

Community and primary care nursing

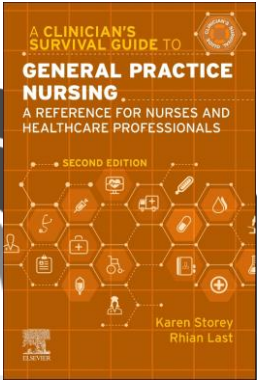
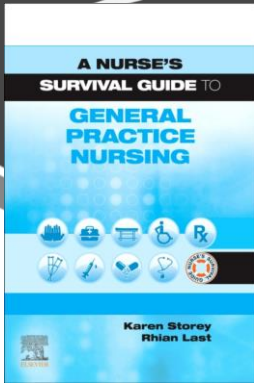
A national update

Karen Storey
National Community Nursing Lead
NHS England

Karen.storey@nhs.net

September 2026

Nursing Leadership Journey



Where this work sits

Transforming Adult Community and Primary Care Nursing programme, 2026 to 2029

Every workstream I will describe sits inside one national programme, with the Deputy Chief Nursing Officer as senior responsible owner. The strategic anchor is the shift of care from hospital to community set out in the 10 Year Health Plan, and the delivery model is neighbourhood health.

1

Workforce and professional development

Career structures, capabilities, education and supply

2

Quality and outcomes

What community nursing delivers, and how we evidence it

3

Patient safety and professional standards

Safe staffing, safe decisions, safe medicines

Three outcome domains. Everything in this pack maps to one of them.

What I will cover

1

Deferred care

National principles, guidance and a template procedure

3

Lower limb wound care

What the first cohort did, and a new implementation research commission

5

Career and capabilities

A national framework for adult community nursing

7

General practice nursing

Safe staffing, consultation time and developing the workforce

2

Safer staffing tool

Masterclasses, community of practice, and the Shelford question

4

Insulin safety

Our response to the HSSIB safety recommendations

6

Primary care capacity

Growth across primary care networks, and what the data does not yet show

8

Neighbourhood health

Why the shift cannot be delivered without community and primary care nursing

Deferred care: the problem we are solving

- Deferred care happens when demand for community nursing exceeds the capacity available, and visits have to be rescheduled, shortened or not delivered on a given day.
- There is no agreed national definition and no consistent approach across services.
- So prioritisation happens informally, at the point of care, usually by an individual nurse at the end of a long day.
- That creates risk to patient safety and to equity, and it places a real professional and moral burden on staff.
- And some community nursing care is not deferrable at all. End of life care, syringe drivers, blocked catheters and time critical medicines cannot wait.

91

senior community nurses shaped this at the national launch event on 6 May 2026

Commissioned through the Chief Nursing Officer's Strategic Advisory Group

Co-led with Lorraine Galligan, Chief Nurse at Birmingham Community Healthcare NHS Foundation Trust

How we are building it

A national task and finish group, with four working groups doing the drafting



Definitions

Deferred care, rescheduled care, care not done, non-deferrable care, and incomplete or clipped care



Principles

Seven principles, each with a realistic note on what it means in practice



Scope and actions

Who the guidance applies to, and the enablers that must follow for it to make a difference

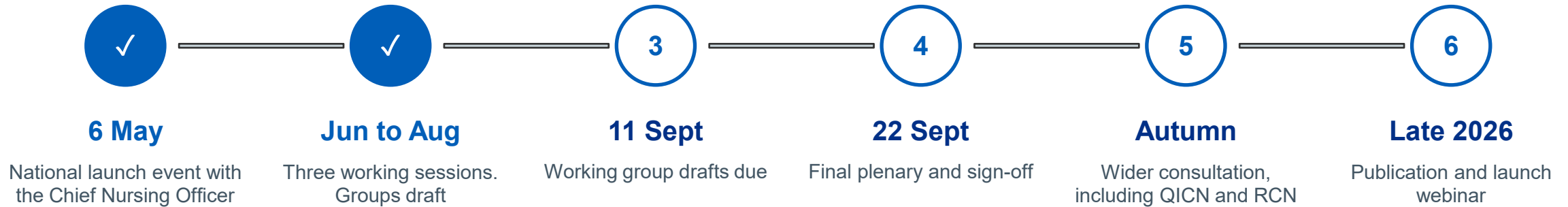


Template SOP

A standard operating procedure any service can pick up and adapt locally

Members are community nurses, executive nurses and sector leaders. Each group has its own co-ordinator and does its own drafting. The national team tidies and circulates. Members will be named as contributors.

Deferred care: where we are



We are two weeks from sign-off. The publishing route is already in train, so it will not hold us up at the end.

What the guidance will contain

And, just as importantly, what it will not do

It will give you

- An agreed national definition
- National principles for deferral decisions, including who decides and at what seniority
- A clear statement of scope
- A template standard operating procedure
- Escalation triggers and a board reporting expectation

It will not

- Create capacity. Guidance does not put more nurses in the team.
- Be a toolkit or a tool. NHS England publishes guidance.
- Replace professional judgement at the point of care.
- Set a national caseload cap or a mandatory ratio.

The purpose is to make an invisible decision visible, consistent and accountable, and to move the risk from the individual nurse to the board.

Community Nursing Safer Staffing Tool

What we have delivered

1

National masterclass

On how to take CNSST outputs to a board and make the case. Delivered nationally and well received.

2

New board reporting template

A ready-made board paper structure. Systems are telling us this is the most useful thing we have produced.

3

Regional train the trainer

Two to three facilitators trained in every region, so the masterclass can be delivered locally rather than centrally.

The triangulated case

The tool on its own does not persuade a board.
Three sources together do.

CNSST II

What the tool calculates you need

Professional judgement

What your senior nurses know about the service

Quality and outcome data

What is actually happening to patients and staff

Safer staffing tool: what comes next



Community of practice

- For the trained train the trainer facilitators
- Four meetings a year
- A place to share practice, test an approach before taking it to a board, and raise issues with us
- Being set up now



The Shelford Group

- We are in discussion about transferring the tool to the Shelford Group
- The logic is that all the safer staffing tools then sit in one place
- No decision has been reached
- I will keep this network informed



A digital solution

- The tool is currently an Excel workbook with manual data entry
- That is the single biggest barrier people report
- We are undertaking a survey to size the problem
- We are building the case to commission a digital solution to automate data collection
- Early stage

Lower limb wound care: the programme so far

Delivered with the National Association of Primary Care

- The first cohort of the wound care programme is complete.
- Phase 2 moves to a neighbourhood focus, working in depth with two neighbourhoods rather than with individual services.
- The aim is to improve care and outcomes for people with a lower limb wound, and to draw out principles that other systems can use.
- Lower limb wounds are a large, under-recognised part of the community nursing caseload. They consume a great deal of nursing time, and outcomes vary widely depending on whether the best practice bundle is followed.
- This is a good example of community nursing and general practice nursing having to work as one team around a single outcome.

Phase 1

First cohort delivered. Complete.

Phase 2

Two neighbourhoods. Supporting those systems to improve lower limb wound care, and turning what works into transferable principles.

Phase 1: what the first cohort did

Four examples from the national cohort, March 2026

1 Taking competency assessment to the team

Jane Todhunter, North Cumbria Integrated Care Trust

Five community nurses in Copeland could not be released for the two day leg ulcer course. Training and OSCE assessment were taken to their base instead. All five were signed off in Doppler and compression.

2 Compression delivered by support workers

Sarah Bagley, Care Plus Group

Targeted training and a competency framework enabled healthcare support workers to deliver compression. Patients starting compression within four weeks of presentation rose from 86 to 97 per cent.

3 Challenging the twice weekly dressing change

Victoria Telling, Evesham Neighbourhood Team

A survey of why dressings are changed so often, and an evidence based guide for new starters, to break the habit, release nursing capacity and reduce waste.

4 Wound care for people sleeping rough

Laijon Itteera, Luton District Nursing Team, CCS NHS Trust

Trust building, regular dressing with compression and multidisciplinary support for a rough sleeper with severe bilateral leg ulcers. Both legs healed between July 2025 and February 2026.

Also in the cohort: a venous eczema pathway in Sheffield, the P.U.L.L Together culture campaign in Hertfordshire, a standardised lower limb pathway across Birmingham and Solihull, and hosiery supplied at the point of assessment in Central and North West London.

Lower limb wound care: the new commission

Implementation research with Health Innovation East

3

vanguard sites

March 2027

completion

- The programme tests delivery of the National Wound Care Strategy Programme lower limb best practice bundle through nurse-led integrated neighbourhood teams.
- It is framed as implementation research. The question is not whether the bundle works. It is what has to be true in a neighbourhood for it to be delivered consistently.
- The output is guidance for systems on how to commission a neighbourhood approach to lower limb wounds, taking account of the wider determinants of health.
- Sites are being confirmed. I will share them with this network once they are.

Insulin safety: our response to HSSIB

Two safety recommendations on supported self-administration of insulin in the community

R/2026/084

National principles for training and competency where a person is supported to self-administer insulin.

R/2026/085

Supportive guidance for staff and for the people and families they support.

- A short life task and finish group will be in place by October 2026.
- It draws on the Community and District Nursing Insulin Programme, Getting It Right First Time, the Community Nursing Clinical Reference Group and the Community Nursing Fellows Alumni.
- Both recommendations will be answered together, with outputs published by March 2028.
- Insulin is a time critical medicine. Delayed or omitted time critical medication is a recognised staffing sensitive indicator, so this work connects directly to the safe staffing and deferred care agenda.

A career and core capabilities framework

For adult community nursing, at last

General practice nursing

- Has had a national career and core capabilities framework for years
- Developed by Skills for Health
- Sets out levels of practice from general practice nurse through enhanced and advanced practice to consultant level
- Used by employers, educators and workforce planners

Adult community nursing

Has had none. Career structures and capability expectations vary by employer.

We have submitted a business case to commission Skills for Health to build one, on the same architecture as the general practice nursing framework.

An adaptation in method. A redevelopment in content.

It will draw on the work of the Community Nursing Fellows, and give particular attention to what makes adult community nursing distinct. Care in people's homes, frailty and multimorbidity, long term conditions, prevention and anticipatory care, rehabilitation, end of life care and multidisciplinary working across health, social care and the voluntary sector.

Primary care and general practice nursing

The other half of the neighbourhood nursing workforce

General practice nursing sits in the same programme and the same three outcome domains as everything else in this pack. Four things are moving at once.



Capacity

Growth in nursing roles across primary care networks, through the Directed Enhanced Service in the GP contract.



Safe staffing

Staffing and consultation time in long term conditions clinics. A new task and finish group.



Development

A national preceptorship offer, and work on how a career in the community is perceived.



Innovation

Group clinics in all seven regions. Men's health, immunisation and cervical self-sampling.

Community nursing and general practice nursing are now planned together rather than separately. Two aligned workforces make a neighbourhood team possible. Two unrelated ones do not.

Building nursing capacity in primary care networks

Additional Roles Reimbursement Scheme, June 2026 quarterly data

4,613

additional advanced nurse practitioners

7,040

additional healthcare support workers

1,291

nursing associates

814

enhanced level practice nurses

- Nursing roles are included in the Directed Enhanced Service in the GP contract. That is the route that has allowed primary care networks to build this capacity.
- The figures show growth in specific roles. They are not yet a complete picture of the general practice nursing workforce.
- Data on nurses new to primary care, and corrected nurse consultant numbers, will be added once it has been through workforce standard data cleansing.

Treat these as directional until the cleansed data is published.

General practice nursing today

A joint report from the Queen's Institute of Community Nursing and the Royal College of Nursing, with input from NHS England

36%

of nurses add patients to already full clinics every day

32%

believe their appointment times are adequate for safe practice

- Clinical complexity is the driver. Multimorbidity, behavioural risk factors, poorly controlled long term conditions, language barriers and medical anxiety were all identified.
- Nurses deliver most of the routine long term conditions review activity in general practice.
- There is no national reference point for what safe looks like when running a long term conditions clinic.

What follows

A task and finish group led by NHS England is developing national principles for safe and effective staffing in general practice nursing.

It will focus on long term conditions clinics, and on what should determine how a clinic is staffed and how long a review needs to be.

It will not set a mandatory appointment length or a national ratio. Practices are independent contractors and staffing is the employer's decision.

It is the primary care counterpart to the community nursing staffing guidance.

The purpose is a professional reference point that a practice, a network or a commissioner can test a clinic model against.

Group consultations: seven regional vanguards

The Primary and Community Care Regional Vanguard programme, delivered with the Experience Led Care Programme



Four priority pathways

- Frailty, including advance care planning and falls prevention
- Type 2 diabetes, including insulin and continuous glucose monitoring
- Catheter care, aligned to the GIRFT guideline
- Lower limb wound care



What each vanguard gets

- Accredited training for the whole multidisciplinary team
- A group clinic coach for 12 months
- A seven step route map and a help desk
- A mobilisation day and monthly community of practice



How it is run

- Louise Brady and Karen Storey selected the seven sites and oversee delivery
- Sites are accountable to NHS England and sign a memorandum of understanding
- Each site secures an integrated care board sponsor

Sites had to bring primary care and community providers together to apply. They go live from October 2026, with evaluation and case studies from January 2027. The model has been recognised by WHO Europe as a good example of workforce development and staff retention.

There is no additional funding attached. What the sites get is the method, the training and the coaching. Two of the four pathways, lower limb wound care and diabetes, are also workstreams in this pack.

Developing the workforce

Preceptorship and the next generation

A national preceptorship offer

- A new working group is refining the national preceptorship offer for primary and community nursing.
- It is collating evidence of what has worked well in preceptorship across both settings.
- It is gathering qualitative feedback as well as quantitative data.
- The output is a summary of best practice principles.

Perceptions of nursing

- A national project on how nursing is perceived, and on attracting the next generation into community and primary care.
- A general practice nurse who also holds a community nursing role will feature in the new marketing campaign.
- The message is that community and primary care are a destination in their own right, not a step taken after hospital.

The recurring international finding is that community is still seen as somewhere you go later in a career. Preceptorship and perception are two of the few levers we hold that change that.

Clinical development and innovation

Three pieces of work with primary care teams



Men's health

- A new e-learning for health module in men's health for primary care.
- Developed with the Department of Health and Social Care, Staffordshire Integrated Care Board and NHS England.
- It sits under the core career and capability framework.



Immunisation and vaccination

- New guidance and resources in development for primary care teams.
- A collaboration between NHS England, UKHSA and regional colleagues.
- New commissioning and training structures are being worked up to raise standards, starting in 2027.



Cervical self-sampling

- Self-sampling has now started for women nationally.
- Education, training and resources are available now.
- A national communications toolkit is published by the Department of Health and Social Care.

Each of these gives primary care nursing teams something they can use now. The commissioning and training structures behind immunisation and vaccination are the piece that takes longer.

Neighbourhood health and community nursing

The shift of care from hospital to community cannot be delivered without district, community and general practice nursing. That is not advocacy. It is arithmetic.



We already do it

Community nursing has worked across organisational and professional boundaries, in people's homes, for decades. The neighbourhood model describes what district nursing has always done.



We lead it

District nursing is a postgraduate, NMC-recordable qualification. It brings clinical leadership, continuity and co-ordination of care to the neighbourhood team.



We must be visible in it

Community nursing risk needs to sit at board level on the same footing as acute demand and capacity. Today it usually does not.

Every workstream in this update is a building block for that. Capacity through safer staffing and the contract. Safe decisions through deferred care. Safe medicines through the insulin work. Career and capability through the frameworks. Outcomes through wound care and group clinics.

Neighbourhood health will only work as a **joint endeavour** between the NHS and local authorities, alongside wider partners.

Three principles of public sector reform:

- Integrated services around people's lives
- Improve outcomes, by focusing on prevention rather than crisis management
- Devolve power to local areas, which understand local needs, with services with and for people.

Measuring success of neighbourhood health

National minimum goals and objectives, plus locally developed aims and outcomes defined through neighbourhood health plans under the leadership of Health and Wellbeing Boards.

National NHS goals, objectives and metrics

1 Improve health outcomes

Targets include:

- reducing non-elective admissions
- improving outcomes for long-term conditions
- improving quality and access to care for children
- better end of life care

2 Improve access to general practice

Objectives include:

- 90% of clinically urgent patients seen the same day by March 2027
- faster access to routine GP care
- improved patient satisfaction

3 Improve experience of planned care

This will include:

- reducing variation in outpatient referrals
- improving coordination of outpatient care & reducing secondary care follow-up appointments

4 Improve urgent and emergency care

- Improving co-ordination of care for high priority cohorts (frailty, care homes, end of life)
- reducing emergency department attendances
- improving ambulance response times
- improving hospital discharge processes

5 Improve patient and staff satisfaction

- introducing patient-reported experience and outcome measures
- ensuring 95% of people with complex needs have an agreed care plan
- introducing neighbourhood staff experience measures

6 Local goals

- Health and Wellbeing boards recommended to consider the local outcomes framework for health and wellbeing, adult social care, Best Start in Life and neighbourhood health and integration
- Enabling those who receive long term support to live in their home
- Adults whose needs are met by admission to residential and care homes
- Consider how neighbourhood plans align with wider public service reform

Aims

- Improve people's health and care outcomes
- Organise services around the person
- Reduce pressure on acute services
- Cut waste and duplication
- Help the NHS deliver against core targets

Delivering neighbourhood health

To deliver neighbourhood health, the NHS and local authorities must transform how they work together alongside wider partners including **voluntary, community and social enterprise organisations (VCSEs)**. ICBs will ensure neighbourhood health becomes the default model of care

Reform agendas

1 Improve routine healthcare

The NHS will support GP access recovery by:

- through new GP access targets
- improving online access
- ensuring practices open during core hours, and reform out of hours
- providing faster access to care
- GPs will be empowered to deliver better care through:
 - proactive population health management
 - reduced bureaucracy
 - improved access to specialist advice

2 Improve proactive care

- Develop Integrated Neighbourhood teams to deliver better management of long term conditions, frailty, children and young people and cancer
- Grow community services
- Reform outpatients, with closer working between GPs and specialists

3 Better alternatives to hospital care

- Expand urgent community response services
- Increase the capacity of virtual wards
- Increase intermediate care capacity
- Piloting 24/7 neighbourhood mental health centres

Read how NAPC helps partners implement neighbourhood health.

Contracting models



Single Neighbourhood Providers (SNPs): Deliver neighbourhood services through integrated teams within a defined area; allow primary care to offer services beyond core GP contracts.

Multi-Neighbourhood Providers (MNPs): Coordinate services across multiple neighbourhoods, supporting consistency, service design and shared risk for the registered population list.

Integrated Health Organisations (IHOs): Hold a whole-population budget, allocate resources across pathways, redesign services and invest in prevention. Initially likely led by high-performing NHS trusts, in partnership with primary and community providers.

All primary care contracts remain nationally contracted. PCNs might evolve into SNPs. More guidance to follow.

Changes for 2026/27

- Neighbourhood footprints considered in terms of local authority boundaries
- Reduce non-elective admissions
- GP access
- Establish integrated neighbourhood teams
- Improve outpatient pathways
- Confirm use of Better Care Funding (BCF)
- Improve primary secondary care interface
- Confirm organisational ownership of deliverables
- Improve data-sharing arrangements
- Plan for April 2027 to April 2029

Other headlines

- **Neighbourhood Health Centres (NHCs):** 250 neighbourhood health centres by 2035, 120 by 2030
- **Workforce:** staff working differently rather than entirely new staff groups providing proactive, preventative personalised care, organisational boundaries
- **Finance:** ICBs prioritise funding for neighbourhood health services locally. National support will include: financial incentives encouraging the shifting care from hospital care to community, reforms to payment mechanisms, & support for outcome-based contracting

NAPC welcomes the continued focus on population health and prevention at a local level.

The national voice for primary and community care, NAPC is a not-for-profit membership organisation leading change, driving innovation and supporting partners across the health and care ecosystem.

Opportunities for Community & Primary Care Nursing

Enhanced role and visibility:

Nurses leading neighbourhood teams, links to community voice.

Shift toward prevention:

More proactive, preventive work and early intervention to reduce hospital usage.

Improved work environment:

less administrative burden via digital tools; more flexibility; better career pathways.

Integrated care:

working more closely with GPs, mental health, social care, voluntary sector.

Opportunity to increase understanding and value of community nursing

Make your voice heard

- Get up to date with national Policy – 10 Year Health plan
- Get involved in local discussions about Neighbourhood Health Services
- Join networks linking to your area of practice
- Be Innovative and demonstrate how you make a difference and have impact
- Participate in shaping the CNO Professional Strategy
- Continue to be the advocates for our citizens
- Collaborate with Higher Education Institutes to reframe pre-registration training
- Welcome and support newly qualified nurses to work in the community

How you can do this

Owning your leadership story

The power of story telling
Crafting your story-

What is your message ?

What are your values ?

What do you value ?

Who is your message for ?

What difference do you want to make?

What are you aiming to change ?

Managing Imposter syndrome

“Do I have what it takes to be a leader?”

Write down everything you've accomplished in the last 12 months

Think of five people in your life and ask them to share your five greatest strengths

Avoid comparing your weaknesses with other people's strengths

Lean into the discomfort you feel about putting yourself out there

Celebrate your wins along the way

Learn to manage the self doubt

Manage with confidence not fear

Focus on building your strengths, not fixing your weaknesses.

Power of networks

Share a common purpose

Shared values

Inspires a shared vision

Enables others to act

Encourages others

Motivational

Call to action

Builds motivational leadership

Builds resilience

Thank you

