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Abstract	The aim of this report is to provide relevant stakeholders (e.g., policy and decision makers) with a set of recommendations to support them in their efforts of achieving an effective transition to a primary care model that is integrated, person-centred care, and where the Family and Community Nurse has the

	potential to be an efficient investment and a key professional in delivering such care.
Keywords	Recommendations, efficient investments, Family and Community Nurse, Primary Care Model, stakeholders.

Signatures

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2 Executive summary

One of the causes of the skills gap identified in the field of Family and Community Nursing is that national governments lack (at different levels) guidance, time and funding to invest in the new Primary Health Care (PHC) models. The purpose of this report is to provide relevant stakeholder groups such as public and private employers, nursing bodies and associations responsible for development of nursing education in community care; and other key policy and decision makers such as regulatory bodies with recommendations and guidance that will support them in the shift from the old PHC model to the new one, which will include the Family Community Nurse (FCN) professional profile.

In the longer term, the ultimate aim is to ensure sustainability for the ENhANCE project results, which at its most central is about achieving a broad and widespread recognition at European level of *Family Community Nurses (FCNs)*. This recognition can be facilitated by ensuring a greater adoption and formal recognition of the professional profile at national or regional level, but also by continuing the work commenced with ENhANCE at European level – namely to ensure a harmonised definition of the FCN Professional Profile relevance of the competencies and the associated European curriculum for FCN.

Given the aim to also achieve greater sustainability and wider uptake of the ENhANCE main project outcomes, but also given the great variability in organisation, structure and responsibility for primary care across Europe including for family community nursing, the recommendations herein have been kept broad to ensure their relevance and applicability across the different cultural, health and social care contexts that the analysis done in Task 2.1 concluded.

Summary of recommendations for efficient investments in Family & Community Nurse:

1. Evidence suggests that healthcare should be designed and delivered to support patient- and family centred health care. There is a need to acknowledge and recognise that the occupational context of the Family and Community Nurse (FCN) who provide community-based or home-based care is very broad, and may range from FCN providing very specialized support to diverse groups of different needs and preferences.

2. Advanced competences and training are required for nurses in this area and the FCN profile is emerging as a new specialist nurse profile. Resources should be committed to raise awareness for the FCN profile and further develop FCN specialisations. At the same time, given the projected increased levels of specialist care, the community

nursing team should have a range of specialist nurses within it, covering all groups supported in the community.

3. Deinstitutionalisation (DI) will mean that there will be an increasing number of people with learning disabilities and mental health problems living in the community - so the present level of demand for care will increase. An efficient coordination between care in the family, in the community and in institutional settings is key to success. Concretely, this entails appropriate support services for informal carers and the implementation of quality control mechanisms with an emphasis on user satisfaction.

4. For the Family and Community Nurse professional to be successfully integrated in the health and social care setting, it is essential to overcome the lack of knowledge and trust among the various roles and responsibilities of the different health and care professionals, often hampered due to the current fragmentation of the service delivery.

5. Training programmes targeting Family and Community Nurses should promote collaborative learning approaches and possibly foster the creation of Communities of Practice for FCNs. This is because these approaches fit well with the actual training needs of professionals, who will need to work in strong collaboration with their colleagues and other professionals.

6. Training programmes targeting nurses should be complemented with interprofessional practice settings to support this new way of learning in the multidisciplinary and interdisciplinary team. In the Continuing Professional Development (CPD) context, online programmes should be offered, as this fits better with the needs of working nurses and provides them the opportunity to familiarise with online communication.

7. A truly person-centred approach is essential, which will require different ways of working away from the prevalent “medicalized” model of care and increasingly towards a more holistic view of an individual person’s health respecting their needs and preferences. Family and Community Nurses must learn to identify and navigate the difficult border between a care service users’ freedom to choose/refuse a service –especially for those with disabilities.

8. Nurse education and training programmes must graduate nurses able to drive progress in primary health care and universal health coverage. Actions to achieve this include: investment in nursing faculty and training teachers involved in nurse education programmes; availability of clinical placement sites and work-based learning; and accessibility of programmes offered to attract a diverse student body. Nursing should emerge as a career choice grounded in science, technology, teamwork and health equity.

9. Allow nurses to work to the full scope of their nursing education. Allowing nurses to practise at the top of their education and experience can result in greater job satisfaction and greater patient satisfaction with care. Enabling factors are training in primary health care, development of standardised practice guidelines and data systems to track patient care outcomes.

10. Where public funding plays a role in Long Term Care (LTC), governments can use this to improve working conditions, for instance through requirements in public procurement. Acknowledging LTC as a distinctive sector in data collection and collective agreements or regulations, and improved coverage of collective bargaining, can help in improving evidence for policies, creating a better working environment and enhancing service quality. This aspect is especially important given the FCN occupational context, which can span both the health and LTC sector.

11. The inclusion of informal carers (family members and friends) and organisations that represent them in Integrated Care Partnerships must become a central principle to release the full potential for synergies across services, better allocate resources and avoid overlaps and the negative effects and costs of service disruption on health status". Community Nurses can have a key role in integrating care services and involving informal carers as equal partners of the care team.

12. COVID-19 pandemic disproportionally affects the vulnerable groups such as the old and frail, the poor, and members of minority ethnic groups. In order to reduce vulnerability, primary care services should be supported and healthcare professionals, community health workers and informal care givers should be motivated to focus more on health promotion, lifestyle programs and intersectoral collaborative actions to increase health equity and resilience in the community.

13. In this post-pandemic era, there is a key need to maintain primary health care practices, establishing community care facilities, extending home-based

programmes, as well as expanding the role of primary health care workers and increasing telemedicine consultations to minimise delays and forgone care for all patients.

3 List of acronyms and abbreviations

CEDEFOP	European Centre for the Development of Vocational Training
CHN	Community Health Nursing
COVID-19	Coronavirus Disease 2019
DI	Deinstitutionalisation
ECCM	Extended Chronic Care Model
EFN	European Federation of Nurses
EIP on AHA	European Innovation Partnership on Active and Healthy Ageing
EPSR	European Pillar of Social Rights
EU	European Union
EUREGHA	European Regional and Local Health Authorities
EUROFOUND	European Foundation for the Improvement of Living and Working Conditions
EXPH	Expert Panel on Effective Ways to Invest in Health
FCN	Family and Community Nurse
GP	General Practitioner
HWF	Health Workforce
ICN	International Council of Nurses
IPCHS	Framework on integrated people-centred health services
LTC	Long-term Care
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Health Care
SEPEN	Support for the Health Workforce Planning and Forecasting Expert Network
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UN CRPD	United Nations Convention on the Rights of Persons with Disabilities
VET	Vocational Education and Training
WHO	World Health Organization

4 Introduction

One of the causes of the skills gap identified in the field of Family and Community Nursing (FCN) is that national governments lack (at different levels) guidance, time and funding to invest in the new Primary Health Care (PHC) models.

4.1 Aims and objectives

The purpose of this report is to provide relevant stakeholder groups such as public and private employers, nursing bodies and associations responsible for development of nursing education in community care; and other key policy and decision makers such as regulatory bodies with recommendations and guidance that will support them in the shift from the old PHC model to the new one, which will include the Family and Community Nurse professional profile.

4.2 Relation to other activities and deliverables

This report takes into account and builds upon the project's earlier analysis and results as reported in ENhANCE deliverable D2.1.1 *"Report on current FCN working and occupational contexts"*, which aimed to provide a snapshot and a broad analysis of the working contexts of the Family and Community Nurse across 21 EU Member States, specifically: Austria, Belgium, Cyprus, Croatia, Finland, France, Estonia, Germany, Greece, Hungary, Ireland, Italy, Norway, Poland, Portugal, Romania, Slovenia, Spain, Sweden, The Netherlands and United Kingdom.

Starting from D2.1.1 and based on a Delphi Study involving a number of experts at European level, the project put forward a definition for the FCN Professional Profile (see D2.2 "FCN Professional Profile), which outlines 28 core competences for this professional. On the top of this Professional Profile, a European Curriculum for FCNs was developed (D3.1.2) which is flexible allowing for it to be adapted and localized according to the specificities of the different contexts. In the project, such flexibility was tested thanks to the localization of the EU Curriculum in 3 localized FCN curricula (for Italy, Greece and Finland respectively) (see D3.3 "Instructional design documents of three national curricula"), that were then piloted with 3 training courses in those same 3 partner countries (see D5.1, D5.2 and D5.3). The Curriculum was also featured with two sets of Guidelines, one for VET designers and one for teachers (D3.2.2 and D4.3.2) to support the instantiation even in contexts different from those piloted in the project, thus allowing the complete design and delivery of innovative training paths for FCNs in any European country.

This report builds on the experience gained and the knowledge developed within the project, and puts forwards lessons learnt and recommendations to support future uptake of the project outcomes and – more generally – to further invest in Family and Community Nursing.

The report will also integrate the relevant inputs stemming from the ENhANCE Final Conference, an online two-day dissemination event, which aims were to (i) discuss the main pathways for moving from the phase of piloting the FCN Curriculum in 3 local contexts, to a phase of wider adoption at European level and (ii) to discuss other factors that are key in enabling a greater uptake and subsequent adoption of the FCN profile as part of the multi-disciplinary team across Europe.

4.3 Report structure

The report is divided into 5 sections.

Section 4 (this section) is the Introduction to the deliverable.

Section 5 develops in greater detail the key justifications and explanations behind the main recommendations targeting primarily policy and decision makers and other relevant stakeholders about how Family Community Nurses can be a potentially efficient primary care investment. This section is composed of a number of inter-related sub-sections to introduce and present different relevant trends and aspects that impact on the development of the FCN profile and the FCN role. More specifically:

- Section 5.1 presents a brief summary the FCN occupational context and profile.
- Section 5.2 the demographic ageing and shifting disease patterns.
- Section 5.3 the trend of deinstitutionalisation.
- Section 5.4 the changing models of care.
- Section 5.5 the health workforce.
- Section 5.6 what is needed for responsive and resilient health systems.
- Section 5.7 about the long-term care workforce.

Section 6 additionally provides a number of inspiring and promising practices across Europe to exemplify with some real-world experiences from investing in the FCN in primary and community-based care.

Section 7 presents stakeholder feedback from ENhANCE Final Online conference, 6 & 20 May 2021.

Section 8 concludes the report.

5 Recommendations for efficient investments in Family Community Nurse (FCN)

It is important to understand the ongoing societal trends both in terms of the ageing population, disease patterns, the organisation of primary care in particular the community-based health and long-term care work force. Moreover, the impact of COVID-19 has possibly accelerated and further strengthened the need for ongoing transitions such as a moving away from large-scale institutional and residential care, and the need for true ageing-in-place, ensuring our social inclusion in our local communities, thus translating into a growing trend for home-based care delivery.

Skills shortages are pervasive in both the health and long-term care (LTC) sector. FCN may occupationally span either of these two domains, which themselves are often fragmented in one country, and receive their funding through different budgets (federal/state level or regional or even local). Thus, depending on their occupational context FCN may belong either the healthcare system or the LTC sector.

Finally, in terms of the organisation of care, health systems, social care and educational systems, vary considerably across Europe not to mention the different ongoing educational reforms in nursing, the different scopes of practice for nurses across Europe and their regulation.

These recommendations below, therefore, are broad in scope, and based on recent, existing and publicly available literature with the aim to provide different relevant stakeholders with a better understanding and notion of FCN as a potentially efficient investment in primary care. Moreover, and as mentioned above, these recommendations also include stakeholder feedback that was obtained in the context of the final ENhANCE Conference held online on 6 and 20 May 2021, which sought to present the final and main ENhANCE outcomes: the European Curriculum, its implementation guidelines, the learnings from the pilots and further reflect on and discuss about the needs of different target groups to ensure the FCN is well placed to be a potential efficient investment in primary care.

5.1 The Family Community Nurse: Towards a better understanding of the FCN occupational context.

5.1.1 Community nursing in Universal Health Coverage

Universal health coverage (UHC) has become the internationally agreed objective of health and development policy and achieving UHC was one of the UN Sustainable Development Goals (SDGs) agreed in 2015 (WHO, 2021)

UHC means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

To make this objective a reality:

- individuals and communities need to have access to high quality health services so that they take care of their own health and the health of their families;
- there is a need for skilled health workers providing quality, people-centred care;
- policy-makers need to commit to investing in universal health coverage.

Universal health coverage should be based on strong, people-centred primary health care. (WHO, 2021).

Crucially linked to this concept are individuals and communities. An essential prerequisite to fulfil the objective of UHC is an effective and well-functioning primary health care (PHC) system, and specifically the need for adequate numbers of skilled, well-educated and trained health workers. Community Health Nursing and Community Health Nurses (CHNs) are recognised to have the potential to make substantial contributions to meet the health care needs of various population groups in a variety of communities (WHO, 2017).

The WHO definition of Community Health Nursing (CHN) is:

> *"A special field of nursing that combines the skills of nursing, public health and some phases of social assistance and functions as part of the total public health programme for the promotion of health, the improvement of the conditions in the social and physical environment, rehabilitation of illness and disability". Community health nursing promotes and protects the health of populations through a combination of knowledge derived from nursing, social and public health sciences."* (WHO, 2017)

To enhance the role of community health nurses some of the key recommendations that were put forward are the need:

- to establish a clear framework for the practice of community health nursing;
- to enhance the education and training of community health nurses to practice in primary health care and community settings; and importantly
- to foster collaboration between key stakeholders in primary care systems
- to develop comprehensive advocacy plans for community health nursing

"Community health nursing is critical for health care systems to develop people-centred service delivery mechanisms for PHC. Achieving large-scale positive health outcomes for people in communities will be made more difficult without effective collaboration between all players in the health workforce including CHNs"–WHO, 2017

To ensure better collaboration and effectiveness, clear mechanisms of planning and implementation must be established jointly by leaders and managers of multidisciplinary health workforce teams – not just in education and training but also in practice and partnerships.

5.1.2 Family Community Nurse: The ENhANCE FCN Framework

To date, at European level, there is no one single and unified definition for the *Family and Community Nurse* and it is not a strictly defined nursing specialisation, which is why a defined professional profile at European level is equally lacking. Thus, within the ENhANCE Alliance, a crucial prerequisite in the start of the project was to define and identify the current working and occupational context of the FCN, by reviewing current professional practices, roles and activities of nurses working in primary care and the link between the family and community activities and roles of so-called Family and Community Nurses.

This was conducted in Work Package 2 (WP2) on the "Definition of the FCN Professional Profile". Led by the University of Genoa (UNIGE), the study entailed interpreting existing research evidence about the role of FCN in the community as well as their different scopes of practice across countries and even at regional level. In summary, as the governance, organisation and funding of primary care varies across Europe and, not surprisingly, the findings showed that also the contexts for Family and Community Nursing vary a great deal not only from country to country, but very often even within the same country.

To highlight some of the main findings from this review, showed, that for instance, Austria and Romania do not have nurse professionals specifically assigned for this role, while in others, there is a system for the provision of care in the community, the roles and the activities, as well as the definitions used, differ from one other.

The "Family and Community Nurse", defined in this way, exists only in Greece, in Slovenia and in some Italian Regional areas, while in Hungary, France, Belgium, Croatia, and Cyprus

there are “Community Nurses”; in the UK there are “District Nurses”, in Norway and Ireland, there are “Public Health Nurses”; in Sweden, Germany, and The Netherlands there are people who provide Home Care Nursing, whereas in Poland there is the “Primary Care Family Nurse”. In Portugal, there are specialized nurses who work in “Community Care Units”. In Finland, after accomplishing Master level in nursing science, nurses can work in various fields, as specialist professions, including family nursing.

Alongside these types of nurses, there are others with different functions and roles, such as "mother and child health nurses" (Hungary), "school nurses" (Sweden and Ireland), "nursing assistants" (Romania and Norway), "health visitors" (Cyprus and Greece), and "transmural nurse" (Netherlands).

Recommendation: *Evidence suggests that healthcare should be designed and delivered to support patient- and family centred health care (ICN, 2016a). There is a need to acknowledge and recognise that the occupational context of the Family and Community Nurse (FCN) who provide community-based or home-based care is very broad, and may range from FCN providing very specialized support to diverse groups of different needs and preferences.*

Based on that, and a Delphi Study involving several experts in the domain of FCN, the FCN Professional Profile was elaborated and consists of 28 core competencies. These are presented in a summary version at the following link: https://www.enhance-fcn.eu/competencies/, which in turn served as the basis for elaborating the first version of the FCN European Curriculum, conducted under WP3.

*The FCN professional profile and core competencies developed within ENhANCE focuses **on transversal (core) skills**. Increasingly these transversal skills are required by all health professionals in particular to ensure a successful transition from fragmented and disease-centred care towards people-centred healthcare delivery systems, and stirred by the growing evidence of a skills mismatch among health professionals.*
Maeda A., Socha-Dietrich K., OECD, 2021

Competencies and skills included in the ENhANCE FCN Curriculum, in fact, match very closely those included in a recent OECD Health Working Papers No. 124, which identified those transversal (core) skills that are becoming increasingly crucial for all front-line health workers to enable them to secure potential benefits of people-centred care, higher productivity, but also improved job retention and satisfaction.

These transversal skills include, among others, interpersonal skills, such as person-centred communication, interprofessional teamwork, self-awareness and socio-cultural sensitivity, as well as analytical skills, such as adaptive problem solving to devise customised care for individual persons, system thinking, openness to continuous learning, and the ability to use digital technologies effectively (Maeda A., Socha-Dietrich K., OECD, 2021).

An interim definition for the FCN and based upon the core competencies that underpin the FCN Professional Profile, used by the ENhANCE Alliance project was:

A qualified professional nurse who is able to apply evidence-based nursing practices (theoretical & practical knowledge, skills and, competencies) in order to identify and assess the health status and the needs of individuals and families in their cultural context and in the community.

Specifically, their role is to control and manage chronic diseases including disorders, syndromes and disabilities by promoting health of the community-dwelling population and, to enhance the family's health by providing nursing care at home in particular, and person-centred care to older people.

With the conclusion of the FCN Pilots where the ENhANCE FCN Curriculum was implemented in 3 different FCN specialisation courses and programmes, see the 3 main localized curricula, available in a summary version here: https://www.enhance-fcn.eu/localized-curricula/ and following the evaluation process with input from External Experts, the finally adopted definition for a FCN was further refined as follows:

*FCN is defined as a qualified-professional nurse at **a multi-dimensional** level that enhances the health of community-dwelling people and their families to **promote health and prevent disease** by **implementing health maintenance strategies** to ensure the wellbeing of the entire community.*

*Specifically, FCN being a highly specialized and competent nurse mainly focuses on the **control and management of chronic diseases** and **disabilities** thus directly improving patients' lives and supporting families.*

The ENhANCE project as a "Sector Skills Alliance" project, its main aim was to design and deliver a Vocational Educational Training (VET) curriculum in the field of Family and Community Nurses whilst at the same time address a key existing and future skills shortage in this domain.

In this context it should be underlined that a 2015 survey showed that the majority of OECD and EU countries covered, had implemented and expanded the scope-of-practice of certain groups of nurses (Maier C, Aiken L, Busse R, OECD, 2017).

Countries have embarked on educational reforms for nurses and moved the primary nursing education partly or fully to higher educational institutions, instigated in Europe by the Bologna process. Yet, many countries are at early stages of implementation. Moreover, roles vary considerably with variations in nurses' roles, skills and responsibilities in primary care. These different roles can be summarised into the following categories:

- advanced nursing roles working as 'generalists' to ease physician (e.g., GP) shortages, geographical imbalances and reduce physician workloads;
- advanced nursing roles focusing primarily on health promotion and prevention (e.g., screenings, immunisations) to scale up prevention activities; and
- advanced nursing roles working as single-disease 'specialists' to improve the management of chronic conditions (e.g. diabetes, breast cancer or coronary heart disease). (Maier C, Aiken L, Busse R, OECD, 2017)

***Recommendation:** Advanced competences and training are required for nurses in this area and the FCN profile is emerging as a new specialist nurse profile. Resources should be committed to raise awareness for the FCN profile and further develop FCN specialisations. At the same time, given the projected increased levels of specialist care, the community*

nursing team should have a range of specialist nurses within it, covering all groups supported in the community.

5.2 The impact of demographic change and shifting disease patterns

Life expectancy has increased greatly in EU countries over the past few decades, but many years of life in old age are lived with some chronic diseases and disabilities (see the indicator Healthy life expectancy). Chronic diseases—such as cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes—also bear an increasing toll on mortality. Moreover, the COVID-19 pandemic has compounded the harm of chronic diseases, given that severe cases of COVID-19 disproportionally affect not only older people, but also those who are obese or have pre-existing conditions. As expected, the prevalence of chronic diseases increases with age. Among people aged 80 and over, 56% of women and 47% of men report multiple chronic diseases on average across EU countries. (OECD/European Union, 2020).

Despite the long-lasting and multidimensional impact of the COVID-19 pandemic across societies, the 2020 edition of the Health at a Glance: Europe report reiterated the importance of not losing sight of the continued major impact of the main environmental and lifestyle preventable risk factors in the current burden of chronic diseases which still continue to bear a growing toll on mortality.

Each year we count 100 of thousands of premature deaths due to air pollution, tobacco and harmful alcohol consumption, unhealthy diets and lack of physical activity. Cross-sectoral policies need to be actively pursued to reduce population exposure to these health risks

Healthy and active ageing is about promoting healthy lifestyles throughout our lives and includes our consumption and nutrition patterns and our levels of physical and social activity. Healthy and active ageing is strongly influenced by an individual's personal choices and their individual responsibility, but it does of course also heavily depend on the environment in which people live, work and socialise and on social and economic disparities. Public policies therefor play a significant supporting role. Proactive measures can help prevent and detect illness and protect people from the effects of ill health. They can help ensure that healthy and active ageing becomes an easier choice, including for those in situations of vulnerability (European Commission, 2021).

Despite improved healthy life expectancy, the older you get the higher the chance of illness or disability. Gradually, many older people become frail and dependent on long-term care. As a result of the ageing demographics, there will be more older patients suffering from chronic

and, in many cases, multiple diseases –known as multi-morbidity. Although healthcare and long-term care systems will both need to respond to increased demand, they face different challenges, such as with regard to their workforce, social protection coverage or quality standards (European Commission, 2021)

According to the 2021 *EC Green Paper on Ageing,* a comprehensive policy response may encompass the need to:

- Invest in quality services and infrastructure, as well as in healthcare research and innovation;
- Ensure the access to healthcare;
- Offer attractive working conditions to address staff shortages; and not least
- Exploit innovative technology to improve efficiency.

Technological progress makes it possible to provide certain services and therapies in new ways, remotely, outside of hospital settings. A greater provision of such outpatient, ambulatory and community care infrastructure is expected not only to provide better health and social care, but importantly also to support older people with their social inclusion, facilitating for them to take part in social and well-being activities.

5.3 Deinstitutionalisation – enabling community- and home-based care

Deinstitutionalisation is defined as the development of community-based services in the form of flexible services and support that can be provided in the user's home as an alternative for care provision in institutional settings. It has become the hallmark strategy of social and care services for individuals with limited autonomy across European countries. Two core arguments underpin the effort to deinstitutionalise care: prioritising users' quality of life and increasing the sustainability of care systems (Ilinca S, Leichsenring K, and Rodrigues R, 2015).

The European experience has displayed high variability in its process towards deinstitutionalisation. It largely depends on the long-term care "typology" of the country and the balance between formal and informal care provision which decisively impacts upon the extent and speed of the deinstitutionalisation process, see Figure 1.

	Demand for care	Provision of informal care	Provision of formal care	Countries
Standard care mix	High	Medium/low	Medium	Germany, **Austria**, France, United Kingdom
Universal-Nordic	Medium	Low	High	**Sweden**, Denmark, Netherlands
Family-based	High	High	Low	Spain, **Italy**, Portugal, Ireland, Greece
Transition	Medium	High	Medium/low	Latvia, Poland, Hungary, Romania, Slovakia, **Czech Republic**

FIGURE 1. A TYPOLOGY OF EUROPEAN LONG-TERM CARE REGIMES.

SOURCE: Ilinca, S., Leichsenring, K. & Rodrigues, R. (2015)

The concept of prevention and early intervention is vital in delaying the need for institutionalisation, and some of the key basic principles can be summarised in Figure 2. In addition, successful strategies to avoid institutionalisation in long-term care need to overcome 'silo-thinking', and to focus on the boundaries between care settings in order to facilitate synergies between different levels of care and (professional) cultures.

Table 2: Ten principles of deinstitutionalisation

Source: Report of the Ad Hoc Expert Group on transition from institutional to community-based care, European Commission, 2009

	Common Basic Principles for deinstitutionalisation
1	Respecting users' rights and involving them in decision-making
2	Prevention of institutionalisation
3	Creation of community-based services
4	Closure of institutions
5	Restriction on investment in institutions
6	Development of human resources
7	Efficient use of resources
8	Control of quality
9	Holistic approach
10	Continuous awareness-raising

FIGURE 2. TEN PRINCIPLES OF DEINSTITUTIONALISATION.

SOURCE: Ilinca, S., Leichsenring, K. & Rodrigues, R. (2015)

***Recommendation**: Deinstitutionalisation will mean that there will be an increasing number of people with learning disabilities and mental health problems living in the community - so the present level of demand for care will increase. An efficient coordination between care in the family, in the community and in institutional settings is key to success. Concretely, this entails appropriate support services for informal carers and the implementation of quality control mechanisms with an emphasis on user satisfaction.*

"There is therefore a growing need in Europe to further focus efforts to provide affordable, accessible and good quality community- and home-based (care) services. This implies, amongst other actions, a growing need for trained and competent health professionals that can plan and oversee the care pathways, provide health education and support for informal and family carers." – Ilinca S., Leichsenring K., Rodrigues R., 2015

5.4 Changing models of care

Nowadays, an effective health system can shift care to its lowest point of complexity and highest level of sustainability. This entails a transition from the traditional hospital-centric approach to more community-based and integrated care structures, putting the focus on person-centred care, chronic disease management capacity and, crucially, on prevention measures (European Commission (DG SANTE), 2019).

As already mentioned, one of the reasons for this shift lies in the increasing demand for health care due to population ageing and the subsequent rise in chronic disease burden of and multimorbidity, all set against a backdrop of constrained public resources. The State of Health in the EU's 2017 Companion Report emphasised this shift in its key conclusions, putting the spotlight on prevention, primary care and integrated care.

5.4.1 Reforms to strengthen primary care as a means to achieve Universal Health Coverage

The full definition for Primary Health Care (PHC) is included in the Declaration of Alma-Ata adopted in 1978 by the International Conference on Primary Care and which states in article VI:

"*Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process." (WHO, 1978)*

Strengthening PHC continues to be a focus of health system reform worldwide. Some of the key messages from the evidence to date, in view of improving PHC include:

- focusing on the social determinants of health;
- transparent and accountable funding processes;
- improved access to health services supported by information technology; and
- interprofessional practice where quality and outcomes are regularly monitored.

"To pursue its goals, primary care should guarantee the provision of services that are 1) universally accessible, 2) integrated, 3) person-centred, 4) comprehensive and community oriented, 5) provided by a team of professionals accountable for addressing a large majority of personal health needs. These services should be delivered in a 6) sustained partnership with patients and informal caregivers in the context of family and community, and play a central role in the overall 7) coordination and 8) continuity of people's care".
– European Commission's Expert Panel on Efficient Investments in Health (EXPH), 2014

Much of the re-design of care models focus therefore on models that emphasise interprofessional education and practice with health team members who are supported to practice to full scope and who understand each other's roles. (ICN Policy Brief, 2016a)

5.4.2 Integrated and person-centred care

Today, the integrated health service delivery is the policy priority of EU Member States. It is based on the efficient re-orientation of activities from hospitals to primary care, home-based and community-based services (European Commission (JRC), 2021).

The EU approach to addressing the challenge of chronic diseases involves an integrated response focusing on prevention across sectors, combined with efforts to strengthen health systems to improve the management of chronic conditions (OECD/European Union, 2020).

The rising demand for healthcare, the increasing burden of chronic conditions and multi-morbidity, as well as constraints in the available human and financial resources for health, prompt countries to change the way healthcare is delivered: confront the fragmentation of health services and shift towards integration, linking or co-ordinating providers along the continuum of care and putting the patient at the centre. Integrated care is a central element of many strategies concerning the transformation and strengthening of health systems. The significance of integrated care as a means for improving health outcomes and the effectiveness and sustainability of health and care systems is acknowledged in policies and actions at national and EU level (European Commission, (DG SANTE), 2020).

The World Health Organization (WHO) at the World Health Assembly in May 2016, presented the Framework on integrated people-centred health services (IPCHS) that aims to address these issues by calling for a fundamental shift in the way health services are funded, managed and delivered (WHO, 2016).

Each of these above-mentioned is elaborated in further detail and followed by a series of potential policy options and proposals linked to each strategy area, visually represented in the Figure 3 where the policy options and interventions of particular relevance for the FCN Professional Profile in the integrated, people-centred care model and across all the WHO 5 strategies for shifting towards integrated people-centred services have been circled in blue. The *Framework* on integrated people-centred health services is a call for a fundamental shift

WHO recommends in its IPCHS Framework five interwoven strategies that need to be implemented to ensure health services are provided in a way that are coordinated around people's needs, respects their preferences, and are safe, effective, timely, affordable and of acceptable quality:

1. Engaging and empowering people and communities;
2. Strengthening governance and accountability;
3. Reorienting the model of care;
4. Coordinating services within and across sectors;
5. Creating an enabling environment

in the way health services are funded, managed and delivered. It supports countries progress towards universal health coverage by shifting away from health systems designed around diseases and health institutions towards health systems designed for people.

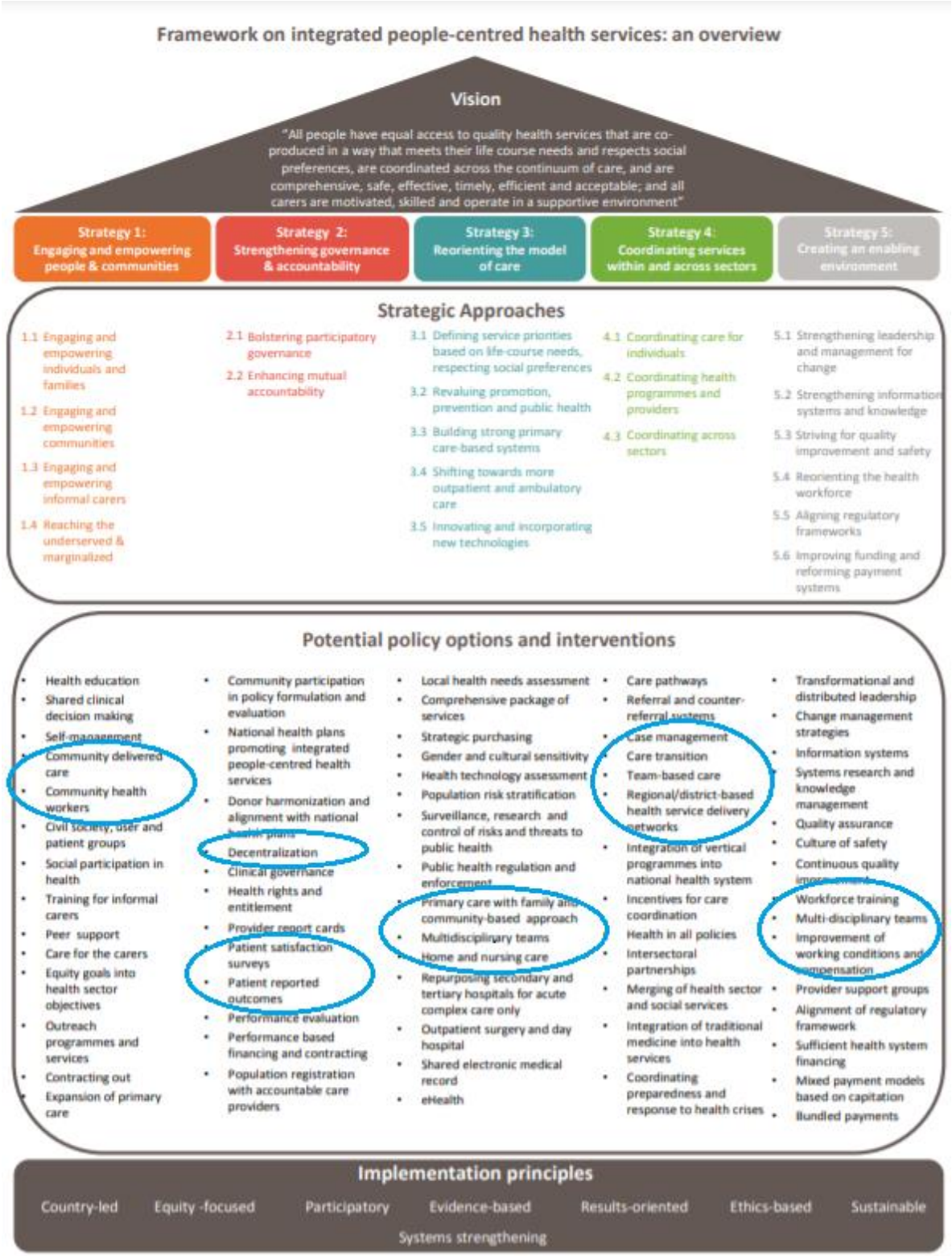

FIGURE 3. WHO Framework on Integrated People-Centred Health Services (IPCHS) with policy options and interventions of relevance for Family Community Nurse

SOURCE: (WHO, 2016) https://www.who.int/servicedeliverysafety/areas/people-centred-care/Overview_IPCHS_final.pdf

5.4.3 Integrated care for older people: What does recent European evidence show?

An increasing number of older people with complex needs live in their homes and communities into their later lives. Their complex needs require multidisciplinary collaboration to optimise the effectiveness of assessment and care coordination processes. Integrated health and social care models appear to provide promising approaches for organising continuous, person-centred care for older people with complex needs living at home.

Recommendation: *Training programmes targeting Family and Community Nurses should promote collaborative learning approaches and possibly foster the creation of Communities of Practice for FCNs. This is because these approaches fit well with the actual training needs of professionals, who will need to work in strong collaboration with their colleagues and other professionals.*

5.4.4 Learnings from 14 European integrated care sites – SUSTAIN project[1]

A cross-national research project "SUSTAIN", studied 14 different integrated care sites in Europe to better understand what does and does not work in terms of improving existing way of working and also eventually transferring good practices to other contexts (Stoop, A. de Bruin SR., Wistow G., et al., 2019)

The 14 sites included in the research were quite different in the types of care and support services provided ranging from home nursing, to rehabilitative care to proactive primary care to frail and older people, dementia care and care to older people being discharged from hospital but also palliative end-of-life care.

[1] EU-funded (H2020) SUSTAIN project *Sustainable, tailored Integrated Care for older people in Europe,* https://www.sustain-eu.org/

"Lack of knowledge and trust about areas of expertise of different health and social care providers was observed. Cooperation between organisations from different care settings, due to differences in culture and visions of organisations e.g. collaboration with community and social care sectors was weak and not yet in place exemplified by separate IT and information systems leading also to difficulties in collaborating."
– SUSTAIN Project, 2019

The analysis was based on the Expanded Chronic Care Model (ECCM) conceptual framework, which is a further development of the Chronic Care Model (CCM). The CCM describes the essential elements of a proactive health system capable of improving the quality of care for people with chronic diseases, and focusses on four components of integrated working: (i) self-management support; (ii) delivery system design; (iii) decision support; and (iv) clinical information systems.

In a further development it was argued it needed to be more broadly-based focusing strongly on prevention. The ECCM was consequently enhanced with three more components: (v) build health public policy; (vi) create supportive environments and (vii) build community capacity. Of the 14 sites, there was a range of different applications of the ECCM model; only two sites included all 7 components in their existing ways of working, whereas 4 sites included only one or two components. Across almost all fourteen sites, local stakeholders mentioned the difficulty encountered in securing coordination and collaboration among the organisations and professionals participating in the site. These could be fairly basic barriers such as the lack of clear and sustainable agreements about roles and responsibilities among organisations and their professional staff.

Recommendation: *For the Family and Community Nurse professional to be successfully integrated in the health and social care setting, it is essential to overcome the lack of knowledge and trust among the various roles and responsibilities of the different health and care professionals, often hampered due to the current fragmentation of the service delivery e.g. between healthcare and social care services. Community nursing team members do not operate in isolation from the rest of the health / care services and the community nursing team should act as a gateway to*

other health services such as primary care services, hospitals, dental services etc

The fragmentation and financial barriers between health and social care sectors, was largely perceived by stakeholders as a barrier to working in a more visionary and committed way. The impact of staff shortages in health and social care, with professionals experiencing heavy workloads also limited their motivation to participate in training programmes.

Finally, another major issue that emerged was the need for better communication with older persons and their informal carers, so that services can be tailored to their needs and preferences, and opportunities for shared decision-making may present themselves. All these issues are central to moving towards more person-centred care and called for further investments.

Improvement plans were therefore co-designed with local stakeholders in twelve of the 14 sites. These plans could be roughly grouped into two categories: (i) General improvements with plans focusing on enhancing knowledge of understanding of different organisations' role and responsibilities including inter-professional training; (ii) improvement plans focusing on direct improvement in care delivery systems and tools e.g. to provide care in a more person-centred way, or emphasising on improving specific care delivery processes such as improving case management, or arrangements for hospital discharge.

5.4.5 The role of nurses in primary care and in improving patient outcomes in the community

The categories of health workers most active in providing primary care and, therefore, mainly affected by the changes in the service delivery models are: general practitioners/family physicians, midwives, nurses, dentists, dieticians, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers, etc. (European Commission (JRC), 2021).

Nursing full scope practice in team-based primary care has been found to be cost effective and improves quality of care, increased patient satisfaction, access and equity, particularly in underserviced areas and populations. In many PHC settings, having nurses as full members of the PHC team is essential to meet the complex health and social needs of populations. In addition, optimal use of nurses in PHC improves access to care particularly for vulnerable populations including those living in rural areas (ICN, 2016a).

Evidence has demonstrated that PHC delivered by nurses, including nurse practitioners for acute and episodic care, chronic disease management and practice operations have resulted in improved quality of care, efficiency and decreased cost.

> *"Maximizing the benefit of nurses practicing in PHC requires a commitment to progressive policy regarding funding and public awareness, competency-based nursing and interprofessional education and the optimization of the nurse's role in PHC with comprehensive process and outcome measures" – International Council of Nurses (ICN), 2016*

Additionally, the ICN emphasises interprofessional education as a key and critical issue in particular to successfully address the lack of knowledge that health care professionals may have about other healthcare professionals. It teaches different care professionals how to negotiate issues of shared scope and knowledge as well as decision making (ICN, 2016a).

Recommendation: *Training programmes targeting nurses should be complemented with interprofessional practice settings to support this new way of learning in the multidisciplinary and interdisciplinary team (ICN, 2016a). In the Continuing Professional Development (CPD) context, online programmes should be offered, as this fits better with the needs of working nurses and provides them the opportunity to familiarise with online communication.*

With the increasing focus on the social determinants of health, nurses are well equipped to provide care based on a broader understanding of health. Nursing education further fosters the development of therapeutic relationships with patients and families, with the aim to fully understand their stories and life contexts and thus to individualise care plans and assist people in navigating the health and social systems (ICN, 2016a).

Recommendation: *A truly person-centred approach is essential, which will require different ways of working away from the prevalent "medicalized" model of care and increasingly towards a more holistic view of an individual person's health respecting their needs and preferences. Family and Community Nurses must learn to identify and navigate the difficult border between a care service users' freedom to choose/refuse a service - especially for those with disabilities.*

> *"Nurse practitioner studies internationally have repeatedly found the effectiveness of nurse-led care in community services, including the findings of a Cochrane Collaboration Systematic Review. Evidence is clear that nurses have a significant role to play in the community-based management of non-communicable diseases, and patient access to appropriate treatment is enhanced by nurse prescribing".*
> *– International Council of Nurses, 2016*

Further, the Opinion of the EC Expert Panel on Effective Ways of Investing in Health (EXPH) on *"Options to foster Health Promoting Health Systems"* mentions that:

> *"…to implement a multi-stakeholder approach to integrating health promotion in a framework of better structure primary care, evidence supports the impact and cost-effectiveness of a range of community- based approaches for population health promotion including, for example, enhanced services delivered by community nurses." – EC Expert Panel on Effective Ways of Investing in Health (EXPH), 2019*

5.4.6 Report on the state of Nursing world-wide

A first-ever *State of the world's nursing 2020* report, developed by the World Health Organization (WHO) in partnership with the International Council of Nurses (ICN) and the global Nursing Now campaign, together with the support of governments and wider partners,

provided a compelling case on the value of the nursing workforce globally, and reaffirms the central role of nurses in achieving universal health coverage and the Sustainable Development Goals (SDGs) (WHO, 2020)

It provided robust data and evidence on the nursing workforce, sorely needed to support policy dialogue and facilitate decision-making to invest in nursing to strengthen primary health care, achieve universal health coverage, and advance towards the SDGs. A key and central message of the report directed to governments, bodies and relevant authorities and institutions is the need for governments to accelerate and sustain additional investment in nursing education, skills and jobs.

***Recommendation**: Nurse education and training programmes must graduate nurses able to drive progress in primary health care and universal health coverage. Actions to achieve this include: investment in nursing faculty and training teachers involved in nurse education programmes; availability of clinical placement sites and work-based learning; and accessibility of programmes offered to attract a diverse student body. Nursing should emerge as a career choice grounded in science, technology, teamwork and health equity (WHO, 2020).*

The report demonstrates opportunities for advanced nursing education and enhanced professional roles, including at the policy level, all which improve population health.

> *"Government chief nurses and other national stakeholders can lead national dialogue on the appropriate entry-level and specialisation programmes for nurses to ensure there is adequate supply to meet health system demand for graduates" – WHO, 2020*

***Recommendation:** Allow nurses to work to the full scope of their nursing education. Allowing nurses to practise at the top of their education and experience can result in greater job satisfaction and greater patient satisfaction with care. Enabling factors are training in primary health care,*

development of standardised practice guidelines and data systems to track patient care outcomes. (WHO, 2020)

Nurses are a cornerstone of integrated care teams, often leading care provision and taking on expanded practice roles, including, where relevant, collaboration with and oversight of community health workers, see figure 4.

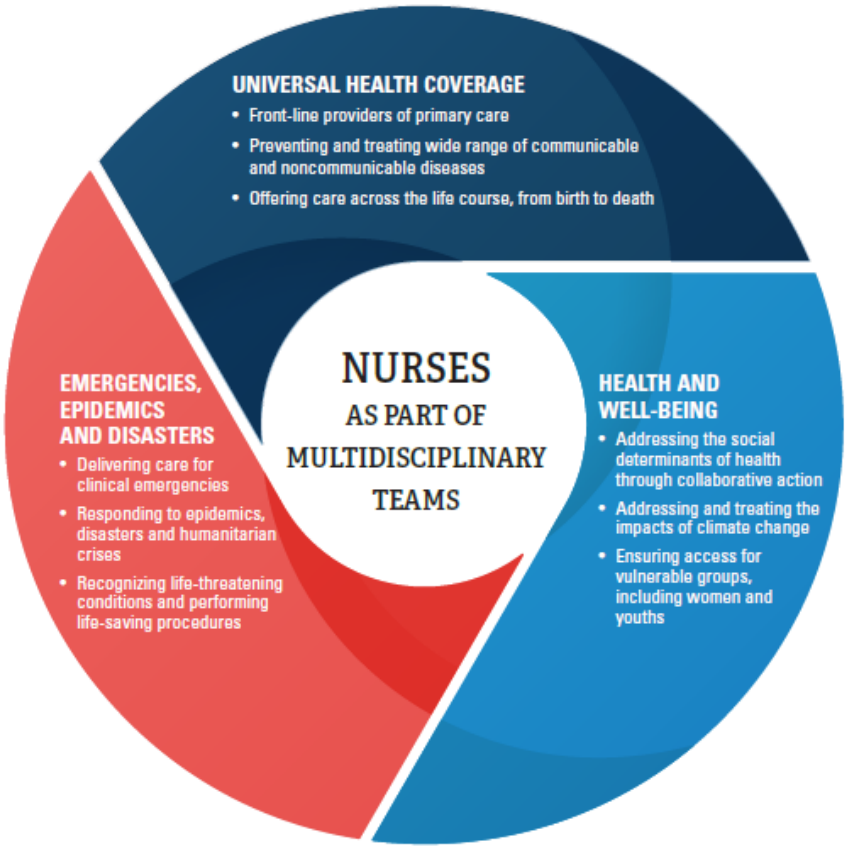

FIGURE 4. Nurses as part of multidisciplinary teams

SOURCE: WHO, 2020 – State of the world's nursing 2020

With regard to nursing practice, the report states that countries should enable nurses to work to the full extent of their education and training. This objective should be part of broader national efforts to adopt care models that optimise the division of tasks in integrated primary health care teams. This entails maximising the contribution of nurses to enhance primary health care in priority areas.

Possible approaches could include advanced practice roles, expansion of nurse-led clinics, and developed or expanded authority for prescribing, with the commensurate development or strengthening of education and training required.

"Nurses with advanced practice credentials should be in settings that optimize their productivity in providing patient care or leadership and management to other clinicians" – WHO/ICN, State of the World's Nursing, 2020

Nurses with advanced practice credentials should be in settings that optimize their productivity in providing patient care or leadership and management to other clinicians.

Nurses functioning in advanced practice roles or in nurse-led clinics should be supported with mentorship or collaborative partnerships as needed, equipped with adequate supplies and medications, have clear clinical and facility guidelines for practice, and access to the required resources, including online reference materials and appropriate technology.

Embedding the required reforms in relevant education, health, labour and other policies requires institutional capacity for effective collaboration and coordination; supportive institutional structures and dedicated resources; leadership and political will; effective managerial oversight; and effective organisational culture.

5.5 The European health workforce

The European health workforce represents a significant portion of the EU total: 8.4% in 2019, or 16.8 million workers. While EU27 employment in this sector increased at a steady pace since 2008, there are significant differences among EU countries in terms of the availability of health professionals to meet the care needs of its populations.

Such cross-country differences become even more concerning when paired with the greying trend affecting the overall health workforce: a high share of elderly employment, which is also growing more rapidly than in the total workforce. This scenario sparks serious concerns about future shortages of health professionals, which have also been highlighted and exacerbated by the immense pressure that the COVID19 pandemic is exerting on health systems (Guagliardo S, Palimariciuc M, (EPC/CESI) 2021).

Data analysis reveals that the European health workforce has a higher educational level on average than the rest of the workforce. However, it is also older and, more worryingly, is

greying at a faster pace. This ageing trend, combined with difficulties in recruiting new graduates, sparks concern regarding future shortages of health professionals.

In the EU, the right to timely access the *'affordable, preventive and curative health care of good quality'* (Principle 16) and the right to *'affordable long-term services of good quality'* (Principle 18) are enshrined in the European Pillar of Social Rights (EPSR).

Though not legally binding, the Pillar marks an important landmark in the movement to ensure older people's right to care is upheld within the European Community (Schulmann, K., Ilinca, S. & Rodrigues, R., 2019).

FIGURE 5. The 20 principles of the European Pillar of Social Rights

SOURCE: Social Platform, https://www.socialplatform.org/news/building-social-europe-through-the-european-pillar-of-social-rights/

Health systems perform a vital social security function, mitigating health and financial risks and contributing to social and economic progress. While EU member states all uphold the common values of universal access to quality and affordable care for all, the organisation and financing of healthcare vary greatly across the Union. Most health financing comes from

government schemes and social health insurance schemes. (Guagliardo S, Palimariciuc M, (EPC/CESI) 2021).

EU27 health spending accounts for significant shares of the Union's overall GDP and total government spending. Since 2001, health expenditure generally increased across Europe, with some countries spending more than others. Nevertheless, investments in the health sector have decreased significantly over the last two decades (European Commission (JRC), 2021).

The COVID-19 pandemic has put the resilience of national health and long-term care (LTC) systems to the test and has made it even more tangible that 'health is a precondition for our society and economy to function'. In response, the Commission has taken the first steps towards building the European Health Union and will support the Member States in detecting shortages in healthcare staff and in taking targeted actions to guarantee the 'availability of sufficient and up-skilled healthcare staff who can be redeployed to new roles in case of emergency (European Commission (JRC), 2021).

5.5.1 Projected shortages of the healthcare nursing workforce

According to the most recent annual issue of the *Analysis of shortage and surplus occupations* covering the period 2019-2020, Figure 6, lists all the occupations reported as shortage occupations in at least nine different countries/regions. The occupation that ranks first on list, and cited as a shortage occupation by the highest number of countries/regions is the *Nursing Professional* (European Commission (DG EMPL), 2020).

Occupation	Number of reporting countries/regions	Occupation	Number of reporting countries/regions
Nursing Professionals	18	Concrete Placers, Concrete Finishers etc.	10
Plumbers and Pipe Fitters	14	Electrical Engineers	10
Cooks	13	Software/App Developers/Analysts	10
Heavy Truck and Lorry Drivers	13	Systems Analysts	10
Welders and Flame Cutters	13	Accountants	9
Applications Programmers	12	Air Conditioning/Refrigeration Mechanics	9
Generalist Medical Practitioners	12	Cleaners and Helpers in Offices, Hotels	9
Software Developers	12	Electrical/Electronic Equip. Assemblers	9
Bricklayers and Related Workers	11	Health Care Assistants	9
Building and Related Electricians	11	Motor Vehicle Mechanics/Repairers	9
Web and Multimedia Developers	11	Nursing Associate Professionals	9
Ag. Ind. Machinery Mechanics, Repairers	10	Sheet Metal Workers	9
Carpenters and Joiners	10	Stationary Plant/Machine Operators	9
Civil Engineers	10	Waiters	9

Source: Analyses of data submitted by EURES National Coordination Offices

Figure 6. Shortage occupations reported by the most countries/regions

SOURCE: European Commission, (DG EMPL) 2020

Nursing professionals also feature and rank on the corresponding lists in 2019 and 2017 - albeit at a lower level of ranking, which suggests that the pandemic seemed to have the impact of making existing shortages more acute, Figure 7 (European Commission (DG EMPL), 2020).

Table 4.1 Comparison of top shortage occupations over time

Occupation	Current report ranking[17]	2019 report ranking	2017 report ranking
Nursing Professionals	1	6	4
Plumbers and pipe fitters	2	4	2
Cooks	3	5	1
Heavy Truck and Lorry Drivers	3	1	4
Welders and Flame Cutters	3	2	3
Applications Programmers	4	0	0
Generalist Medical Practitioners	4	7	2

Figure 7. Top shortage occupation rankings in 2017, 2019 and 2020

SOURCE: European Commission, (DG EMPL) 2020

The demand for nurses is expected to continue to rise in the years ahead because of population ageing while many nurses are approaching retirement age. Concerns about growing shortages have prompted actions in many countries to increase the training of new nurses. Some countries have also addressed current shortages by recruiting nurses from abroad (OECD/European Union, 2020).

Demographic change and the rise in number of older people is the key driver of the demand for health and LTC services and the related workforce. The most important demographic indicators for workforce planning in health and LTC sectors are changes in the size, age structure and health conditions of the population, the patterns of health and LTC utilisation by population and its unmet medical needs (European Commission (JRC), 2021).

In the period 2018-2030 alone, according to CEDEFOP, the EU-27 will need 11 million newly trained or imported health and LTC workers to satisfy the rising demand in the health and LTC sectors. The majority of these new job openings (around 87%) is to replace the departure of health workers due to retirement or other types of voluntary departure (European Commission (JRC), 2021).

An important aspect is that the availability of health workers in each country is impacted by labour migration, among other factors. The main cause of labour migration is due to differences in working conditions across countries. Health professionals are by far the most

mobile workers within the EU, with high numbers of doctors and nurses working in a country other than the one where they obtained their qualification (Guagliardo S, Palimariciuc M, (EPC/CESI) 2021).

5.5.2 Planning and forecasting the healthcare workforce

In 2019, there were 4.45 million nurses and midwives employed in the European Union (EU), counting both professional and assistant nurses and midwives (Eurostat, 2020). This corresponded to half a million more nurses and midwives being employed in the EU in 2019 compared to 2012, with a steady increase over this period, see Figure 8.

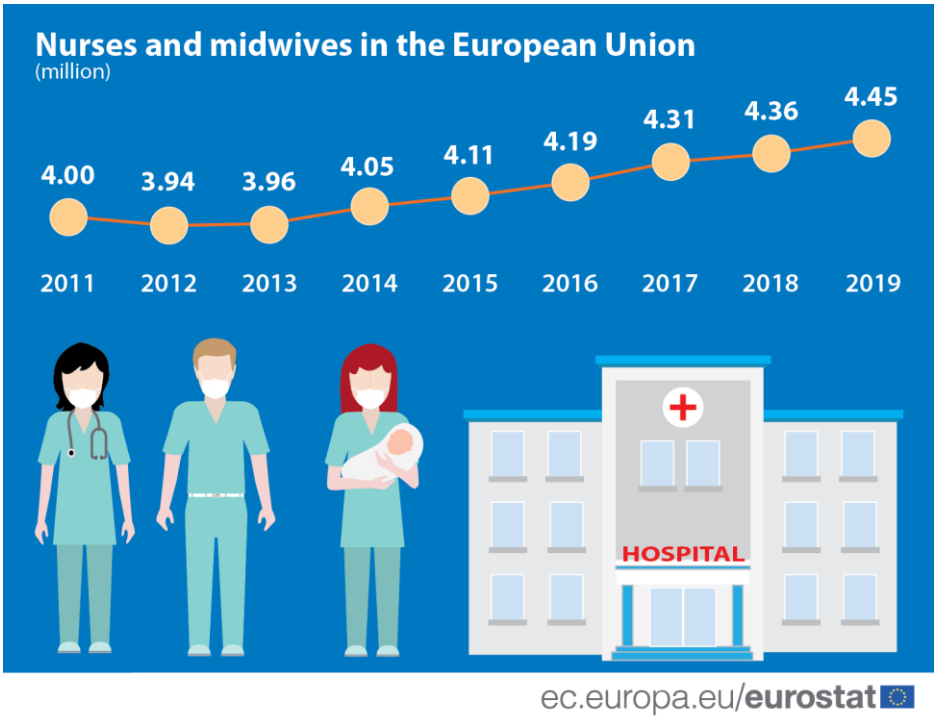

Figure 8. Nurses and midwives in the EU

Source: Eurostat (2020) Nurses and midwives –Employment data 2011-2019

The share of nurses and midwives in the total workforce was 2.2% in the EU in 2019. Among the EU Member States, Germany stood out with a share of 3.4%, followed by Finland (3.0%), Belgium (2.9%) and Ireland (2.8%).

Effective strategic planning of the health workforce (HWF) is of crucial importance in the EU and worldwide. Moreover, as the lessons learnt from the COVID-19 pandemic have revealed, the importance and value of the health workforce planning and managing have become even more evident and significant as a key element for healthcare systems. The “Support for the Health Workforce Planning and Forecasting Expert Network” (SEPEN) gathered experts into

one community in order to focus on various topics related to HWF strengthening and developing cross Europe.

Managing shortages and maldistribution of skills is a high priority in many Member States. A majority of countries report on shortages of General Practitioners (GPs), and of some medical specialists, mainly in remote and rural areas, as well as a persistent shortage of nurses. The role of digital care solutions and promotion of the digital transformation of health care provision could have a role in the organisation of care and also enhance resilience of healthcare providers in emergency situations. (European Commission, DG Health & Food Safety, 2021)

> *"Knowledge transfer between Member States should be continuously fostered to enable the deployment of new strategies and models of care. For instance exchanging experiences and methods to recruit and retain Health workforce appropriately, to upscale the HWF with transversal skills, or to create new professionals and new roles of professionals can contribute to more effective HWF management and planning"*
>
> *SEPEN Health Workforce Planning and Forecasting Expert Network, 2021*

Another issue that needs addressing in order to avoid current and future shortages, concerns the *retention rate of nurses* in the profession, a key issue in most countries. As a case in point, in Norway, the government has adopted a series of measures in recent years to recruit more students to nursing education programmes and improve the working conditions of nurses to increase retention rates. A multi-year Competence Lift 2020 action plan was adopted in 2016 to increase the number and competencies of nurses and other health workers to avoid future shortages. This action plan will be extended over the next five years under the Competence Lift 2025 (OECD/European Union, 2020).

5.6 Towards responsive and resilient health systems

Shifts towards preventative and community-based healthcare are changing the roles and functions of health professionals and associate professionals, who are increasingly expected to fulfil new roles that focus on the promotion of good health and the prevention of disease and injury. In a number of EU countries, public health practitioners, nurses and community care workers, have played a key role in improving patients' adherence to treatment regimes, knowledge of their conditions and self-management. This move towards preventative care

requires expertise in social care as well as healthcare, so it is likely that we will witness an increasing convergence of functions and skills among these categories of workers (OECD, 2018).

Health promotion and disease prevention, multidisciplinary teamwork and an integrated service delivery are all challenges that need to be faced by a future health workforce. Other important and relevant issues linked to the health workforce is the question of workforce ageing, recruitment and retention issues and uneven geographical distribution.

5.6.1 Ensuring the right skills mix: Task shifting and moving towards advanced nursing roles

Task shifting and changing the skill mix is yet another way to explore new ways of providing care. In response to shortages of doctors, several countries have started to implement more advanced roles for nurses in hospital and primary care, including “nurse practitioner” roles. Evaluations of nurse practitioners in primary care in countries like Finland, the United Kingdom and Ireland show that advanced practice nurses can improve access to services and reduce waiting times, while delivering the same quality of care as doctors for a range of patients, including those with minor illnesses and those needing routine follow-ups. These evaluations find a high patient satisfaction rate, while the impact on cost is either cost-reducing or cost-neutral (OECD/European Union, 2020).

According to the 2019 Opinion of the EXPH on *“Task shifting and Health System Design”,* the term Task Shifting was already defined by the WHO, over a decade ago, as *“the rational re-distribution of tasks among health workforce teams”* (European Commission, EXPH, 2019).

In the EXPH Opinion from 2019, Task shifting is defined as *“a redistribution of tasks among health workers for reasons of health system accessibility, effectiveness or efficiency”.* An example being to enhance the role of nurses and pharmacists, including prescribing by non-physicians The Opinion also considers task distribution, task sharing and competency sharing, which recognise that responsibilities are often shared between different professional groups and with the patient and, in some cases their families.

In addition, medical progress has been characterised by a continuing process of enhancement of skills and the corresponding tasks performed, driven by changing patterns of disease and technological advances. One such example is the enhancement of the role of nurses, which has attracted most attention from researchers, in areas such as the management of chronic disease. There is now considerable evidence that nurse-led clinics achieve better results than those conducted by physicians in the management of uncomplicated chronic diseases (European Commission, EXPH, 2019).

Likewise, in response to shortages of doctors, several countries have started to implement more advanced roles for nurses in hospital and primary care, including “nurse practitioner” roles.

> *“Evaluations of nurse practitioners in primary care in countries like Finland, the United Kingdom and Ireland show that advanced practice nurses can improve access to services and reduce waiting times, while delivering the same quality of care as doctors for a range of patients, including those with minor illnesses and those needing routine follow ups. These evaluations find a high patient satisfaction rate, while the impact on cost is either cost-reducing or cost neutral.”* – OECD/European Union, 2020

According to the EXPH Opinion on Task Shifting, one problem which is encountered when studying the benefits of Task Shifting is the limited evidence base, as many of the changes that take place are never evaluated. In contrast to the introduction of pharmaceuticals and other innovative products and interventions, which are subject to intensive evaluation and lengthy approval processes, the adoption of new professional roles often takes place without any scrutiny, unless it is linked to the implementation of new technology. Even then, attention typically focuses on the equipment rather than the entire package, comprising the technology, the operator, and the supporting system (European Commission, EXPH, 2019).

However, the Opinion does emphasise: *“There is extensive evidence that a move away from traditional roles can be associated with as good or higher quality care, such as the routine management of uncomplicated chronic disease by nurses or non-physician health workers rather than doctors”.*

Further, in the Opinion, a review of task shifting in primary care found nurse practitioners working at high levels of advanced practice in Finland, Ireland, The Netherlands, and the United Kingdom. There was some, but much more limited task shifting in Belgium, Croatia, Cyprus, Denmark, Estonia, Hungary, Iceland, Italy Latvia, Lithuania, Luxembourg, Malta, Portugal, Slovenia, Spain, and Sweden. However, no significant task shifting was noted in Austria, Bulgaria, Czech Republic, France, Germany, Greece, Norway, Poland, Romania, Slovakia, or Switzerland.

At the same time, it is important to note that the *OECD Programme for International Assessment of Adult Competencies* (PIAAC) results showed that some 76 percent of doctors and 79 percent of nurses reported over-skilling in their current job, while 51 percent of doctors

and 46 percent of nurses reported under-skilling. When stratified by education levels, it becomes evident that advanced nurses (master's level or above) face a very high level of over-skilling – nearly twice the level of other professionals, see, Figure 9, (Maeda A, Socha-Dietrich K, OECD, 2021).

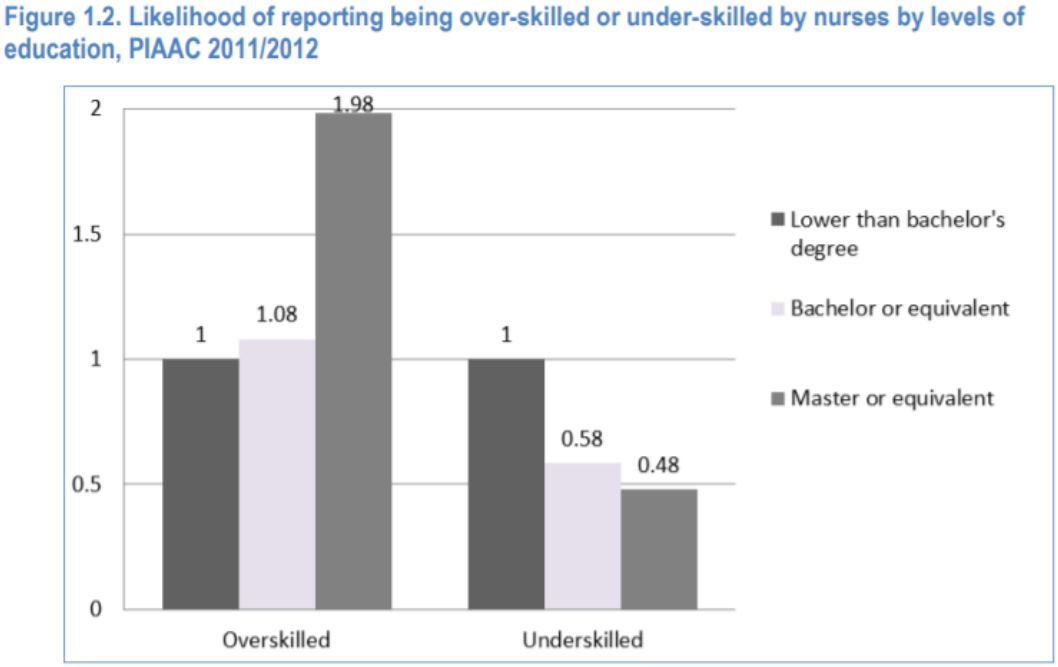

Figure 9. Likelihood of reporting being over-skilled or under-skilled by nurses by levels of education

Source: Maeda A., Socha-Dietrich K., OECD, 2021

5.7 The Long-term care (LTC) workforce – a key component in home-based care

LTC is defined as "a range of services and assistance for people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or are in need of some permanent nursing care." (EUROFOUND, 2020)

The daily living activities for which help is needed may be the self-care activities that a person must perform every day (activities of daily living, or ADLs, such as bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the toilet, and controlling bladder and bowel functions) or may be related to independent living (instrumental activities of daily living, or IADLs, such as preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone).

LTC workers include people who provide such LTC services. They work in residential care, home care (in sheltered or non-sheltered homes) and community (day) care services, which can be publicly or privately provided or financed. LTC workers may also be privately employed by households.

It is important to mention LTC in this context, because in particular nurses can be employed in both LTC and healthcare (EUROFOUND, 2020).

LTC contributes to the quality of life and employment prospects of people with LTC needs, including older people and people with disabilities, enabling them to enjoy their rights (in line with the EPSR and the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD)). The LTC workforce, not to be ignored, is a significant and important sector and key in delivering a person-centred quality service (EUROFOUND, 2020).

In fact, as a proportion of the overall workforce, the LTC workforce has expanded steadily, by one-third, over the past decade and is expected to grow further. In the EU, 6.3 million people work in the LTC sector. A notable feature, more so than in healthcare, is that migrants and mobile workers form an important part of the LTC workforce (mainly in domestic LTC in some countries). Cross-border work is frequent in cases where differences in working conditions and salaries between bordering areas are large.

Moreover, staff shortages differ within and between countries but are often most urgent for skilled nurses. They depend on supply and demand dynamics, which are sensitive to policies. Moreover, the key issues in LTC are that more than 80% of LTC workforce is female, and also salaries in LTC are much lower than in hospitals, which is a problem for recruitment and retention. As an example, in Portugal, among 407 residential LTC nurses, 75% were female and 25% were male. Additionally, even the best-paid professions in LTC (specialist nurses, social workers, physiotherapists) are usually paid around the national average wage). Pay in the private sector is usually worse than that in the public sector (EUROFOUND, 2020).

***Recommendation*:** *Where public funding plays a role in Long Term Care (LTC), governments can use this to improve working conditions, for instance through requirements in public procurement. Acknowledging LTC as a distinctive sector in data collection and collective agreements or regulations, and improved coverage of collective bargaining, can help in improving evidence for policies, creating a better working environment and enhancing service quality. This aspect is especially important given*

the FCN occupational context, which can span both the health and LTC sector. (EUROFOUND, 2020)

Several countries have therefore, launched new education programmes to respond to this skilled nursing shortages in LTC. In Denmark, two new educational programmes were launched to tackle this shortage: (i) a specialised education for nurses in primary care and an advanced practice nurse in primary care; a 2-year 120 ECTS masters degree with a strong clinical focus (EFN, 2018b).

As mentioned, in section 2.4, Principle 18 of the EPSR includes the right for everyone to good quality, in particular homecare and community-based services. The provision of LTC services of good quality, in particular home-care and community-based is a key priority for the nursing profession (EFN, 2018b).

Home- and community-based care services are key in enabling people with LTC needs to stay in the community. Good access to high-quality home and community-based care services is a key element in achieving this. At the same time (particularly relevant for nurses who form an important share of both the LTC workforce and the healthcare workforce) is that their basic/minimum pay is set by agreements that cover both LTC and healthcare, and differences in pay can mostly be explained by level of training and experience (which tend to be higher in healthcare). However, sometimes, pay is better in healthcare than in LTC for people with the same qualifications, while the reverse is rarely true. This makes recruitment and retainment particularly challenging in LTC, in particular for skilled nurses (for whom more work is available in healthcare). An idea for policymakers seeking to attract workers, and to reduce inequality between men and women and address deprivation could be to consider improving pay in the LTC sector (EUROFOUND, 2020).

5.7.1 Valuing Informal Carers as equal partners in care

Informal carers play a central role in the provision of long-term care (LTC) in Europe. According to some estimates, as much as 80% of all care is indeed provided by families, friends and neighbours (Hoffmann, F & Rodrigues, R. (2010). An informal carer is a person who provides – usually – unpaid care to someone with a chronic illness, disability or other long-lasting health or care need, outside a professional or formal framework.

Informal carers are an inherent as well as an indispensable part of the provision, organisation and sustainability of health and social care systems. In terms of numbers, in the EU, 6.3 million

people work in the LTC sector. This number compares with 44 million people providing frequent informal LTC to family or friends (EUROFOUND, 2020).

Informal carers will become even more important in view of the changing health and care needs, due to demographic ageing and the increasing prevalence of frailty and chronic conditions.

As underlined by the European Foundation for the Improvement of Living and Working Conditions *"understanding todays' needs requires acknowledgement that care needs and care provision affect not only the persons in need of care, but also their households and their informal carers".*

***Recommendation**: The inclusion of informal carers (family members and friends) and organisations that represent them in Integrated Care Partnerships must become a central principle to release the full potential for synergies across services, better allocate resources and avoid overlaps and the negative effects and costs of service disruption on health status". Community Nurses can have a key role in integrating care services and involving informal carers as equal partners of the care team.*

5.7.2 What lessons and impact from the COVID-19 pandemic

The COVID-19 pandemic has exposed the existing structural weaknesses of European health systems and, in many cases, their unpreparedness to absorb a health crisis of this magnitude. Despite the increase in the number of health professionals over the last decade, it has not been enough to equip European health systems to respond to sudden increases in demand for care. Considering some of the lessons learnt from this health crisis, health systems must become better prepared to absorb and respond to shocks like the spread of infectious diseases (Guagliardo S., Palimariciuc M., (EPC/CESI) 2021).

The first wave of the COVID-19 pandemic made pre-existing shortages of doctors and nurses more visible and acute in many countries. Some countries, such as Norway, Switzerland and Germany, had a relatively high number of doctors and nurses per capita prior to the start of the pandemic relative to other countries. This provided them with a greater potential to respond to the steep rise in demand for care, assuming that the activities of some of these health professionals could be reallocated to deal with the crisis (for instance via additional training). On the other hand, countries in Central and Eastern Europe, such as Poland, Latvia and

Romania, had comparatively fewer doctors and nurses per population, and therefore less capacity to respond to the epidemic, see Figure 10. (OECD/European Union, 2020)

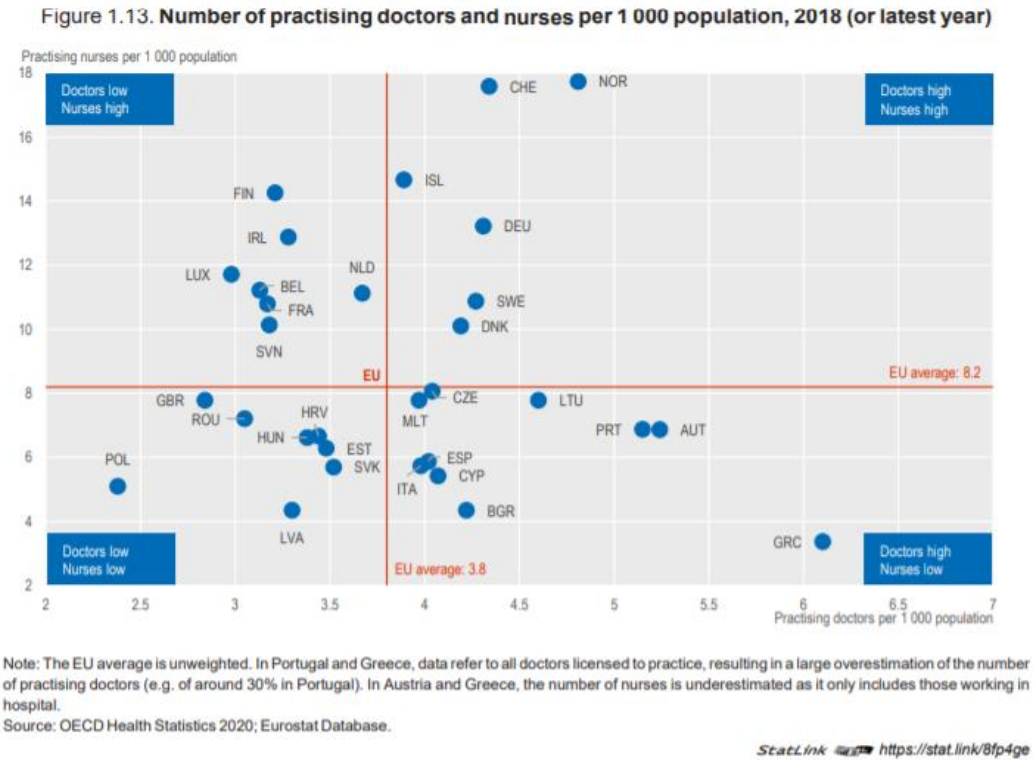

Figure 10. Number of practising doctors and nurses per 1000 population

SOURCE: OECD/European Union, 2020

During the first phase of the pandemic in the spring of 2020, the COVID-19 outbreak did not reach the same peak in cases and mortality as in many countries in Western and Northern Europe. Still, since August, the situation has deteriorated in some Central and Eastern European countries such as the Czech Republic and Romania, overstretching an already limited staffing capacity.

Before the crisis, many European countries focused on ensuring a right skills mix for the primary health care workforce. The scope of practice of nurses in Estonia, Ireland, Latvia, Sweden and the United Kingdom had already been expanded. Community pharmacists have also been taking a greater role in health promotion and prevention, notably in remote and underserved areas, in Belgium, the United Kingdom (England), Finland, Italy and Switzerland (OECD/European Union, 2020).

During the pandemic, the implementation of such policies has accelerated. For instance, the scope of practice of community pharmacists has rapidly been expanded to allow for greater continuity of care for non-COVID-19 patients. In Austria, France, Ireland, Portugal and Spain,

pharmacists can now prescribe chronic medications and have been allowed to extend prescriptions beyond what they were previously allowed to do (OECD/European Union, 2020).

The EXPH, moreover in November 2020, adopted its Opinion on "the organisation of health and social care following the COVID-19 pandemic", one in this context relevant recommendation being:

> ***Recommendation**: The COVID-19 pandemic disproportionally affects the vulnerable groups such as the old and frail, the poor, and members of minority ethnic groups. In order to reduce vulnerability, primary care services should be supported and healthcare professionals, community health workers and informal care givers should be motivated to focus more on health promotion, lifestyle programs and intersectoral collaborative actions to increase health equity and resilience in the community.* – European Commission (EXPH), 2020

The need for strong and resilient primary health care

With the COVID-19 pandemic well into its second year, evidence is increasing demonstrating the major risks and consequences of not giving sufficient weight to non COVID-19 health care needs, resulting in urgent health problems remaining undiagnosed and exacerbated chronic illnesses (OECD/European Union, 2020).

Crucially, a US study demonstrates that the number of visits to ambulatory practices declined by nearly 60% during March 2020, and by around 50% for primary health care visits over the same period (OECD, 2021), see Figure 11.

Figure 1. Reduction in primary health care consultations during the first wave of the COVID-19 pandemic

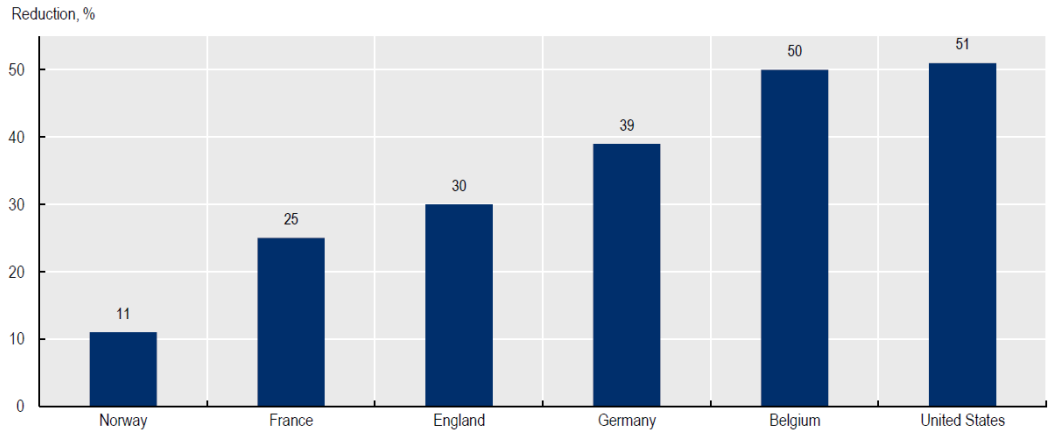

Figure 11. Reduction in primary health care consultations during the first wave of the COVID-19 pandemic

Source: OECD, 2021

A lesson learned and key recommendation going forwards is that for health systems to be resilient against health crises of this magnitude, strong primary and community health care – the frontline of all health systems – is essential. Primary health care delivers the first line of care in communities during the acute phase of a health crisis, and helps maintaining continuity of care for people with chronic conditions. Primary health care also reduces pressure on the entire health systems by providing comprehensive and preventive care during and after the crisis (OECD, 2021).

Policy responses that help to manage an unexpected surge in demand and maintain continuity of care for all range from reconfiguring primary health care delivery around team-practices, community care centres and home-based programmes, developing innovative roles for pharmacists and community health workers, increasing the adoption of digital technology and well-designed incentives (OECD, 2021).

The expansion of home-based programmes during the pandemic aims at reducing the risk of COVID-19 transmission but also to maintain high quality care and continuity of care, especially for people living with chronic conditions. Such programmes provide primary health care and hospital care at home, but also include social and behavioural health needs. Counselling, health education, and support from digital technologies play an important role.

As an example, in Slovenia, community nurses provided home-based care during the first wave of the COVID-19 pandemic, notably for elderly people having chronic conditions, but

also for COVID-19 patients. Health care services included for example health education, prevention, curative and long-term care (OECD, 2021).

Recommendation: *Maintaining primary health care practices, establishing community care facilities, extending home-based programmes, expanding the role of primary health care workers and increasing telemedicine consultations are key to minimise delays and forgone care for all patients. (OECD/European Union, 2020)*

5.7.3 COVID-19 as a catalyst driving integrated care pathways and service delivery

The COVID19 pandemic has demonstrated that effective responses require quick, collaborative and large-scale reactions, and that the current fragmentation in health and care systems inhibits these prerequisites.

The VIGOUR project[2] funded under the 3rd European Health Programme, aimed to systematically review current practices in the health and care sector to see how existing services could be improved and scaled up to deliver better joined-up care. As the COVID-19 pandemic reached all VIGOUR countries, some lessons could nevertheless be drawn from the VIGOUR partners' COVID-19 experience in relation to improving current practices through better integrating service delivery across health and social care.

One lesson gained during the pandemic encourage the need to build more connected health and care systems enabling collaboration across care settings and disciplines. The pandemic could potentially act as a catalyst to redesign and integrate care pathways thus equipping us for any disruptive changes that may come beyond COVID-19. (Lindner S et al, 2020)

> *"Home and community-based care services are key in enabling people with LTC needs to stay in the community. The COVID-19 crisis may accelerate the move away from large-scale residential LTC." – EUROFOUND, 2020*

[2] The EU-funded (EU Health Programme 2014-2020) VIGOUR project: *Evidence-based guidance to scale-up integrated care in Europe* https://vigour-integratedcare.eu/

6 Selection of FCN practices in primary care settings across Europe

A selection of interesting and inspiring practices showcasing real-world examples of Family and Community Nursing are listed below, and have been compiled and extracted from the following publications:

- EFN Report on Good Nursing Practices for Primary Care – A comparative Review of 11 European countries, 2018.
- EUREGHA *A showcase of best practices from EUREGHA's members on Primary care, 2018.*
- OECD Health working Paper No. 98 *Nurses in advanced roles in primary care: Policy levers for implementation, 2017.*
- European Commission, Report of the Expert Panel on Effective ways of Investing in Health (EXPH), *Opinion on Task Shifting and Health System Design, 2019.*

Specifically, the comparative overview published by the European Federation of Nurses[3] on Good Nursing Practices in Primary care emphasises that nurses who work in primary care are, in many countries, the key professionals involved in the management and coordination of complex care for individual patients as well as their families and their experience and skills are therefore essential to the success of primary care (EFN, 2018a).

6.1 Denmark: Prescribing rights for nurses in the community

In Denmark, due to the rapid demographic ageing and also with the associated growing complex needs of people in the community, community nurses are growing in importance. The Danish Nurses Organisation[4] is part of a working group regarding "the delegation rights" for nurses in the community, that specifically focuses on prescribing rights. The purpose is to ensure that nurses' competencies are used optimally to the benefit of patients.

In view of the growing complexity of care, the EXPH opinion on Task shifting exemplifies the role of community nurses in Denmark, who have had to take responsibility for patients with conditions that would previously have been managed in hospital, including dialysis, administration of intravenous chemotherapy, and complex palliative care. Similarly, those looking after frail elderly residents in care homes are providing care that would once have been administered in hospital.

[3] The European Federation of Nurses: www.efnweb.be
[4] The Danish Nurses Organisation : www.dsr.dk

Estonia: Investment in family nurses in the prevention of CVD

Family nurses, in Estonia, whose remit are in the field of primary care since a number of years, focus a lot of their effort in prevention e.g. to prevent cardiovascular disease (CVD), individuals in the risk groups (40-60 year olds) are invited to regular check-ups, which also provides family nurses the opportunity to provide patients with preventive information for health promotion purposes and thus to trigger and promote healthy behaviours in this population group and before CVD manifests itself as a condition. The regular check-ups also support the family nurse in establishing an early diagnosis.

A current initiative is the nationwide system of health centres being developed in Estonia, which will bring together the home nurses and the family nurses. This intends to simplify the work of the teams in primary care centres and also to raise the nursing care quality.

6.2 Slovenia: Community nurses a growing proportion of the community-based healthcare workforce

Similarly, in Slovenia, nurses are strongly involved in primary care. Across all regions in Slovenia, a strong community-based care model is being developed with Community Nurses as the leaders with both a preventive and curative role. Among the conclusions of a project of the Ministry of Health (2011-2017) concerning the need for additional nurses in family practice recommended its implementation across all community health centres by the end of 2018. Concretely, this recommendation, translates into the need for an additional 700 workplaces for family and community nurses in Slovenia.

6.3 UK: Advocacy to raise the profile of the District nurse

The Queen's Nursing Institute[5] (QNI) promotes community nursing specifically to nurses, employers, educators and policy makers. They are a registered charity who seek to raise the profile and the voice of nurses serving their communities because we, and nurses themselves, are consistently presented with evidence that the community nursing perspective is not heard during the development of health policy and of care planning and delivery. QNI have highlighted the complexity and high quality of nursing provided by district nurses working in the community. However, there has recently been a drop of 6,000 community nurses in the NHS since 2010, equalling to 15% reduction. The role of the funder of community and specialist training in England, Health Education England, is changing fundamentally at the moment, with funding being reduced for nurse training across the board, including for community roles.

[5] The Queen's Nursing Institute (QNI): https://www.qni.org.uk/

Additionally, in a new report from a joint project between the Royal College of Nursing[6] (RCN) and QNI calls for urgent investment in District Nursing, as new figures show the number of District Nurses working in the NHS has dropped by almost 43 percent in England alone in the last ten years. The report, Outstanding Models of District Nursing, calls for a commitment to investment and training to meet the challenges caused by *simultaneous rising patient demand and falling numbers of these highly qualified staff* (Fanning A, 2019).

6.4 Spain: Family nurses helped expand preventative approaches for chronic diseases

In the region of Catalonia, Spain, one of the main focuses towards further developing their primary care model has to increase its responsiveness which would also enable increased efficiencies. An investment focus has been on developing and operationalising multidisciplinary primary care teams. The key components include: population orientation, multidisciplinary teams, service package, attention to working conditions, health services contracting, health information systems, and evidence-based practice and quality improvement.

One of the key learnings from their sustained reform in developing primary care multidisciplinary teams over the period of 2003 to 2015, is that the new family medicine specialty and the role of nurses helped to expand the scope of services towards a preventative approach. Preventative activities foster quality of care when primary care professionals work effectively in teams. This is shown in the significant decline in chronic obstructive pulmonary disease and diabetes mellitus.

Other key outcomes were that the societal reputation of primary care services, family doctors and nurses have positively evolved thanks to a continuous investment in physical and information infrastructures as well as health campaigns based on primary care. Additionally, the multidisciplinary nature of primary care teams has led to improved responsiveness and health outcomes. Family doctors benefited from the contribution of primary care nurses to increase the accessibility, comprehensiveness, continuity and coordination of services.

6.5 Italy: Family Community Nurse officially recognised by law, and pilots of trained FCN are being scaled up in rural regions.

National law defines the Essential Levels of Health Care (LEA) and provides a framework for the management of chronic diseases. A conference of regions released, in September 2020,

[6] The Royal College of Nursing : https://www.rcn.org.uk/

some guidelines for FCN integration in the social-health care system. At the regional level for Liguria region the reference framework is the regional Social Health Plan.

The FCN has been identified in the current Regional Health Plan as a key innovative figure, but the actual integration of this figure in the regional health system is connected to 2 main elements: (i) the research activities carried out by *Regione Liguria* as partner in EU-funded projects; and (ii) new PHC issues opened by the current COVID-19 pandemic.

A first step of *Regione Liguria,* in the frame of an EU-funded project about FCNs, took place in 2016 with the CONSENSO Project[7], an Interreg project funded under Alpine Space programme, aimed at developing and testing a health- and social care model centred on Family and Community Nurses. This new model has been tested in 5 pilot regions. *Regione Liguria* tested the model in Alta Val Trebbia, a mountain "inner" area where over-65s compose about 35% of the population. Spurred on by the COVID-19 pandemic, the Italian government issued in May 2020 the Decree Law no.34 which empowers and reorganises the welfare networks and formally introduced for the first time Family and Community Nurses as a key professional in social-health care services. In summer 2020, *Regione Liguria* formally adopted the national law with a decree and identified in 8 FCN per 50.000 inhabitants – representing the current need of the regional system. FCNs will be integrated in the whole regional territory, scaling up the same approach adopted by CONSENSO in Alta Val Trebbia. Moreover, the 44 FCN trained in the framework of ENhANCE project will be employed under this new law and the Master Course organized by the University of Genoa will be repeated next year in order to provide the needed workforce.

[7] CONSENSO Project, and Interreg project funded under the Alpine Space Programme, https://www.alpinespace.eu/projects/consenso/en/home

7 Stakeholder feedback from ENhANCE Final Online conference, 6 & 20 May 2021

Part I of the ENhANCE Final Conference was held on 6 May 2021 Zoom webinar, counted 197 attendees (speakers included), and featured a series of presentations from both within and without the ENhANCE Alliance and discussed upcoming perspectives for the Family Community Nurse, and zoomed in on the current situation of this profile and future developments across various European regions (Liguria region, Italy; Greece and Finland) who were represented in the project. A full report and all presentations are accessible at: https://www.enhance-fcn.eu/2021/05/10/watch-again-the-enhance-final-conference/

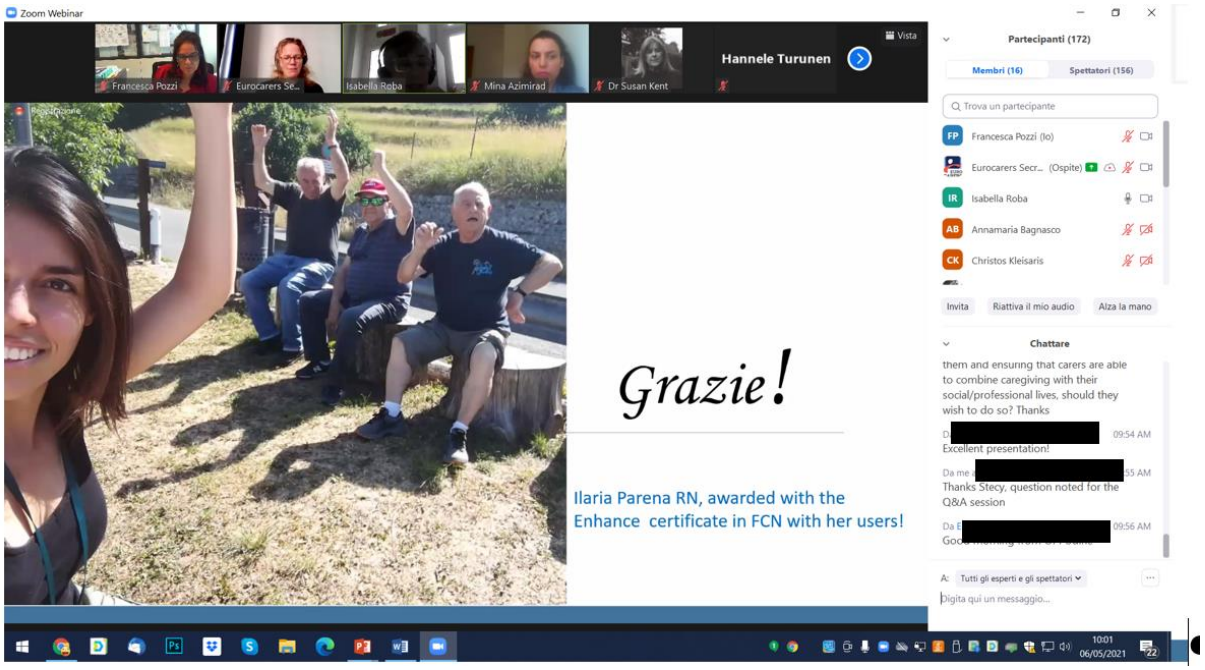

Figure 12 – Screenshot of the presentation by ALISA on May, 6th, 2021

In summary, the event demonstrated the importance of maintaining efforts and commitments to further strengthen the role and professional profile of the Family and Community Nurse in community care, the need to shed light on the many faces of the FCN role ranging from first and foremost (i) the crucial public health role; (ii) the community-based care and first-response (iii) intermediary and anticipatory care but also (iv) complex/chronic care.

Beyond the need for a European curriculum for FCN, the event showed that across Europe, investments in FCN crucially depend on the regions or country's continued investment in transitioning to a "preventive" approach to health, and good access to primary care and community-based and not least homecare services accessible "across the life course" from

prenatal care to palliative care. This is far from being the case across Europe and many regions are still lagging behind in developing UHC as a prerequisite and basis for quality PHC.

Continued efforts are needed to advocate for a better understanding and recognition of the important and multi-faceted role of FCN. This advocacy should be primarily achieved through the representative bodies in those countries and regions such as professional and regulatory nursing bodies and their key role in speaking with one unified voice for the profession and nursing role. Another important activity that should be done is to ensure sustainability of investments is the need to collect supporting evidence of the added value community nurses provide in terms of improving patient outcomes, delivering better quality and person-centred care, and perhaps even reducing costs (e.g., through less hospital admissions and successful hospital discharge). To do this however it will be important to develop the suitable Key Performance Indicators (KPIs) that can quantifiably measure their impact.

Part II of the ENhANCE Final Conference was held on Thursday 20th May 2021, in the format of a Zoom webinar, and had 124 attendees (speakers included). The programme was broader, and the main aim was to open up the discussion on the wider issues of community-based care by including a number of stakeholder perspectives, as well as policy makers at EU-level.

Figure 13 - Speakers and panellists of May, 20th, 2021

Member of European Parliament *Frances Fitzgerald* opened the discussion, who herself has a background as a social worker and familiar of working in a multidisciplinary team and with community nurses, highlighted that the opportunity is now to look more closely at the needs of frontline workers such as nurses, carers and the challenges in long-term care. Some of the

key challenges being recognition of care, career progression and training. A huge opportunity is the care economy to deliver meaningful care services. Moreover, with the momentum and trend of health moving towards a European competence it will be ever more important at European level to harness the political will because the challenges facing all Member States in terms of care and health cannot be managed without a clear European focus. In the meantime, the EPP group has called for a European Care Strategy, that takes a fresh look on caring (across the life course from childcare to care of older persons) and how to support carers and what the role of the EU should be. She called for the need for better European-wide data to be collected in the field of caring including informal care; the need for equality and gender equality (work-life balance) about who is doing the caring; the need to ensure social protection for carers and the need to focus on training and the need for upskilling and reskilling. EU's Recovery Fund has money that should go to support front line workers such as nurses, but there is a need for coordination and political will to do this.

Keynote speaker Professor Loredana Sasso, Full Professor of Nursing, UNIGE, focused on the context of the Family and Community Nurse "figure", and the growing demand for this profile in view of the overall shift we see in disease patterns and demographic ageing, moving towards a preventive approach and active model of care with healthy ageing, self-care and self-management as a basis. Dr. Milko Zanini, Assistant Professor and Researcher at the Dept of Health Sciences at UNIGE, provided more details surrounding the occupational context for FCN, the importance of the holistic, whole-of-family approach and not least the need for FCN to be able to be the "spider in the web" able to network across different services not just clinical, but also social, occupational, etc. Given the diverse needs of individuals, a key component is being able to communicate with persons and their families concerning their need, which further emphasises the social importance of this Family and Community nurse specialist.

For the panel session, 5 invited panel speakers, representing different stakeholder groups and priorities and conveyed their key thoughts about what is required to deliver efficient community-based care that is equitable and meets the needs of communities and families.

Dr Susan Kent, Professor Associate in Nursing, Midwifery, Community and Public Health at Dublin City University could provide the view from the community nurse perspective. If 3 words could summarise the call to action to successfully deliver community-based care, these would be *Evolve, Innovate, and Demonstrate!*

Evolve: The community nurse profession and practice will change in response to the patients' needs and wants, but other disciplines need to allow for this to happen rather than spend energy protecting their professional turfs. More autonomy in practice is needed; community

nurses need to be able to work both individually and in teams. Curricula needs to change at postgraduate level in particular when it comes to nurse leadership and ensuring a seat at the top table. Access to formal and informal education that is funded and supported.

Innovate: Keep up with technology. Community Nurses cannot remain ritualistic in practice, but flexible and adaptable which will ensure community services can grow and have a greater impact. Community nurses are bridgebuilders, but need to break down barriers – legislative, regulatory, educational, institutional - and be flexible to work both individually and in teams. Healthcare providers and clinical governance must recognise that nurses can be an innovative solution and alternative provider for care (task shifting, skill mix), and help in reducing waiting lists and avoiding hospitalisations. New shared funding models and governance models of care. Digital technology as part of their daily routine.

Demonstrate: Even if there is a clear shortage of nurses in Europe, the impact of community nurses needs to be quantified with measurable KPIs in Community practice; something that is still underdeveloped compared to the acute sector, and needs further strengthened. Nurses are the agents of change!

Finally it is important that community nurses implement principles of solidarity which will be key to achieving leadership for the nursing profession. If nursing is so wonderful and needed for governments, then why are nurses not at the decision-making table? This needs to change!

Borja Arrue, Project and Policy Officer with AGE Platform EU, from the perspective of older people, highlighted the precarious situation of care services for older people. Covid19 exposed a lot of the pre-existing challenges. There is a need for an existential shift in the way societies think about the way care services and care policies are designed for older people. There is a need for civil society to be very active to ensure these models for care can change in a way that ensure the rights and dignity of older people. Some general key values are participation in society, autonomy, inclusion – these are core values for older peoples and need to be respected in the design of care services. Access to community-based services is key, reflecting the desire of a large majority of older people who want to continue to live in their own community and in their own homes. This is a basic equality right for older persons. The long-term care sector should not constantly be de-prioritised and the low consideration of this sector needs to change (low recognition, low retention) through better working conditions. At European level the EPSR Principle 18 on Long Term Care should be used as the policy hook to hold Member States accountable. The need for a life-course approach to the care of older people. Care should not be seen from something separate from their lives but something that is needed along everybody's life course. This change would moreover help in trying to shift

the ageist lens upon which many societies' care models and services, especially those for older persons are built.

Kathy McLoughlin, Vice President Research at Eurocarers and Head of Innovation and Strategic Partnerships at Family Carers Ireland called for the need to further develop measures to support family carers will be crucial and help the financial sustainability of future care needs. In this respect there are needs across three key areas: (i) recognise family carers are unique in the social welfare system: (ii) maximise those who can benefit from the income; and (iii) develop a pension solution for carers. Specific funding streams and a core bundle for carers need to be developed not only in Ireland but also across Europe. Many living in poverty and absolutely need

A public health and preventive approach to family carers would be helpful, as there is also a need to support the carer across the continuum of care. Respite is vitally important, but not the only support required for carers. There are many other supports are needed such as counselling, advocacy, education, training and peer support. Carers' needs should be more systematically assessed to determine their needs and ensure they can develop a sustainable care routine. For this a triage-type tool could be used by GPs and nurses. Home-care schemes when developed should systematically integrate within the services they offer, specific support measures for carers.

Luk Zelderloo, Secretary General of EASPD, European Association of Service Providers for Persons with Disabilities, key elements was the (i) ongoing blurring of professions and boundaries e.g. between community nurses, social workers, personal assistant, which increases complexities and what impacts on the definition of curricula for these professions, which, additionally may have varying definitions from one country to the next. Another element is the ongoing trend of the *Uberisation* of care and support services (such as care platform), which is having a terrible impact on, not only the working conditions for the care professionals, but also the quality of the services provided. The trend seems to be continuing and very worrying. This needs to be further evaluated and acted upon.

Looking towards the services of tomorrow, these care services will be becoming more tailor-made, flexible, user-driven and person-centred. These services should aim at inclusion and participation, and quality of life. Services need to be community-based and inclusive and investments are needed to develop community and homecare allowing people to live autonomously in their communities and in their own homes. Services of tomorrow will be hybrid and be a combination of informal carers, family carers, professionals which will lead to more complex caring structures and people working in the sector need to be sufficiently

prepared. A new development, seen especially during the Covid-19, combination of technology and face to face support will become more frequent. Services need to be co-produced with the service users and their family carers but also the funders. At EU level key points were that the care and social service sector is totally underrepresented in the Recovery plans and in terms of funding. Also, crucial to invest in the workforce – there is a shortage, and right competences (e.g. digital skills) is needed. Finally, lots of positive developments ranging from ESPR, discussion on LTC, European Disability Rights Strategy, Green Paper on Ageing, but all these processes need better coordination and should be steered towards family and community based care.

Dr Chariklia Tziraki, Hellenic Mediterranean University, Community-based Healthy Ageing and Resilient Activities (CHARA) Research Team closed the round table with a plea for a needs-based end-user co-designed approach defined at local level, the importance of building skills of informal carers and the need for better recognition and pay and pensions. Also when talking about communities we should not neglect the rural and remote areas in Europe which often have an older population. We absolutely need to value the knowledge, capacity and utility that older persons possess that they have acquired over their lives, and that should be put to use in our communities, rather than the pervasive view where the societal value is seen to drop once you reach retirement age. Central funding is needed implement services, but the partnerships of care and solution needs to be found with actors at community level. CHARA is trying for instance to bring various professionals and non-professionals together – community nurses, informal caregivers, social workers to define what the needs and solutions can be. Finally, the need for better respect, recognition and understanding by medical doctors of the work done by community-care workers.

The full recording of the webinar is available via “News” update on the ENhANCE website, see: https://www.enhance-fcn.eu/news/

8 Conclusions

The aim of this report was to provide relevant stakeholders, e.g. policy and decision makers, with a set of recommendations to support them in their efforts of achieving an effective transition to a primary care model that is integrated, person-centred care, and where the Family Community Nurse has the potential to be an efficient investment and a key professional in delivering such care.

The recommendations principally targeted relevant stakeholders with responsibilities relating to the organisation, funding and delivery of nurse education but also concerning the governance, structure, organisation, regulation and delivery of family and community-based care at national, regional or local level. Given the diversity across Europe of education and healthcare organisation, service delivery, these recommendations do not aim to be exhaustive, but merely attempt to bring to attention some of the key aspects that can enable a successful shift to the new PHC model. The importance of this shift to community and/or home-based care seems to only have been further heightened by the ongoing COVID-19 pandemic.

In view of the diversity of the FCN professional profile, its role and varying scopes of practice across Europe, the ENhANCE European FCN Curriculum has taken a high-level approach and delivered a global reference curriculum for the FCN, defining the core competencies and transversal skills, whilst providing for a flexible and modular approach, allowing for it to be “localised” i.e. adapted and contextualised by educational providers to their specific needs, socio-cultural settings.

Nevertheless, there are shared commonalities and “take-home messages” for all stakeholders, in order to ensure that investments in FCN specialist training, education and care delivery have the potential to be efficient at least in terms of providing personalised, quality care and in improving health outcomes for older people, for people with disabilities and their informal carers (largely unpaid). Notably, evidence supports that primary health care delivered by nurses, have resulted in improved quality of care, efficiency and decreased costs.

To achieve integrated care however in the true meaning of the word, more efforts and investments are needed to ensure better communication and increased understanding of the different roles of care professionals (especially those between health and social care). There is still a lack of awareness and knowledge about the roles of different professionals in the community and among all the different care professionals involved in PHC and community based care, which thus leads to a siloed and fragmented approach to care.

There is, not only, need for more knowledge and understanding, but also need to build and strengthen the trust between different specialist roles. The vital support provided by informal carers (often family members) needs to be more specifically recognised and supported, especially since up to 80% of all care in Europe is provided by informal carers. As needs and preferences of both patients and family members may differ, it is important for the FCN to be aware and coordinate care using a people-centred, whole-of-family approach.

Finally, care models should strive to allow FCN to work to their full scope of practice and experience, and more data needs to be collected about nurses working in the Long Term Cacre (LTC) sector. Specific attention and action is required in the LTC field to improve working conditions, work environment and pay for FCN. Better data capture and coordination in the field of LTC would be helpful as this would support not only improving the quality of life and wellbeing of those receiving care and their families, but would ultimately also lead to greater job satisfaction for FCN, as a career choice with prospects and good working conditions.

The ENhANCE European FCN Curriculum has through the local ENhANCE pilots in Greece, Finland and Italy successfully demonstrated the potential to flexibly adapt the curriculum and deliver modular study programmes that meet different local contexts, educational settings, and population health needs.

As the recent WHO/ICN State of World's Nursing report says: "*Nurse education and training programmes must graduate nurses who drive progress in PHC and UHC"*. Expected actions should for instance include greater investment in a competent nursing faculty, availability of work-based learning, and ensuring accessibility of programmes offered to attract a diverse student body.

To conclude, evidence demonstrates that nurses are a cornerstone of integrated care teams, often leading care provision and taking on expanded practice roles, including, where relevant, collaboration with and oversight of community health workers.

Echoing the earlier demand of the European Federation of Nurses, the ENhANCE alliance wholly subscribes that governments and decision makers across Europe should ***continue to invest in the expansion of community, family and home-based care services and strengthen the profile of the FCN as a highly specialised nurse, part of the multidisciplinary team, thus ensuring efficient and equitable access to quality primary care services across Europe.***

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