Objectives Reduce the number of avoidable PED attendances of babies under 1 month.

Methods PED attendances 01/01/2019 to 31/12/2020 of infants under 1 month were analysed. Attendances were plotted on a monthly run chart with a baseline median calculated on 2019 data. Discharge diagnoses for the first 6 months of 2020 were recorded and analysed to give an overview of attendance reasons and areas on which to focus interventions. An ‘avoidable attendance’ was classed as ‘feeding problem’ or ‘jaundice’ as these do not typically require specialist paediatric emergency medicine input. Monthly overall PED attendances and hospital live births numbers 2019–2020 were noted. Interventions included multi-disciplinary team meetings with Maternity, Paediatrics and Safeguarding. Care pathways (hospital & community) were reviewed and extra resources allocated to maternal feeding & support.

Results A total of 805 infants under 1 month attended PED January 2019 to December 2020, n=372 (2019) vs n= 433 (2020). The baseline median of monthly attendances under 1 month old was 29 patients per month (2019) vs 36 patients per month (2020). Live births were similar 5143 (2019) vs 5109 (2020). PED discharge diagnosis January to June 2020 (n= 224) showed 27% (n=61) due to ‘jaundice’ and 21% (n= 47) due to ‘feeding problems’ with none of these infants admitted. PED attendances under 1 month old dropped from a peak of 55 patients (July 2020) but has not dropped to consistently below baseline median. Alternative pathways to access services were not included in analysis. The increased number via PED might reflect the true number normally seeking healthcare input (e.g. HV, GP, Paediatrics and Maternity services) but an unintended consequence of COVID-19 related service alterations means PED is the default route for F2F review or parental support/reassurance. Separate in-depth analysis of 2020 hospital wide attendances under 1 month old suggests a wider system issue.

Conclusions During 2020 under 1 month old PED attendances increased above the baseline of 29 patients to 36 patients per month despite overall PED attendances dropping 25% compared to 2019. Analysis suggests 50% were jaundice/feeding related. Interventions across our local healthcare system have yet to demonstrate a sustained and statistically significant drop below the baseline median. Local analysis continues and long-term targets on avoidable PED attendances may have merit.
Britain (including under the separate legal system of Scotland) until 1926, when the first Act was passed which regulated this in England and Wales. Until then, child adoption was an informal and generally secretive procedure which gave the adoptive parents no rights whatsoever: a biological parent could (and in some cases, did) appear at any time and demand custody of a child they had neither seen nor contributed to the care of for years at a time.3

By the early 1920s both the NCAA (National Child Adoption Association) and NCUMC (National Council for the Unmarried Mother and her Child) had begun to call for new legislation to be introduced on child adoption, arguing that since ‘adoption’ was occurring in any event legislation would provide better safeguards for the children involved.1

Finally the Adoption of Children Act is established in 1926 covering England & Wales. It was followed by the Adoption of Children (Northern Ireland) Act 1929 and the Adoption of Children (Scotland) Act 1930.1

Initially, adoptions were seen as a way of providing security for war orphans and children born to unmarried mothers. During 1960s and 1970s the number of babies available for adoption fell rapidly because of improved birth control and changing public attitudes, adoption practice changed its focus to finding families for children with ‘special needs’, such as those in local authority care who had been abused, neglected or had physical or learning disabilities. On the basis of the Houghton Committee report on adoption in 1972, The Children Act 1975 &amp; Adoption Act 1976 recommended that:

- Adoption societies would have to work closely with local authorities & would be subject to much more stringent approval criteria.
- Introduction of ‘freeing a child for adoption’, if necessary by court order against parental wishes.
- Giving adopted adults in England & Wales the right to obtain a copy of their original birth certificate.
- According to The Adoption & Children Act 2002 (the current law) adoption can happen by 2 routes
  - Parental consent
  - Placement order

REFERENCES
2. Jenny Keating.

Quality Improvement and Patient Safety

NEWBORN AND INFANT PHYSICAL EXAMINATION SCREENING: QUALITY IMPROVEMENT IN THE ENGLISH NEWBORN SCREENING PATHWAY

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Background The newborn and infant physical examination (NIPE) screening programme screens newborn babies within 72 hours of birth in England for congenital heart disease, congenital cataracts, developmental dysplasia of the hip, and cryptorchidism (bilateral and unilateral undescended testes). Failsafe of completion of NIPE screening is managed on the national NIPE IT system SMaRT4NIPE (S4N). This is implemented in 135 of 136 trusts in England and records the end to end screening pathway including outcomes for screen positive babies. Babies are eligible for screening irrespective of their gestational age at birth however babies that are ‘too ill’ for screening are managed as a mitigation to coverage with an acceptable threshold for the key performance indicator of 95% within 72 hours of age (2019–2020). Feedback from clinicians and monitoring of the completeness of the data recorded on S4N prompted quality improvement work in the NIPE screening pathway.

Objectives Quality improvement of newborn screening coverage and timely entry into diagnostic and treatment services in the NIPE screening programme.

Methods 1. Analysis of completeness of outcome recording on S4N with monitoring reports shared with screening commissioners and screening quality assurance.

2. Professional expert groups to revise clinical guidance, identify refinements in the hip and eye screening pathway and clarify definitions of ‘too ill’ and ‘too young’ for screening.

Results In 2018–2019 when between 33 and 77 (120 trusts with S4N) did not record outcomes against the 5 NIPE standards with less than with 50% data completeness for those that did. Following quality improvement work which included additional training sessions for providers in the use of S4N and production of monitoring reports for screening commissioners Q4 2020 data in England is now between 71 – 88.5% complete for each of the 5 NIPE standards (135 trusts with S4N).

Refinements to the screening pathway include improved clinical guidance with photographs of abnormal red reflex, change from ophthalmology review within 2 weeks of age to within 2 weeks of screen for eye referrals and changes to the recommended timeframe for hip ultrasound to between 4 and 6 weeks with specialist review by 6 weeks for all babies (positive clinical examination and hip risk factors). Babies that are aged less than 34 weeks corrected gestational age are deemed ‘too young’ to have the newborn screen and the clinical handbook gives examples of what is meant by ‘too young’ for screening. These changes improve clinical efficacy of the pathways.

Conclusions Improvements in the completeness of recording of NIPE screening including outcomes on S4N provides assurance that babies with screen positive conditions are being followed up and referred and seen within the recommended timelines. Clarification of ‘too ill’ and ‘too young’ for NIPE should improve the standardisation of approach across England. It supports the practice of completion of NIPE examination prior to discharge for babies born prematurely. The screening pathway refinements recommended by the expert group have been incorporated into revised NIPE standards following external consultation. These are to be implemented from April 2021.