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Abstract:	Nursing needs policy, it provides the context to our practice, roles, knowledge and frames our patients' day to day lives. This article defines what we mean by policy and what influences its development. With the use of health policy examples the implications for nursing are explained and ideas on how policy is implemented in practice set out. As health is a devolved issue policy comparisons are made between the four regions of the UK. Finally, the implications of current policy change on nursing roles and skill mix shows how future developments in our professional are being directed.
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The implications of health policy for nursing: At a glance

This article will:

- Outline the importance of health policy and how it provides a context to nursing
- Define health policy and what influences it
- Identify current health policy focus and implications for nursing
- With the use of policy examples explain policy implementation and how health policy impacts directly on nursing.
- Indicate differences in health policy between the devolved administrations of the UK.
- Summarise implications of current policy change on the nursing roles and skill mix.

Introduction

Health policy frames our professional roles; it defines nursing practice and nursing knowledge, prioritises and targets resources and directly impacts on our patients' day to day lives. Nurses might argue that we 'don't do policy', but in the highly politicised setting of the NHS, when nurses are in the front line of health policy delivery, this is not an option (Traynor 2013). Take NHS England's new *NHS Long Term Plan* (2019), which guarantees investment in community practice, primary care, mental health and improved integration so that health and social services, and local government, work in partnership to deliver more personalised care (NHS England 2019). This policy requires implementation of new service models [See policy Case Study A: Box 1], bespoke patient-focused care and greater use of digital technology, all which directly impact on nurses: what knowledge we need, how we work, how we develop as a

profession [See policy Case Study B: Box 2]. Health policy provides the context to modern nursing practice. Policy is all around us and to be effective as practitioners we need to understand it.

Defining policy

A policy is a position or course of action reflecting decisions, intentions and choices made by governments, society, or a group which sets out how resources and actions will be prioritised to address areas of concern (White 2012; Allsop 1995). Where policy focuses on health, governments seek to change its practice, delivery, financing and/or organisation by directing the activities of healthcare organisations such as the NHS (Buse et al. 2005). Health policy means different things. It relates to *content*: improving the population's health; but it also relates to *process*: how things are done; and to *power*: who influences and drives it (Walt 1994). So, an increasingly complex picture emerges as we consider what health policy is and how it impacts on nursing practice. In addition, it is derived from many sources: through guidance (e.g. via NICE), regulation (e.g. CQC) and/or legislation (e.g. the Health and Social Care Act 2012). Legislation gives legal force to policy, regulation and procedure (Blakemore & Warwick-Booth 2013). See Table 1 for further information and examples of the different forms that policy takes. [Insert Table 1].

Policy influences and development

Policy is driven by politics, ideology, evidence-based research and lobbying from interest groups (Traynor 2013); and since health policy in the UK is devolved to England, Wales, Scotland and Northern Ireland, political influence and ideology are regionally distinct (Blakemore & Warwick-Booth 2013). One area where scientific research has driven policy that directly affects the nursing profession is in tackling universal public health concerns such as

smoking, alcohol and sugar intake and exercise; and these policies are increasingly divergent between health regions. How such issues get noticed or make it onto the policy agenda is directed by political and media agendas and the lobbying influence of pressure groups with commercial or special interests (Traynor 2013). Consequently, what influences and supports the development of health policy is messy and the reality of translating evidence, ideology, power and media pressure into policy, and then practice, is not linear or easy to understand (Harvey & Kitson 2015). To illustrate the challenges and complexities let's consider, by way of an example, health policy in relation to the care of people with Long-Term Conditions (LTCs).

Health policy in relation to care of people with Long-Term Conditions (LTCs)

The UK's population is living longer; is more likely develop an LTC with age; and often suffers multiple co-morbidities (Department of Health 2014). Increasingly, care of people with LTC demands innovative and preventive responses from nurses. What might once have been deemed acute conditions – like heart failure or cancer – are now seen as chronic, and long-term. Traditionally, nurses have focused on disease and its symptoms; now we need a broader approach, one that takes account of the complexities of caring for people with LTCs. Health promotion, complex treatments and a shift in the organisation of care from acute response to the greater integration of health and social care, are now major influences on UK health policy.

The World Health Organisation (WHO) reveals that the UK has a high prevalence of overweight and obesity in adults, with 2008 data showing that 64.7% of the adult population is overweight and 26.9% obese (WHO 2013). Linked to these high rates of excessive weight is data from 2012 which shows that 39% of the adult population in England did not meet the minimum guidance for physical activity (WHO 2013). Alongside smoking and excessive

alcohol consumption, taking insufficient exercise and being overweight are the four modifiable health behaviours that contribute significantly to the risk of developing LTCs. In relation to my own geographical area of practice, the North-East of England, Public Health data (2016-2018) shows high rates of alcohol-related harm and of smoking; the worst levels in England, with poor rates of physical activity and 66.1% of the adult population overweight (PH England 2019a), which translates into high rates of mortality from all cancer and cardiovascular disease in persons aged under 75 years of age (PH England 2019b). This evidence gives a clear indication of the factors influencing and driving health policy and how lifestyle affects our long-term health. [Similar, geographically distinct public health data is available from the Scottish Public Health Observatory: <https://www.scotpho.org.uk/>]

In an effort to reduce the impact of chronic disease, nurses enable key health improvement policy by directly tackling smoking and alcohol intake while encouraging increasing physical activity and promoting awareness of the importance of maintaining a healthy weight. Since LTCs cannot be 'cured' the nurse's role is to enhance an individual's functional status, to help people live well and to educate them in preventative measures so that they stay well. Two key policy documents – in England the *Five Year Forward View* (NHS England 2014) and, in Scotland, *Gaun Yersel!* (NHS Scotland/LTCAS 2008) – acknowledge that we are living longer but that, as we age, we are more susceptible to conditions that we previously might not have survived (Nolte & McKee 2008). These policies have become levers for change in nursing practice.

The likelihood of suffering and experience of living with an LTC are dramatically affected by an individual's socio-economic status (Annesley 2015; Loretto & Taylor 2007). People living in the most deprived areas of the UK are more likely to have at least one LTC, with clear

evidence that people facing the greatest social deprivation are more likely than those in affluent areas to acquire one LTC by the age of 40 and to develop a second by the age of 50 (Department of Health 2014). This epidemiological, demographic and socio-economic time bomb is of significant concern to governments and health care professionals (WHO 2011). A number of contemporary public health policy themes has emerged in response, such as: the importance of preventing and anticipating illness so that action can be taken early; promoting personal responsibility – ‘*health is everyone’s business*’; and helping people to take more control over their own health (Public Health England (PH England) 2018a).

Experience shows that legislation can be slow to enact public health policy. For example, the Alcohol (Minimum Pricing) (Scotland) Act 2012, aimed at preventing alcohol-related harm, was passed in 2012 but only came into effect in May 2018. However, policy implementers have shown themselves to be more responsive. In Scotland, for example, clinical managers embraced the message contained in *Gaun yersel!*’ and, in partnership with district nurses, have driven the policy into direct front line nursing practice (Annesley 2015). In England, the *Five Year Forward View* has informed subsequent policy initiatives and underpins the new *NHS Long Term Plan* (2019).

For two hypothetical case studies which further illustrate the impact of policy on integration of care, supporting care of people with LTCs and nursing knowledge, see Boxes 1 and 2 [Insert Boxes 1 and 2].

Current health policy focus and implications for nursing

Alongside LTCs, obesity and mental health problems in children and young people are key topical health policy issues that place nursing provision under increased pressure. It is

estimated that 10% of those aged 5-16 years have a diagnosable mental health condition (Mental Health Foundation 2015); and, in 2016-17, 20% of children aged 11-12 were identified as obese (NHS Digital 2018). Childhood obesity is particularly pronounced in the North-East of England with 22.8% of children aged 10-11 identified as obese (PH England 2019c). Poor diet and obesity across all age ranges is contributing to a rising incidence of Type 2 diabetes (PH England 2014). While policy develops in response, nurses are already dealing with the everyday consequences of the crisis in health. Sometimes, we must take the initiative, as further illustrated in the policy case studies in **Boxes 1 and 2**.

The evolving policy context is overtaking traditional interventions, so nurses should be aware of new approaches and seek best practice where they can – for example, recognising people's power to help themselves and considering strategies to help people change their lifestyle, drawing on behavioural and social sciences (PH England 2018b). The complexity of these issues also means that we cannot rely on a single institution to solve them: the NHS needs to join forces with local councils and voluntary and private sector providers to create better integration of services. As the contexts of care delivery, location and method change, we must transform our roles as nurses. We must adapt to keep pace with such changes in society as well as responding to the financial challenges to best manage resources and ensure safe, high quality patient care.

It is implicit that for health policy to succeed it must be implemented. The process of policy delivery can appear unpredictable, messy and complex (Cairney 2012). To help understand how policy is delivered in practice, it is useful to consider the policy process in a five stage model: getting ideas onto the agenda; formulating policy; adoption; implementation and evaluation (Anderson 2011). However, this model perpetuates the perception that policy

implementation is top-down. In reality, and as revealed by research, it is recognised that such hierarchical models are too simplistic (Schofield 2001); that a range of actors shape and inform policy; that bottom-up strategies work alongside policy directives to interpret and operationalise initiatives.

This shift in understanding is reflected in the implementation of the Health and Social Care Act 2012, which marked a move away from centralised control of the NHS in England (Iacobucci, 2017a). It sought to reorganise the NHS in a number of ways, but most significantly through the establishment of clinical commissioning groups (CCGs), which passed the purchase of health services, for a local community, to GP-led collectives (Moran et al 2017). Nurses, in the form of a governing body nurse, also play an important role in the leadership, governance and decision-making of CCGs (Dempsey & Minogue 2017). Here health policy has directly impacted on the opportunities in influence and leadership that nurses can demonstrate, with the voice of the nursing profession shaping the context of care for local communities. These opportunities have been provided by the enacting of policy and allow nurses to exercise their power in policy implementation.

Nurses also adapt and apply policy to their practice in, for example, primary care where district nurses have been shown to respond directly to the UK policy demand to shift focus of intervention from hospital to a community setting (see above; Haycock-Stuart & Kean, 2013).

In summary, health policies aim to influence care and affect nursing directly by changing:

- The location of care – to move it closer to home and away from in-patient facilities: nurses are caring for sicker patients at home.

- The focus from treatment to the promotion of health and prevention of illness so that nurses are working more directly across the life-span in a less episodic way;
- Roles and responsibilities, directing nurses to work in integrated teams that bridge health and social care and adapt to an integrated model of delivery around multiple health conditions rather than a single disease and;
- Taking nursing away from a traditional bio-medical health model to a greater appreciation of wider health determinants – the idea of integrating health in all policies.

These policy themes are not mutually exclusive. They overlap as they seek to acknowledge the changing needs of the population and respond to requirements to improve public health and the closer integration of social and health care. Policy implementation directly impacts on nursing and reinforces the need for nursing leadership to deliver policy in practice (Haycock-Stuart & Kean, 2013). But delivering policy on the 'front line' highlights the demand for a different type of leadership. Indeed, the importance of nursing leadership is a core principle of the current English Nursing and Midwifery Strategy: Leading Change. Adding Value (NHS England 2016a).

Policy agendas may conflict directly with professional principles, neglecting or challenging nurses' ability to deliver patient-centred care. To implement front line policy, nurses need additional training, workforce resources and the development of specialist knowledge. These resources may be absent or in short supply. For example, policy ideas addressing prevention and health promotion require nurses to use coaching or motivational interviewing to meet

policy directives: ‘*making every contact count*’ (NHS England 2016b). These are new skills, which pose a significant challenge and a potential barrier to policy implementation.

More thoughtful policy making should engage those who will be directly impacted, so the process ought to include front line nurses to help anticipate conflicts and resistance and mitigate barriers to implementation. A good example of this bottom-up approach to policy is the development of NHS Scotland’s policy promoting self-management for people with LTCs. ‘*Guan Yersel!!*’ (see above; NHSScotland/LTCAS 2008), written by the Scottish Department of Health in collaboration with voluntary sector workers engaged with people living with LTCs. Much can be learned from its success, which promoted efforts to encourage participation and collaboration, ensured positive communication and a strong patient focus to self-management (Annesley 2015). Success was ensured by leadership from the policy-makers and those targeted with implementing patient self-management in practice: specialist nurses and District Nursing teams.

Despite this progressive approach to policy development *Guan Yersel!!* still posed challenges to implementation. A health policy that focuses on promoting personal responsibility can be seen as ‘*healthcare on-the-cheap*’, since it subtly shifts the responsibility of treatment from practitioner to patient. Even more concerning, promoting personal responsibility over professional expertise best serves those who can already help themselves, resulting in a ‘*policy paradox*’. Self-management is most successfully exercised by people who already understand how to manage their LTCs but does little to help those who can least manage their LTCs: people living with more than one LTC and those who are socio-economically disadvantaged. The unintended consequence is that policies focusing on personal responsibility polarise and accentuate health inequalities, rather than creating an environment that reduces them. This is

a huge healthcare challenge for the whole sector, from policymakers to nurses (Annesley 2015).

Organisation of health care in the UK

Health policy and spending are devolved to the four regions of the UK, since 1999 in Scotland and Wales and 2000 in Northern Ireland (Murray et al 2013). So, while the four regions have faced similar challenges, they have approached them with contrasting policy solutions (Greer 2004). NHS England has focused on the internal market as its driver and promoted a top down managerial model, while NHS Scotland's approach has been to promote professionalism, using networks of clinicians to plan resource allocation and agree how care should be prioritised (Greer 2004). The contrast between a heavily managerial, market driven model in England and a clinician led model in Scotland explains why the health policy stories of both regions have diverged.

In England and Scotland health policy priorities are largely similar but the means by which these priorities are converted to policy differ. Both regional health services prioritise public health, children and young people, mental health and inequalities in health, technology and workforce (NHS England 2017, NHS Health Scotland 2018). However, NHS England still takes what could be interpreted as a '*disease informed approach*', as well as focusing on the competitive purchase of services as a driver for improvement (NHS England 2017). In Scotland the policy approach is informed by a desire for integration of health and social care, with a strong emphasis on collaboration, fairness, inclusivity and a healthy environment (NHS Health Scotland 2018). In England, therefore, nurses are both purchasing provision and acting as the primary agents for policy delivery; in Scotland, nurses are more directly integrated into policy interpretation (Annesley 2015).

The health policy story in Wales and Northern Ireland is less well developed. Wales abolished the purchaser-provider split in 2009 and focuses on performance management through the leadership of NHS Trust chief executives, adopting what has been described as an innovative local approach to health policy (Bevan et al 2014). In contrast Northern Ireland, whose elected Assembly is currently suspended, has made the least progress in implementing health policy (Bevan et al 2014). Their approach has been described as permissive managerialism, led by civil servants with little political interest or involvement from policy implementers (Greer 2005).

See **Diagram 1** for an overview of the key organisations that make up health care in the UK, which illustrates the different sources of health policy across the UK. **[Insert Diagram 1:]**

Policy implications for the nursing profession

Policy matters for our profession: for who a nurse is; for what nursing means and how we do our job. As we have seen, policy addresses existing and anticipated areas of concern in healthcare and its organisation; and one important challenge in the 71st year of the NHS is workforce pressure, not just on staffing levels and costs but in relation to roles, responsibilities and skills mix. Currently, 600 095 nurses are registered with the NMC, with a documented decline in Registered Nurses (RN) coming from Europe following the EU Referendum in June 2016. In April 2018 the NMC reported that “*between April 2017 and March 2018, 3,962 people left [the NMC register] – an increase of 29 percent*” (NMC 2018a). This, combined with the replacement of NHS bursaries for nursing and midwifery students with tuition loans in August 2017 (only in England; Scotland, Wales, and Northern

Ireland have maintained an NHS bursary) is having a considerable impact on nursing numbers, one that is likely to worsen the NHS staffing crisis.

One policy response, as advocated in Lord Willis' review '*Shape of Caring*' (NHEE 2015), is the development of the Nursing Associate, designed to bridge the gap between the roles of Health Care Assistant (HCA) and RN. However, this scheme will only operate in England and presents an unknown challenge for nursing's professional regulator (NMC 2018b). **The impact of this new role on nurse staffing levels in England will take time to emerge.**

Hopefully, it will go some way to redressing the imbalance in nurse staffing numbers in England which currently, out of the four regions of the UK, has the lowest rate of WTE nurses per 1000 population at 5.8, with Scotland having the highest at 7.9 nurses per 1000 population (Bevan et al 2014). **However, there is concern that this role represents a dilution of skill mix which will do little more than plug a staffing gap and constitutes a retrograde step, which will neither promote professional status nor recognise the investment needed to ensure high quality nursing care (Rafferty 2018).**

Conclusion

This health policy article has **shown** why nurses need to understand policy. The NHS faces considerable challenges, and these are reflected in many of the policy themes explored here. Nurses and nursing need to recognise and adapt to these challenges if **we are** to move forward and continue to provide universal, equitable, comprehensive and high-quality care (Iacobucci 2017b). Health policy and its implementation relies on nurses to bridge the gap between policy and practice. The impact of health policy on our ability to deliver and coordinate care is of contemporary and ongoing relevance and is reflected in Platform 7 of the new NMC Future

Nurse Standards (NMC 2018c). Policy and its process are essential elements of nursing and will govern the future development of the profession.

For further policy information and guidance please see **Table 2: Useful Websites [Insert Table 2: Useful Websites]**

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Box 1: Policy Case Study A: Integrating health systems

The challenge of an ageing society is that the traditional way of moving through the NHS, by which you see your GP, are referred for treatment, treated, discharge and return home, no longer applies. For the increasing proportion of the population who are grappling with not just one but three, four, or more long-term conditions, and are elderly, the experience of the NHS is very different. Their care and needs do not fit with this traditional, segregated approach. Policy has promoted new models of organisation, team work and collaboration which try to create a better fit for our patients. More often, community nurses are part of integrated teams that bring together health and social care, physical and mental health. The policy aim is to create a collaborative approach around patients with chronic long-term conditions, rather than individual nurses, GPs, social workers, or occupational therapists addressing a symptom or an aspect of patient care. This develops a combined team approach that is more effective and efficient for the patient and better utilises the skill and knowledge of the team members.

Philip's case shows how integrated care and the use of a community care co-ordinator improved his care. Philip is 79-years-old, diagnosed with Parkinson's disease 8 years ago. Within the same time period he has become increasingly deaf and has been diagnosed with type II diabetes and atrial fibrillation. In addition, he is being treated for Meniere's disease, prostatitis and hypertension. Jayne, also 79 years, Philip's wife of 54 years, is his main carer as they seek to continue to live independently. Recently, the couple have felt increasingly isolated and frustrated by the care they receive from their local district general hospital. They were never seeing the same person, having to repeat information and were confused medication instructions that conflicts with those of their GP. Consequently, they were losing confidence in the hospital care they were receiving. Philip maintains as much independence as possible and manages his medication; he eats well but fatigue, his diminishing mobility and loss of confidence due to his deafness and Meniere's disease mean that he only leaves the house occasionally.

Recently, Philip and Jayne have been allocated a community matron to act as their care co-ordinator, which has meant an improvement in communication between the GP, his hospital consultant, and the Parkinson's specialist nurse. The community matron is based in an 'integrated care hub' which allows access to health and social care coordinators and community based allied health care practitioners. Philip and Jayne are visited by the community occupational therapy team who have information on his situation, and adaptations are under way to help Philip about the house. An increase in frequency of assessment by the speech and language therapist has helped with his swallowing. A local befriending service allows Jayne to get out once a week without the anxiety of leaving Philip alone.

Philip, and in turn Jayne, have benefited from better teamwork around him addressing his chronic conditions. In line with the current NHS Plan (2019) this integrated, collaborative approach supports nurses and other healthcare practitioners to work together and develop the best care for the community and individual patients.

Box 2: Policy Case Study B: An example of how health policy has impacted on nursing knowledge

In the UK it is estimated that 3.2 million people in the UK have diabetes (Diabetes UK 2014). Type I diabetes accounts for approximately 10% of all those diagnosed with the disease (Diabetes UK 2014). Type II diabetes is linked to obesity, but not everyone who is obese gets diabetes. Genetics studies show us that there are more sub-types than simply Type I or Type II and that people with Type I and Type II have very different developmental disease pathways. This genetics knowledge has significant impact for diagnosis and treatment and can inform the personalisation of nursing care.

Freddie, a 21-year-old, presented to his health centre Nurse Practitioner with raised blood glucose. He was not overweight but had a strong positive family history of Type II diabetes. To control his blood glucose Freddie was prescribed metformin by his non-medical prescriber nurse. Knowledge of genetics ensured his nurse was able to discuss the impact of genes on the development of his disease but also the benefit of genetic testing to assess his susceptibility to metformin and determine if this was the best drug to manage his blood glucose.

For nurses to deliver the personalised care set out in health policy papers, they have developed non-medical prescribing skills and knowledge about the genetic influence on disease and its treatment.

Freddie, has tailored, personalised care supported by the latest genomics and research. These are important elements of a modern NHS, showing the development of specialist nursing knowledge and **clinical leadership, key themes in health policy** (NHS England 2016a).

Where policy comes from: organisation of health in the UK

UK Government			Devolved spending to:		
Dept. of Health and Social Care, England			Scottish Government		
			NHS Scotland	Community health services	
Health Education England: Education training and workforce development	NHS England: commissions primary care services including: GP practices, pharmacist and dental services	Public Health England: local public health services	14 Health Boards, 6 Special NHS Boards and 1 public health board provide health care to the people of Scotland		
	211 CCGs: commission secondary care services	152 local authorities in England			
Regulators: there are a number of regulators and professional bodies, including: CQC: regulates health + social care NHS Improvement: regulates NHS Trusts NICE: guidance and quality standards NMC: regulator of UK Nursing and Midwifery standards and from Jan 2019 Nursing Associate standards (later England only)			Welsh Government		
Commissioned health care delivered to population of England through NHS Trusts which combine to provide secondary care, mental health, NHS 111, learning disability and community services			NHS Wales		Public Health and Social services
			Health care to the people of Wales		
			Northern Irish Government		
			Hospital Services	Social Care services	Family health services
			Health care to the people of Northern Ireland		

Informed by BMJ 2017; NHS Scotland Scotland's health on the Web (2018)

<https://www.scot.nhs.uk/about-nhs-scotland/>

Table 1: Legislation, Regulation, Policy, and Guidance

Legislation	Regulation	Policy	Guidelines
<p>Definition: policy, regulation and procedure enacted in law.</p>	<p>Definition: to control, direct and maintain standards in health and social care. A regulatory duty can be ascribed to an organisation by legislation.</p>	<p>Definition: goals, ideas, priorities set out by governments and their departments. Can be informed by legislation and regulation.</p>	<p>Definition: make recommendations on how professionals deliver clinical care, or interventions to promote public health or how to improve outcomes through service improvements. Can be informed by legislation and policy.</p>
<p>Examples of legislation that apply to health:</p> <p>The Health and Social Care Act (2012) – applies in England only.</p> <p>The Nursing and Midwifery Order 2001 (SI 2002/253) – establishes the NMC and sets out its primary purpose.</p> <p>Alcohol (Minimum Pricing) (Scotland) Act 2012 – established in 2018 a statutory minimum price of 50p per unit of alcohol.</p>	<p>Examples of regulation that apply in healthcare:</p> <p>The Clinical Quality Commission (CQC) is a regulatory body for adult social care services in England ensuring fundamental standards of quality and safety are maintained.</p>	<p>Examples of health policy:</p> <p>NHS England (2016a) Leading Change, Adding Value. A Framework for Nursing, Midwifery and care staff.</p> <p>NHS England (2019) NHS Long Term Plan</p>	<p>Guidelines that apply to health are issued by organisations such as:</p> <p>NHS Improvement; National Institute of Clinical Excellence (NICE); Royal College of Nursing; Healthcare Improvement Scotland.</p>

Table 2: Useful websites:	
Department of Health & Social Care https://www.gov.uk/government/organisations/department-of-health-and-social-care	Scottish Government Health and Social Care https://www.gov.scot/health-and-social-care/ and https://www2.gov.scot/Topics/Health
NHS Health Education England https://www.hee.nhs.uk/	NHS Scotland https://www.scot.nhs.uk/
NHS England https://www.england.nhs.uk/	Welsh Government Health and Social Services https://gov.wales/topics/health/?lang=en
Local Government Association https://www.local.gov.uk/	North Ireland Department of Health https://www.health-ni.gov.uk/
Public Health England Local Authority Health Profiles https://fingertips.phe.org.uk/profile/health-profiles	The Scottish Public Health Observatory https://www.scotpho.org.uk/

The implications of health policy for nursing: at a glance

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This article will:

- Outline the importance of health policy and how it provides a context to nursing
- Define health policy and what influences it
- Identify current health policy focus and implications for nursing
- With the use of policy examples explain policy implementation and how health policy impacts directly on nursing.
- Indicate differences in health policy between the devolved administrations of the UK.
- Summarise implications of current policy change on the nursing roles and skill mix.

Dear Reviewer, thank you for the feedback and suggestions on this submission and the previous.

I provide the following explanation and response to the points raised

1 - Although you have considered the inclusion of case studies as a means of illustrating how policy affects nursing practice, neither of these actually offer any real detail for the reader to understand the influence of policy on practice. Case Study 1 relates more to nursing knowledge rather than policy and the second case study is too superficial to develop understanding / learning in the reader.

Response: I have re-written what was case study B and re-named this case study A. This now shows the influence of policy on nursing and how patients and their carers experience care. Case study B: remains the same as it serves to illustrate how policy impacts on nursing knowledge and our professional development.

2 - Parts of this draft read like an amalgamation of old assignments / articles with some ad hoc additions

Response: This submission has been written for this journal and is not an amalgamation of older work or previous articles.

3 - Look to the WHO Global Health Observatory for contemporary health issues that subsequently lead to the development of LTCs (This offers you the scope to address point 1 offered in the first draft). NHS Digital Data 2018, can also be supplemented with UK Health Observatory Data, which would offer readers the scope of finding relevant information related to individual UK countries.

Response: The recommended sources have been added to sections on page 3-4 and page 5 with directions on how readers can access information specific to their local context of practice. In addition, these UK sources have been added to Table 2: Useful website.

4 - There is a lot of current literature that addresses how policy development is research focused - some of what has been included is outdated.

Response: I have sought to include a wider range of contemporary research focused literature. Where references appear dated, I consider these as seminal and support definitions of policy and health policy and explain the thinking behind the policy process.

5 - Pg 5 - there is a statement which resembles a 'value judgement' and a key Act, i.e. the Health and Social Care Act has been omitted ... The second full paragraph and the one after is no longer the case, again the citations are outdated.

Response: Page 5 has been reviewed and re-written with more careful consideration of the Health and Social Care Act 2012.

6 - I don't think that you have addressed the points you wanted to (as outlined in the abstract) as the focus has not been maintained.

Response: I have reviewed the whole submission and sought to provide a focused article in a manner that highlights the practical impact of policy on nursing practice. In light of the changes and development made the summary points and abstract has been reviewed.

Yours faithfully,

Author