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Nurse led care

Determining long term effects is harder than measuring short term costs

What's the difference between medical and nursing care? The answer is not straightforward, but shortages in the medical workforce mean that nurses are increasingly called on to undertake work that was previously done by doctors (such as undertaking surgery, prescribing drugs, performing triage in emergency departments), whereas shortages in the nursing workforce mean that healthcare providers now do many tasks that nurses are trained to do. This fluidity in professional roles and competencies enables the health workforce to respond to need, but are outcomes for patients being improved?

Do these benefits come at an additional cost, and if so, to what end, but are outcomes for patients being improved? This fluidity in professional roles and competencies enables the health workforce to respond to need, but are outcomes for patients being improved?

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The ways in which nursing teams in the nurse led units make decisions about discharge also need to be explored. Nurses may, rightly or wrongly, be more conservative in discharging patients. They may err on the side of caution, but the benefits of these conservative decisions can only be judged with longer term follow up.

Do these two new studies help us understand the differences between medical and nursing care? We think they usefully remind us that nursing care is not necessarily less costly and that the extra costs may be worth the benefits but that health outcomes need to be measured carefully in studies of sufficient power. It should not be assumed that the outcomes of nursing and medical care are equivalent.

The skills of healthcare professionals and their assistants are much in demand and constitute a limited resource that needs to be deployed in the most cost effective way. Although UK health policy supports the development of nursing roles, as nurses take on more duties and responsibilities we must also question what, if anything, is being lost from nursing, to whom and does it matter?

Nicky Cullum  professor

Karen Spilsbury  research fellow

Gerry Richardson  research fellow

Competing interests: KS and GR have conducted and published evaluations of nurse led intermediate care.


Large scale food retail interventions and diet Improving retail provision alone may not have a substantial impact on diet

Ensuring communities have good access to healthy affordable food is one of the government's joined up strategies to improve public health and reduce health inequalities.1 3 Policy solutions for deprived communities without good access—food deserts—have focused on improving provision of food retail as part of a wider suite of recommendations for population dietary change focused around awareness, affordability, and acceptability.2 However, the evidence for the widespread existence of food deserts and their impact on population health has been contested.1 3 This has meant that although retail based policy recommendations to reduce diet related health inequalities now exist,1 3 the evidence to inform how, when, and where to reduce these inequalities is only now emerging.

Recently completed projects in Newcastle, Leeds, and Glasgow have started to provide us with this evidence.2-4 The Newcastle study concludes that food deserts exist only for a minority of people who do not or cannot shop outside their immediate locality and for whom the locality suffers from poor retail provision of foods that compose a healthy diet. Key predictors of healthy eating were found to be dietary knowledge, relative affluence, and healthy lifestyle—retail provision was not independently associated with diet.

The Leeds and Glasgow studies were both prospective evaluations of the impact of large scale food retailing. Utilising an uncontrolled before-after design the Leeds study concluded that access to food improved notably after the intervention. The average distance travelled to the main food store fell to under 1 km, and the percentage of people walking to the main food store tripled to over 30%. Substantial increases in consumption of fruit and vegetables of between 0.25 and 0.5 portions per day were also reported, particularly for respondents who switched to the new provision. In contrast the Glasgow study, a controlled quasi-experimental study, found little evidence for an overall effect of the intervention for fruit and vegetable consumption in portions per day. For those consumers who switched their main food shopping to the new store an improvement in fruit and vegetable consumption of around 0.35 portions per day was seen though the evidence for this was very weak. A substantial positive improvement in one measure of psychological health (GHQ-12) and a weak positive effect on self reported health was seen in switchers.

How should this evidence be interpreted? Firstly, the term food desert, although a striking metaphor, has unintentionally led to such polarisation of views by researchers, policy makers, and other interest groups so as to be of limited further use. The authors of the Newcastle study propose that the focus should be on food equity instead.6

Secondly, ambiguity remains over whether large scale food retail interventions work. Despite the reporting of positive changes in fruit and vegetable consumption in the Leeds study, pre-intervention and post-intervention designs alone rarely provide compelling evidence that an intervention has been successful. Changes in the prevalence of risk factors and