

Northern Neonatal Operational Delivery Network (NNODN) 	
Clinical Guideline	
Title	Repatriation Guideline
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This clinical guideline has been developed to ensure appropriate evidence based standards of care throughout the Northern Neonatal Operational Delivery Network (NNODN). The appropriate use and interpretation of this guideline in providing clinical care remains the responsibility of the individual clinician. If there is any doubt please discuss with a senior colleague.	
It is the responsibility of all users of this guideline to ensure that the correct version is being used.	

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1.0 Introduction

Neonatal Networks and Healthcare Commissioners recognise that improving outcomes for the most vulnerable babies requires a multi-disciplinary streamlined approach. This involved centralising delivery and specialist care in centres of excellence, while also enabling local units to provide appropriate care closer to families' homes.

Infants requiring high dependency, intensive care or tertiary-level specialist care are transferred to the nearest appropriate Neonatal Intensive Care Unit (NICU) or Local Neonatal Unit (LNU), in line with Northern Neonatal Operational Delivery Network (NNODN) pathways. Once clinically stable and their needs align with Local Neonatal Unit (LNU) or Special Care Unit (SCU) specifications, repatriation should be arranged to facilitate care nearer the family home.

These transfers are scheduled and classed as non-emergency; ongoing parental conversation should occur, and a formal repatriation referral should be planned at least 24 hours in advance whenever possible. Repatriations are typically arranged during daytime hours by the Northern Neonatal Transport Team (NNeTS).

The term "*repatriation*" has historically been used within neonatal services to describe the transfer of a baby to a neonatal unit closer to their home. However, feedback from families has indicated that this terminology is not their preferred choice. To support a more family-centred approach, the phrase "*moving closer to home*" should be used when communicating with families wherever possible. This wording reflects both the geographical and clinical aspects of the transition while aligning more closely with the language families feel comfortable with.

1.1 Aim of the Guidance

This guideline ensures that infants and families within the NNODN receive timely, appropriate care as close to home as possible. It aligns with the principles of Safe and Effective Repatriation of Infants: A BAPM Framework for Practice 2023, which prioritises placing infants and their families at the centre of care.

It aims to:

- Improve clinical outcomes and family experience
- Promote timely and coordinated repatriation
- Ensure access to emotional and practical support for families
- Ensure repatriation is delivered within a trauma-informed, neuroprotective and Family Integrated Care (FiCare) framework

2.0 Guideline Scope

In accordance with the Safe and Effective Repatriation of Infants: A BAPM Framework for Practice 2023, repatriation is defined as the transfer of an infant to a neonatal unit closer to home for ongoing care following a period of neonatal intensive, high dependency, and/or specialist care. The purpose of repatriation is to ensure that infants who no longer require intensive or high dependency care can continue with their care either in a Local Neonatal Unit (LNU) or Special Care Unit (SCU) closer to their family home. (Toolkit High Quality Neonatal Services (Department of Health, 2009)).

This guideline provides clear and consistent guidance for healthcare professionals involved in the repatriation of infants within the NNODN. It aims to support a coordinated and safe repatriation process that prioritises the clinical needs of the infant while enhancing neuroprotective trauma informed FiCare practices.

This guidance does **not** cover escalation/uplift of care for clinical reasons.

3.0 Guideline Summary

- Clinical safety is paramount and must align with national service specifications.
- Efficient and timely repatriation, delivered within a trauma informed and FiCare framework, will improve the experience of families. Families must be kept informed and involved at every step.
- Timely, frequent, multidisciplinary, accurate communication with documentation between referring and receiving units is essential to the process –
- Multidisciplinary communication is essential between clinicians/nurses/Allied Health Professionals, psychologists and pharmacists (AHPPPs), transport teams and network leads at all stages of the repatriation process.
- Escalation should follow a clear pathway.
- Governance processes need to be in place to ensure learning when it is identified that things could be done better.
- Accurate data collection in the BadgerNet discharge form will enable audit and improvement of repatriation across the NNODN.

4.0 Main Guideline Content

4.1 Parental preparedness & family support

Following medical or surgical intensive care, infants should be repatriated to a neonatal unit closer to home whenever appropriate. While families are free to choose a maternity booking hospital outside their local catchment area, this choice applies to **maternity services only**. In line with the principles of Safe and Effective Repatriation of Infants: A BAPM Framework for Practice 2023, the return to local neonatal services will be arranged as clinically appropriate.

Repatriation should ideally prioritise the Unit nearest to the family's home, with consideration given to the most accessible transport links to ensure convenience for the family and continuity of care. Receiving hospitals should also take into consideration the location of the registered GP, especially where the baby may need longer term community follow up.

It is the aim to avoid several sequential repatriations to different units as circumstances evolve.

The final decision on the most appropriate unit should be communicated with the parents prior to the baby being ready for transfer. Effective communication about the repatriation process is essential to ensure a smooth transition for both the baby and the parents.

Repatriation preparedness can be commenced early - antenatally or soon after admission. From an early stage during the NICU admission, a structured, clear discussion should take place with parents regarding the anticipation for repatriation once their baby no longer requires intensive care. By ensuring a well-structured and transparent approach to repatriation, neonatal teams can facilitate a smoother transition for infants and provide parents with the necessary support throughout the process.

Parents should be given information about the receiving unit and signposted to the NNODN website for further details. In addition, units should ensure that up-to-date information, including virtual tours, is accessible via their websites and where appropriate, linked through on the NNODN website.

Where possible and practical, arrangements should be made for parents to visit the receiving unit prior to the transfer.

Neonatal teams can use the Moving Around the Network animation to support parents and guide them through the repatriation process. The resource can be accessed via this link or via the QR code.

<https://nornet.org.uk/parents-families/>



A trauma-informed approach to family communication is essential to ensure repatriation is conducted with sensitivity and transparency.

Families should be supported to understand the criteria for their infant's repatriation as soon as possible. Information should be clear, jargon-free, and provided in accessible formats. This ensures that when repatriation occurs, both the process and rationale are fully understood.

Communication must also accommodate specific needs, including translation into the family's first language, easy-read versions, or the use of visual aids where required.

Transferring to another unit should not disrupt established breast feeding, expressing, skin-to-skin or parental participation in feeding and caregiving. Parents should be encouraged and supported to maintain skin to skin and comfort holding before and after repatriation.

4.1.1 Key points for these discussions

Discussions to include:

- **Timing:** Conversations can be commenced antenatally. It is essential to begin conversations with parents soon after admission, revisiting them regularly as the baby's condition evolves.
- **Clarity:** Use simple, jargon-free language to explain what repatriation means and why it is planned. Think about the terminology used in these discussions e.g. 'Reduction in intensity' vs 'Step-down'.
- **Preparedness:** Families will need to be prepared both for the prospect of the transfer itself and for the differences that they will encounter in their local neonatal unit.
- **Neuroprotective Trauma Informed FiCare Approach:** Acknowledge and address any concerns families may have about moving to another unit, including travel, support, and care differences. Some families will struggle with the transfer and may be distressed by the idea of moving or the practical arrangements (for example uncertainty, long waits, moving whilst they were not on the unit). Families and the staff supporting them may need support from a psychological professional to navigate this period. Having a trauma informed approach to neonatal repatriation throughout the unit helps to make sense of distress and develop strategies to support families experiencing distress.
- **Planning Together:** Parents should be recognised as partners in care and involved in shared decision making throughout the transfer process, including identifying the most appropriate and accessible LNU/SCU for repatriation.
- **Provide written, virtual, verbal Information:** Offer information through various available platforms and/or contact details for support services of the units involved. Many neonatal units offer online virtual tours, face to face visits or information booklets. There is a helpful video for parents, and information leaflet regarding moving around the network available on the NNODN website. It is important that parents are made aware of these resources and supported to access them (considering families without access to a smartphone or computer, who speak English as an additional language or who have a disability impacting their ability to access resources).

4.1.2 Effective communication with families

Effective early communication ensures parents feel informed, involved, and supported, leading to better outcomes and experiences for both infants and families. Digital parent platforms such as vCreate, Badger Diaries for example, should be referenced and utilised where appropriate to enhance parental communication and continuity of care for parents.

The repatriation of clinically stable infants who no longer require intensive care will be initiated by the neonatal team at one of the NNODN NICUs. Planning should begin as soon as the infant is born at or transferred to a NICU.
4.1.3 Addressing Family Reluctance
Some families may express a reluctance or anxiety regarding the repatriation process. It is important to explore and understand the reasons behind this hesitation and provide appropriate support. Practical considerations such as travel planning, childcare responsibilities, and the perceived convenience or proximity of the current unit may influence the family's preference to remain where they are. In some cases, families may have had a previous negative experiences or trauma associated with care at their local unit, which can make the idea of returning feel distressing or unsafe. Some families may feel that returning to a smaller unit means that their baby will be less well cared for and not understand or recognise the positive step in their baby's journey that a repatriation should bring.
4.2 Triggers and considerations for repatriation
In line with BAPM guidance, gestational age and weight thresholds should guide, but not determine, repatriation decisions. Clinical stability and overall care needs must take precedence. Decisions should be made collaboratively between referring and receiving teams. This approach is particularly important during periods of regional capacity pressures, where flexible and collaborative network working supports equitable access to neonatal care across the North East North Cumbria region.
The weight and corrected gestational age thresholds for considering safe transfer of a preterm infant vary from the thresholds used for keeping an infant in an LNU or SCU at the time of delivery. This is because babies become more robust and better able to tolerate elective transfer, as they gain weight and maturity. However, the transfer itself, despite the best endeavours to maintain a calm environment, may still be a stressful experience. The weight threshold for repatriation is $\geq 1000\text{g}$. However, infants in the 800-1000g range may be considered for transfer in specific cases where they are considered very stable and safe for transfer, following discussion and agreement with the receiving unit.

The specific repatriation thresholds for clinically well and stable babies for each unit type are described in the table below.

Criteria	LNU	SCU
Corrected gestation (singleton)	≥ 26 weeks	≥ 30 weeks
Corrected gestation (multiple)	≥ 26 weeks	≥ 30 weeks
Weight	≥ 800g	≥ 1000g
Respiratory support	CPAP High Flow Short term ventilation following discussion with referring NICU	High Flow following discussion with referring NICU or LNU
Parenteral Nutrition	Yes	No
Central Venous Access	Yes	No
Volume of feeds	Half enteral feeds and tolerating for 48 hours	Half enteral feeds and tolerating for 48 hours
Continuous feeds	Yes	Following discussion
MRI following cooling	Yes	Case by case. Based on availability
Stoma care	Yes	Yes
Ventricular reservoir	Yes	Rare, considered following discussion with local team
Palliative care	Yes	Yes

Reference: Safe and Effective Repatriation of Infants: A BAPM Framework for Practice 2023

4.2.2 Retinopathy of prematurity (ROP)

Clear communication of screening schedules is essential. Transfer timing may be adjusted if treatment is anticipated.

4.2.3 Feeds

In line with BAPM guidance, in most cases, an infant would be expected to be tolerating at least 50% enteral feeds, for a least 48 hours, prior to repatriation from a tertiary unit to an LNU or SCU. This could be lower for transfer from NICU to LNU at consultant discretion. In post-surgical babies it might be closer to full enteral feeds.

4.2.4 Ventricular taps and tapping a ventricular reservoir

There is an expectation that an LNU would be able to care for an infant with a 'ventricular reservoir in situ' and perform the procedure of tapping a ventricular reservoir, if required. For transfer back to SCU, this should happen after consulting neurosurgery and SCU.

4.2.5 Twins and multiples

Please prioritise keeping neonatal siblings together whenever possible. Separation can amplify experiences of trauma for the family and impact long term outcomes for infants.

Where multiples are cared for in different locations, or where a twin or multiple sibling has died, teams should ensure sensitive communication, coordinated support and a trauma-informed approach to care.

4.3 Repatriation Procedure

Early in the NICU admission, experienced staff must clearly, unambiguously and sensitively discuss the likelihood of repatriation with parents, especially if the baby was originally booked or born in LNU or SCU. Once a NICU or LNU consultant deems the infant stable and no longer in need of intensive care or ventilation, the agreed-upon receiving unit should be notified by telephone, involving them in discharge planning if the baby has complex needs.

Where an infant is booked to deliver or is born in an LNU or SCU and transferred to a NICU or surgical unit it should be explained from the outset that there is high likelihood baby will be repatriated back to the local unit.

Once the receiving unit has accepted the baby, the referring unit is to contact NNeTS.

In alignment with the Safe and Effective Repatriation of Infants: A BAPM Framework for Practice, a gradual reduction in the intensity of care should be implemented, where clinically appropriate, over a period of 24–48 hours following repatriation. This includes decreasing the frequency of clinical observations and adjusting the level of nursing support. Such a phased approach allows families time to adjust to the care environment and practices in the home unit and supports a smoother transition from the referring unit (BAPM, 2022).

4.4 Triggering a Repatriation Flowchart

NNeTS Repatriation Flow Chart



NNeTS repatriation
conversation guidance

All conversations should be conducted with civility and remain professional at all times. Recognition should be given to the challenges that both receiving and sending units may be facing at the point of request.

4.5 Repatriation Process

As described by NNeTS

- Baby delivered at or admitted to a NICU or LNU
- Local unit informed of the admission (if the baby was delivered at a NICU or LNU) and the potential for repatriation
- At an appropriate stage, a conversation is held with parents about the potential repatriation, engaging them in the process
- Clinical assessment of the baby by the NICU or LNU team
- Consultant decision confirms that baby is fit for transfer
- Discussion with parents explaining the repatriation plan to facilitate care closer to home. Assessment of parental readiness/concerns
- A repatriation is triggered following the steps outlined in the NNeTS repatriation guidance document (above)
- Receiving unit expected to accept the baby within 48 hours
- NNeTS initiate the transport process and receive all relevant clinical information relating to the baby from the referring unit
- NNeTS team attends and prepares for transfer

4.5.1 AHPPPs & Multidisciplinary Involvement

Referring and receiving units should involve AHPPPs at every appropriate opportunity throughout the repatriation process. Handover between AHPPPs and the wider multidisciplinary team (which could include but not be limited to, the infant feeding lead, developmental care lead and FiCare lead), at both the referring and receiving units should be encouraged.

Include the AHPPP plan within the discharge summary. Recognition that specialist AHPPP services are not universally available. Ongoing requirements for AHPPP input should ideally not form a barrier to repatriation. Each case needs to be carefully considered.

4.6 Infection

In accordance with *Safe and Effective Repatriation of Infants: A BAPM Framework for Practice 2023*, the absence of isolation facilities or pending microbiology results **should not delay transfer**.

Colonisation status must be communicated at the point of referral, and transfers should proceed irrespective of an infant's bacterial or viral colonisation status. The transferring unit must provide the receiving team with the complete infection or colonisation profile to ensure appropriate infection prevention measures. Where clinically indicated—such as for RSV, CMV, GBS, or antibiotic-resistant organisms including MRSA, ESBL, or VRE—further discussion may be required among senior medical and nursing staff, microbiologists and infection control teams.

The lack of a cubicle for isolation of the infant is also not a criterion for refusal.

4.7 Surgical Cases – Post-operative Care and Repatriation

Following surgery, babies who are clinically stable can be repatriated to an alternative Neonatal Intensive Care Unit, Local Neonatal Unit, or Special Care Unit, as appropriate.

The repatriation pathway is designed to support babies in receiving safe, effective care closer to home, reducing family separation and promoting continuity of care.

Repatriation decisions should consider:

- The clinical stability and ongoing care needs of the baby.
- The ability of the receiving unit to provide the required level of post-operative support.
- Parental readiness and understanding, supported by appropriate education and involvement in care.
- The education, training, and confidence of staff at the receiving unit in managing post-surgical babies.

This approach ensures that both families and local teams are supported, whilst maximizing opportunities for babies to be cared for in a local setting.

4.8 Recommended Timeframe for Repatriation

The receiving neonatal unit is expected to accept a repatriation **within 48 hours** of the initial request being agreed.

If the receiving unit is unable to accept the baby within 48 hours, or if the transfer is delayed due to transport availability, the case will be added to the monthly >48hrs delayed transfers list, and the delay captured as part of a more detailed ongoing audit process.

These instances will be reflected in the NNODN reporting and will be reviewed via the Governance & Assurance meeting. Where a unit is unable to accept a repatriation, a consultant-to-consultant discussion, facilitated by the referring unit, is recommended to clarify the required level of care and assess transfer urgency particularly when capacity is a limiting factor.

4.9 Updating BadgerNet

The Patient Record Referral function within BadgerNet plays a vital role in facilitating efficient and timely communication between neonatal units. It allows for the secure and seamless sharing of clinical records, which supports discussions surrounding patient transfer and repatriation. Through this feature, receiving units can immediately access the referred infants' clinical information directly within BadgerNet, removing the need to manually summarise or email details.

Access is tightly controlled, and records are only visible to the originating unit and authorised personnel from the receiving unit who have appropriate BadgerNet access. Access is also time-limited, based on parameters set by the referring staff or unit. Both units benefit from real-time visibility of the same clinical data, improving clarity, safety and collaboration throughout the referral process.

For the patient record referral function, users are required to click on the 'Create new referral' button that will open the following form so that the record can be shared with another neonatal unit via BadgerNet.

T:FDHV74PI2CF - BAPM, Baby
(NHS246810) Baby girl, singleton, born 01 Jan 23 at 00:01 at 23+1 weeks weighing 645 grams.
Guys and St Thomas Hospital (nru) - Admitted 01 Jan 23 at 00:30 from Labour ward. CGA is 25wks, 3day, Day 17 of life.

Admissions
Unit admission details for all care episodes
(1) Guys and St Thomas Hospital (nru)
01 Jan 23 at 00:30
Admitted 01 Jan 23 from Labour ward.

Baby girl
Name: BAPM, Baby
NHS: TFDHV74PI2CF
Local: NHS246810
Badger: AA99JR
DOB: 01 Jan 23 at 00:01 (16 days ago)
Born at: Guys and St Thomas Maternity
Gestation: 23 weeks 1 days
Birthweight: 645 grams
Blood group: A+
Corrected Gestation: 25 weeks 3 days

Admission
Admitted: 01 Jan 23 at 00:30 to Guys and St Thomas Hospital (nru)
From: Guys and St Thomas Maternity, (Labour ward)
Type: Inborn - Booked
Category: Neonatal intensive care
Reason: Prematurity
Consultant: Dr Susen Tan
Admit weight: 645 grams
Admit temp: 37.4 °C
Problems: Extreme prematurity (<26 weeks). Signs of respiratory distress of newborn.
Notes: Born via C/S - Breech; no reason affixed at birth; none.

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

Data Opt Out - Baby
No data opt-out details recorded

As part of the referral process, the clinical record can be shared securely with another neonatal unit using the Patient Record Referral function in BadgerNet. A complete referral entry includes several automatically and manually completed fields. The date and time are automatically generated when the form is opened, and the user field is populated with the name of the person logged into the system.

The referring hospital field allows users to search for and select the appropriate neonatal unit with which the record is to be shared. A free-text field is provided to document the reason for sharing the record. Additionally, an expiry date and time can be set, after which access to the shared record will no longer be available to the receiving unit.

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: Rawan, Zeshan

Summary
No referrals / data sharing for this patient

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.

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.

4.10 Refusals and delays to repatriation

Delays in repatriation within the NNODN has the potential to cause multiple problems:

- It causes distress to families as it leads to uncertainty and impedes the process to enable care closer to home
- Contributes to capacity issues in specialist centres, resulting in delays in getting sick infants uplifted to tertiary centres
- Resultant capacity issues can impact the network system so that specialist NICU cots are not available within the network when required and therefore can require transport teams to have longer distances to cover, to move infants for intensive care or surgical cots

4.10.1 Escalation Process for Declined Back Transfer

Disagreements regarding transfer suitability will be resolved through discussion between the NICU/LNU Consultant, the LNU/SCU Consultant, LNU/SCU lead nurse and should also include a member of the NNeTS team.

Where it cannot be resolved between the referring and receiving unit despite clearly meeting the repatriation criteria and availability of cots, the ODN Clinical Lead and Network Manager are to be informed.

Delayed repatriations (over 48 hours) will be reviewed by the NNODN. Monthly reports of all transfers delayed beyond 48 hours will be generated from BadgerNet, and referring units may be asked to provide further information on the cause of delay.

When a baby is clinically appropriate for transfer this should be recorded on the BadgerNet system within the Discharges section.

The screenshot shows the 'Discharges' section of the BadgerNet system. On the left is a sidebar menu with options: Patient Summary, Admissions, Pregnancy details, Procedures / events, Tasks / reminders, Daily notes, All patient notes, Patient reports, Other reports / labels, Growth charts, Daily summary forms, Baby Diary, Discharges (highlighted in green), Simple stay view, and Follow-up. The main content area is titled 'Discharges' with a subtitle 'Summary of all discharges from any unit.' Below this is a search bar and a status indicator 'Now in unit - day 1 of stay.' The interface is divided into several panels: 'Discharge details' with fields for Date (not discharged) and To (not recorded), a 'Report' button, and 'Time of Discharge'; 'Letter Details' with 'Principal diagnosis' (No diagnosis recorded) and 'Principal procedures' (No principal procedures recorded); 'Summary of Stay' with a 'Summary of stay report...' button, 'GI/Hepatic' status (Jaundice), and 'BCG Risk' status (BCG indicated (unknown), BCG given (unknown)); and a 'DQ Checklist' on the right indicating 'Data quality items to be completed' and '5 still to be done'. A red arrow points from the 'Discharge details' tab to the 'Summary of Stay' panel.

To indicate that an infant is ready for transfer or discharge, users should navigate to the Discharge section in BadgerNet and open the Discharge Details tab. Within the 'Baby Awaiting' section, selecting 'Transfer to other hospital' from the drop-down menu signals readiness for repatriation. The receiving hospital's name should then be entered. Once completed, this information is automatically reflected in the 'Cot Availability' report under the Unit Reports tab, ensuring it is visible to the intended receiving unit.

The screenshot shows a software interface for patient management. On the left is a sidebar with a menu including 'Patient', 'Admission', 'Pregnancy', 'Procedures', 'Tasks', 'Daily', 'All patients', 'Patient', 'Other', 'Growth', 'Daily', 'Baby', 'Discharge' (highlighted in green), 'Simple', and 'Follow-up'. The main window is titled 'Ready to Transfer/Discharge'. It contains several sections: 'Ready to Transfer/Discharge' with a date/time picker and a dropdown menu currently set to 'Baby awaiting'; a dropdown menu with options 'Transfer to other hospital' and 'DischargeHome/Ward/PostCare' (indicated by a red arrow); 'Discharge' with a date/time picker and a 'Discharge to' dropdown; 'Measurements' with input fields for 'Weight' (grams), 'Length' (cms), and 'Head Circumference' (cms); and 'Data at time of Discharge' with a 'Populate from end of stay data...' button, 'Discharge Address', 'Discharge Postcode', and 'Milk at Discharge' fields. At the bottom are buttons for 'Audit trail...', 'Previous Tab', 'Next Tab', 'Save & Close', and 'Cancel'.

Repatriation should not be declined where capacity is available, as this may compromise the NNODN NICU/LNUs' ability to accept admissions and maintain patient flow across the system.

Both referring and receiving units should consider capacity and staffing issues to identify which unit is more significantly affected. If a receiving unit is unable to accept a transfer, the following procedure should be followed:

- Consultation: The senior nurse discusses the request with the consultant on duty, reviewing current patients to identify those who could be discharged home or transferred to alternative wards (e.g., postnatal, transitional care, or paediatric wards).
- Staffing assessment: The senior nurse/manager evaluates whether suitably competent staff can be redeployed from other areas or if additional bank staff should be arranged.
- Shift planning: Assess staffing and patient movements for subsequent shifts and advise whether repatriation can be temporarily deferred.
- Notification: Contact the NNeTS team as soon as capacity becomes available to facilitate transfer.
- Escalation: If a receiving unit consistently declines back-transfers, the NNODN Team will support discussions with senior management at the receiving hospital to resolve the issue.

Families should be informed that, while transfers usually return infants to their local NNU, an alternative unit may occasionally be used to ensure timely care if the referring NNU is

under significant pressure. Clear, supportive communication helps families understand the rationale and maintains confidence in their baby's care.

4.11 Out of Region Repatriations

These situations may occur following unexpected delivery at a geographically remote location, following a planned admission for specialist treatment or occasionally following a capacity transfer outside of the ODN. These repatriations should be undertaken as soon as it is clinically appropriate to support families and maintain regional capacity. Families who move to a new address during a prolonged NNU admission may also fall into this category.

5.0 Resources

Moving around the network animation	https://nornet.org.uk/parents-families/ 
Parent Information Leaflet – Moving Between Hospitals	
Facilities Document	
“About me” documents	
Checklist for Babies Being Transferred by NNeTS	neonatal-checklist-for-babies-being-transferred-by-nnets-07-04-25.pdf
Referring Unit Nursing Transfer Letter	nnets-form_regional-referring-unit-nursing-transfer-letter_final_nov-2017.pdf
NNeTS Guideline for Parents Travelling with their baby	nnets-parents-travelling-with-their-baby_g02_for-network-update-2024-rt-final.pdf

6.0 Monitoring & Audit

- Monthly monitoring of delayed repatriations

Appendix

Appendix 1 - Communication

Safe and Effective Repatriation of Infants A BAPM Framework for Practice

Communication

Trauma informed communication underpins safe and effective repatriation (see Figure 2).

Figure 2

Trauma informed communication

From the point of admission, families should feel listened to, and involved in discussions about their baby. Communication should aim to promote trust, transparency and collaboration between a family and the clinical team, respecting and empowering parents' voices and choices and supporting them to recognise that their baby is safe throughout the repatriation process.

Families should also hear the message "It is important to us that we are flexible and work with you to make decisions to meet the needs of your baby and your family. It is also important that we provide the right care for your baby in the right place at the right time. When it is safe, the right care for your baby will be in a unit closer to your home. If there are parts of the plan that feel tricky, the team can support you with that."

The following NHS England e-learning for health course explores this approach in greater depth, with very helpful specific examples of conversations about repatriation <https://www.e-lfh.org.uk/programmes/recognising-and-managing-conflict-between-childrens-families-and-healthcare-providers/>

Communication with families

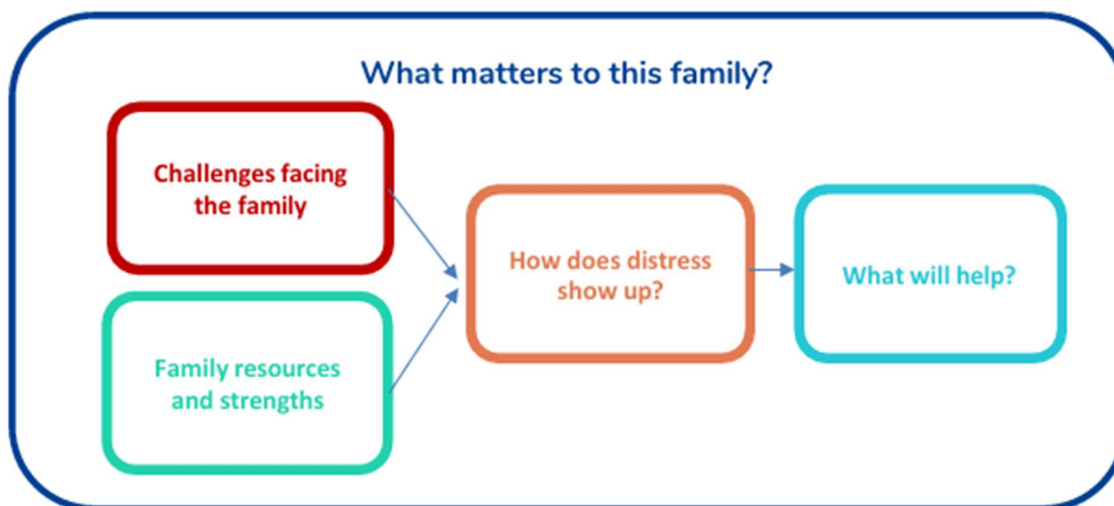
The following principles will help to deliver a trauma informed approach to communication with families:

- 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 (see Appendix 4 for good practice resources).
- 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 especially intensive levels of care prior to repatriation.
- 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.
- 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.

Appendix 2 - Support for Families (taken from the BAPM Repatriation Framework)

A framework for support

The following framework can be used to inform collaborative dialogue with a family to aid understanding of the support required around repatriation:



What matters to this family?

Understanding a family's preferences, priorities, values and cultural needs will help a team to engage with and collaborate in partnership with a family.

Challenges

What are the factors that may make repatriation more challenging for a particular family? This may include experiences of trauma, practical considerations, or differences in understanding.

Strengths

What strengths, resources and skills does a particular family have which will help them navigate the repatriation process? This may include a support network, or ways of managing distress that are working well.

How does distress show up?

Families may experience some uncertainty, concern and worry about the repatriation process, especially if they have experienced trauma during their perinatal journey. Communication of distress is shaped by families' own experiences and their cultural stories about distress. Taking time during an admission to understand how family members may express distress will help identify when and what type of support is best offered, regarding repatriation process and more generally.

What will help?

Understanding a family's preferences for the support they are offered, and their relationship with help more generally, will guide the clinical team towards offering support which is sensitive and attuned to a family's needs when difficulties arise.

Understanding reluctance

When families express reluctance to engage in a repatriation plan, efforts should be made to understand what underlies their reluctance and offer support where needed (see box below).

Understanding reluctance

There are many possible reasons why families may be reluctant for their infant to be repatriated to a local unit. There may be practical considerations why the current unit is preferable; historic trauma or problematic experiences of care in the home unit may make repatriation feel threatening for parents; traumatic experiences during a baby's current admission may make it harder for a family to feel that repatriation to a lower intensity of care is a safe plan.

The care team should take time to understand any reluctance expressed by a parent. The following communication approaches can help staff with these conversations.

Open questions to explore a family's perspective:

- "Help me understand your reluctance."
- "What is your relationship with that hospital?"
- "What would need to be different for this plan to feel ok for you?"

Reflect back feelings that families express:

- "You're feeling scared if your baby will be ok in the new unit."
- "You feel overwhelmed with the idea of getting to know a new team."

Approach with the attitude of "What matters to you?" and not "What is the matter with you?" More information on this approach can be found at:

<https://www.whatmatterstoyou.scot/>

Holding **firm boundaries** about the need for repatriation, at the same time as **understanding and being sensitive and responsive** to the challenges for a family is the essence of **compassionate, trauma-informed approach** to repatriation.

References

1	BAPM 2001 standards for providing intensive and high dependence care
2	Safe and Effective Repatriation of Infants A BAPM Framework for Practice June 2023
3	Department of Health (2009) <i>Toolkit for High-Quality Neonatal Services</i>
4	NHS England Neonatal Critical Care Service Specifications EO8/S/a
5	NHS England Neonatal Critical Care Retrieval (Transport) EO8/S/b