CPHVA

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Professional Briefing:

The New Birth Visit

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Unite in Health Professional Officer Team



Introduction

Welcome to this professional briefing designed to help practitioners achieve and maintain evidence based, quality practice. This briefing is designed to be a source of reference and should be used to enable you to begin your enquiry. It is the start rather than the endpoint of your enquiry so you will need to access further sources of information depending on the specific information that you require. Unite/CPHVA hopes that you will use the information to:

- Raise the profile of the health visitor and health visiting services as the service with the required knowledge and skills to undertake this assessment visit safely and competently
- Raise the profile and importance of the new birth visit when seeking to engage and develop ongoing relationships with clients (mothers and families)
- Help you to influence and contribute to the thinking of managers and commissioners when they are seeking to make decisions about changing service design and delivery options.

Throughout this document the term new birth visit will be used to refer to the first contact with the client (mother) after the birth of the baby.

Policy

In past years the health visiting service was reduced in both size and scope of practice. Thankfully, as a result of research evidence and lobbying the National Health Visitor Plan, or Health Visitor Implementation Plan: a Call to Action[1] was launched in 2011. This document clearly articulated the expectation of the role for health visitors in the provision of public health services which includes 'full delivery of new model of health visiting including the universal elements of Healthy Child Programme'. Service design needs to be informed by the evidence base as commissioners and practitioners will want to offer services that are proven to make a difference to families and to be cost effective.

In addition to this, more recently services identified as the sole remit of the HV were further confirmed with the release of the Health Visitor Mandate in England in August 2014.[2] This identifies certain elements of the universal service of the 0-5 Healthy Child Programme[3] namely, the new baby review. This has been identified as an important time to provide parents with support, giving their baby the best start in life.

In the last five years there has been a change in the way that health visitor and health visiting services are delivered in all four countries of the UK. Key policy documents, HV Implementation plan in England, Healthy Futures NI, Getting it Right for Every Child, Scotland.[1, 4, 5] have identified the important role of health visitors in the early years and are implementing workforce changes to allow HVs to increase their capacity in order to deliver outcomes now apparent from the evidence base.

The New Birth Visit

This is a significant component of the work undertaken by all health visitors and has been throughout the service's history. The ante natal contact should be the first point of contact that a health visitor has with the woman. The new birth visit should be a subsequent visit with the mother, new baby and family. However, in some cases it is still the first visit, contrary to the Healthy Child Programme[3] which identifies first contact in the antenatal period. There is a challenge to achieving contact in the antenatal period; some of the things influencing the reduced potential for contact in the antenatal period are the increased mobility of people, their dependency on temporary housing and the number of women who choose to continue working until late in their pregnancy (36+ weeks gestation).

Much research relating to the new birth visit within the field of health visiting in the UK was conducted in the late 80s[6] and was within the field of public health nursing in Europe and the US. Many issues raised are still relevant to healthcare today. In 'Why Health visiting' 2013[7], a clear case is made of the value and skills used by a health visitor in areas such as the development of partnership working between client and practitioner and between practitioners working across professional boundaries.

The requirement to contact the mother following the birth of the baby dates back to the 1946 National Health Service Act.[8] Subsequent interpretation of the Act has meant that the contact results in a home visit, by the health visitor (home/welfare) which takes place between ten and fourteen days following the birth.

This is considered to be the ideal because it is the time at which care and direct involvement can be transferred from the midwifery service. However, in this era of evidence based practice, it must be acknowledged that continuing to do this activity with this timing is not well supported by evidence nor is there any evidence to say the time scale is an ideal time for assessment. However, it is also important to note that there is no research to revoke this timescale as the ideal time for this assessment either.

Many provider organisations in the UK are currently reviewing or have reviewed and changed the way in which they deliver this service. The key issues that were under review were the timing of the visit and the professional who undertakes it. The Healthy Child Programme clearly identifies this as the role and expectation of the health visitor but in a few circumstances may be done by the Family Nurse.

Anecdotal evidence suggests that is has been undertaken by community staff nurses and community nursery nurses. There is no evidence to support this practice, in fact the policy direction is clear, that this is within the health visitor remit. Unite/CPHVA is concerned that deviation from the health visitor as the professional who performs this visit seriously undermines the Healthy Child Programme and the Health Visitor Implementation Programme.[1, 3]

In the past the decision to not use a health visitor for these visits would have had a potential impact on the health and wellbeing of the children and family. This activity was apparently justified in situations where the family is deemed to be 'low risk', or 'routine'. However, decisions were based on a variety of information sources such as the woman's obstetric, medical and general history and history related to contact with other services, such as care services, this is not evidence-based. There is no doubt that this information is relevant to the overall assessment of family need but research finds it is of limited value when used in isolation of other important information. The current Healthy Child Programme[3] states that it should all be delivered and led (service) by the health visitor.

Also research has proven that tools used to make these decisions are inaccurate when used in isolation of a robust and holistic assessment.[9] Research has shown it is not possible or safe to label a client contact as safe or routine until it has been completed.[10] Thus, any health visitor decision made, which is based on limited information available is thereby placing the client (mother, child and family) at risk of breaching the NMC Code of Conduct and Ethics[11] because s/he is not able to justify the rationale for her/his actions if making a decision based on inadequate information.

A review of the literature relating to the new birth visit suggests that it concentrates on the timing of the visit at the expense of giving attention to the skills, knowledge requirements of the professional completing the visit, the rationale for the visit and the content and the outcome of the visit.[8, 11] However, these factors deserve equal consideration because they contribute to the success and effectiveness of the visit.

The literature states the new birth visit has three key functions. Firstly, it is an important time at which to develop a relationship with the mother and the family. It is also the time when an assessment of the baby's growth and development and the family situation is started. These key functions will be explored later in the following section.

Functions of a new birth visit

1. Relationship development
2. Assessing the baby's growth and development
3. Assessing the family situation in order to make a decision about the most appropriate care requirements, for example, core, targeted or intense service intervention.

1. Relationship Development

Research demonstrates that the foundations of an effective relationship between the mother and the health visitor, if not established in the ante natal period, are laid down during the new birth visit and continue to develop over time. This facilitates partnership working, client empowerment and trust. Even more than that, these foundations are strengthened if the health visitor uses the time during the new birth visit to try to 'get to know' the mother and share information about the health visiting service and how to use it.[13, 14, 15]. The importance of these features is illustrated in the Peckover study,[16] which demonstrates that mothers who had a good relationship with their 'named' health visitor chose to disclose domestic violence, and at this disclosure did not happen in situations where they did not have a good relationship. Similarly, Chalmers[17] proposes that there are three important phases of relationship development and progression through each of the phrases in turn enables the health visitor to feel confident that the client would, and could access the service when needed. This knowledge enables the health visitor to confidently reduce the level of monitoring/surveillance provided for families.[17, 18] (see table below.)

Table 1:
Relationship development during the first contact visit

Phase	Action
The entry phase	In which the health visitor is allowed to enter into the physical and emotional family environ ment. This is an important feature of the new birth visit because in situations where the health visitor is allowed into the physical environment only, the ability to fulfil the objectives of the new birth visit is severely restricted.
The health promotion phase	In which the health visitor is able to discuss strategies for health promotion that are relevant to the mother and the family. This may need to be focused on the child initially in order to encourage the mother to accept the advice.
The termination phase	In which the health visitor outlines the content and outcome of the visit and agrees an action plan with the mother. This should contain the details of how to contact the health visitor and reasons why people may want to contact her/him.

Source[17,18]

2. Assessing the baby's growth and development

The new birth visit allows the health visitor to see and examine the baby.[3] This one of the contacts that is most valued by mothers,[19] and is part of the healthy child programme.[3]

3. Assessing the family situation in order to make a decision about the most appropriate care requirements for example, core, targeted or intense service intervention (community, universal, universal plus, universal partnership plus.[3]

Health visitors gather information during the new birth visit that informs their decisions and judgements about the content of the care plan, and the care delivery programme and helps them to establish the urgency with which the service must respond to the client's needs [18, 19]. In practice, many consultations are complicated and it is imperative that the information that is collected is collated. This means that it is possible to identify what the information means to the mother, baby and the family in the context of their lives and the situation in which they are living.[10, 18] Following the findings of the assessment, the health visitor will agree a care plan in partnership with the client with onward referral if needed. It may be that there are other vulnerability tools that have been developed locally which the health visitor can use.

Purpose of the new birth visit

The health visitor must collect, analyse and critique the following categories of information during the new birth visit to ensure that s/he is able to maintain the health, well-being and safety of the mother, baby and family:

i. The mother's health and wellbeing - psychological, physical and emotional.

ii. The pregnancy labour and delivery including listening and reflection.

iii. Healthcare provided to the baby including newborn screening tests, the weight and condition of birth, establishing status of any known health problems, feeding types and patterns and progress since birth.

iv. Public health status of the family for example, the quality of the parental relationship, the presence of health challenges such as poor diet, obesity, smoking and drug use.

This will ensure that the health visitor is able to offer the mother, baby and family the service which will meet the needs that s/he has identified. The health visitor will provide information and factsheets on services that the family can access if in need of more support.

Line of accountability

Evidence suggests that in some organisations health visitors have been instructed to delegate the new birth visit to the community staff nurse or community nursery nurse members of the team where clients are considered to be 'low risk' or 'not vulnerable'. In these situations the health visitor is expected to make a decision about the forthcoming visit in terms of the anticipated outcome. For example a visit to a mother who has given birth to a second child may be considered low risk and meet the criteria for delegation. Other criteria for delegation may include the fact that there has been no known contact with social services, and that there are no known concerns in relation to the mothers obstetric, medical or general history. However, research states the decisions and judgements made using these criteria may result in practice which is outside of the Nursing and Midwifery Council's Code of Professional Conduct, and is unsafe and poor quality because each situation is different.[11] For example, the partner/father of the baby may be a different person, there may be different people living in the household since the birth of the first baby and social circumstances may be different since the birth of the first baby. The health visiting service may not be aware of these changes because they may not have been contact in the years preceding the birth of the second baby. It is imperative that due regard is given to the line of accountability in the situations. For example, accountability remains with the person delegating.[11] It is her/his responsibility to ensure that the person to whom s/he is delegating has the required knowledge and skills to undertake the task competently.

Furthermore, the health visitor must be able to justify her/his actions and non-actions in order to meet the requirements of accountability which is laid down in the NMC Code of Professional Conduct[11] and s/he will not be able to do this in the absence of all relevant information.

Comparison of the skills and knowledge provided during preparatory education programmes for nursing and specialist community public health nursing (health visiting)

Nurses and specialist community public health nurses (health visitors) complete very different programmes of education and thereby achieve different skills and knowledge on successful completion of the respective education programmes.[20,21] The following section will compare some of the skills and knowledge that the nurse and the specialist community public-health nurse will gain during their respective education programmes and be expected to illustrate at registration with the NMC. Specific proficiencies pertinent to the delivering the new birth visit have been selected to illustrate the way in which to disciplines may approach this area of practice (see table 2 overleaf). The comparison is provided here as a way in which to enable the reader to objectively consider the rationale for the decisions that s/he makes about delegating any work to other members of the team.

Competency: Fitness for Purpose and Practice

Competency is the term used by the NMC to describe the knowledge, skills and judgement that a practitioner has to enable her/him to practise safely and effectively.[9] Employers have a responsibility to ensure that the practitioners they employ have the skills to undertake the work that they are employed to do.

Furthermore, employers also have a responsibility to recognise and reinforce good practice and performance.[10] This will influence the decisions that are made about service delivery.

The following proficiencies are selected from the Standards of Proficiency for Pre-registration Nursing Education and the Standards of Proficiency for Specialist Community Public Health Nurses.[20,21] These documents outline the national requirements for registration of nurses and Specialist Community Public Health Nurses with the NMC.[20,21]

Table 2: Standards of proficiency for registered nurses & specialist community public health nurses (health visitors)

Competencies at registration		
Specialist community public health nurses/ health visitors	**Registered nurse**	**Correlation √**
Domain		
Search for health needs	**Care delivery**	
Collect and structure data and information on the health and well-being and related needs of a defined population.	Systematically collect data regarding the health and functional status of individuals, clients and communities through appropriate interaction, observation and measurement.	
Analyse, interpret and communicate data and information on the health and well-being and related needs of a defined population.	Seek specialist/expert advice as appropriate.	
Develop & sustain relationships with groups and individuals with the aim of improving health and social well-being.	Utilise a range of effective and appropriate communication and engagement skills.	
Identify individuals, families and groups who are at risk and in need of further support.		
Undertake screening of individuals and populations and respond appropriately to findings.	Provide support and education in the development and/or maintenance of independent living skills.	
	Develop and document a care plan to achieve optimal health, habitation and rehabilitation based on assessment and current nursing knowledge.	
	Identify expected outcomes, including a time frame for achievement and/or review in consultation with patients, clients, their carers, family and friends and with members of the health and social care team.	
	Contribute to the application of a range of interventions which support and optimise the health and well-being of patients and clients.	
	Analyse and revise expected outcomes, nursing intervention and priorities in accordance with changes in the individual's condition, needs or circumstances.	
	Demonstrate the ability to transfer skills and knowledge to a variety of circumstances and settings.	
	Recognise the need for adaptation and adapt nursing practice to meet varying and unpredictable circumstances.	
	Ensure that practice does not compromise the nurse's duty of care to individuals or the safety of the public.	
Stimulation of awareness of health needs		
Develop, sustain and evaluate collaborative work.		
Communicate with individuals, groups and communities about promoting their health and well-being.	Consult with patients, clients and groups to identify their need and desire for health promotion advice.	
Raise awareness about the actions that groups and individuals can take to improve their health and social well-being.	Identify and respond to patients' and clients' continuing learning and care needs.	
Develop capacity and confidence of individuals and groups (including families and communities), to influence and use available services, information and skills, acting as an advocate where appropriate.	Identify, collect and evaluate information to justify the effective utilisation of resources to achieve planned outcomes of nursing care.	
Work with others to protect the public health and well-being from specific risks.	Establish priorities for care based on individual or group needs.	
Influence on policies affecting health		
Work with others to plan, implement and evaluate programmes and projects to improve health and well-being.	Analyse and interpret data accurately to inform nursing care and take appropriate action.	
Identify and evaluate service provision and support networks for individuals, families and groups in the local area or setting.	Provide relevant and current health information to patients, clients and groups in a form which facilitates their understanding and acknowledges choice and individual preference.	

Develop, implement, evaluate and improve practice on the basis of research, evidence and evaluation.		
Facilitation of health-enhancing activities	Care management	
Work in partnership with others to prevent the occurrence of risks related to health and well-being.	Use appropriate risk assessment tools to identify actual and potential risks.	
Work in partnership with others to protect the public's health and well-being from specific risks.	Communicate safety concerns to a relevant authority.	
Prevent, identify and minimise risk of interpersonal abuse or violence, safeguarding children and other vulnerable people, initiating the management of cases involving actual or potential abuse or violence where needed.		
Plan, deliver and evaluate programmes to improve the health and well-being of individuals and groups.	Participate with members of the health and social care team in decision making concerning patients and clients.	
	Review and evaluate care with members of the health and social care team and others.	
	Maintain one's own accountability and responsibility when delegating aspects of care to others.	
	Demonstrate the ability to co-ordinate the delivery of nursing and health care.	
	Literacy: interpret and present information in a comprehensible manner.	
	Problem-solving: demonstrate sound clinical decision-making which can be justified even when made on the basis of limited information.	

Source [21,22]

Consideration of these proficiencies illustrates that nurses and specialist community public health nurses (health visitors) are educated to undertake similar areas of practice. However, further analysis of the proficiencies clearly illustrates that the depth of activity undertaken by each discipline is very different. For example, people on both programmes gain skills and knowledge which helps them to engage with clients about health promotion.

Stimulation of awareness of health needs

"Communicate with individuals, groups and communities about promoting their health and well-being" (SCPHN)[21].

Care delivery

Consult with patients, clients and groups to identify the need and desire for health promotion advice. (registered nurse)[22]

These examples clearly illustrate that health visitors are able to undertake health promotion activities in order to advance client health and well-being. However, nurses are prepared to offer health promotion advice. Both activities are important; however, professionals undertaking new birth visits need to be able to actively advance client health and well-being rather than merely offer advice about how to do so. This is especially important in situations where clients are only seen on one occasion.

These two documents clearly illustrate that the education programmes provide a different focus for each discipline. The registered nurse is prepared to undertake specific tasks, for example:

"Collect data"
"Use a range of communication and engagement skills"
"Identify and respond to patients"
"Use appropriate risk assessment tools"[21]

This means that a community staff nurse undertaking a new birth visit will adopt a task oriented approach based on the provision of specific instructions because this is the focus of the education programme that s/he has completed in order to become a registered nurse. Many organisations have tried to accommodate this by providing specific written instructions detailing a list of actions that must be completed and information that must be collected during a new birth visit. However, the community staff nurse may experience difficulties and may not be able to complete the task safely if information which is not on the checklist comes to light during the new birth visit. For example, this situation may arise when the client is unwell, when family circumstances and living arrangements have changed and someone is present in the home during the visit who is not known to the service. The community staff nurse will not be able to analyse this information or identify what it means because the education programme is not prepared to do this.

Conversely, proficiencies within the specialist community public health nurse (health visitor) programme prepare the health visitor to undertake a range of activities to achieve the outcome, for example,

"Develop and sustain relationships"
"Collect and structure data"
"Undertake screening of individuals and populations and respond appropriately to findings"
"Work in partnership with others to protect the public's health and well-being from specific risks"[18]

This means that the health visitor is able to approach the new birth visit in a holistic way which allows her/him to collect central, peripheral and previously unknown information in order to complete a comprehensive assessment. This enables the health visitor not only to collect the information but also to identify what it means in terms of the client (mother, baby, family) in the context in which they are currently living. The health visitor is also able to interpret information in order to make a decision about the service to offer. s/he is thereby able to make a judgement about when the situation must be reassessed in order to ensure that the client receives the level of service which best meets their health and well-being requirements.

Case scenario: A new birth visit to a mother who has just had a second baby and has no known/recorded obstetric, medical or social history which might lead to concerns about risk or vulnerability. This scenario is likely to meet the requirements for delegation of the new birth visit to the community staff nurse. However, once the visit is complete more information is collected which significantly changes the assessment of need for example:

The mother divorced the first child's father 18 months ago and has been with the current partner for just under a year. This is an unplanned pregnancy. Her partner has recently moved into the family home because he has been made redundant. The mother is the higher wage earner but has taken maternity leave to care for the baby. The relationship with her partner is fragile and they have been arguing a lot since he moved into the family home. The baby was born via normal delivery and weighs 2.5 kg 38 weeks gestation. Mum has decided to breastfeed because she was not able to do so following the birth of her first child.

Significant information

Fragile relationship

Changing family dynamics and composition of the household

Difficult financial situation

Baby's weight is low in relation to gestation all age

Potential difficulty with breastfeeding.

Analysis (establishing meaning)

Potential for relationship to breakdown which may impact on the first child as well as the new baby

Problems associated with dependence on financial benefits and limited income

Potential problems arising from the weight of the baby and not knowing why mum was not able to breastfeed her first baby.

This example illustrates the problems that may arise when a judgement is made purely on the basis of information that is known and recorded. The fact that a woman has had a baby already does not necessarily mean that they can be considered 'low risk' because family situations and social circumstances may change. Furthermore, it also illustrates the fact that a new birth visit does not merely require the person completing it to collect information. Rather, it requires a person to complete an assessment which involves collecting information analysing it to establish meaning and prioritising the different components in order to develop a care/action plan to meet the client's actual and potential health and social care needs.

Standards for Practice

The following section presents the proficiencies which most closely relate to the new birth visit and are used here to illustrate the way in which the health visitor has the knowledge of skills to undertake this area of practice competently. Findings from research and literature are also presented to illustrate the way in which the knowledge and skills linked to these proficiencies are used by health visitors in practice.

Search for health needs[20]

"Develop and sustain relationships with groups and individuals with the aim of improving health and social well-being"[10]

Peckover suggests[16] that clients who have a good relationship with their named health visitor chose to disclose domestic violence. This disclosure did not happen in situations where the relationship was not established and developed.

The presence of an effective relationship facilitates client empowerment, which encourages clients to work in partnership with the health visiting service during service delivery. [14,13,21]

Research suggests that the relationship is developed when health visitor actively listens to the mother, normalises the events, does not panic about what the mother is saying and acts in a friendly way whilst still retaining the requirement required client practitioner professional boundary. [12]

An effective relationship with the client also enables the health visitor to feel confident about went to terminate the contact.[17,18,23]

The knowledge and skills required to develop a relationship with another person are different from those required to communicate with another person. Hence, the registered nurse, following completion of the education programme is able to communicate with clients and

"Utilise a range of effective and appropriate communication and engagement skills"[21]

However, in order to complete the new birth visit competently and completely, research has shown that it is important to do more than communicate with the client.[16,17,18] Rather, it is imperative that the practitioner develops a relationship and maintains it over time.

Moreover, the proficiencies suggest that there are several activities involved in searching for health needs. For example, the focus may be on the individual, groups of individuals or data. Activities relating to these components may be undertaken in isolation or collectively. Again, the proficiencies illustrate that the nurse and SCPHN are able to undertake this area of practice at different levels. For example, the nurse is able to:

"*Use appropriate risk assessment tools to identify actual and potential risks*"[21]

This illustrates that nurses are able to identify risk when using specifically designed risk assessment tools. However, the health visitor is able to adopt a multi-focused approach to searching for health needs as illustrated by the proficiencies gained during the specialist community public health nurse education programme. For example:

"*Undertake screening of individuals and populations and respond appropriately to findings*"[21]

"*Collect and structure data and information on the health and well-being and related needs of a defined population*"[21]

Health visitors have been recognised as the lead professional for the delivery of public health focused child health promotion interventions.[1]

Hall and Elliman also state that is not possible to provide effective, quality services to children and families if they are based purely on a protocol driven process.[24]

It is difficult and inappropriate to anticipate the outcome of the new birth visit in advance of its completion.[9] Hence; it is not possible to diagnose the mother and baby as 'normal' before the health visitor has made the assessment even if the mother is having second or subsequent baby.[9]

Conclusion

The new birth visit is a significant contact with the mother, baby and the family. It is the time at which information about the mother, child and family must be collected, collated and the content analysed in order to plan immediate and long-term actions to meet actual and potential health and social care needs. Research and current health policy states that it is imperative that this important visit is undertaken by a practitioner who has the necessary educational preparation and expertise to complete it safely and competently.[1,17,18] This is a position which Unite/CPHVA is strongly committed to. The research and literature clearly illustrate that this person is the specialist community public health nurse (health visitor). This document has outlined the rationale for this decision by providing:

- An analysis of the characteristics of the education programmes which lead to a qualification as a registered nurse and those which lead to qualification as a specialist community public health nurse (health visitor)
- An analysis of the essential features of the new birth visit
- An analysis of the rationale for achieving the essential features during a new birth visit
- A review of the research and literature that illustrates the way in which the essential features of the new birth visit can be met and the outcome that can be achieved.

Health visitors in practice must take care to ensure that they are able to justify the actions and the non-actions that they take in practice in order to work within the Nursing and Midwifery Council Code of Professional Conduct and thereby be accountable to the profession, the employing organisation, the regulator and their colleagues.[11]

It is anticipated that the information within this document will provide health visitors in practice with the necessary information to respond to unreasonable calls from managers and commissioners to delegate the 'normal' new birth visit to other community staff members of the health visitor team.

Recommendations

1. The health visitor must work within the realms of the Nursing & Midwifery Council's Code of Professional Conduct and is accountable for the tasks that s/he delegates to junior members of the team irrespective of the instructions which s/he receives from managers/commissioners. For this reason the health visitor must be able to justify the actions and the non actions that s/he takes in practice. It is not sufficient defence to state that the task was delegated in line with the organisation's instructions.[10]

2. Health visitors must have a clear understanding of their skills and knowledge and be able to articulate this to managers and commissioners in order to help them understand the tasks that can and cannot be delegated when providing evidence-based, safe and quality services to clients during the new birth visit.

3. Community staff nurses must work within the realms of the Nursing & Midwifery Council's Code of Professional Conduct and must therefore understand and clearly articulate the ways in which they are working in a responsible and accountable way within the health visitor team.

4. Health visitors must take steps to be actively involved in the discussions about service design and delivery especially where this impacts on their professional accountability and the regulatory status of the profession. It is not sufficient to merely choose not to engage with unfavourable organisational and operational change that is taking place.

5. Service reviews and operational changes must be based on evidence from research and the literature in order to ensure that service provision is safe and appropriate for the client group.

6. Service development projects which assert that the new birth visit can be classified as 'normal' in advance of it taking place are incorrect, inappropriate and unsafe, and should **not** be part of current evidence based practice.

7. The new birth visit is a valued and important contact for mothers, children and families following the birth of a baby and the needs presented during the visit may be different each time it takes place. Therefore new birth visits to mothers who have had a second and subsequent baby should not be classified as 'normal' until the visit has been completed.

8. The label of 'normal' cannot be allocated to the new birth visit for a client (mother, child, family) who has had more than one baby in the absence of further essential information. Hence the label of 'normal' should not be allocated to visits in the absence of other essential information.

9. The new birth visit is the time at which information is collected, collated and analysed in order to make a decision about the service to provide, and the timescale for provision. Managers and commissioners must be helped to identify the complex nature of the information collected at this time and the need to obtain this information in order to successfully meet the health and social care needs of the client.

10. Health visitors must take steps to actively engage with the research and literature in order to keep up-to-date with developments in relation to the new birth visit. (Hence this professional briefing should be used as a starting point and not the only source of evidence to support engagement with managers and commissioners.)

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The Community Practitioners' and Health Visitors' Association (CPHVA) is a professional section of Unite Health Sector which has about 100,000 members working in the health sector. Unite/CPHVA is the third largest professional nursing union and is the only union which has public health at its heart. Unite/CPHVA is the UK professional body that represents registered nurses, community nursery nurses and health visitors who work in a primary or community health setting.

The sector is itself part of the Unite trade union with 1 million members nationwide.

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