

THAMES VALLEY & WESSEX NEONATAL OPERATIONAL DELIVERY NETWORK

Framework for Repatriation of Neonates within TV & Wessex Neonatal ODN

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Implications of race, equality & other diversity duties for this document	This guideline must be implemented fairly and without prejudice whether on the grounds of race, gender, sexual orientation or religion.

Contents

Glossary of Terms	2
Summary of recommendations	2
1.0 Executive Summary.....	2
2.0 Aim of Guideline	3
3.0 Scope of Guidelines.....	3
4.0 Guideline Summary	4
5.0 Guideline Framework.....	4
5.1 Repatriation responsibilities	4
5.2 Communication with Families	5
5.3 Process of repatriation	5
Planned delivery in NICU / in utero transfers to NICU /LNU	5
After birth and admission to a NICU/LNU.....	5
Transfer back for ongoing local LNU/SCU care.....	6
5.4 Criteria for repatriation to a Local Neonatal Unit LNU / Special Care Unit SCU	7
Minimum threshold for Repatriation to a Local Neonatal Unit (LNU)	7
Minimum threshold for repatriation to a Special Care Unit SCU	8
5.5 Repatriation delays	8
6.0 References /Resources	9
Appendix 1: Overview Framework for repatriation from NICU/LNU to SCU	10
Appendix 2A: Repatriation Parent Information Leaflet	12
Appendix 2B: Transfer; Our Baby Steps Journey Card.....	14
Appendix 3: Family Communication Record – for repatriation/Family Liaison Link Nurse	15
Appendix 4: BadgerNet Patient Record Referrals Function (Break glass Function)	17
Appendix 5: BAPM Categories of Care August 2011	20
Version Control.....	21

Glossary of Terms

Summary of recommendations

[Repatriation of Infants FINAL_060623.pdf](#) pg. 5

Timely repatriation has several potential benefits: decreased family stress, earlier involvement of primary care providers and more efficient use of resources within the perinatal network

Published evidence on repatriation is limited, mainly from non-UK settings and of an observational nature. These studies have shown that repatriation is safe, cost effective and decreases total length of stay.^{4,5} Unpublished data collected as part of a repatriation quality improvement programme (QIP) in an English Local Maternity and Neonatal System (LMNS) showed 14.6 days of care further away from home than necessary in a randomly selected cohort of 13 babies born < 27 weeks

1.0 Executive Summary

This guidance provides a framework for the repatriation of neonates within TV & Wessex Neonatal ODN to their local neonatal unit; this includes the repatriation from a NICU to local LNU / SCU or LNU to local SCU within the Network. There are clear guidance and specifications on levels of care that can be provided in different levels of units i.e.: NICU, LNU & SCU with recommendations and care pathways indicating where babies should receive intensive care, high dependency care and special care (Neonatal Service Specification 2024).

There is BAPM guidance Safe and Effective Repatriation of Infants June 2023 outlining recommendations on repatriation to local LNU & SCUs for care closer to home when NICU /LNU care is no longer required, transfer and local care can safely be provided closer to home It is important to ensure that babies and their families receive the highest quality of care as close to home as possible (Toolkit High Quality Neonatal Services DOH 2009).

The decision to repatriate for local care in some situations can be complex and can depend on several different factors, and should only be considered when:

- appropriate level of care can be provided in the local unit and regular input of tertiary specialist care is no longer required
- the baby's condition is stable, and safe transport can be undertaken

It should be agreed by the clinical team responsible for the care of the baby in the NICU/LNU in conjunction with the family and the local team. The timing of repatriation to the local LNU/SCU should be regularly considered and reviewed. The local LNU /SCU clinical team should be notified of the birth of the baby (i.e. Delivery after in utero transfer (IUT)) and regularly updated on the infant's progress and readiness for local repatriation for ongoing care.

Ideally repatriation would be discussed with the family as part of the Periprem Optimisation counselling, prior to in utero transfers

Parents and carers should be made aware of the pathways for ongoing local neonatal care, provided with local unit parent level information, and opportunities to visit / video tour and meet the local neonatal team and unit. The Repatriation/Family Liaison Link Nurse Role has been created to ensure families have contact from their local LNU/SCU's by an appointed member of staff who can have regular contact with them and arrange visits to their local units, answering any questions they may have.

There may be specific situations that will influence a decision to transfer a baby no longer needing intensive care e.g., practical difficulties of parents accessing their local SCU, presence of close family relatives

near to the NICU/LNU. Equally there may be occasions when the transfer of a baby still requiring ongoing high dependency support is appropriate i.e. when the pathway of care is towards palliative care. (Appendix 1: Overview Framework for Repatriation from NICU/LNU to LNU/SCU)

2.0 Aim of Guideline

The aim of this guidance is to provide a clear framework and guidance to:

Ensure safe effective clinical decision making and communication in repatriation for local neonatal care within network governance protocols, including handover of clinical information and care provision between the different neonatal units and clinical teams involved.

Define the minimum thresholds for repatriation to the local unit of booking following an episode of uplift in care for any baby who receives neonatal care following delivery outside of its local unit of booking i.e. following IUT for foetal medicine care, maternal medicine or in utero transfer for delivery and neonatal care.

Ensure that the needs of the baby and family are considered and assessed to determine the best location of care as close to home as possible.

To facilitate repatriation and safe transfer for ongoing care in their local unit.

Ensure that parents remain informed and involved in the care of their baby in the different neonatal units with seamless transition following repatriation for ongoing care.

3.0 Scope of Guidelines

Thames Valley		
TRUST	Hospital	Designation
Oxford University Hospitals NHS Foundation Trust	- John Radcliffe Hospital, Oxford	NICU
Buckinghamshire Healthcare NHS Trust	- Stoke Mandeville Hospital, Aylesbury	LNU
Frimley Health NHS Foundation Trust	- Wexham Park Hospital, Slough	LNU
Milton Keynes University Hospital NHS Foundation Trust	- Milton Keynes General Hospital	LNU
Royal Berkshire NHS Foundation Trust	- Reading	LNU

Wessex		
TRUST	Hospital	Designation
University Hospital Southampton NHS Foundation Trust	- Princess Anne Hospital	NICU
Portsmouth Hospitals University NHS Trust	- Queen Alexandra Hospital	NICU
University Hospitals Dorset NHS Foundation Trust	- Royal Bournemouth Hospital	LNU
Salisbury NHS Foundation Trust	- Salisbury District Hospital	LNU
Hampshire Hospitals NHS Foundation Trust	- Basingstoke and North Hampshire Hospital	SCU (Temporary designation)
Hampshire Hospitals NHS Foundation Trust	- Royal Hampshire County Hospital, Winchester	SCU (Temporary designation)
Dorset County Hospital NHS Foundation Trust	- Dorset County Hospital, Dorchester	SCU

Isle of Wight NHS Trust	- St Mary's Hospital	SCU
University Hospitals Sussex NHS Foundation Trust	- St Richard's Hospital, Chichester	SCU

4.0 Guideline Summary

Babies should receive the highest quality of care as close to home as possible (Toolkit for High Quality Neonatal Services DOH 2009). In general babies should be repatriated from a NICU to LNU or if relevant to their SCU of booking and LNU to SCU within 48 hours of meeting repatriation criteria.

Receiving units have a responsibility to provide capacity to care for the babies being repatriated within 48 hours of the request being made.

Additional measures may need to be undertaken to create adequate capacity within LNU's and SCUs and these may include the following:

- Putting in place additional staffing including bank or agency staffing
- Reviewing all babies suitable for discharge home or ongoing care on paediatric unit
- Escalation to ODN biweekly staffing and capacity meetings to support repatriations and network flows in the event of delays of acceptance for repatriation Women booked for delivery with onsite NICU services, under the care of fetal medicine / maternal medicine, should be counselled antenatally to explain neonatal pathways of care within the Network including transfer of care back to local neonatal services
- Where women have booked for maternity care away from their local unit, they should be informed about neonatal network pathways of care, including transfer of care back to local neonatal services, as soon as possible after the identification of the baby's potential or actual requirement for neonatal critical care.

5.0 Guideline Framework

5.1 Repatriation responsibilities

All units should engage with the processes of notification and communication of outlier babies within their unit and follow the repatriation guidance.

Referral units should ensure that local units are notified of the birth of a local baby within their unit within 48 hours of admission and engage with the local LNU /SCU with regular communication updates.

Referral units have a joint responsibility for preparing families for repatriation to their local unit with the receiving local LNU/SCU. The Repatriation/Family Liaison Link Nurse Roles within NICU'S LNU's &SCU's should be in place to support repatriation pathways as a point of contact for families to build relationships prior to transfer.

Referral units are responsible for the clinical care and safety of the baby, that the minimum criteria for repatriation have been met and that the patient is safe for transfer and ongoing local care.

Receiving units should prioritise assessing capacity for acceptance of the baby for repatriation early in the day to enable timely transfer and referral to SONeT service.

Clinical teams involved in the care of a baby including subspeciality teams i.e. surgical, cardiac teams and allied health professionals are responsible for ensuring an ongoing management plan and handover of care information have been provided.

5.2 Communication with Families

The following principles will help to deliver a trauma informed approach to communication with families:

- Conversations with families about the necessity for repatriation should occur at an early stage and should be approached in an open and honest way by the care team.
- Families should be supported (through provision of clear and jargon-free information in a variety of formats) to understand the criteria for their baby's repatriation at an early stage such that, when repatriation occurs, the reasons and process are transparent
- Information should be provided in a format appropriate to any communication needs, including in families' first language, in easy read or with visual aids.
- When repatriation is anticipated, families should be given the opportunity for regular updates by the clinical team to support them in understanding their baby's progress. This is with the aim of supporting parents to appreciate that the repatriation plan is clinically safe for their baby. Such support is of particular importance for families whose baby has been acutely unwell or required intensive levels of care prior to repatriation.

It is vital that families understand the importance of engaging with their local teams and the benefits for their baby and them as a family.

- If specialist AHP services are not available in the receiving unit, parents should be informed about this well ahead of repatriation and where possible, appropriate plans to be put in place to support the parent and receiving unit. This should not be a barrier to repatriation to local care
- All families should have the opportunity to visit their home unit and meet the new team prior to their baby's repatriation. All units should have details and virtual tours available to families on their websites linked to through central network websites (BAPM 2023) [Home - Neonatal Network South East](#)

5.3 Process of repatriation

Planned delivery in NICU / in utero transfers to NICU /LNU

- Antenatal counselling of women in local services prior to IUT should be an opportunity to explain pathways of neonatal care including transfer of care back to the local neonatal service when this is appropriate. This should be included in the perinatal optimisation and antenatal counselling with parents
- Women booked for delivery with onsite NICU services under the care of foetal medicine / maternal medicine should be counselled antenatally to explain neonatal pathways of care within the Network including transfer of care back to local neonatal services This should be included in the perinatal optimisation and antenatal counselling with parents

After birth and admission to a NICU/LNU

- Local LNU/SCUs units should be notified of the admission of their local baby by the NICU/LNU following delivery by the clinical team i.e. Nurse in charge / Neonatal Coordinator within 48 hours of admission. Local teams may not be aware of the birth of a baby following the IUT of the mother or women who were booked for delivery in a specialist centre.
- Parents should be made aware that their baby will be transferred back to their local NICU, LNU SCU for on-going care when it is appropriate for their baby. They should be provided with written generic information on repatriation for ongoing care to their local unit. (Appendix 2: Repatriation Parent Information Leaflet) and signposted to the 'Moving closer to home' Video via V-Create or YouTube.
- Parents to be offered the opportunity to create their personalised neonatal journey using the Neonatal Journey cards available to them on all units. Their personalised document can be taken with them to their local unit along with any parent learning documents they may have started to complete. i.e. Parent led Tube Feeding learning package. The Journey Cards are a record of the

care parents have been giving their baby and will be transferred by the parents to be continued in the receiving unit. This will enable parents to continue providing the same care for their baby in their local unit. Parents will only need local orientation to the unit and should not need retraining i.e. in care and feeding their baby.

- There should be regular weekly communication between the NICU/LNU and the local unit to share information on the clinical condition and where appropriate, provide an anticipated or estimate of expected length of stay in NICU/LNU, this can be carried out by the Neonatal Unit's Nursing Coordinator. It may not always be possible to anticipate the duration of the expected NICU/LNU stay. Information shared should be recorded using the Network Repatriation Communication Record (Appendix 3) to support effective communication.
- Local LNU/SCU should ensure up-to-date records of outlying baby communications between the units are maintained and should be widely available to the local team i.e. local unit repatriation folder. This can be done by using a Network Repatriation Communication Record or via an EPR white board system. All documented communication records should be included in the baby's medical record once transferred to the local unit.
- Local Units to allocate their Repatriation/Family Liaison Link Nurse to contact the family on a regular basis i.e. weekly, to form a relationship with them, prior to repatriation. A record of communication should be completed and kept in the patients notes. (Appendix 4: Family Communication Record)
- Parents should be offered the opportunity to visit the local LNU /SCU during their babies stay in NICU/LNU prior to repatriation. This could be facilitated virtually, i.e. via V Create/ Padlet or an in person visit to the neonatal unit, this will be arranged by the Link Nurse.
- For complex babies with multidisciplinary team (MDT) input i.e., specialist medical / surgical teams / allied health professional, involvement of the multidisciplinary teams across sites should consider holding a virtual multiprofessional meeting involving the referring and receiving clinical teams as well as parents. This can be facilitated by a Teams meeting with the health care professionals and parents and should occur prior to transfer as it offers families the opportunity to meet teams and ask questions, prior to transfer. A record of the MDT should be shared and included in the patient record.
- When a baby meets the minimum criteria for transfer back to an LNU/SCU and is no longer requiring intensive or high dependency care, surgical, cardiac and subspecialist care in a NICU/LNU it may be considered for repatriation to the local LNU/SCU. The baby must be stable and receiving high dependency or special care and be suitable for transfer. (See Criteria for Repatriation section).
- It is a NICU/LNU Consultants responsibility to ensure that a baby meets criteria for repatriation and is fit for transfer and repatriation to its local LNU/SCU for ongoing care.
- Parents to be provided with up-to-date information about their local LNU/SCU during their stay in NICU in preparation for repatriation and ongoing care and should be included at all stages of discussion and planning. This should include written Parent Information Leaflet on their local unit from the SONeT PIL on SONeT website, given the opportunity to view a virtual tour/ web-based information and be invited to be involved in planning meetings and discussions had prior to repatriation.

Transfer back for ongoing local LNU/SCU care

- The units should prioritise acceptance of local babies back into their care in a timely manner within 48 hours, to ensure the effective flow of babies across the Network.
- An MDT Teams meeting with the NICU /LNU team and the local LNU/SCU team should be considered in planned repatriations to their local service of complex babies i.e.: specialist medical / surgical team / allied health professional involvement. A record of the MDT should be shared and

included in the patient record. It may not be necessary for those transfers that have had a short period of stay in a NICU/LNU

- The Nurse Coordinator should contact the local LNU/SCU to arrange repatriation and ensure that a cot is available. Once agreed the NICU/LNU should contact the Neonatal Transfer Service SONeT to arrange the repatriation to the local SCU
- The NICU/LNU medical team should contact the LNU/ SCU medical team to communicate the clinical details of the baby prior to transfer. The local team should be provided with an update of clinical information. If an MDT Teams meeting for complex patients between the referring and local unit to plan repatriation to the local unit has been undertaken this may not be necessary. All babies should have a completed neonatal discharge summary on Badgernet, with printed copy outlining the care episode, current and on-going clinical issues. The baby should be recorded as transferred on Badgernet discharge.
- The Patient Record Referral function (known as Break Glass function) on Badgernet for information sharing should be considered (see Appendix 4). This enables the Badgernet records to be visible to the local team. This function only needs to be activated for those baby's that were not born in their local unit. The records of those babies transferred to a NICU/LNU after birth should already be available to their local unit. This tool allows the safe secure sharing of clinical records between neonatal units.

5.4 Criteria for repatriation to a Local Neonatal Unit LNU / Special Care Unit SCU

Minimum threshold for Repatriation to a Local Neonatal Unit (LNU)

- Considered clinically stable for transfer
- Corrected gestational > 27 weeks and current weight 800gms Multiples >28 weeks corrected gestation and ideally repatriated together.
- Respiratory support: Off invasive ventilation for 48 hours, stable on continuous Positive Airway Pressure (CPAP) ≤ 6 cm H₂, or High Flow ≤ 8 L/min or Low Flow ≤ 0.3 L /min
FiO₂ should be ≤ 30 % for most babies or ≤ 40 % in stable established chronic lung disease (CLD)
- No significant apnoea's or desaturations
- Cardiovascular support: Stable with no inotropic support needed. Stable on cardiovascular medications i.e., Beta blockers/ Sildenafil, doses stable and a clear plan from the specialist team
- Nutrition: Babies should be tolerating a minimum of 75ml/kg/day of enteral feeds for at least 24 hours prior to transfer. Babies can be receiving Total parental nutrition (may be unit exceptions)

Babies transferred from local units or born in an onsite NICU i.e. term/ moderate or late preterm infants may not need to meet all these criteria

Clinical judgement should be used in considering the readiness for repatriation and may require further clinical discussion prior to repatriation for local care. Examples include Extreme preterm infant 22/40 to 26 +6 / 40, post-surgical, infants with congenital cardiac disease, infants with complex needs i.e. subspecialist involvement.

Consideration points include the following:

- Feeding pattern and adequate growth
- Medical and nursing intensity for specialist needs
- Subspecialist face to face review or investigations

Consultant discussion / MDT cross site meeting should take place in these situations where the minimum criteria is met, and repatriation is not considered safe or appropriate or in situations where higher level of support is needed i.e., palliative care or non-invasive ventilation (NIV) for CLD and local care is deemed preferable.

Minimum threshold for repatriation to a Special Care Unit SCU

- Considered clinically stable for transfer
- Gestation > 32 weeks and over 1250 gms (with sustained growth) multiples >32 weeks corrected gestation and ideally repatriated together
- Respiratory support: Stable on High Flow \leq 6L/min with Fio₂ < 30% or Low Flow \leq 0.3 L /min. Babies would usually have been off invasive respiratory support for minimum of 72 hours, off CPAP for minimum of 48 hours. Stable CPAP should be considered (BAPM 2023)
- Nutrition: Babies can be on intravenous fluids or some enteral feeds with no specific need for TPN. Babies born at ELBW would usually be tolerating 120mls/kg /day enteral feeds

Babies transferred from local units or born in an onsite NICU/LNU i.e. term/ moderate or late preterm infants may not need to meet all these criteria

Consultant discussion / MDT cross site meeting should take place in these situations where the minimum criteria is met, and repatriation is not considered safe or appropriate or in situations where higher level of support is needed i.e. palliative care or NIV for CLD, and local care is deemed preferable.

Variation Notes:

Variation for LNUs within the region may occur for weight and TPN. This may depend on access to TPN / nutritional support.

Repatriation transfers requiring higher levels of support may be appropriate i.e., palliative care close to home or where stable infants are receiving substantially higher levels of respiratory support which are likely to continue in the medium to longer term.

The thresholds for consideration of repatriation detailed are triggers, at which point active plans for repatriation should be considered and discussed between the referring and receiving units. The final decision should take into consideration the specific clinical needs of the baby, the needs of the baby's' family, social factors and wider overall best place of care. Safety and best care should be considered in these decisions.

5.5 Repatriation delays

All units have a responsibility for documenting (Appendix 3: Network Repatriation Communication Record) when a repatriation transfer is delayed: the reason, estimated timeframe and specific requirements needed i.e. clinical parameters or local unit's measures i.e. staffing needed to support repatriation to the local unit not adequate.

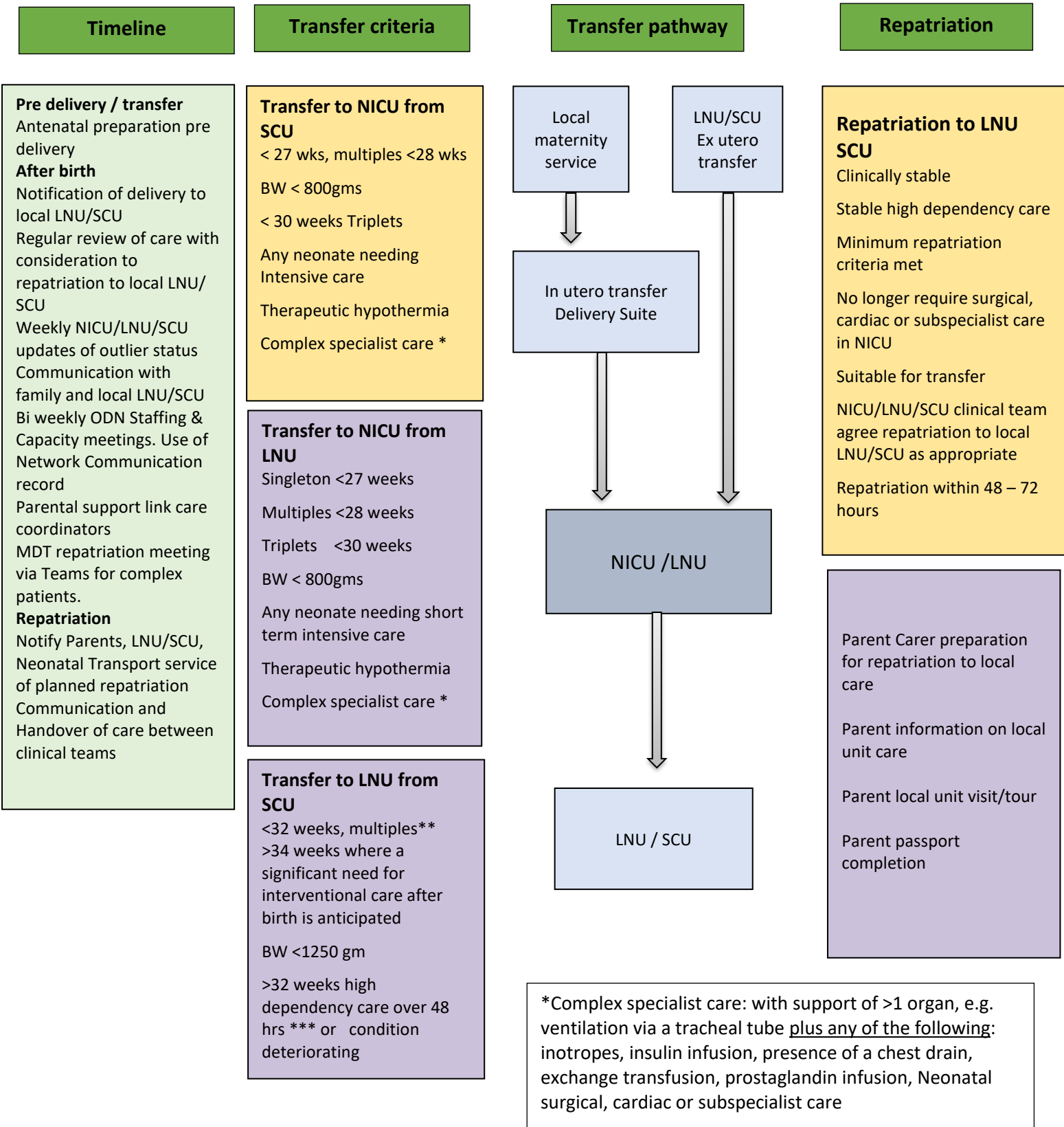
Colonisation or local practise need for an isolation cubicle is not an indication for repatriation refusal and measures within the TV & W Neonatal ODN Health Care Associated Infection HCAI Colonisation Transfer Guidance 2021 should be followed. Babies identified to need isolation as per local Trust Infection guidance can be cared for:

- In an incubator
- In a cubicle or side room
- In an open ward with augmented local infection control practices to prevent cross transfer of multi resistant organisms.

6.0 References /Resources

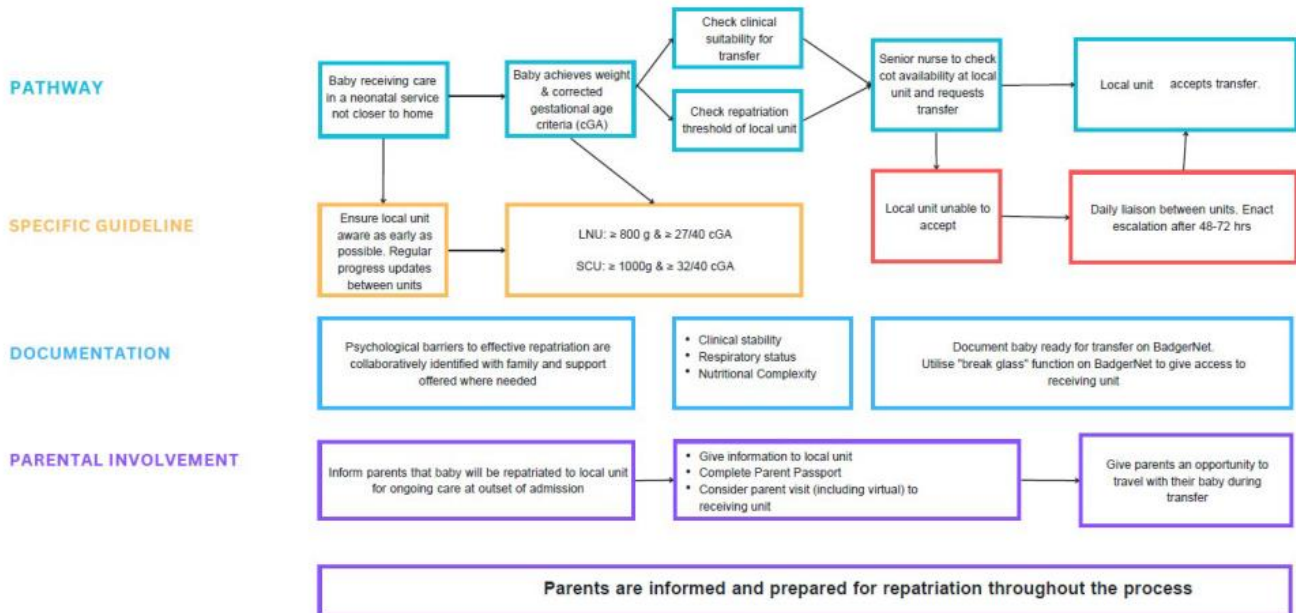
- [BAPM Categories of Care August 2011](#)
- [Neonatal-critical-care-service-specification-March-2024.pdf](#)
- [Service and Quality Standards for Provision of Neonatal Care in the UK | British Association of Perinatal Medicine](#)
- [Toolkit for High Quality Neonatal Services DOH 2009](#)
- [BAPM Family Integrated Care Framework 2021](#)
- [Neonatal Critical Care Transformation Review December 2019](#)
- [Safe and Effective Repatriation of Infants | British Association of Perinatal Medicine 2023](#)
- [Home - Neonatal Network Southeast](#)

Appendix 1: Overview Framework for repatriation from NICU/LNU to SCU



****Multiples < 34 weeks for agreed SCU *** Discussion with NICU /SONeT Consultant**

Repatriation flow chart



Appendix 2A: Repatriation Parent Information Leaflet

NEONATAL UNITS



GET IN TOUCH



Mail

england.tv-w-neonatalnetwork@nhs.net
<https://neonatalnetworkssoutheast.nhs.uk/>



Neonatal Intensive Care Units

Oxford
Portsmouth
Southampton

Local Neonatal Units

Milton Keynes
Wexham Park
Reading
Stoke Mandeville
Basingstoke
Winchester
Salisbury
Bournemouth

Special Care Baby Units

Chichester
Dorchester
Isle of Wight



Scan for VCreate
repatriation video

REPATRIATION OF YOUR BABY TO YOUR LOCAL NEONATAL UNIT

 **THAMES VALLEY & WESSEX
NEONATAL NETWORK**

In the UK neonatal units are designated by the level of care they deliver. Neonatal Intensive Care Units (NICU's) look after preterm babies from 22 weeks, sick term babies and babies who need therapeutic hypothermia or have complex specialist care. Local Neonatal Units (LNU's) look after babies from 27 weeks gestation and Special Care Units (SBCU's) from 32- 34 weeks gestation.

Within the Thames Valley & Wessex Neonatal Network there are 14 different neonatal units. All the units have specially qualified neonatal staff, who can care for your baby at each stage of their neonatal journey.

Babies admitted to neonatal units receive their care at the hospital where the most appropriate level of neonatal care can be given. For some babies this may not always be provided at the local booked hospital closest to their home. Mothers may be transferred for the most appropriate maternity care and delivery, or babies may be transferred after birth to hospitals where additional neonatal care can be provided. The location of care for your baby may change throughout their neonatal journey and whilst this may not be close to your home initially, the aim is to transfer your baby back to your local unit as soon as they are well enough, and it is safe to do so.

When possible, if you require hospital care after delivery, you will be transferred to a maternity unit in the same hospital as your baby.

You may have met the neonatal team in your local unit before your baby is transferred for specialist care, but this may not have happened if you were transferred before your baby was born. Throughout your baby's stay you are encouraged to be with them and care for their needs. As well as this your local unit will receive regular updates on your baby's progress and will be aware of your family needs prior to repatriation.

The transfer of your baby for ongoing care in your local unit, will be planned between the referring unit, the local unit and yourselves. We encourage you to visit your local unit or have contact with the local team, prior to your baby's transfer. Please ask a member of the nursing team how to get in contact with your local neonatal Repatriation Link/Liaison Nurses or Senior Coordinators within each unit.

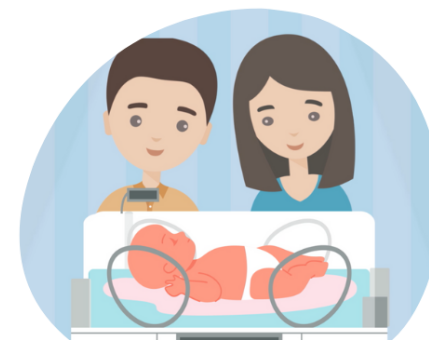
We would never transfer your baby without discussion with yourselves. However, the unit may need to contact you at short notice if the neonatal unit becomes full and your baby's care needs can be safely met by a local unit closer to home.

Moving units can be very daunting for parents but we will make every effort to support you throughout your baby's transfer.

The local team will have had regular updates about your baby's progress and your family's needs throughout your neonatal journey. This should help with the transition from one unit to another and any questions you may have. We will be able to provide you with general information about your local unit before transfer and the local team will orientate you to the unit once you arrive.

It may take several days for you to settle in and feel comfortable in a unit. This is a very normal feeling to have, but your new setting will soon become more familiar. Your local unit will be ready to help you to continue to develop your relationship with your baby, and to flourish and grow with the additional support of close friends and family around you.

We are always willing to answer any questions you have. Please contact a member of the nursing or medical team, who will be happy to help you.




Appendix 2B: Transfer; Our Baby Steps Journey Card

Date: / /

Transfer

Referring Hospital:



Receiving Hospital:

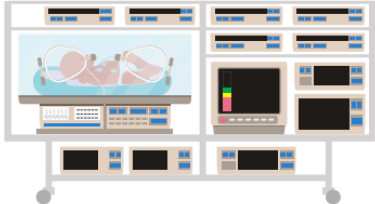
Moving from one hospital to another

Your baby may need transfer to another hospital for a variety of reasons, the neonatal team will explain why your baby needs to be transferred to that particular unit. This may be to give different care or treatment that your baby needs at this stage of their neonatal journey or to move to a unit closer to your home.


Moving units can be very daunting for parents but staff will support you throughout your baby's transfer.

The ambulance is specifically designed for neonatal transfers and has all the equipment that your baby needs including emergency equipment. The team are skilled neonatal specialists who are able to give the same care on the journey that your baby has received in the unit. They will always discuss with you the option of traveling with your baby in the ambulance.

A typical transport incubator



Scan the QR code below for more information:

Neonatal Transport service South East website		Transfer Closer to Home – repatriation video	
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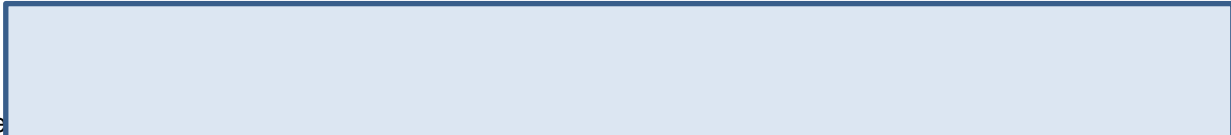
Appendix 3: Family Communication Record – for repatriation/Family Liaison Link Nurse

Family Communication Record

Baby's name:	DOB:	Gest:
Type of delivery:	Birth weight:	
Parent/carer email address:		
Transport:	Accommodation:	
Referral for travel/accommodation expenses:	Other information/notes:	
Date:	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Facetime <input type="checkbox"/> In Person	
Participants:		
What was discussed?		
Action/Follow up/Support		
Additional comments		
Next contact date:		



Thames Valley & Wessex Operational Delivery Networks
(Hosted by University Hospital Southampton NHS Foundation Trust)



Family Communication Record

Date:	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Facetime <input type="checkbox"/> In Person
Participants:	
What was discussed?	
Action/Follow up/Support	
Additional comments	
Next contact date:	

Appendix 4: BadgerNet Patient Record Referrals Function (Break glass Function)

The Patient Record Referral function within Badgernet (also known as Break Glass), is a vital tool in supporting effective and timely referrals. The tool allows the safe and secure sharing of clinical records (within Badgernet) between neonatal units to support transfer and repatriation discussions. The benefits of this are that:

1. Clinical records are accessible immediately by the receiving unit within Badgernet, eliminating the need to re-summarise / copy and paste information into emails.
2. Records are only accessible by the unit sharing records and staff on the receiving unit with access to Badgernet.
3. Duration of access to the record is time limited and set by the unit /staff sharing the record.
4. Both the sharing and the receiving unit can view the same information during discussions.

1. Accessing the Patient Record Referral Form

The Patient Record Referral form can be found on the admissions screen

Patient record referral
No patient record referrals recorded for this care episode.
Create new referral...

Clicking on the 'Create new referral' button will open the following form so that the record can be shared with another neonatal unit via Badgernet

2. Sharing clinical record with another neonatal unit:

Below is a complete example of a patient record referral.

- a. Date/Time: is automatically populated with the date/time the form was opened
- b. Referring hospital: is the hospital / neonatal unit with whom you wish to share the patient record; this opens a search window to select the correct hospital.
- c. Reason for sharing record: free text.
- d. Expires: date/time the record will no longer be available to unit shared with.
- e. User is automatically populated with the user logged in completing the form

Baby referral - Guys and St Thomas Hospital (nnu)

T:FDHV74PI2CF (NHS246810) BAPM, Baby
 Baby girl, singleton, born 01 Jan 23 at 00:01 at 23+1 weeks weighing 645 grams.
 Admitted 01 Jan 23 at 00:30 from Labour ward. Now in unit - day 17 of stay.
 Note Entry Day 17 Jan 23: Day 17 of life. Corrected gestational age is 25 weeks, 3 day Working weight 700g

Share patient record with other unit

a 17 Jan 23 at 13:12

b Referring hospital Queen Elizabeth, Woolwich Code: RQN03

c Reason for sharing record Repatriation to booking hospital.

d Expires 24 Jan 23 at 23:30

e User Rawin, Zeshan

Summary
 No referrals / data sharing for this patient

There is a section below this (Review at other hospital) which is for the destination hospital to complete and will be covered in the next section. Once the patient record referral form has been updated and the form has been saved and closed, the admission screen will be updated to show the active record referral.

Patient record referral
 Status: Active until 24 Jan 23 at 00:00
 Date: 17 Jan 23 at 13:12
 Unit: Queen Elizabeth, Woolwich
 Reason: Repatriation to booking hospital.

3. Accessing a Patient Record Referral

Patients Patient Lists Unit Daily Update Data Quality Unit Reports Service Console Videos Events Menu ClinBer

Search for titles

- Surgical Days
- Surgical reviews
- Radiology
- All abdominal X rays
- All cranial ultrasounds
- Respiratory Support
- CRAP
- Discharged in oxygen
- High flow oxygen
- Nasal Cannula oxygen
- Oxygen at 28 days
- Oxygen at 36 weeks correct
- Reassessed
- Tracheostomy
- Ventilated
- Tracheostomy
- ROP
- All ROP Events
- ROP - All screens due
- ROP - Book appointment
- ROP - Dates
- ROP - Follow up
- ROP - Hat screen
- ROP - First screen due now
- ROP - Treated
- Two Year Follow Up
- All two year follow ups
- MSOP Two year followup due
- Two year followup done
- Two year follow up due
- Two year follow up not done
- Unit referrals
- Referrals

Babies that have been shared with your unit

Returned 1 results.

National ID	Hospital ID	Name	DOB	Admitted	IP	Dist	BS	Current Unit	Referring to Unit Name
T:FDHV74PI2CF	NHS246810	BAPM, Baby	01 Jan 23	01 Jan 23	23	645		Guys and St Thomas Hospital (nnu)	Queen Elizabeth, Woolwich

Shared patient records can be found in **Patient Lists, Unit referrals, Referrals list.**

Double clicking on a patient from the list will open the patient record in Badgernet.

While the patient record is read only to the unit it has been shared with, opening the Patient Record Referral form from the admission screen will allow the unit to complete the 'Review at other hospital' section of the form. This is not mandatory – although is good practice to complete, providing an audit trail of when the record was viewed, and any other salient information recorded in 'Review comments'

Baby referral - Guys and St Thomas Hospital (nnu)

T:FDHV74PI2CF (NHS246810) BAPM, Baby
 Baby girl, singleton, born 01 Jan 23 at 00:01 at 23+1 weeks weighing 645 grams.
 Admitted 01 Jan 23 at 00:30 from Labour ward. Now in unit - day 17 of stay.
 Note Entry Day 17 Jan 23: Day 17 of life. Corrected gestational age is 25 weeks, 3 day Working weight 700g

Share patient record with other unit

17 Jan 23 at 13:12

Referring hospital Guys and St Thomas Hospital (nnu) Code: R3121

Reason for sharing record Repatriation to booking hospital.

Expires 24 Jan 23 at 00:00

User Rawin, Zeshan

Review at other hospital

Time reviewed 19 Jan 23 at 13:26

Reviewed by Dr Smith

Review comments Record reviewed and referral discussed via phone.

4. Accessing patient ready to Transfer/Discharge on Badgernet

1. Access discharge details stab from Discharges section of Badgernet.
2. Flag baby as fit for repatriation by selecting 'Transfer to other hospital' in the dropdown menu in the 'baby awaiting' section.
3. Enter name of the hospital where the baby is being repatriated to.
4. Once populated this information will be available to receiving unit on unit reports tab under 'cot availability' report

T:ZG3KG7VHM1E TEST, Baby
Baby boy, singleton, born 09 Nov 22 at 09:00 at 31+4 weeks weighing 1196 grams.
Admitted 09 Nov 22 at 09:17 from Theatre. Now in unit - day 91 of stay.
Note Entry Day 7 Feb 23: Day 91 of life. Corrected postnatal age 4 weeks past term. Working weight 1196g

Discharge details

Discharge letter details

Discharge Diagnoses (VON)

Research projects

Final Neonatal Outcome

Ready to Transfer/Discharge

Planned date of discharge

Date and Time baby fit to transfer/discharge at

Baby awaiting

Hospital Name and Code Code:

Suitable for

Appendix 5: BAPM Categories of Care August 2011

INTENSIVE CARE

General principle: This is care provided for babies who are the most unwell or unstable and have the greatest needs in relation to staff skills and staff to patient ratios.

Definition of Intensive Care Day:

- Any day where a baby receives any form of mechanical respiratory support via a tracheal tube
- BOTH non-invasive ventilation (e.g., nasal CPAP, SIPAP, BIPAP, vapotherm) and PN
- Day of surgery (including laser therapy for ROP)
- Day of death

Any day receiving any of the following:

- Presence of an umbilical arterial line
- Presence of an umbilical venous line
- Presence of a peripheral arterial line
- Insulin infusion
- Presence of a chest drain
- Exchange transfusion
- Therapeutic hypothermia
- Prostaglandin infusion
- Presence of repleg tube
- Presence of epidural catheter
- Presence of silo for gastroschisis
- Presence of external ventricular drain
- Dialysis (any type)

HIGH DEPENDENCY CARE

General principle: This is care provided for babies who require highly skilled staff but where the ratio of nurse to patient is less than intensive care.

Definition of High Dependency Care Day: Any day where a baby does not fulfil the criteria for intensive care where any of the following apply:

- Any day where a baby receives any form of non-invasive respiratory support
- (e.g., nasal CPAP, SIPAP, BIPAP, HHFNC)

Any day receiving any of the following:

- parenteral nutrition
- continuous infusion of drugs (except prostaglandin &/or insulin)
- presence of a central venous or long line (PICC)
- presence of a tracheostomy
- presence of a urethral or suprapubic catheter
- presence of trans-anastomotic tube following oesophageal atresia
- repair
- presence of NP airway/nasal stent
- observation of seizures / CF monitoring
- barrier nursing
- ventricular tap

SPECIAL CARE

General principle: Special care is provided for babies who require additional care delivered by the neonatal service but do not require either Intensive or High Dependency care.

Definition of Special Care Day: Any day where a baby does not fulfil the criteria for intensive or high dependency care and requires any of the following:

- oxygen by nasal cannula
- feeding by nasogastric, jejunal tube or gastrostomy
- continuous physiological monitoring (excluding apnoea monitors only)
- care of a stoma
- presence of IV cannula
- baby receiving phototherapy
- special observation of physiological variables at least 4 hourly

TRANSITIONAL CARE

General principle: Transitional care can be delivered in two service models, within a dedicated transitional care ward or within a postnatal ward. In either case the mother must be resident with her baby and providing care. Care above that needed normally is provided by the mother with support from a midwife/healthcare professional who needs no specialist neonatal training. Examples include low birth-weight babies, babies who are on a stable reducing programme of opiate withdrawal for Neonatal Abstinence Syndrome and babies requiring a specific treatment that can be administered on a post-natal ward, such as antibiotics or phototherapy.

Version Control:

Version	Date	Details	Author(s)	Comments
1	2014	Written		
2	2018	Reviewed		
3	2022	Reviewed and updated	Repatriation Group	Reviewed ready for Governance Meeting June 2022
4	2022	Ratified	Repatriation Group	Ratified at Governance Meeting June 2022
5	2025	Reviewed and updated , alignment with BAPM Framework	Repatriation Group	
6				
Review Date:	December 2028			

