



Hoskins, R.A.J. (2009) *Health visiting - the end of a UK wide service?*  
Health Policy, 93 (2-3). pp. 93-101. ISSN 0168-8510

<http://eprints.gla.ac.uk/7165/>

Deposited on: 26 February 2010

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**Title:** Health Visiting – the end of a UK wide service?

**Journal:** Health Policy

**Word count:** 5214

**Abstract:**

In 1997 Health Visiting was deemed by New Labour to be an important player in reducing health inequalities. It was acknowledged that if Health Visiting was to fulfill this vision it would have to work out with its traditional child health role and also engage with groups, communities and populations to tackle the determinants of ill health. Twelve years on, external factors such as, NHS cut backs, recent changes to how Health Visitors are regulated throughout the UK and devolved Health Visiting policy making structures have led to the rapid demise in status and legitimacy of Health Visiting and its wider public health role. This article argues that the unintended consequences of devolved Health Visiting policy has resulted in 3 recent community nursing and health-visiting reviews in Scotland and England which have made divergent policy recommendations about the role of the Health Visitor in tackling health inequalities. The recommendations outlined in the Scottish review in particular threatened to jeopardise the very future provision of a UK wide Health Visiting service. If Health Visiting is to survive as a UK wide entity, a radical independent rethink as to its future direction and its public health role is urgently required.

## **1 Introduction**

In 2012, Health Visiting will celebrate its 150<sup>th</sup> anniversary. Today, to become a Health Visitor (Specialist Community Public Health Nurse) one has first to be a registered nurse or midwife and undertake 45 weeks of specialist theory and practice. This was a far cry from 1862 where the educational input given to the first Health Visitor who was employed by the Salford Ladies Sanitary Reform Association consisted of lectures on the principles of good sanitary health [1]. Although rooted very firmly in a public health advice dispensing role targeted at urban working class families, one of the first recorded examples of Health Visitors taking a more radical collective public health role could be seen by their intensive lobbying which influenced the passing of innovative legislation which introduced child and maternity benefits and a national maternity service [2]. The foundations of a nationwide Health Visiting service evolved over the next 50 years, built on the three pillars of child health surveillance, maternal support and advice and public health, a triumvirate which helped to reduce the burgeoning rate of infant mortality during the first half of the 20<sup>th</sup> century [3]. However, the tension between the social (community/population) and the medical (family/individual) focus to the Health Visitor's public health role has been a subject of much contention and fierce debate throughout this period [4]. It was the twin impact of the 1946 NHS Act [5] and the publishing of the highly influential principles of Health Visiting practice [6] (See Figure 1) which extended the remit of the Health Visiting service from the cradle to the grave and legitimised Health Visitors working strategically to influence local policy and provide community solutions to individual child health problems which intensified this debate.

This paper argues that the tectonic plates of that old public health fault line have been re-activated by a recent seismic shift towards devolved policy making structures in Scotland, Wales and Northern Ireland and recent regulatory changes which impact on Health Visiting throughout the UK. Both these factors have combined to compromise the very existence of a strategic collective public health role and the provision of a UK wide Health Visiting service.

It was just over a decade ago, that New Labour inherited record-breaking levels of child poverty [7] and health inequalities[8]. Unlike the outgoing Conservative administration, New Labour not only recognised that these problems existed moreover it set out a policy agenda to tackle them. Health Visitors were at the forefront of New Labour's plans to tackle health inequalities within the NHS arena and improve public health throughout the UK. There was Government recognition that if Health Visitors were to become major players in this endeavor, they would have to work outside their traditional role of child health surveillance to do so. In England, a resource pack was designed to equip Health Visitors with the necessary skills to do just that (See Figure 2)[9]. This meant Health Visitors taking on a more strategic public health role, working with groups, communities and populations to find solutions to child health and family problems. The implementation of the Hall four report on 'Health for all Children' not only enhanced the evidence base of Health Visiting practice but also made way for the vision of an extended public health role becoming a reality [10]. Hall Four did this by recommending that Health Visitors spend less time implementing ineffective routine developmental

screening procedures, thus releasing the potential of freeing up additional time to pursue this endeavor [11].

These policy and practice changes were consistent with this new wider public health emphasis to Health Visiting practice, which endorsed and reflected New Labour's flirtation with the Social Capital evidence base, which focused on civic renewal, and building social cohesion as a means of improving public health[12]. This new direction was endorsed in policy documents throughout the UK [13];[14];[15];[16].

Twelve years on, in a worsening public health climate consisting of widening health inequalities[17], missed child poverty reduction targets[18] and a recession, one could be forgiven for thinking that there was a strong case for continuing investment in the Health Visiting service especially its public health nursing role. However, on both accounts the opposite has been the case. To understand why, this article will identify the external factors which have synergised to throw the legitimacy of the service and in particular its public health role into crisis.

## **2. External factors which have affected Health Visiting and its wider public health role:**

**Recent changes to the regulatory framework of Health Visiting have paradoxically progressively weakened its potential to deliver its wider public health role.**

This is not the first time that Health Visiting has found its professional identity under threat. In 1969, the profession successfully lobbied against recommendations made by the Mayston Report to absorb Health Visiting and hospital nursing under one general division [19]. The recent downgrading of the status of Health Visiting can be traced back to its removal from statute by means of the passing of the Nursing and Midwifery Order

in 2001[20]. This act of parliament, recommended replacing the previous regulatory body for nurses, midwives and Health Visitors, the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC) by the Nursing and Midwifery Council (NMC). The significance of this being that previously, the UKCC had 3 compulsory registers – nursing, midwifery and Health Visiting where it was a legal requirement for members of all three disciplines to be registered on their discrete register in order to practice, whereas the Nursing and Midwifery Order 2001 recommended that the NMC close the Health Visiting register and set up a new non compulsory 3rd part of the register in its place[21]. This meant that for the first time in 85 years, Health Visiting is now no longer regarded as a distinct profession in statute as there is no longer recognition of the Health Visiting title[20]. This was demonstrated not only in the absence of the title of Health Visitor in any part of the Order or explanatory notes [21]but also the acronym NMC, is symbolic of Health Visiting's weakened status as only two of the three parts of the register (Nursing & Midwifery) are reflected in its title. Paradoxically, the rationale given for removing the title from statute was to give the new NMC the additional flexibility to acknowledge Health Visiting's expanded public health function, and not to anchor it to the limitations of its previous role [21]. A point which the Health Visitors professional body the Community Practitioners and Health Visitors Association (CPHVA) also endorsed which prompted Lord Clement-Jones whilst moving an amendment to the Order to accuse the CPHVA of 'failing to obtain adequate assurances from Ministers and to have caused a great deal of unhappiness among its members by failing adequately to debate these matters' [21].

The consequences of closing the Health Visiting register in 2004, resulted in Health Visiting being absorbed into a new more generic specialist community practitioner register instead which presented a formidable barrier to the ‘educational development and recruitment of Health Visitors’[22]. A decision which coincided with the numbers of health-visitors being recruited, trained and employed going into free fall[23];[24]. The United Kingdom Public Health Association’s (UKPHA) Health Visiting special interest group argues that these regulatory factors have unintentionally sent out a very strong signal to potential purchasers of Health Visiting services that if the Government does not appear to value Health Visitors, why should commissioners recruit them?[23]. This very much echoes Baroness Noakes’ warning in her speech in support of Lord Clement-Jones’ unsuccessful attempt to amend the Order about the consequences of removing Health Visiting from statute, when she said ‘that names matter because they send powerful signals to the outside world’[21].

**An NHS cash deficit and new alternative health services being provided which don’t need Health Visitors:**

The Government’s policy of respecting the fiscal autonomy of Primary Health Care Trust’s (PHCTs) purchasing decisions [25] has unintentionally militated against the purchasing of Health Visitors. For example, the Department of Health does not have overall control of those all important public service agreement targets which directly impact on the wellbeing of new parents and infants [22]. This has resulted in cash strapped PHCTs cutting back on commissioning Health Visiting services by employing cheaper and less qualified Health Visitor substitutes such as staff nurses and nursery nurses instead, which in turn has thrown service provision into crisis. In England, the



number of full time equivalent Health Visitors is at a 13-year low [23] which is equivalent to one Health Visitor job being lost per day and an estimated 500,000 visits to families not taking place[26]. In addition there has been a 40% drop in training places for new Health Visitors which has been compounded further by an ageing workforce[26].

A range of new NHS walk-in centres, NHS 24 and NHS Direct have also shifted the focus away from public health nursing to downstream crisis intervention and are out with the control of primary care[27].

**There is a discrepancy between Health Visitor attitude towards being involved in the wider public health role and their ability to implement it:**

Recent skills audits have demonstrated that Health Visitors want to become actively involved in implementing the extended public health role but have felt under equipped in terms of their knowledge and skills base to carry it out [28]; [29]. There is also some evidence to suggest that Health Visitors have been denied access to these development opportunities to gain access to these essential skills [30]. Brocklehurst argues that it is unrealistic to expect Health Visitors to participate in this new vision, if the structures and culture which impede its implementation within primary care remain unchanged [31].

For example, GP attachment with its lack of geographical focus means that Health Visitor energies tend to be exclusively channeled into medical tasks which are focused on individuals as part of their heavy caseload responsibilities to the exclusion of tackling the determinants of poor health by forming key partnerships at a more strategic community or population level [32];[33];[34].

**The underdevelopment of the academic base of Health Visiting.** Health Visiting has not developed its evidence base sufficiently to articulate its role in the multi disciplinary public health movement. This is partly because the impact and legitimacy, which would have been derived from a separate Health Visiting evidence base, is not there as its evidence is drawn from a wide variety of disciplines such as paediatrics, mental health and social work, each with its own individual identity [22]. There are only a handful of Community Nursing Professors in the UK, not all of whom are Health Visitors. There are a few prolific academics who regularly publish research in high impact academic journals on the subject of Health Visiting but there is no specific high impact UK Public Health Nursing journal for them to publish in. Those seminal public health nursing papers which do exist, tend to be published in high impact journals which are not Public Health Nursing specific or in low impact journals within the specialism. These factors have combined to stifle academic debate and new ideas as to what public health nursing is and could become.

### **3. The future of Health Visiting as a UK wide service was very nearly determined by a devolved and divergent policy approach taken in Scotland to tackling health inequalities**

Unlike Health Visiting's regulatory body the NMC which has a UK wide remit to oversee its members, the power to determine what Health Visitors do, where they do it and who they do it with has been devolved from Westminster to Scotland, Wales and Northern Ireland respectively. Devolution has produced Health Visiting policies which foresee divergent futures for the profession which paves the way for its demise as a national UK wide service.

There have been far reaching community nursing and Health Visiting reviews in Northern Ireland [35], Wales [36], Scotland [37]; [38] and England [39]. Whilst Northern Ireland's Health Visiting review is still in the process of reporting back, Wales is considering strengthening the public health role of its Health Visiting service to include a fully integrated service for individuals, communities and populations [36]. This article will now focus on the recommendations of the English Review [39] and the 2 reviews in Scotland, one at a national level: the formerly proposed Scottish Review of Nursing in the Community (RONC) [37] and one in Greater Glasgow & Clyde Health Board [38]. RONC comprehensively rejected the wider public health role of the Health Visitor and in addition took the radical step of recommending making the discrete roles of the Health Visitor, school nurse and district nurse obsolete[37]. These roles were to be absorbed into a new service model, the generalist Community Health Nurse which if it had been implemented would have had a strong anticipatory care and chronic disease management focus. The combining of a clinical and a preventive role always had the potential of creating prioritisation problems for the community health nurse. What task should receive priority, administering an insulin injection or attending a vital community meeting to articulate the case for £20,000 of funding for a local food cooperative? The strategic work that Health Visitors do such as building social capital in deprived communities, tends to take much lower priority compared to nursing responsibilities which have major clinical consequences for the patient and legal consequences for the practitioner if not carried out immediately.

The scope of the literature review which legitimised the creation of a generic Community Health Nurse was restricted to looking at the key areas highlighted within Scotland's two

strategic NHS documents [40];[41]. These areas included: anticipatory care, managing long term conditions, managing hospital admission and discharge, supporting unpaid carers, the impact on patient outcomes when the nurse uses IT and reducing health inequalities. Of these key areas of community nurse activity, which are heavily clinically orientated, reducing health inequalities is the only key theme and characteristic that relates to the daily work remit of Health Visitors [42]. It is not surprising therefore that the Scottish Review's assessment on how health inequalities should be tackled was also heavily influenced by the strong anticipatory care approach outlined in these documents [40];[41].

For example, Scotland's strategic review of the NHS, 'Building a Health Service Fit For the Future', recommended that the health gap between rich and poor should be reduced by ensuring that those who live in deprived areas who are vulnerable to long term conditions should be systematically identified by means of anticipatory care and referred to the NHS at the earliest possible opportunity [40]. A recommendation which subsequently relies heavily on a pharmacological approach rather than a public health means to reduce health inequalities[43].

Anticipatory Care can be defined as 'the essential union of prevention with care and cure' [44] and was strongly emphasised throughout the Scottish Review of Nursing in the Community. If anticipatory care and not child health was the main remit of the recently proposed Community Health Nurse, one can see why the Review recommended that the discrete roles of the Health Visitor and the School Nurse which accounted for the preventative component of anticipatory care should be sacrificed in favour of absorbing them into the more holistic and dominant, care and cure element, by expanding the

district nurses role. Therefore the Scottish Review adopted the anticipatory care route and not the child health alternative to reducing health inequalities and was criticised for it. Concerns were raised about the over emphasis on co-morbidity to the detriment of a specific child health focus with regards to the proposed Community Health Nurse role [45];[46]. The lack of a child health and child protection focus to the role was a very real fear, especially with regards to the media criticism that was directed at child protection services in failing to prevent the tragic infant deaths in the Climbie and Baby P cases. A recent survey suggests that one quarter of Health Visitors thought a similar tragedy was 'somewhat' or 'very likely' to happen in their caseload [47]. In addition to this criticism, the influential Scottish Parliament's Health and Sport Committee outlined its concerns about young children with mental health problems slipping through the net due to an acute shortage of Health Visitors [48]; [49]. In response to these criticisms, the Scottish Government has now decided to abort the generic Community Health Nurse model and has charged the Modernising Community Nursing Board with the responsibility of coming up with a more acceptable model for Scotland instead [50].

The reason why there have been 2 separate reviews of community nursing and of Health Visiting in Scotland was because not every Scottish health board bought into RONC's vision, Greater Glasgow & Clyde, the largest health board in Scotland declined the invitation to participate as one of the Pilot areas. Instead Greater Glasgow & Clyde conducted their own alternative review of Health Visiting [38] and like the English Review [39] has decided to tackle health inequalities by means of attempting to uncouple the social class trajectory of the child from that of its parents by tapping into David Olds' child health evidence base of intensive family visiting [51]. This approach defined as

progressive universalism means reducing the health inequalities gap by providing support for all, but more intensive support for those who need it most [39].

The price that Health Visiting in Greater Glasgow & Clyde has had to pay for its survival is two-fold. The service is now located entirely in the Children and Family Services directorate which means that in some instances social workers are now in charge of Health Visiting teams, a factor which could compromise the much revered non stigmatised status which Health Visiting holds in the eyes of its client group[6];[52].

Greater Glasgow & Clyde have also brought Health Visiting's traditional cradle to the grave service and its wider public health role to an end by recommending that Health Visitors cease all non-child related services and concentrate exclusively on providing a domiciliary service for children up to the age of 19 and vulnerable families instead[38].

Within the English Review, the original New Labour vision of a wider public health role for Health Visiting has also been extinguished. The concept of wider public health working has been addressed under the euphemistic category of 'additional areas of practice' that 'Health Visitors or other nurses' can become involved in [39]. By using the term 'other nurses' when it comes to being involved in a wider public health role, the English Review strongly implies that the skills required to work at a group, community or a population level are somewhat inferior to those necessary to working with children and vulnerable families and can be delivered without undertaking the 45 weeks of specialist theory and practice to become a Specialist Community Public Health Nurse (Health Visitor). The recommendations contained in the Greater Glasgow & Clyde and the English reviews both confirm the observation that when put under fiscal pressure, Health

Visiting retreats into its child protection evidence base to justify its existence, rather than engaging with its wider public health role [53].

#### **4. Discussion**

It is clear from the recommendations made by the 3 reviews in Scotland and in England that Health Visiting is entering a very uncertain phase in its 150-year history. The recent aborted attempt in Scotland to reform community nursing, quite clearly demonstrates how the unintended consequences of devolved policy making, driven unlike the rest of Britain by an anticipatory care approach to tackling health inequalities nearly extinguished 150 years of the discrete health visiting role in the UK.

It is interesting to note that Health Visiting's recent makeover in Greater Glasgow & Clyde and in England has only been made possible because both reviews chose not to use the widely appraised Principles of Health Visiting [6] (see Figure 1) which were originally devised by the Council for the Education and Training of Health Visitors [42] as a template to structure its future. The four Principles consist of Health Visitors searching for health needs, stimulating an awareness of health needs, influencing policies affecting health and facilitating health enhancing activities [42]. Principles, if they had been used, would have stated that problems identified at a child health and vulnerable family level could also be addressed by searching for and acting on health needs, or influencing policy in the local community which could positively affect the health of every child. For example, family problems such as poor nutritional status, accidents in the home, road traffic accidents, damp housing and poverty can be addressed by Health Visitors working with other agencies to provide: healthy breakfast clubs to enhance the

nutritional and dental status of school children[54]; food co-operatives to encourage community uptake of fresh fruit and vegetables at wholesale prices[54]; road traffic calming measures to prevent road traffic accidents[55]; accident prevention equipment loan schemes to promote home safety[56]; negotiating the installation of central heating in a council estate[57] and welfare benefit screening to maximise the incomes of the poor[58]. These are just several practical examples of what can be achieved when Health Visitors are encouraged to work with other agencies for the benefit of every family in the community and not just the ones on their caseload. Of course, measuring how effective these projects are is also an urgent priority if this vision is ever going to materialize. As Elkan argues, Health Visiting research has been process and cost fixated to the detriment of measuring outcomes [59].

It could be argued that a properly resourced and trained community Health Visiting service has the legitimate status, the trust and the high levels of acceptability which are the essential pre requisites for successful partnership working at a domiciliary level and at a wider community level [60]. It is by using a partnership and empowerment model to assess the needs of children and families which enable Health Visitors to tailor the creation of new community services such as those mentioned to the needs of potential users which marks off their unique contribution to promoting public health. Paradoxically, cutting the thread which connects Health Visiting to its wider public health remit, diminishes its effectiveness and removes that unique strategic ingredient which identifies it as being the only branch of nursing that is able to provide community solutions which every family can access to problems identified at an individual level. If



the potential of the public health role of the Health Visitor is to be corralled within an exclusively ring fenced child health / vulnerable families remit - what future is there for Health Visiting? The Greater Glasgow & Clyde and the English reviews have ignored the importance of Health Visitors promoting public health at a strategic level by deeming the task to be so lacking in status and skill level that it can be delegated to non specialized nurses, how long will it be before the commissioning of other nurses forces Health Visiting to retreat from its last vestige of legitimacy – its child health heartland? As already mentioned, in some parts of the country, there are Primary Care Trusts which have ‘Health Visiting deserts’ where staff nurses who are cheaper to employ have now taken over the previous Health Visitor’s child health remit. This practice has been firmly rejected by 76% of parents who when surveyed stated that they wanted ‘parenting support and advice on their child's health and development from a trained Health Visitor with up-to-date knowledge’[61]. Only 33% of parents found staff nurses or nursery nurses as an acceptable substitute for Health Visitors [61].

The ditching of the highly criticised recommendations contained within RONC has ensured that the specialist skills of health visitors will not now be lost to Scotland [62]. Furthermore, recent firm pledges from both Labour [63] and Conservative parties [64] in England would also indicate that there is a future for Health Visiting as both parties have recommended increasing Health Visitor recruitment. However this has been counterbalanced by fears that there are new moves afoot to close the controversial 3rd part of the register - specialist community public health nursing [65]. The Community Practitioners and Health Visitors Association argue that if the 3rd part of the register did

close with no Health Visiting specific alternative opening in its place, that this would complete the 'legal abolition of Health Visiting' which would result in 'a loss of recognition of the unique characteristics of public health practice'[65]. In reality this could encourage even more commissioners and employers to employ cheaper, registered nurses who have no specialist public health qualification. It therefore appears that there are two very divergent policy agendas at work here. One which makes tackling health inequalities and child poverty by improving child health and parenting a top social policy priority whilst the other appears to be systematically running down the very service that has historically been charged with addressing this task in favour of cheaper less well trained substitutes. A point also noted by the recent House of Commons, Health Committee review into Health Inequalities [66].

## **5. Conclusion – a way forward?**

If the unimplemented vision of Health Visiting engaging with the full range of public health nursing activities outlined in the DOH continuum[3] (see Figure 2) is ever going to become a reality, immediate steps need to be taken to rethink what Health Visitors do, where they do it and who they do it with. This debate has already been kick started by the UK Public Health Association (UKPHA) Health Visiting special interest group who has posed some challenging questions [53].

Should Health Visiting be divorced from nursing? Who should employ Health Visitors – the health service, local authorities or the voluntary sector? Should there be a new College of Health Visiting to oversee recruitment, education, regulation and research? Should the entry gate be widened to include non nurses?

It appears that there are two priorities here which need to be urgently addressed. Firstly, reversing the dramatic decline in Health Visiting numbers and being better prepared to deliver the wider public health remit in the future.

### **Reversing the dramatic decline in Health Visitor numbers.**

One of the ways that this could be done quickly and effectively would be to rejuvenate an ageing workforce by widening the entry gate into Health Visiting by including applicants who are not nurses. If there can be a direct non nursing entry route into one of the most clinical of all nursing branches – Midwifery, then surely the time has come for the same to apply for the least clinical of all - Health Visiting?

According to the UKPHA it is no coincidence that the recent freefall in Health Visitor numbers overlapped with the closure of the separate Health Visiting register in 2004 [22]. Therefore the second solution to increasing Health Visitor numbers would be to re-establish its name in statute and by re-opening a discrete Health Visiting register. If NHS Managers and PCT Commissioners are to value Health Visitors instead of viewing them as a soft option when it comes to cutting back on services [67], Health Visiting's flagging legitimacy needs to be renewed and strengthened as a matter of utmost urgency if it is to make any meaningful contribution to tackling the raft of public health problems [68] which are expected to be unleashed very shortly as an estimated 3 million people in Britain become unemployed [69]. A re-opening of a discrete Health Visiting register and a renewal of the title in statute would also send a strong message to Primary Care Trusts,

that the Government does support qualified Health Visitors and doesn't approve of lesser trained nurse substitutes working with the under fives and their parents in their place.

**Being better prepared to deliver the wider public health remit in the future.**

There is a difference of opinion between the UKPHA and the CPHVA as to whether the public health role would fare better if Health Visiting divorced itself entirely from nursing [70]. This debate is crucial to the future vision of Health Visiting having a wider public health role. The UKPHA argues that it is the public health role and not the nursing one which makes Health Visiting unique and this could best be developed out with nursing. Furthermore, the UKPHA also argues that being closely tied into nursing is a marriage of inconvenience as it has resulted in the development of a limited medicalised public health role. Whilst agreeing with this analysis, the CPHVA does not share the view that a divorce from nursing would be in the best long term interests of Health Visiting [70]. Perhaps the answer lies in keeping Health Visiting within the nursing family but splitting up its public health role in two, by creating two separate but linked Health Visiting roles in recognition that perhaps the new role of the health visitor in England and Greater Glasgow & Clyde is too narrow to ever address a wider public health remit. One of these health visiting roles would be the domiciliary child health / child protection role which would continue as it is currently functioning in England and Greater Glasgow & Clyde Health Board. Working closely alongside the domiciliary Health Visitor would be the community Health Visitor who would not be GP Attached or have a case-load, thus removing some of the barriers which have constrained health visitors from addressing their wider public health remit in the past [32;33;34]. Therefore,

the only child health remit that the community Health Visitor would have, would be to develop a much more strategic way of working in accordance with the principles of Health Visiting [42] (see Figure 1) to seek tailored group, community and local policy solutions to child health or family problems identified by their domiciliary health visiting colleagues at a case-load level. The role of the community Health Visitor would also be responsible for influencing policy at a local level and instigating partnership working with local agencies to address the unmet health needs of marginalised groups within the community who fall out with the narrow child health / child protection remit of the domiciliary health visitor. Perhaps the Health Visitor student who came through the non nursing entry route might be best equipped to take on this community role which would be one way forward to ensuring that Health Visiting is better equipped to deliver on its wider public health role in the future.

A new College of Health Visiting could have responsibilities for health visitor recruitment, education and research. The College would also need to recommend gold standard recruitment levels throughout the United Kingdom and ensure that they were being met and lobby furiously if they were not being implemented. The College could also set curriculum standards for evidence based Health Visitor education and ensure that no Health Visitor in future feels ill prepared to take on a wider public health role. A College dedicated exclusively to the further advancement of Health Visiting set up along charitable status lines similar to that of the Queens Nursing Institute [71] could also stimulate Health Visiting's flagging research base particularly its wider public health role by funding the evaluation of good practice.

Only bold and imaginative strategic responses to these ideas, coupled with strong leadership and devolved Government endorsement, will secure the future of Health Visiting and shape its public health function throughout the United Kingdom above and beyond its 150<sup>th</sup> anniversary.

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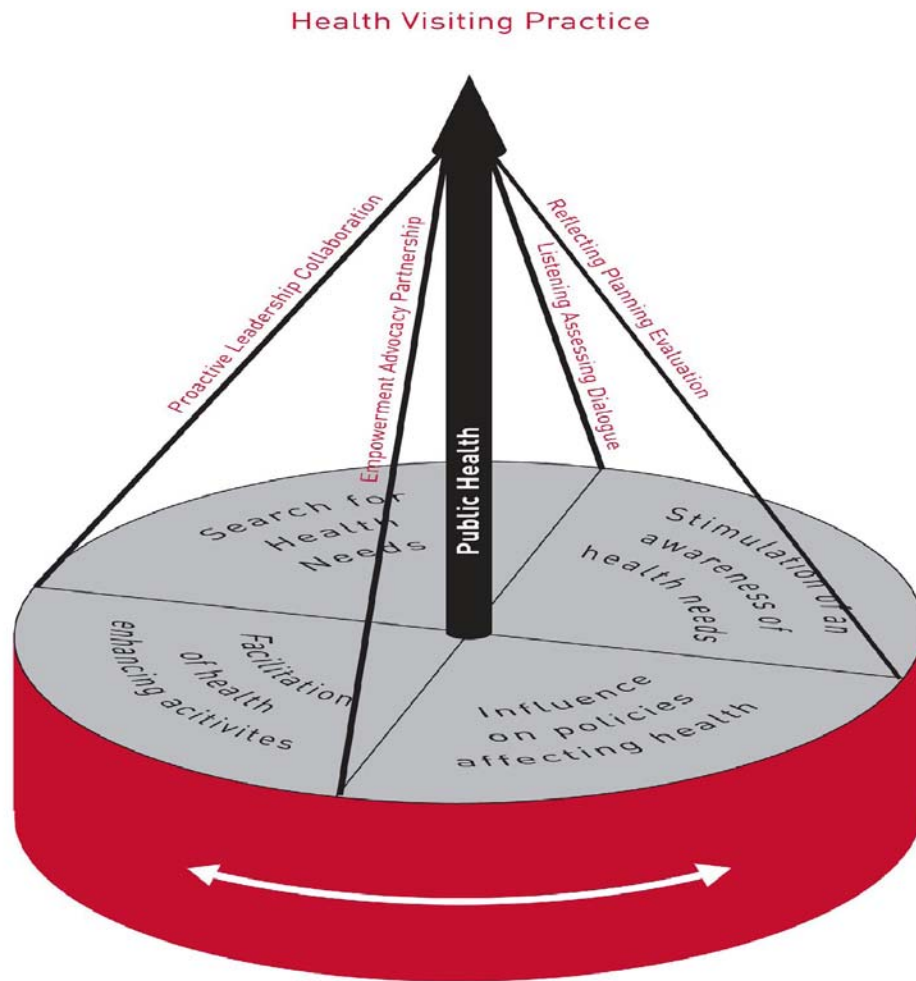


Figure 1  
Principles of Health Visiting Practice

## A continuum for public health practice in health visiting

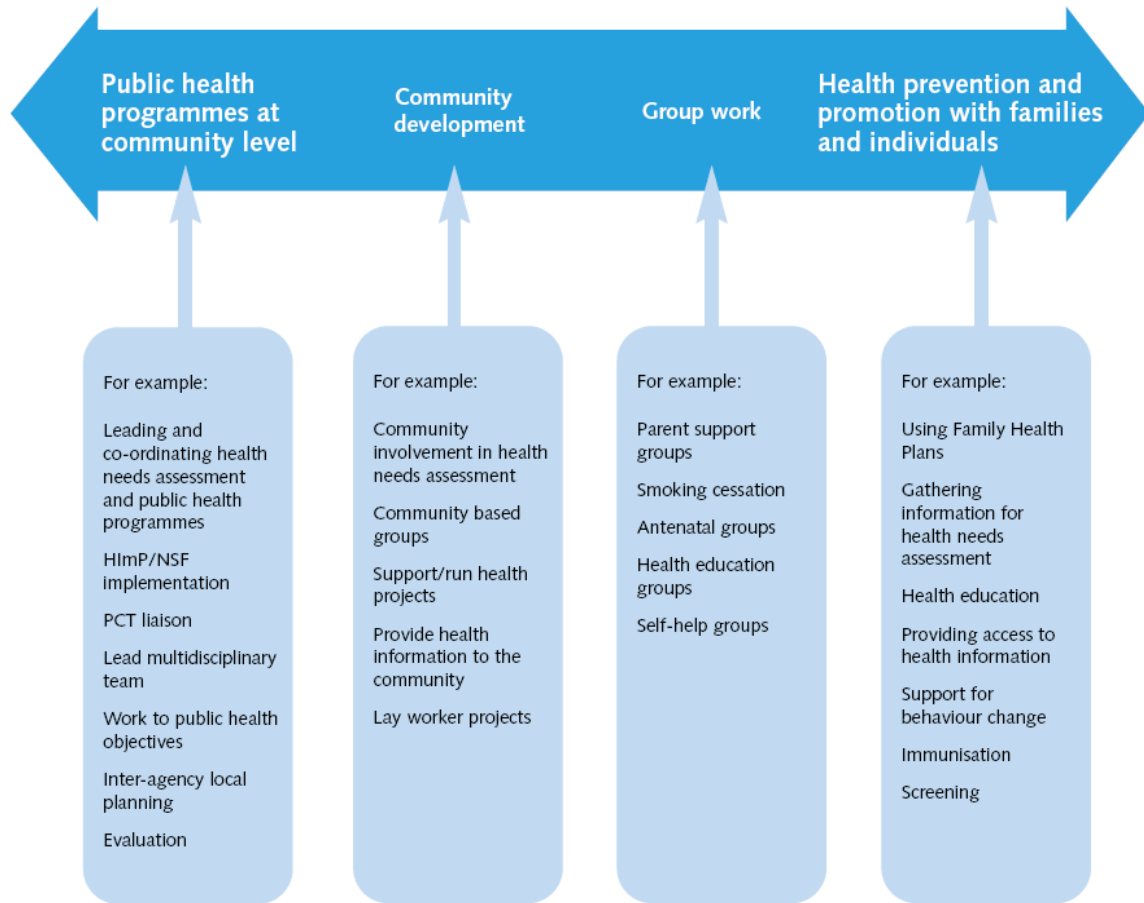


Figure 2  
A continuum for public health practice in health visiting.