Royal Cornwall Hospitals
NHS Trust

Screening for Newborn Infant Physical Examination (NIPE) Clinical Guideline

V5.2

November 2025

Summary Flowchart

Where possible, arrangements for the NIPE should be made with the parents on the day of the baby's birth and prior to discharge from hospital.

Eligible population: All babies born in RCHT managed area or receiving post-natal care by an RCHT employed midwife, to be offered NIPE, with parents' consent, to be completed within 72 hours of age.

Declines: If screening declined: Enter onto SMaRT4NIPE (S4N) system. Decline letter sent and email screening team to inform of decline.

Babies born in the community or a cross-border hospital.

Any baby discharged without a NIPE examination.

All NIPEs must be completed for babies on Wheal Fortune, prior to discharge. For babies in other areas, every effort should be made to complete NIPE prior to discharge and definitely if being discharged beyond 24 hours.

NIPEs for these babies should be completed in the community setting.
If discharged after 24 hours without a completed NIPE, complete Datix report.
Liaise with community team prior to discharge to organise a NIPE in the community within 72 hours of birth via on-call community team leader in daytime hours (see daily staffing sheet).

If midwife providing postnatal care to the baby is NIPE trained, the opportunity should be taken to complete NIPE check.

Screen negative: Routine child health surveillance, NIPE at six to eight weeks.

Screen positive: Refer as referral pathway (Appendix 4).

All examinations must be entered on the S4N system at the time of the examination.
If examination is being completed in the home or at a base where S4N is not available, or if the NIPE failsafe system S4N is not working, then a paper copy of the NIPE documentation can be found on TR11/MIDWIVES/SCREENING/NIPE.
Please email Screening with patient details and any referrals made, so the failsafe system can be updated once S4N working.

1. Aim/Purpose of this Guideline

1.1. A full physical examination of the newborn (NIPE) within 72 hours after delivery is the required Standard of the UK Public Health England Screening Programme. The dual purpose of this examination is to confirm normality, thereby reassuring parents and carers, and to identify and act upon any abnormalities.

1.2. This guideline applies to all RCHT medical staff, advanced neonatal nurse practitioners (ANNPs), neonatal nurses and midwives qualified to undertake examination of the newborn where the Trust supports them in this role.

1.3. Full newborn examination is in addition to the initial examination undertaken by the midwife or neonatal team member directly following birth and in addition to examinations for any medical concerns at birth.

1.4. This guideline details who can perform a NIPE screen, timing of the NIPE examination, details of the examination required, recording the examination findings on the 'SMaRT 4 NIPE' (S4N) system and referral pathways.

1.5. This version supersedes any previous versions of this document.

1.6. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. Guidance

2.1. Information and verbal consent for routine NIPE screening should be gained from the parent/guardian prior to the screening examination wherever possible. Please provide written information in a timely manner prior to the NIPE examination being performed (Inpatient and Outpatient NIPE information leaflets) Additional information is available for parents of babies who are on the neonatal unit https://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-babies-in-special-care-units. If screening is declined, inform the screening team via email, a decline letter should be sent to the parents/guardians and a copy to the General Practitioner (GP), Health Visitor (HV) and Child Health Information Service (CHIS). A follow up examination should be offered at six to eight weeks with the GP. Update S4N by entering 'No' in the consent box and update the Child Health record and local patient notes with the reason for decline.

2.2. In the last month of pregnancy parents should be redirected to the post-natal section of 'screening tests for you and your baby'. Parents whose baby has been admitted to NNU (Neonatal Unit) should be directed to 'screening tests for you and your baby in special care units'.

2.3. **Timing**

The first full physical newborn examination should be performed within 72 hours of the baby's birth. There is no lower age limit on undertaking the Newborn Examination (NEW 2024). Screening may be delayed where a clinical decision is made because the baby is 'too young' or 'too ill' for NIPE newborn screening.

'Too young' is defined as babies born < 34 weeks gestation. Screening may be delayed until these babies reach ≥ 34 weeks and zero days (34^{+0}) gestation.

'Too ill' screening should be completed as and when the baby's condition allows.

If the baby is born in the community, then the responsible midwife should arrange for the baby to be examined in the Community setting. All examination findings to be recorded on the S4N National Database see Section 2.9.

2.4. **Training and maintaining competencies**

2.4.1. Midwives and Nurses receive training by undertaking an Examination of the Newborn (NIPE) university accredited course. On completion of this and/or are new to the trust they are required to undertake (NEW 2024).

- Attendance of face-to-face local half day training- run quarterly.
- Completion of Electronic Learning for Health NIPE module.
- Complete the NIPE Competency Framework.
- Complete NIPE Peer Review Framework with Neonatal Consultant NIPE Lead, ANNP NIPE Lead or senior Neonatal team member.

- Send all completed documents to screening team.

- Local e-learning package on the use of S4N and the Maxims referral process, completion of this will generate an S4N username and password allocation by the Screening Team.

2.4.2. All NIPE practitioners at RCHT wishing to maintain their competency and remain on the RCHT NIPE register must complete yearly:

- Attendance of face-to-face local half day training.

- Completion of Electronic Learning for Health NIPE module.

- Complete the NIPE Competency Framework and send completed documents to screening team.

2.4.3. Failure to complete the above within 18 months of the last update will result in being removed from the NIPE register.

2.4.4. If a practitioner has had a period of more than six months and is in date with training without completing a NIPE, then it is advised that that the practitioner completes a peer review assessment with Neonatal Consultant NIPE Lead, ANNP NIPE Lead or one of the senior neonatal team, to update their clinical practice.

2.4.5. This information will be recorded on the NIPE Midwife practitioner's database, held by the screening team. A team of experienced NIPE examiners will be available within both hospital and community settings to provide mentorship and peer review support for:

- Midwives undertaking a university accredited module.

- Preceptee midwives undertaking competency cases.

2.4.6. All training and competency documents can be found in TR11/MIDWIVES/NIPE ADMIN.

2.4.7. A risk assessment for maintaining competency has been undertaken for the Neonatal team. It is encouraged but not mandatory that the Neonatal team complete the above processes to demonstrate competency and continuous professional development.

2.4.8. Junior doctors/core trainees training in paediatrics receive a specific neonatal/postnatal ward induction programme which includes supervised neonatal examinations and have the backup of Specialist Registrars, ANNPs and Consultants whilst competency is achieved and throughout their placement.

2.4.9. ANNPs receive initial training as part of the neonatal nurse practitioner programme and continuous practice maintains their competence alongside attendance at the annual update sessions.

2.5. **NIPE Senior Team**

Neonatal Consultant- Clinical NIPE Lead.

ANNP- Deputy Clinical NIPE Lead.

Antenatal and Newborn Screening Co-Ordinator- NIPE Programme Lead.

2.6. **Examination of the Newborn**

2.6.1. Ensure parents have reviewed the post-natal section of 'screening tests for you and your baby' and received the local information leaflets regarding the NIPE examination (Appendix 7) prior to the NIPE being performed.

2.6.2. An important element of the examination of the baby includes a discussion with the mother/ parents around family history including BCG (Bacillus Calmette Guerin) risk factors and any antenatal/ maternal concerns. The woman's handheld notes, electronic record and/ or maxims should be checked for an antenatal plan of care for any suspected/ known problems. Any such information should be documented in the neonatal notes and consulted for guidance and planning.

2.6.3. The practitioner should have increased vigilance during the examination if one or more of the risk factors are present:

- Chromosomal or genetic anomalies.
- Trisomy 21 is classed as 'screen positive' and should be managed separately.
- Family history in first degree relative of history of heart muscle or electrical problems of the heart.
- Parental consanguinity.
- Maternal exposure to viruses.
- Maternal conditions such as diabetes, lupus and epilepsy.
- Teratogenic drugs taken in pregnancy.

2.6.4. The NIPE examination should include heart, eyes, hips, and in male infants, examination of the testes.

The examination should also include:

- Review family, maternal and perinatal history, plot birth weight and head circumference in the child health record or on NHS growth charts and document in notes section on S4N.
- Ascertain any carer's anxieties and observe interaction with the baby.

- Feeding method and any concerns.
- Undress baby completely during the examination.
- Check if baby has passed meconium and urine. If baby has not passed meconium within 48 hours of birth, refer immediately to the ANNP or Registrar on neonatal unit for review. Document this on S4N.
- Observe baby's general condition: colour, breathing, behaviour, activity, posture and cry.
- Examine the exposed parts of the baby first: facial symmetry, scalp, head, including fontanelles, nose, mouth including visualising the palate**,** tongue and gums, presence of suck reflex, position and placement of ears.
- Examine the baby's **eyes** for size, position, symmetry of the eye size and cornea, absence of discharge, red reflexes (using an ophthalmoscope) and note any subconjunctival haemorrhages.
- Palpate the neck and clavicles, check limbs, hands, feet and digits, assessing proportions and symmetry.
- Assess the cardiovascular system- colour, capillary refill time, heart rate, size and shape of chest, brachial and femoral pulse volumes, auscultate **heart** for rate, rhythm, and any added sounds, position of cardiac apex.
- The key areas for auscultation are upper right sternal edge, upper left sternal edge, lower left sternal edge, the apex and mid scapulae.
- Undertake pulse oximetry, record and compare oxygen saturation readings from the RIGHT hand to a reading from either foot are both over 95% and less than 3% of each other.
- Respiratory effort and rate, listening to air entry across chest fields and symmetry of chest movement.
- Observe the baby's abdomen- palpate to identify any organomegaly, masses or hernia. Examine the umbilical cord.
- Observe the baby's genitalia and anus, to check normal appearance, positioning, and patency.
- Palpate **testes** in male infants for presence or undescended position (see appendix 5). Observe the scrotum for symmetry, size and colour.
- Inspect the bony structures and skin of the baby's spine, noting on the RCHT body map (see appendix 5) any birth marks, sacral dimples with the baby prone.
- Note the colour and texture of the skin as well as any birthmarks or

rashes.

- Observe tone, behaviour, movements and posture to complete the assessment of the central nervous system (CNS).
- Check **hips**, symmetry of the limbs and skin folds and any restriction in the abduction of the hips. Perform Barlow and Ortolani's tests.
- Consider any specific known risks in the baby's home, and alert appropriate professionals to parents who may have problems in caring for their baby.
- Ensuring that parents know how to assess their baby's general condition and access help and inform them of the next Child Health Surveillance planned review.

2.7. **Abnormalities detected on screening process for referral for further medical investigation, treatment or care if required**

2.7.1. See Appendix 5 for specific NIPE referral system pathways for screen positive baby.

2.7.2. Non urgent referrals should be within normal working hours where possible, Urgent referrals can be made at any time via the neonatal registrar/ANNP or consultant.

2.8. **Communication and Documentation**

2.8.1. The examination should be recorded onto the baby's online S4N record with printouts and filed into the babies Child health record and main hospital notes (if in hospital).

2.8.2. If an anomaly or risk factor is identified, the parents should be informed and any plan for investigation, treatment or care discussed and documented in the neonatal notes and Child Health Record, with relevant written patient information provided. All entries should be dated, timed, and signed with name and designation printed.

2.8.3. The baby's S4N record should be updated, recording any referrals made in the S4N system/Maxims discharge letter/Badger discharge letter as appropriate. Any senior review completed also needs to be updated on the baby's S4N record and in the baby's neonatal notes by the NIPE examiner and/or senior reviewer. Clear communication as to who's responsibility this is following the review is essential.

2.9. **SMaRT 4 NIPE (S4N) system**

2.9.1. **Training**

It will be the responsibility of the Health Professional undertaking the examination to record the findings of the examination on the S4N IT system.

All staff undertaking NIPE will receive training in the S4N system by online training. Contact screening team for details on how to access the training. On successful completion of the training, a username will be generated by the screening team and sent to the staff member.

2.9.2. Accessing S4N

Once training has been received, the S4N application should be downloaded on to your desktop from the RCHT applications catalogue.

There are a number of user guides available on the resource page of S4N to assist with any training needs on S4N.

2.9.3. Password generation

Once S4N training has been completed a username will be generated and emailed via an nhs.net email address

The username should be typed in to S4N and 'forgotten password' selected.

2.9.4. Documentation

The NIPE examination should be completed at a site with access to the S4N system and entered real time. If not possible, the examination should be documented on the Infant Record Form and details entered onto the S4N system, as soon as reasonably possible, remembering to add date and time the examination was completed.

If S4N is unavailable, the NIPE should be documented on a paper form, this can be found under TR11/SCREENING/NIPE. In addition, an e-mail should be sent to the screening team with the baby's details, outcomes of the NIPE, and any referrals in order for the local failsafe to be updated.

Once the examination is complete the following documentation should be generated.

2.9.5. Babies who screen negative and without risk factors:

NIPE Examiner print one A5 form and one A4 form.

A5 forms (inpatient and outpatient):

- To be inserted into the Personal Child Health Record (PCHR) 'red book' to be inserted by NIPE examiner or handed to parent if book not available.

A4 form (inpatient only):

- To be inserted in the baby's medical records by NIPE examiner.

2.9.6. Babies who screen positive or have risk factors for hip, heart, testes or eye follow guidance in NIPE Referral Pathway, see Appendix 5.

2.9.7. Please attach the sticker with the screening failsafe number (Appendix 9) to the inside cover of the Child Health Record 'Red book' for parents to follow up any outstanding appointments made from the NIPE examination.

2.10. **Daily NIPE check list**

- The UK National Screening Committee (UKNSC) policy for NIPE is that all eligible babies will be offered screening. The screening should be offered and completed within 72 hours of birth.

- Weekdays the NIPE Failsafe Officer will generate a list of any outstanding NIPE's and communicate this as early as possible to the on-call matron, individual community teams and Neonatal team in order for those individual teams to make plans for the NIPE to be completed.

- Weekends and bank holidays the NIPE midwife will generate the outstanding NIPE list and will be responsible for communicating any outstanding NIPE's with the neonatal unit. In addition, the NIPE midwife will join the community Midwife weekend huddle to distribute any outstanding NIPE's to the community teams and be available perform any NIPE's that can't be completed in the community.

- For those babies leaving the hospital without a NIPE examination please attach a NIPE sticker (Appendix 8) to the front of the green handheld notes alerting the Midwife and parents as to when the NIPE should be completed by. Please ensure that the parents have a NIPE leaflet (Appendix 7).

2.10.1. **Babies < 48 hours old:**

- These babies are between birth and 48 hours old. Any babies in this group and still in hospital should be added to the daily NIPE work list by the designated daily NIPE midwife.

- If baby is in the community, the midwife should arrange for examination to be completed.

2.10.2. **Babies 48-72 hours old:**

- These babies are between 48-72 hours old and it is the responsibility of midwife caring for woman and baby to ensure that the NIPE check is done before 72 hrs of age consider escalation to the team leader and/or matron so that a NIPE trained practitioner can be sourced to complete the NIPE within the 72 hour time frame.

- If baby is in NNU and their condition does not allow for the NIPE examination, mark this on the S4N system with the mitigations of 'too ill' or 'too young'.

2.10.3. **Babies over 72 hours old:**

- These babies are over 72 hours old and have breached the 72-hour standard.
- If baby is in hospital and their condition allows, ensure baby is examined the same day/ as soon as possible.
- If baby is in the community setting midwife must make arrangements for baby to be examined ASAP, either in the community setting or the hospital setting. This check must take priority. The reason for the breach of 72 hours will be recorded in S4N, this is a mandatory field.
- Complete a Datix and e-mail the screening team with the outcomes and reasons as to why the NIPE was not completed within 72 hours.

2.11. **Declines (see Appendix 6)**

If parents decline part or all of the NIPE examination for their baby the parents should be fully informed of the different elements of the newborn examination and why screening is offered, ensure this is recorded in the S4N system by:

- Selecting decline.
- Complete reason.
- Save (directly from risk factor tab).
- Then press 'save and exit'.

The daily checks by the failsafe team will identify if parents have declined an examination. A declines letter will be sent by the team to the parents, GP and Health Visitor.

Parents should be informed that their baby will remain eligible for a NIPE screen up to six weeks of age and can change their mind at any point in time.

2.12. **In the event of a baby who is deceased**

Ensure this is recorded on S4N and removed from any worklist immediately to prevent any further distress to parents as they may be contacted to arrange screening.

2.13. **Transfers in and transfers out**

If a baby is transferred to another care provider prior to the completion of screening. The formal handover must include information about NIPE. The transfer must also be completed on S4N to the care provider. If a baby is transferred in from another care provider, information about NIPE status must be requested, if NIPE has been complete, information about whether a positive or negative screen and the requirements for any referrals.

2.14. **Babies moving in less than six weeks of age.**

Contact should be made with the parents and enquire whether baby has received a NIPE examination. If no NIPE has been completed offer an appointment at the next available outpatient's clinic on NNU or if baby still under midwifery care arrange for a NIPE examiner to contact the parents.

2.15. **Screening failsafe**

- **Daily:** Monday to Friday (excluding bank holidays) the screening team will download the daily worklist and ensure that all eligible babies have an appointment planned within the 72-hour time frame. Communication to take place with the wards, matron on call, community teams and neonatal unit to ensure arrangements are in place for the examination to be completed. Daily download of births from RADAR and uploaded into local tracker. Each S4N record will be accessed to identify whether a screen negative or screen positive result. For screen positive babies, the failsafe team will ensure that all appropriate referrals have been made and that appointments have been generated within the correct time frame. Outcomes are entered into S4N on a regular basis as appointments are attended.

- Check S4N for any babies transferred in, check NIPE status and action any referral requirements.

- Check S4N for any transfers out, make contact with the receiving units screening team and inform them of NIPE status and any referral requirements.

- Check for any movers in under six weeks of age.

- Check S4N for any parents declining NIPE for their baby and follow declines process (Appendix 6).

- **Weekend/ Bank Holidays:** Midwife who is rostered for the unit NIPE checks will print off the daily work list from S4N and ensure that all eligible babies have a plan in place for NIPE to be completed within the correct time frame. NIPE unit Midwife will attend the community huddle to communicate any outstanding NIPE's in the community and make a plan if unable to be facilitated by offering appointments in the acute unit by the unit NIPE Midwife. Escalation will take place to team leaders and matrons of any outstanding NIPE's without a plan for the NIPE to be completed within the 72-hour time frame.

2.16. **Key Performance Indicators (KPI's) and National Standards**

These are national standards set by the national screening committee. These can be found here: Newborn and infant physical examination screening programme supporting information from 1 April 2024 - GOV.UK. (NEW 2024).

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Babies who screen positive or with suspected abnormalities of the eyes, heart, hips and testes have been referred in line with the local and national standards and guidance.
Lead	Screening Team.
Tool	• Screen positive/ suspected eyes abnormalities seen in line with the referral pathway. • Screen positive/ suspected hip abnormalities/ risk factors seen in line with the referral pathway. • Screen positive/ suspected cardiac abnormalities/ risk factors seen in line with the referral pathway. • Screen positive/ suspected testes abnormalities/ risk factors seen in line with the referral pathway.
Frequency	Quarterly check as part of KPI process.
Reporting arrangements	A bi-annual report will be presented at the post-natal operations group and included in the biannual report at the Antenatal and New-born Screening Board and the annual report. A screening assurance report is presented annually to the Women's and Children's Care Group Meeting. Results from this compliance monitoring will be included in these reports.
Acting on recommendations and Lead(s)	Any deficiencies identified will be discussed at the post-natal operations group and an action plan agreed. Action leads will be identified and a time frame for the action to be completed by. The action plan will be monitored by the postnatal operations group.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within a time frame agreed on the action plan. A lead member of the group will be identified to take each change forward where appropriate. The results of the audits will be distributed to all staff through the newsletters and team/ward meetings.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Screening for Newborn Infant Physical Examination (NIPE) Clinical Guideline V5.2
This document replaces (exact title of previous version):	Screening for Newborn Infant Physical Examination (NIPE) Clinical Guideline V5.1
Date Issued/Approved:	November 2025
Date Valid From:	November 2025
Date Valid To:	February 2028
Directorate / Department responsible (author/owner):	Newborn Screening Coordinators and Charlotte Lea; Neonatal Consultant
Contact details:	01872 253092
Brief summary of contents:	Performing a newborn examination using the NIPE smart database system, referral pathways, NIPE clinics.
Suggested Keywords:	Newborn, neonatal, NIPE, NIPE Smart, Midwife examination, referral.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Neonatal Audit and Guidelines Group. Maternity Guidelines Meeting.
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	None required
Related Documents:	1. Newborn and infant physical examination screening standards valid for data collected from 1 April 2021 to 31 March 2024 - GOV.UK.

Information Category	Detailed Information
	2. Newborn and infant physical examination: programme handbook - GOV.UK. 3. National Institute for Health and Clinical Excellence (2006) CG 37 Postnatal care: routine postnatal care of women and their babies London:NICE www.nice.org.uk. 4. National Screening Committee: Newborn and Infant Physical Examination guidance (2106): Newborn and infant physical examination: clinical guidance - GOV.UK. 5. Lee T., Skelton R.,Skene,C. (2001) Routine neonatal examination:effectiveness of trainee paediatrician compared with advanced neonatal nurse practitioner Archives of Disease in Childhood: Fetal and Neonatal edition Vol85.no 2 pp F100-104. 6. Lomax,A (2001) Expanding the midwife's role in examining the newborn British Journal of Midwifery Feb, vol 9.no 2 pp 10-102.
Training Need Identified?	Yes- accredited course/ module for accreditation for midwife NIPE checks.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/Newborn Care

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
August 2013	V1.0	Initial Issue. Neonatal Referral Pathway (NIPE) clinical guideline.	M.Denholm, New-born Screening
March 2017	V2.0	Addition of full new-born examination, NIPE Smart system, clinic information and updated referral pathways.	Judith Clegg, ANNP Jan Clarkson, New-born screening.

Date	Version Number	Summary of Changes	Changes Made by
February 2018	V3.0	Clarification of referral pathways and use of NIPE Smart records/forms/letters (Appendix 5). Alteration of criteria for midwife NIPE. (Appendix 3). Amended Appendix 4 pathways.	Judith Clegg, ANNP. Jan Clarkson, New-born Screening.
August 2018	V3.1	Undertake pulse oximetry, record and compare oxygen saturation readings from the RIGHT hand to a reading from either foot are both over 95% and within 3% of each other.	Clare Sizer, Patient Safety Midwife
February 2019	V3.2	Change to the title to add 'Screening for' at the beginning.	Jenny Stevenson and Jan Clarkson Antenatal Screening Midwives.
January 2020	V3.3	Change to training section to include annual updating sessions. Change to referral process for family history of cardiac condition. Change to physio referral process from paper referral to maxims referral.	Jan Clarkson, Antenatal and New-born Screening Midwife
August 2020	V3.4	Changes to exclusion criteria. Changes to physio referral services. Changes to declines process.	Jan Clarkson, Antenatal and New-born Screening Midwife
September 2020	V3.5	Timeframe for NIPE reduced from six hours to two hours throughout.	Jan Clarkson, Antenatal and New-born Screening Midwife
September 2021	V4.0	Updated in line with new national handbook and screening standards and upgrade of S4N IT system.	Jan Clarkson, Antenatal and New-born Screening Midwife
March 2022	V4.1	Statement in flow chart about paediatric team doing any NIPE when seeing patient removed.	Dr. Christopher Bell; Neonatal Consultant

Date	Version Number	Summary of Changes	Changes Made by
May 2022	V4.2	Appendix 5 Table: 'NIPE Pathways for Hospital and Community Referrals'. Alternations to initial actions and Maxims referrals. Updated Directorate / Department responsible (author/owner).	Ruth Naunton, Antenatal and Newborn Screening Coordinator
June 2023	V4.3	Change of language to 'atypical genitalia', physio referral for clavicle fracture moved to top priority. Exclusion criteria updated in appendix 4. NIPE pathways for hospital and community referrals table updated. SpR amended to neonatal tier 2 (ANNP middle grade doctor).	Dr Charlotte Lea; Neonatal Consultant
January 2025	V5.0	Updated throughout. Addition of appendices 7, 8 and 9.	Ali Gentle; Antenatal and New-born Screening Midwife
March 2025	V5.1	Update to appendix 5, regarding cardiac conditions.	Sam Padmanabhan; Paediatric Consultant
August 2025	V5.2	Significant laceration or bruising causing skin breakdown pathway added to appendix 5.	Chris Bell; Neonatal Consultant

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Screening for Newborn Infant Physical Examination (NIPE) Clinical Guideline V5.2
Directorate and service area:	Newborn Care
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Neonatal Audit and Guidelines Meeting
Contact details:	01872 253092

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To give all RCHT medical staff, advanced neonatal nurse practitioners (ANNPs), neonatal nurses and midwives qualified to undertake examination of the New-born guidance on the full examination of the new-born.
2. Policy Objectives	To ensure that all new-borns, examined by staff employed by RCHT, receive a full physical examination in line with the national screening standards.
3. Policy Intended Outcomes	To identify and review any suspected or actual New-born abnormalities.
4. How will you measure each outcome?	Compliance monitoring tool.
5. Who is intended to benefit from the policy?	New-born babies and their parents.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guidelines and Neonatal Audit and Guidelines meetings.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the parent/ carers needs- i.e., available in different languages if required/ access to an interpreter if required.
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parent/ carers with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison Team or for specialised equipment.

Protected Characteristic	(Yes or No)	Rationale
		Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly.
Marriage and civil partnership	No	All staff should be aware of any marital arrangements that may have an impact on care (for example: separated parents, domestic abuse).
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Neonatal Audit and Guidelines Group.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Too Unwell for NIPE Newborn Screening

Screening may be delayed if the baby is unwell (see below for possible clinical reasons why this may be required).

These babies should be accounted for in the KPI data submission, giving the reason for delay as mitigation against the 72-hour performance threshold. This is not an exhaustive list as clinical judgement should still be used when assessing suitability for newborn NIPE screening:

- Respiratory support (other than low flow oxygen), including the presence of chest drains for the first 72 hours.
- Any cardiovascular support, for example, inotropes, prostin.
- Ventilated infant until extubated.
- Baby on non-invasive respiratory support
- Therapeutic hypothermia.
- Intense phototherapy (double or more, need for immunoglobulin/exchange transfusion.
- Chest drain in place (without additional respiratory support).
- Umbilical lines in place/ arterial lines in place.
- Post-operative, until off analgesia.
- Unstable hypoglycaemia until off intravenous dextrose.
- Where active reorientation of care to comfort/ palliative care is taking place.

Appendix 4. ‘Too Young’ for NIPE Newborn Screening

If a baby is born before 34+0 weeks gestation, screening can be delayed to 34+0 weeks corrected age. The baby continues to remain eligible for NIPE newborn screening and screening should be performed as soon as the baby is deemed old enough and is well enough. Any baby born below 34+0 weeks are automatically identified on the S4N system by a ‘GA’ flag, to assist with management of the records. Please see the S4N user guides within the ‘Resources’ section of the S4N system for further information.

The screening of babies before 34+0 weeks corrected age (for example, those considered well enough) is a local clinical decision. However, it is not recommended to routinely perform the NIPE newborn screening examination before 34+0 weeks due to the potential for findings to subsequently change, and inappropriate referrals being made. It is envisaged that NIPE newborn screening prior to 34+0 weeks would happen in circumstances where there is a risk that otherwise the NIPE may not be performed later or missed.

If a baby has reached 34 weeks + 0 days corrected age but is still considered ‘too ill’ for NIPE, then screening can be delayed further (please see ‘too ill’ for NIPE newborn screening).

Appendix 5. Referral pathways for possible anomalies

Referral Pathways for possible anomalies noted at the NIPE Check

If the healthcare professional performing the newborn examination identifies any anomaly, a referral should be made to the **appropriate neonatal** team member (ANNP/ Registrar or above) who will be able to provide advice for further referral/review. The person performing the new-born examination who identifies any anomaly (screen positive result) should consult the referral pathway and contact the Registrar/ ANNP on Neonatal Bleep/ via switchboard for advice.

- Contact with the neonatal team should be made as soon as possible and **within usual clinic working hours where possible. Urgent referrals can be made at any time.**

- Community referrals, check referral pathway guidance and Bleep Neonatal Registrar via switchboard within above working hours for non-urgent. **Urgent referrals can be made at any time.**

- Any baby with a NORMAL NIPE examination but a 1st degree relative history of the following cardiac conditions should have a review at the 6–8-week NIPE check and a referral made for a routine review, to a Paediatrician with expertise in Cardiology, if required.

  - Aortic stenosis due to bicuspid or unicuspid aortic valve.

  - Channelopathies- Long QT syndrome, Brugada syndrome, CPVT (Catecholaminergic polymorphic ventricular tachycardia).

  - Cardiomyopathies where Clinical Genetics have confirmed diagnosis in first degree relative- Hypertrophic Cardiomyopathy, Dilated Cardiomyopathy, ARVC (Arrhythmogenic right ventricular cardiomyopathy).

  - Neuromuscular conditions and connective tissue disorders where there is a cardiac involvement.

- A letter to be sent to the GP by the screening team identifying any baby that needs a family history cardiac review at six to eight weeks (NIPE practitioner to update screening team).

- Referrals for hip scans, physio, undescended testes, hypospadias and ophthalmology should be made by the NIPE examiner via maxims internal referral system.

- The baby's S4N record should be marked that a referral has been made, a senior review or referral to the GP has been requested. **The S4N system should be updated once further examination/plan of care is made.**

Any baby who appears unwell or raises concern must be immediately discussed with a senior neonatal team member, neonatal tier 2 (ANNP or middle grade doctor) or above, and assessed for potential admission/ immediate review. If an anomaly is identified the parents will be informed immediately and any plan for investigation, treatment or care will be discussed and developed with them **any referrals should be clearly documented in the baby's notes, S4N system and PCHR Red Book.**

Nipe Pathways for Hospital and Community Referrals

Abnormal examination finding	Initial actions	Further actions whilst awaiting Senior review.
Abnormal or dysmorphic appearance, including abnormal head shape. Not including moulding.	Bleep Neonatal Registrar/ ANNP through switchboard at time of examination.	Plot Occipitofrontal Circumference (OFC), document any other findings. Do not discharge from hospital until senior review.
Severe or large haematoma /swelling crossing cranial suture line, not considered to be caput.	Bleep Neonatal Registrar/ ANNP through switchboard at time of examination.	Plot OFC, Check jaundice with TCB and plot on appropriate chart for gestation.
Facial asymmetry, facial nerve palsy not previously been reviewed by member of senior medical team.	Bleep Neonatal Registrar/ANNP through switchboard at time of examination.	Ensure baby able to close eyes and suck/latch to feed (consider IFT referral). Document delivery type and take history from mother re. any improvement/ deterioration. If still apparent will need neonatal follow up. If unable to close eye, consider eye drops.
Abnormality of the ear, pits or tags.	Refer to hearing screening guideline. Refer as appropriate to audiology. NO renal scan needed.	Take any relevant family history. Ensure no other abnormalities present. For review at six to eight week GP check.
MOUTH		
Natal teeth.	Bleep Neonatal Registrar/ANNP through switchboard at time of examination.	Referral letter to maxillofacial team. Maxims internal referral. *Check tooth stability, if tooth is loose then this is an urgent referral.

Abnormal examination finding	Initial actions	Further actions whilst awaiting Senior review.
Cleft lip +/- palate.	Admit to postnatal ward via Neonatal Registrar/ ANNP. Monitor feeding ability. Refer to hearing screening.	Neonatal team to inform Bristol Cleft team same day referral. Cleft Lip and Palate (CLAP) Management Neonatal Clincial Guideline (cornwall.nhs.uk).
EYES		
Small or absent eye. absent red reflex/ white response. Abnormality of the Iris, eye lid.	Bleep Neonatal Registrar/ANNP through switchboard at time of examination.	Maxims referral 'Paediatric ophthalmology for paediatricians'. To be seen within one to three week and email: rch-tr.EYEHCA@nhs.net.
Subconjunctival haemorrhages.	Take history of delivery and if always present from birth. Note on S4N.	Escalate any safeguarding concerns as per guidelines.
First degree family history of eye anomalies.	If NIPE eye examination normal, for review by GP at six to eight weeks.	Screening team to send letter to GP via maxims requesting six to eight week review.
RESPIRATION		
Any signs of respiratory distress, e.g., grunting, stridor.	2222 in hospital or 999 ambulance transfer in community, initiate NLS.	Check observations and saturations. Check temperature. Prepare for emergency transfer to hospital or neonatal unit.
HEART		
Cyanosis/ under 90% oxygen saturations.	2222 in hospital and 999 Ambulance transfer from home. NNU admit.	Monitor saturations, administer oxygen.
Murmur but clinically well.	Bleep Neonatal Registrar/ANNP through switchboard at time of examination.	Check femoral pulses, pre and post ductal saturations. Follow murmur guideline.

Abnormal examination finding	Initial actions	Further actions whilst awaiting Senior review.
Murmur + concern. Absent or weak femoral pulses or >3% difference in pre and post ductal saturations.	Urgent bleep to Neonatal Registrar/ ANNP and consider preparing for ambulance transfer. 2222 in hospital.	Monitor saturations, administer oxygen initiate NLS.
Family history of cardiac conditions.	See appendix 5.	Screening team to send GP letter.
ABDOMEN		
Abdominal mass. Abdominal wall defect. Large liver or spleen. Imperforate anus or abnormally positioned anus.	Urgent bleep to Neonatal Registrar/ ANNP and consider preparing for ambulance transfer. 2222 in hospital.	Take history, any vomiting, any signs of distension, take observations. Feeding history. Prompt review by neonatal team.
GENITALIA		
Hypospadias **with** palpable testes in the scrotum and good urine stream.	Via Maxims internal referral system.	Ensure normal genitalia and hypospadias is glandular and not severe such as proximal or penoscrotal/ scrotal or perineal.
Bilateral impalpable testes.	Urgent bleep to neonatal registrar, See separate guideline (Disorders of Sex Development Atypical Genitalia.)	Prepare for transfer in to be seen within **two hours** of diagnosis.
Unilateral palpable testis not located in the scrotum with hypospadias. Unilateral impalpable testes with or without hypospadias.	Bleep Neonatal Registrar/ ANNP through switchboard.at time of examination to arrange senior review.	Review within 24 hours on neonatal unit. Make maxims referral 'neonatal hypospadias service' and 'neonatal undescended testes outpatient services'
One or both testis that are palpable but not located in the scrotum without hypospadias.	If unsure Bleep Neonatal Registrar/ ANNP for discussion.	Maxims referral 'neonatal undescended testes outpatient services'. GP to review at six to eight week check.

Abnormal examination finding	Initial actions	Further actions whilst awaiting Senior review.
Hydrocele	Review by senior to confirm hydrocele, US may be required in hospital.	Ensure descended teste on contralateral side to hydrocele.
LIMBS		
DDH (Developmental Dysplasia of the Hip) hips dislocated/ dislocatable hips.	Referral for hip ultrasound on Maxims 'Neonatal Hip referral service' (two week timeframe). Give parents/ carers information leaflet.	Maxims referral 'Neonatal hip referral service' and send email to screening team rch-tr.screening@nhs.net and Claire Hawkins claire.hawkins11@nhs.net. Patient referral will be triaged and will be offered urgent hip ultrasound (local pathway).
DDH hips- risk factors first degree relative of hip problems in early life. Breech presentation on or after 36 weeks irrespective of presentation at birth or mode of delivery, this includes babies who have had a successful ECV (External Cephalic Version). Breech presentation at the time of birth between 28 weeks gestation and term. Multiple births- all babies from a multiple pregnancy where any of the NIPE hip risk factors listed above are present and/or one of the babies has a screen positive result. Clicky hips. Plagiocephaly/ torticollis arthrogryposis.	Referral for hip ultrasound on Maxims.	Maxims referral 'Neonatal hip referral service'. Give family DDH patient information leaflet.

Abnormal examination finding	Initial actions	Further actions whilst awaiting Senior review.
Positional talipes.	Referral for hip ultrasound on Maxims. Separate referral for physio on Maxims.	Maxims referral 'Neonatal hip referral service'. Maxims referral 'Neonatal Orthopaedic Physio Outpatient referral'.
Fixed talipes.	Referral to Paediatric physio for two week review.	Maxims referral for hip scan and urgent (2 weeks) physio referral via maxims.
Additional digits.	Bleep Neonatal Registrar/ ANNP through switchboard at time of examination.	For upper limb conditions contact Consultant Plastic and Hand Surgeon Miss Dunlop via switchboard and email patient details to her Margaret.hewins@nhs.net and Rebecca.dunlop@nhs.net. For lower limb conditions a referral should be made to Consultant Plastic Surgeon Mr Mackenzie at Derriford plh-tr.plasticsreferral@nhs.net and an inter-provider transfer form (via neonatal service consultants secretary).
Brachial/ arm palsy, suspected ± clavicle fracture.	Bleep Neonatal Registrar through switchboard at time of examination.	Physio referral via maxims. Pain relief if indicated. Information leaflet to parents. Take history from delivery.
SKIN		
Skin tags.	GP referral to plastic surgeon.	Inform GP at time of NIPE.
Birth marks.	Review will depend on size, nature and position of lesion. Record on NIPE check.	If senior review not required, then Midwife to review at appropriate timely interval. Use body map if required.

Abnormal examination finding	Initial actions	Further actions whilst awaiting Senior review.
Significant laceration or bruising causing skin breakdown.	Contact Neonatal Registrar through switchboard at time of examination.	Refer to Tissue Viability. If lesion requires ongoing dressing then: • Give parents open access to PAU (Paediatric Assessment Unit) for out of hours complications whilst dressing ongoing. • Offer parents option of home dressing by parents, dressing in PAU with TV support or by practice nurse (TV to discuss). • Ongoing follow up as determined by Tissue Viability.
Rash of concern.	Review will depend on size, nature and position of lesion. If unsure of diagnosis, then bleep Neonatal Registrar/ ANNP through switchboard at time of examination. Jaundice follow local guideline.	Document clearly and on body map.

Appendix 6. Pathway for Declined NIPE Examination

Pathway when parents decline the new-born NIPE examination for their baby.

Screening providers should use information in ‘screening tests for you and your baby’ to inform parents about the new-born and 6-8-week physical examination.

- During the antenatal period.
- Before the new-born examination is offered.

Parents who decline the new-born examination should be informed that the optimum time for the examination is within 72 hours, however, it can be completed up to 6 weeks.

After 6 weeks the examination offered will be the six to eight week infant examination.

The NIPE screener, offering the test, should ensure parents have contact details should they wish to take up the offer of the New-born examination. This decision should be recorded in:

- SMaRT4NIPE.
- PCHR red book.
- In the child records on E3.

A member of the screening team will identify any baby who has a decline status in SMaRT4NIPE.

Using the locally agreed template, a letter to the parents will be created in maxims, outlining the purpose of the examination, the parents right to decline and contact details should they change their minds.

A copy of the letter should be sent to:

- Community Midwife.
- Health Visitor via coco.childrenscmc@nhs.net.
- GP.

Appendix 7. NIPE Leaflet

Congratulations on your recent birth!

This information is to help you understand the **Newborn Infant Physical Examination (NIPE)**, often referred to as the 'Baby Check'. It is a national recommendation that the NIPE examination is completed within the first 72 hours of life.

What is the NIPE?

The NIPE is a screening examination done by a specially trained health care professional (HCP); this may be a Midwife, Advanced Neonatal Nurse Practitioner or a Doctor. The HCP will usually start by asking you some general questions about your baby's feeding, nappies, the pregnancy and family history. The examination will need your baby to be naked in just a clean nappy. Your baby will have a top to toe examination including the mouth, chest, tummy, bottom and limbs. The examination includes four areas of specific screening (eyes, heart, hips and for boys the testes). If anything unusual is found, this will be discussed with you. Please do ask questions if you have any concerns. You have the right to decline this examination if you wish.

Why should my baby have this examination?

The purpose is to identify any problems early so if treatment is required it can be started as soon as possible. You will be told the results straight away. Usually nothing of concern is found but if your baby does need further investigations then these will be explained and discussed with you. Sometimes the HCP may request a second opinion from a senior colleague.

If you are aware of any baby health problems which run in the family, it is very helpful if you can find out the details from relatives prior to being seen.

The Eyes - are screened as two or three in 10,000 babies are born with problems with their eyes, some which require treatment. The examination will involve looking at the size and shape of the eyes; shining a bright light called an ophthalmoscope into the eyes to check for cataracts. It is not a vision test. The eyes can change as babies get older so if you have concerns about their eyes or vision do discuss this with your GP or health visitor.

The Heart - is examined using a stethoscope to listen to the baby's heart and chest. Sometimes an extra or unusual sound can be heard, called a heart murmur. In most cases when a murmur is heard the heart is normal but in a small proportion of babies there is a problem which needs further investigation and treatment. If a murmur is heard the plan will be discussed with you in more detail.

The Hips - are examined as one or two in 1,000 babies have a condition known as Developmental Dysplasia of the Hip (DDH) where the hip joint is unstable. If left untreated this can cause a limp and joint problems later in life; DDH can be successfully treated if found early. If the hips feel unstable this will be explained in more detail and baby will be referred for an ultrasound scan. Some babies, for example those who were breech, are at higher risk of DDH even if the examination is normal so they will have an ultrasound booked for few weeks of age.

The testes - Baby boys scrotums are examined to check for the testicles as sometimes they may not be in the right place and may still be descending into the scrotum. One in 100 baby boys have undescended testicles which will require further check-ups to reduce the risk of fertility issues in later life.

For more information on the NIPE check, please follow the QR codes:

Appendix 8. NIPE Sticker

Newborn Infant Physical Examination (NIPE)

Please scan QR code for further information about your baby's NIPE

I was born / / @ :

My NIPE is due by / / @ :

My NIPE has been completed on / / @

My NIPE has not been completed ☐

If your baby's NIPE has not been completed before discharge from hospital you may be asked to travel to an appointment for this to be completed. Please alert staff if this may be an issue for you.

Appendix 9. NIPE Failsafe Sticker Sheet

Please call 01872 253092 to follow up any outstanding appointments made during the Newborn Infant Physical examination (NIPE).	Please call 01872 253092 to follow up any outstanding appointments made during the Newborn Infant Physical examination (NIPE).	Please call 01872 253092 to follow up any outstanding appointments made during the Newborn Infant Physical examination (NIPE).
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