has reiterated this by stating that "Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions." Furthermore, NICE defines health promotion as "giving people the information or resources they need to improve their health. As well as improving people's skills and capabilities, it can also involve changing the social and environmental conditions and systems that affect health" (NICE, 2020). This highlights the importance of understanding the social determinants of health and the role of health education, as well as nurses having the skills and knowledge of a range of health promotion theories and models.

» **Empowerment and health education are fundamental to health promotion.**

Within the NMC *Future Nurse* standards (2018a), Platform 2 (pp. 11–12) focuses solely on promoting health and preventing ill health (see also *Chapter 1*). The outcomes for this Platform aim to ensure that, at the point of registration, the newly registered nurse will have the underpinning knowledge and skills to undertake their role in health promotion and the protection and prevention of ill health. This is also embedded in the NMC *Code* (2018b) which specifies that nurses must:

> *"2.2. recognise and respect the contribution that people can make to their own health and wellbeing*
>
> *2.3. encourage and empower people to share decisions about their treatment and care*
>
> *3.1. pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
>
> *3.3. act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it."*
>
> (NMC, 2018b, pp. 6–7)

There are many models for promoting health and these are not explored within this chapter. Nevertheless, whatever model is used, as both the WHO definitions and the NMC (2018b) make clear, empowerment of the individual or community is vital. Empowerment can be defined as "the act of acquiring power and the ability to make decisions and take control over one's life" (Naidoo and Wills, 2016, p. 75) and is a *bottom-up* approach to improving health.

This challenges the power relations between individuals and nurses: individuals have the freedom to choose and we, as nurses, cannot force them to make what

we perceive to be a healthy lifestyle choice, even when based on the best evidence; e.g. stopping smoking. What we can do is boost an individual's self-confidence to identify and achieve their own 'healthy goal' and this can be seen as an empowering or strength-based approach.

Empowering people enables them to gain the knowledge, skill sets and attitudes to gain control of their lives and adapt to the changing world and their life circumstances. This can be achieved by using facilitation skills to enable individuals to develop their own coping mechanisms and/or personal skills (Health Education England (HEE), 2017). Within this context, it is important to consider health literacy; i.e. an individual's ability to find health information and services and to understand the information to make an informed decision about their health (NMC, 2018b). As a nurse, you need to present information in an accessible, person-centred way to enable understanding (NMC, 2018b).

There are three key concepts associated with empowerment:

Self-esteem: self-esteem can be defined as "people's evaluations of their own self-worth—that is, the extent to which they view themselves as good, competent, and decent" (Aronson *et al.*, 2001, p. 19; cited by Sciangula and Morry, 2009). Self-esteem is central to an individual's personality, motivation and attainment in life (Walsh, 2018).

Self-efficacy: self-efficacy is defined as "the extent to which people believe they are competent to confront the challenges in life" (Niven, 2006, p. 365). An individual needs to feel that they have the power within them to make changes and that they are worthy of making this change. Furthermore, they need the coping strategies and skills to make the necessary changes to their behaviour in order to improve their health.

Locus of control: an individual's belief about whether they have control over their lives and health indicates that they have an internal locus of control. In contrast, if they believe they are subject to fate and are powerless they have an external locus of control (Niven, 2006, pp. 364–5).

Individual empowerment

One example of a brief health promotion intervention that can empower individuals and help them change their health behaviours is Making Every Contact Count (MECC). This can be used in any health or social organisation and is:

> *"... an approach to behaviour change that uses the millions of day-to-day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and*

wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations."

(Public Health England *et al.*, 2016, p. 6)

MECC is a brief opportunistic evidence-based health promotion intervention which uses healthy conversation skills. The use of MECC seeks to reduce health inequalities, prevent illness and improve health in a supportive way by empowering individuals to make changes to their health behaviours.

MECC is a person-centred approach which treats the individual with dignity and respect and values their experience. It acknowledges that an individual is the expert on themselves. There are four key principles related to behaviour change that underpin MECC which, as health promoters, it is important to remember:

- "People are responsible for their own choices.
- Being given information alone does not make people change.
- People come to us with solutions.
- It is not possible to persuade people to change their habit". (HEE, 2017, p. 10).

It is a method for a brief intervention which may only be for 30 seconds to five minutes. Between 30 seconds and two minutes equates to MECC level 1 (Very Brief Intervention) which is sufficient time to provide support and encouragement for individuals, or highlight a specific health issue and/or signpost them to resources (Public Health England *et al.*, 2016). MECC level 2 is a Brief Intervention which is longer than two minutes and "involves oral discussion, negotiation or encouragement, with or without written or other support or follow-up. It may also involve a referral for further interventions, directing people to other options, or more intensive support" (Public Health England *et al.*, 2016, p. 15).

As nurses we are aware that the conditions that are the major causes of premature death in the UK are cancer, heart disease, strokes, respiratory conditions, dementias, and self-harm which are associated with lifestyle factors such as smoking, poor diet, high blood pressure, obesity, alcohol and drug use (NHS, 2019). Hence, the focus of nurses can be concentrated on, for example, smoking cessation, reducing alcohol intake, having a healthy well-balanced diet and reducing weight. However, what is important to the individual needs to be elicited and may include a physical, mental or emotional health and/or wellbeing goal.

Central to a successful MECC interaction are using the Healthy Conversation Skills, which are:

1. "Use Open Discovery Questions to help someone explore an issue [How and What].
2. Reflect on your practice and conversations.

3. Spend more time listening than giving information or making suggestions.
4. Use Open Discovery Questions to support someone to make a SMARTER plan." (HEE, 2017, p. 5).

SMARTER goals are ones that are Specific, Measurable, Achievable, Relevant, Time-bound, that can be Evaluated and Reviewed. The nurse also needs to have the knowledge and skills to signpost individuals to appropriate local services and resources. You can take a recognised Royal Society of Public Health MECC accredited course to develop your Healthy Conversation Skills.

ACTIVITY 11.2

Reflect on an individual health promotion activity with a patient/service user that you have either undertaken or observed. What factors contributed to it being an empowering interaction and how could it be improved further?

Community empowerment

In contrast to individual empowerment, community empowerment is:

> *"a process by which communities gain more control over the decisions and resources that influence their lives, including the [social] determinants of health. Community empowerment builds from the individual to the group to the wider collective and embodies the intention to bring about social and political change".*
>
> (Laverack, 2007, p. 29)

The WHO (2017) identifies that for community empowerment to be achieved there needs to be community ownership and action that explicitly aims at social and political change. A community may not be geographically linked, but could have shared issues or characteristics: for example, a virtual social media group with a shared interest such as politics, gardening or cooking. The strength of this is that collectively, the community can have a greater influence and control over their quality of life within their defined community (WHO, 2017).

An example of a geographical community project is the Cultivating Lives Project, Grow Your Own Club. This project aimed to improve community cohesion on the Isle of Sheppey (Mehmet and Stacey, 2014). The Isle of Sheppey is an area of high socio-economic deprivation and the Cultivating Lives project was initially begun by a volunteer and an independent charity "to support social and environmental regeneration through community engagement" (ibid., p. 89). It was developed by the South East Coastal Communities and funded by the Higher Education Funding Council and became a joint project with the community and two universities in order to grow food, plants, shrubs and trees locally within

a community garden. The outcomes included not only access to fresh food and plants, but also social connection, thereby reducing isolation by encouraging individuals to work together (such as clearing the land) and increased community knowledge of horticulture and agriculture.

The UK Men's Sheds Association can also be seen in terms of community empowerment. This Association supports local opportunities for men to meet and practise practical skills and be creative (in sheds or somewhere similar). Currently there are 444 across the UK (UK Men's Sheds Association, 2018). They provide an opportunity for men to meet and converse with other men, which addresses the loneliness and isolation many men feel as they may have fewer social connections than women. Indeed, it is well documented that loneliness and isolation have an impact on health and wellbeing (Milligan *et al.*, 2015). Many Men's Sheds also participate in local community projects (UK Men's Sheds Association, 2018).

ACTIVITY 11.3

Read Platform 2 of the NMC document *Future Nurse: standards of proficiency for registered nurses*. In the area where you live or in which you are a nursing student, explore online what local community initiatives exist which aim to improve quality of life; for example, a community chef team, gardening club or community exercise group such as Walking for Health. Consider how you could contribute to and become actively involved in a community empowerment project such as these.

CHAPTER SUMMARY

- Nurses have an important role in public health and health promotion in relation to the health and wellbeing of individuals, families, communities and populations.
- Opportunities in clinical practice should be sought to discuss "the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people's individual circumstances" (NMC, 2018a).
- Empowering individuals, families and communities is an important aspect of changing behaviours.
- The wider determinants of health have an influence on an individual's life expectancy and health inequalities.
- Each of the four countries of the UK has a public health strategy, with local areas identifying their own specific health and social care needs.

Further information

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