British Association of Perinatal Medicine

Safe and Effective Repatriation of Infants

A BAPM Framework for Practice

June 2023

Contents

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Glossary of terms

AHP	Allied Health Professional
ANNP	Advanced Neonatal Nurse Practitioner
BAPM	British Association of Perinatal Medicine
CPAP	Continuous Positive Airway Pressure
FiCare	Family Integrated Care
HRG	Healthcare Resource Grouping
ICB	Integrated Care Board
IPC	Infection Prevention and Control
IUT	In Utero Transfer
LMNS	Local Maternity and Neonatal System
LNU	Local Neonatal Unit
MDT	Multi-Disciplinary Team
NHSE	National Health Service England
NICU	Neonatal Intensive Care Unit
NTG	Neonatal Transport Group
ODN	Operational Delivery Network
PICC	Percutaneously Inserted Central Catheter
QIP	Quality Improvement Programme
ROP	Retinopathy of Prematurity
SAMHSA	Substance Abuse and Mental Health Services Administration
SCU	Special Care Unit
TCVC	Tunnelled Central Venous Catheter

Summary of recommendations

1. Clinical safety is paramount, and any repatriation guidance should stay within national service specifications for neonatal critical care.

2. Timely repatriation has the potential to enhance family experience with use of trauma-informed care framework.

3. Infants and their families should be signposted to appropriate and relevant information about the repatriation process, and offered support using guidance/tools listed in this framework.

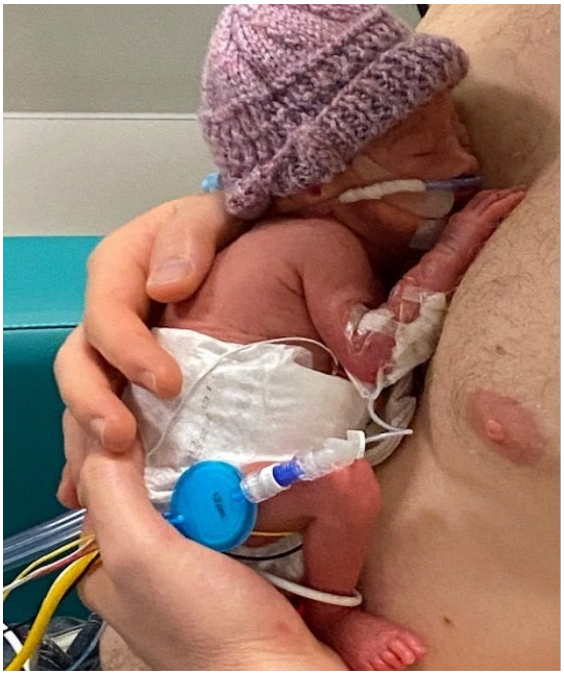
4. Multidisciplinary involvement, regular and responsive communication between providers, transport service, network teams and other governance systems are essential to the repatriation process.

5. Ongoing requirement for specialist Allied Health Professional input into infant's care should be carefully considered during the repatriation process. However, it is important to acknowledge the fact that specialist AHP services are not currently available in all units. To maintain sufficient capacity in NICUs this should not form a substantial barrier to repatriation. Trusts unable to provide these services should prioritise addressing this gap in their workforce planning.

6. Data collection and audit listed in this framework should be used to build and improve existing pathways and processes.

7. Repatriation criteria listed in this document are broad recommendations and should be adjusted to meet specific local/regional needs.

Parent Story



Six days after the birth of our daughter Jessica at 27 weeks at a large level 3 hospital, we were moved to a level 2 hospital closer to home.

We **felt nervous** about the move but the **transportation team were very reassuring and empathetic**, giving us a **leaflet preparing** us for what the trip would involve, allowing me to travel in the ambulance with Jessica and keeping me updated throughout the journey.

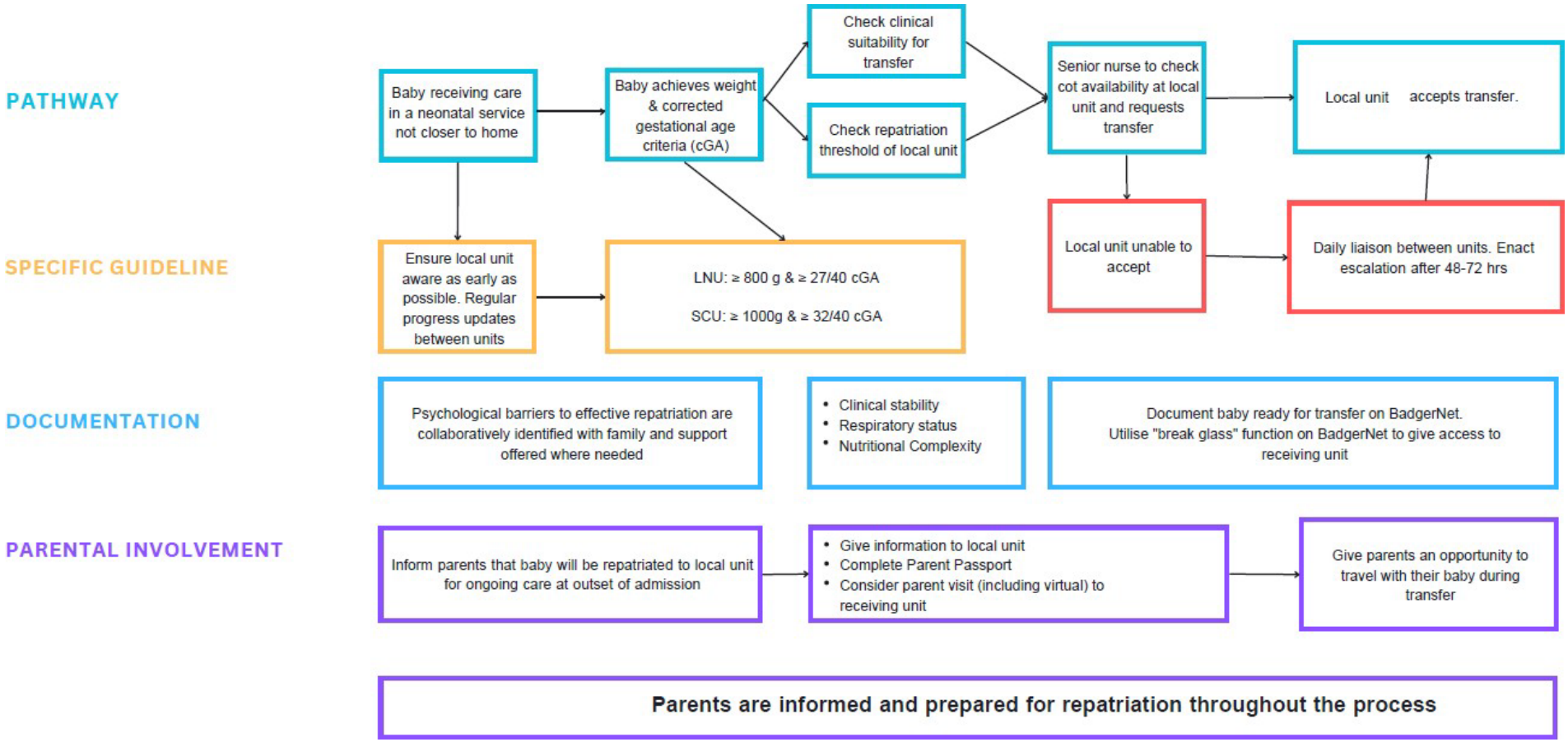
The differences between a level 3 and level 2 hospital **were greater than we'd expected** and including this as part of our **preparation**, and possibly arranging for pre-visit and chat with local team would have definitely helped with the transition.

We found the unit smaller and the staff didn't speak as quietly as they did at the level 3 hospital. Seemingly trivial things, such as a metal dustbin hitting the sink next to Jessica's incubator as staff threw away gloves, medicine etc, really matter when your baby is premature and she underwent numerous tests on arrival which we hadn't expected. Next day the consultant came and spoke to us and explained that it was safe for Jessica to be in a level 2 unit and focus then was on support her growth and development. We were introduced to physiotherapist and developmental care team which we found useful.

Information on the **availability/accessibility** of these services beforehand would have put our minds at ease.

That said, Jessica's medical care was fantastic. Thanks to the doctors, consultants, dieticians and physios she is doing really well and for that we are really grateful.

Repatriation flow chart



Introduction

Purpose

This framework intends to promote a shared understanding of the benefits of safe and effective repatriation following a period of neonatal specialist and/or intensive care. It aims to place infant and family at the centre of the process to enhance family centred/integrated care, thus ensuring better outcomes and experience for infants and their families.

"The differences between a level 3 and level 2 hospital **were greater than we'd expected** and including this as part of our **preparation**, and possibly arranging for pre-visit and chat with local team would have helped with the transition."

Lived experience of a parent

Background

Safe, high quality, family centred care at an appropriate location closer to home is a vital aspect of neonatal care. Neonatal care is organised and delivered within perinatal care networks. This model recognises the importance of pathways for specialist care within an agreed geographical footprint. Regionalisation of neonatal care into defined geographical areas or networks has unquestionably improved outcomes[1,2] for infants who require intensive care but this resulted in the need for infants to be transported between services in a network.

There are 10 Neonatal Operational Delivery Networks (ODN) established and functioning within England and similar arrangements exist across Northern Ireland, Scotland and Wales. The units are designated as Special Care Units (SCU), Local Neonatal Units (LNU) and Neonatal Intensive Care Units (NICU). All levels of units are expected to provide transitional care service to support infants with lower level of needs, allowing mothers and infants to stay together. Specific criteria for various types of neonatal care are outlined in the BAPM Service and Quality Standards and the neonatal service specification in England (NHSE E08Sa)[3].

Transfer of these infants to an appropriate level of care closer to home is referred to as repatriation. Repatriation is less well studied than acute transfer but forms an important aspect of networked neonatal care. 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.

Limited evidence from literature backed by pragmatic, logical narrative indicates that repatriation following a period of specialist care is a vital cog in the wheel of neonatal care. This framework intends to provide broad guidance on principles, processes and procedures that would aid effective repatriation.

Definition

Repatriation: Transfer of an infant to a unit closer to home for continuing neonatal care following a period of neonatal intensive, high dependency and/or specialist care.

Synonyms: Back transfer, Retro transfer.

Scope

This document intends to provide guidance to health care professionals pertinent to repatriation of infants to a neonatal unit closer to home for ongoing care. It does not cover escalation of care for clinical reasons. Capacity transfers are not the focus of this framework but because of its association/relevance will be briefly addressed in the section on Capacity repatriations.

Typical Repatriation scenarios

- Return to a neonatal unit closer to home following a period of medical or surgical intensive care.
- Returning to home service following; specialist opinion, investigation, treatment, procedure (e.g. surgery/cardiac/ROP), or clinical review. The returning service may sit outside of the ODN pathway.
- Geographical return to local area: When babies are born outside of their local area in which the pregnancy was booked, often due to parents being on holiday, visiting other areas of the country or being overseas.
- The choice of booking hospital for maternity services is open and families may choose to book at maternity unit outside their local catchment area. This choice is for maternity services only and repatriation to local neonatal services will occur as appropriate.

Framework for Practice: process and review

Principles of effective repatriation:

These high-level principles aim to ensure an individualised care approach for each infant, to support the right level of care in the right clinical setting for on-going care needs.

- Family involvement throughout the entire process.
- A trauma-informed approach (see Figure1).
- Care closer to home whenever possible.
- Standardised approach across networks.
- Multidisciplinary (MDT) involvement from referring and receiving units should include: parents, neonatal transport service, lead consultant, lead quality nursing roles (FiCare, Discharge Planning etc), AHPs, and Practitioner Psychologist.
- A standard dataset should be agreed and monitored at network level to inform benchmarking and quality improvement.
- Consistent Infection Prevention and Control (IPC) guidelines should be in place, with robust communication of known colonisation or infective micro-organisms.
- Aim to complete repatriation within 48 hours of agreed unit specific criteria being met – this should be outlined in network guidance.
- Escalation process to be in place to facilitate timely repatriation.
- Audit/evaluation of family experiences of repatriation should be carried out.

Trauma Informed Approach to Neonatal Repatriation

Figure 1

Repatriation, and neonatal transfer in general, can be a significant source of distress for families. In the context of an already potential traumatic hospital admission[6], repatriation should be understood as a "critical event" for families[7,8] which may amplify or exacerbate parental experiences of trauma.

To mitigate the risk of increased vulnerability for families around repatriation, this framework adopts a trauma informed approach (SAMHSA, 2014)[9], by:

- **Realising** the potential for repatriation to be experienced by families as traumatic.
- Supporting staff to **recognise** when families are experiencing trauma in the context of repatriation. Outlining pathways for **responding** to trauma through additional support
- **Resisting re-traumatising** families in the way that repatriation is approached.

In line with the principles of a trauma informed approach (SAMHSA, 2014)[9], this framework aims to promote, within the repatriation process, experiences of:

- **Safety:** Families feel that their baby is in a safe environment.
- **Trust & transparency** between families and care teams.
- **Collaboration & mutuality** in the relationships between families and care teams.
- **Peer support** for families.
- **Empowerment, voice and choice** for families
- Sensitivity to **cultural, historical and gender issues**.

Additional information about trauma informed approaches in neonatal care and perinatal period can be found in Sanders and Hall (2018)[10], and in the following NHSE good practice guide: https://www.england.nhs.uk/publication/a-good-practice-guide-to-support-implementation-of-trauma- informed-care-in-the-perinatal-period/

Roles and Responsibilities

To ensure that the principles of effective repatriation are enacted, individual roles and responsibilities need to be identified.

Networks

- Ensure a repatriation pathway is in place and unit specific repatriation criteria agreed as per service specification. This should be reflected within network guidance.
- A tracking system of in-utero transferred women for all units should be in place.
- Involve parents/families in development of local criteria ensuring co-production of network guidance.
- Include repatriation metrics in quality dashboards; these metrics should include:
  - Number of High Dependency (HRG2), Special Care (HRG3) and Transitional Care (HRG4)[^] days provided in NICUs for infants born to mothers not booked in that centre.
  - Time from clinical readiness to repatriate to actual repatriation.
  - Reasons for delays to clinical readiness to repatriate (including clinical factors, staffing, infrastructure issues, availability of specialist AHP and Psychology services at the receiving unit to support ongoing care).
- Monitor/audit defaults or exception on above metrics.
- Ensure escalation pathways in place and followed for refusals and delayed repatriations.
- Facilitate shared learning across the network to improve safe and effective repatriation.
- Ensure standardised repatriation information and resources are available for families.
- Discuss repatriation data on network governance meetings.
- Ensure there is a process for adopting FiCare passports across the network units.

NICUs

- Adhere to Network guideline.
- Ensure repatriation planning starts soon after admission in partnership with parents
- Referring unit to activate "Patient Referrals function" in BadgerNet settings, to enable receiving unit to view patient record for any babies who have not previously been in the unit but are to be repatriated from the referring unit. (See Appendix 1, Sections 1-3).
- Ensure the 'Patient ready for transfer' box is checked on Discharge details section in BadgerNet (Appendix 1, Section 4).
- Ensure escalation pathways in place and followed for refusals and delayed repatriations.
- Consider a repatriation liaison/link role (see sample job description in Appendix 2).
- Ensure network FiCare passport use in local service.
- Ensure there is a process in place for ongoing referrals to AHPs and specialist Psychology as required.

[^] These should be reported using HRG2016 levels of care which refer to HRG2 as XA02Z, HRG3 as XA03Z and HRG4 as XA04Z

LNU /SCUs

- Adhere to Network Repatriation Guideline.
- Develop and maintain a process to monitor infants transferred in or ex-utero from your service.
- Seek weekly updates from NICU in order to plan timely repatriation.
- Prioritise surgical repatriations in order to protect surgical cot capacity within surgical NICUs
- Exception reports to ODN with analysis of delay in accepting back transfer.
- Ensure escalation pathways in place and followed for refusals and delayed repatriations.
- Consider a Repatriation liaison/link role (see sample job description in Appendix 2).
- Ensure network FiCare passport use in local service.
- Ensure there is a process in place for ongoing referrals to AHPs and specialist Psychology as required.
- Arrange for parent visit or virtual tour prior to repatriation.

Transport service

- Agree on network repatriation and stability criteria for transfer.
- Audit practice against these criteria and present at network meetings.
- Agree on a process for organising repatriations that is easy for teams to navigate and delivers timely transfers.

LMNS/Commissioners/Integrated Care Boards

- Consideration to be given towards a cot bureau service across LMNS systems which is sustainably funded.
- Commissioning agreements for neonatal units and transport services should focus on deliverability and accountability for network pathways.
- Ensure commissioning of transport services is financially sufficient to provide capacity for safe and effective repatriation.

Support for families

Support for families around repatriation should be considered according to a stepped model of care, such as the Paediatric Psychosocial Preventative Health model[11]. Because repatriation is a time of change and transition and can be seen as a "critical event" for families[7], all families should have access to universal support. For those families who experience more worry or concern about repatriation, or for whom there are additional psychosocial risk factors (e.g. limited network of support in friends and family), targeted support should be offered to minimise the impact of the repatriation transition. When the needs of the family are more complex or acute, specialist support should be available.

Universal support

- Information and communication about the repatriation process should be clear and collaborative (see "Communication" section).
- Where possible, a gradual reduction of intensity of care (e.g. frequency of observations and level of nursing care) should be adopted over a period of 24 – 48 hours following repatriation to allow families time to adjust to new care practices on the home unit.
- Families whose baby is repatriated should have access to a network of peer support by parent support groups, or where available veteran parents for peer mentoring.

Targeted support

- Appendix 3 outlines a framework for collaborative dialogue with a family to identify targeted support needs.
- For families who are reluctant to engage in a repatriation plan, Appendix 3 also offers suggestions for how conversations can be approached to understand their reluctance.
- Members of the MDT should have access to training and support from psychological professionals to engage in these conversations.

Specialist support

Specialist Psychological Support

- For families who experience concern and worry about repatriation, psychological support should be offered, in line with the model of care described in the standards 'Psychology Staffing on the Neonatal Unit'.
- Families may have been receiving additional support from psychological professionals during their baby's admission prior to repatriation. In such cases, a joined-up approach should be taken with collaborative handover of support from the NICU or LNU to the home unit.
- Where the provision of psychological support in the home unit is not equivalent to that in the NICU or LNU, units could arrange an agreement to allow a brief, time-limited period of continuity from the NICU or LNU psychological support service during the transition. The purpose of this continuity is to ensure there is a safe ending to any ongoing intervention, and to signpost families to alternative sources of support.

Allied Health Professions (AHPs)

- Relevant AHPs should be involved early in discussions about repatriation. It is important for families to feel reassured and confident that the continuum of care is unbroken.
- If infants are under the care of an AHP there should be a process in place to ensure an active referral is made for ongoing care with counterparts in the receiving unit if this service is available. If such service not available, an onward referral to community services should be made by tertiary service prior to repatriation.
- To ensure the ongoing quality of care for specific treatment plans, relevant AHPs should communicate between units. These conversations should begin early if longer term AHP care is likely.
- Communication of treatment plans from referring centre AHPs should be provided in a written format to receiving unit AHPs to support repatriation. In addition, a verbal handover may also be useful to support AHPs in receiving units.
- Where possible, AHPs should add a brief summary of care to the discharge letter.

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.

Communication between provider units

Adequate preparation and early communication between referring and receiving unit is a key aspect of a safe and effective repatriation process[11].

- Include infants who fulfil repatriation criteria in daily safety huddles and handovers.
- Regular two-way communication between receiving and referring unit regarding infant's clinical status and plan for repatriation. This should include communication between AHPs and practitioner psychologists, where applicable.
- Where there is a delay or complex requirements, consultant to consultant communication should take place.
- Where there is safeguarding concern and/or multi-agency involvement in infant/family's care this should be communicated to receiving unit well in advance of repatriation. This would enable adequate dialogue and planning between relevant professionals.
- A process to audit these interactions with an aim to improve communication should be in place.
- Patient Record Referral function within Badgernet (Appendix 1) should be utilised where appropriate. This allows receiving local unit to view read-only record of an infant that is within their catchment area, who is currently within another unit.

Repatriation Criteria

This section includes an indicative list of criteria for repatriation of infants. Individualised assessments of readiness for repatriation must be specific to each baby, recognising their clinical needs, available expertise and facilities and the unit-specific criteria in the preferred Local Neonatal Unit (LNU) or Special Care Unit (SCU), as well as the specific needs of each individual family.

Criteria for repatriation detailed in this guidance considers definitions in the NHS Service Specifications for Neonatal Critical Care for NICUs, LNUs and SCUs for England. Any exceptions to this should be agreed at network level with agreements clearly documented and agreed with Specialist Commissioning and LMNS.

Guiding principles

- **Clinical stability of the baby is more important** than corrected gestation and weight criteria for repatriation purposes.
- There should be a **clear on-going management plan** of the infant's care needs before repatriation, including ongoing input from specialist teams (see section 5.4). Specialist AHP and specialist psychological input should also be considered.
- **Multiple births should be repatriated together**, and separation of families should be avoided wherever possible, as this can result in (or amplify) experiences of trauma for family.
- 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.
- It should be acknowledged that the benefits of a networked approach for repatriation may result in infants moving to care settings that are unable to offer a full range of AHP and psychological services/support. Innovative models of support could be considered e.g., virtual MDTs, ward rounds etc to extend a level of support. However there should be an appreciation that not all centres offer ongoing MDT support (including AHPs) due to capacity and current funding.
- Repatriation transfer is a planned event on most occasions and therefore should happen during normal working hours to minimise disruption to families.

Proposed criteria for repatriation

The provision to meet these criteria may not be in place within all units, for example a SCU may not be able to provide parenteral nutrition or non-invasive respiratory support. These criteria are to outline where consideration to repatriation should take place if the facilities and skills are available in the LNU/SCU. Gestational and weight threshold need to be met along with with other criteria before repatriation.

Criteria	LNU	SCU
Corrected gestation (singleton)	≥ 27 weeks	≥ 32 weeks
Corrected gestation (multiple)	≥ 28 weeks	≥ 32 weeks
Weight	≥ 800 grams	≥ 1000 grams
Respiratory support	CPAP/High Flow Oxygen Short term ventilation following discussion with referring NICU	CPAP/High Flow Oxygen
Parenteral nutrition	Yes	No
Central Venous Access	Percutaneously Inserted Central Line (PICC or Long line) Tunnelled Central Venous Catheter (TCVC e.g., Broviac or Hickman Line)	No
Volume of feeds	Half enteral feeds and tolerating for 48 hours	Half enteral feeds and tolerating for 48 hours with no expected issues in reaching full enteral feeds
Continuous feeds	Yes	Yes- where dietetic and SLT input is available to put a home plan into place.
MRI following cooling	Yes (based on available expertise and resources, to be agreed at ODN level)	Yes (based on available expertise and resources, to be agreed at ODN level)
Stoma care	Yes	Yes
Ventricular reservoir	Yes	No
Palliative care	Yes	Yes

Criteria for transport service

- Where an infant is to be transferred across commissioning or network borders the responsibility for the transfer lies with the team covering the infant's booking hospital of delivery (as per service specification).
- The final decision on fitness for transfer will be with the Transport Clinician.
- All fluids should be made up to the requirements in local Transport guidelines.
- All transport teams should to be able to provide all common non-invasive ventilation modes in order to facilitate timely repatriation.

Babies with complex care needs

Some infants may have complex care needs beyond that encountered in extreme preterm or a sick term baby e.g., post-surgical infants, need for complex ongoing interventions (ventricular drainage), long-term parenteral nutrition, tracheostomy care, etc. Repatriation decision for these infants should not be just criteria based but include all relevant stakeholders (including local paediatric service for infants > 44 weeks corrected gestation). Specialist teams should ensure clear ongoing management plans are made and communicated to local teams for transfer.

Repatriation outside normal pathways

Out of area repatriations
There may be situations where following an unexpected delivery in a network outside the family's geographical network, a planned admission for specialist treatment or capacity, or family re-location requires repatriation across network boundaries. The following should be considered:

- Network to monitor out of area activity.
- Responsibility of transport of these infants sits with the home network.
- Principles of communication to be continued and observed.
- Family support should be offered as outlined in Appendix 3.

Capacity repatriations
Capacity/staffing or extraordinary incidents related to infant movements should follow locally agreed escalation pathways.

- Receiving units will still be expected to be compliant with agreed service specifications for the service.
- Networks should have clear business continuity and escalation plans.

Other scenarios specific to maternity care
Antenatal counselling of women in local services prior to in-utero transfer should be an opportunity to explain pathways of neonatal care including back transfer to the local neonatal service when this is appropriate.

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.

Additionally, 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.

Infection prevention and control
Repatriation of babies should proceed irrespective of their bacterial or viral colonisation status. However, the referring unit must communicate any colonisation or infection status of the baby so that appropriate precautions and any required enhanced measures can be put in place at the receiving unit. Further discussions between senior medical and nursing staff should include the microbiologist and infection control staff where appropriate. Lack of isolation facilities or results from microbiology investigations should not delay transfer. Networks should have guidance on levels of isolation relevant to their units.

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Appendix 1: Patient Referrals in Badgernet

NB The example used in this guide is a fictional patient used for demonstration purposes only.

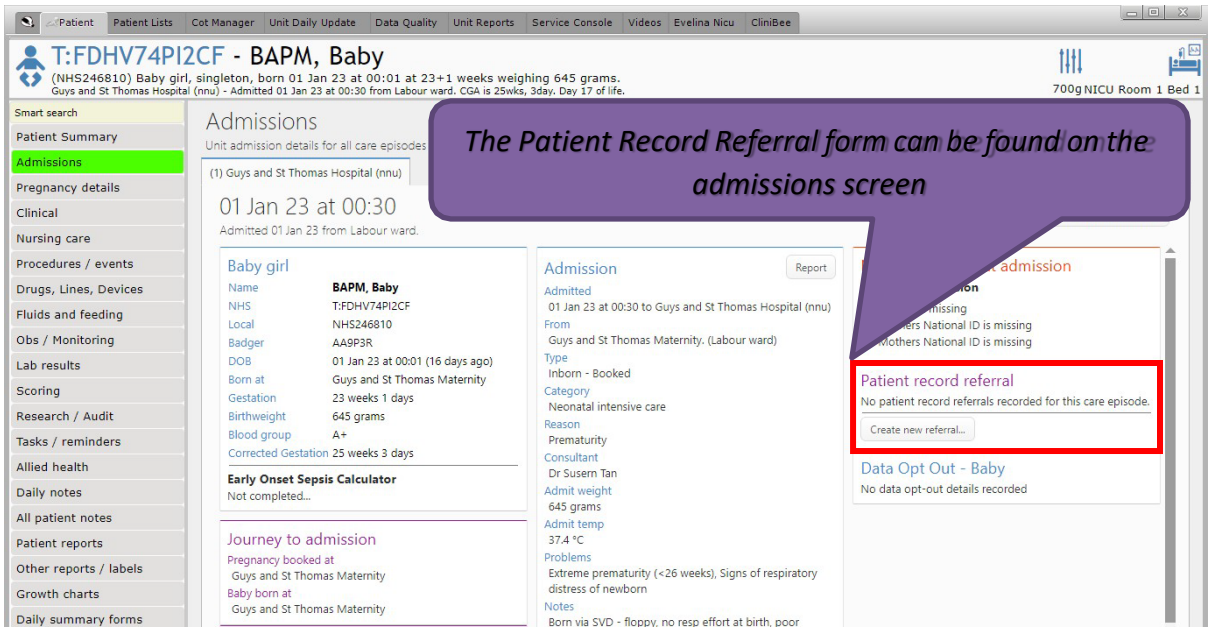
The ***Patient Record Referral*** function within Badgernet (also known as ***Break Glass***), is a vital tool in supporting effective and timely referrals.

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

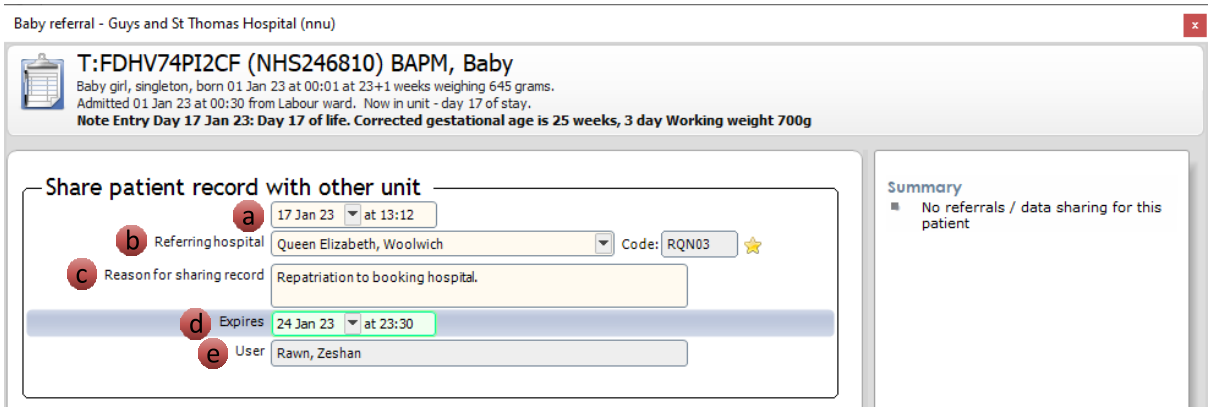


Clicking on the '***Create new referral***' button will open the following form so that the record can be shared with another neonatal unit via Badgernet.

2. Sharing clinical record with another neonatal unit

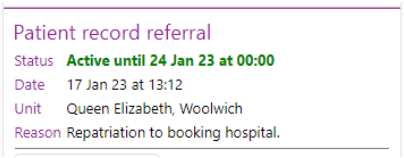
Below is a complete example of a patient record referral.

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.

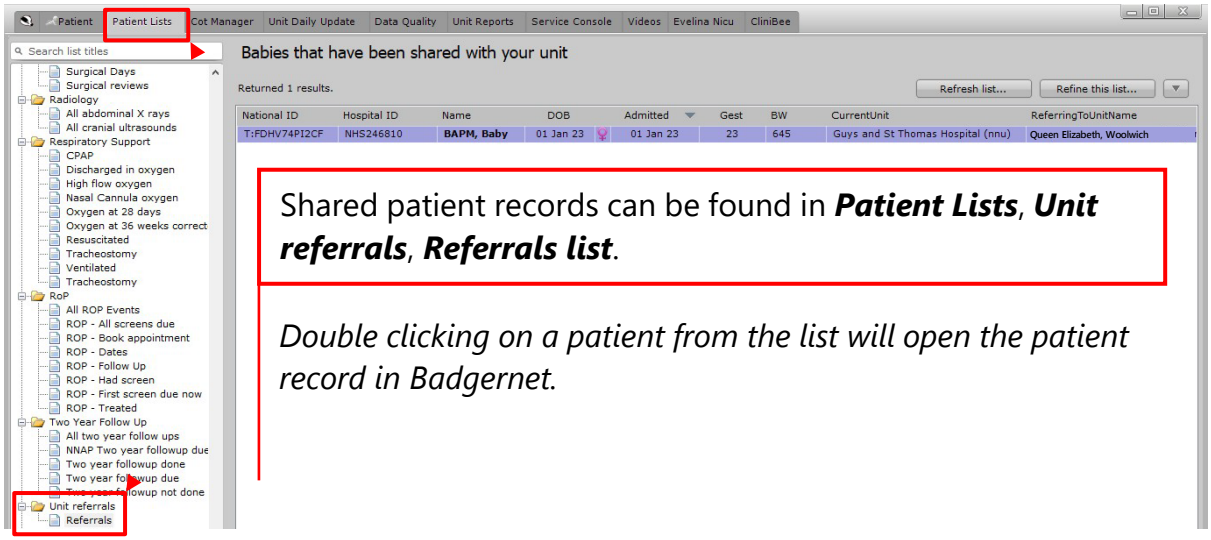


There is a section below this (***Review at other hospital***) which is for the destination hospital to complete and will be covered in the next section.

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.



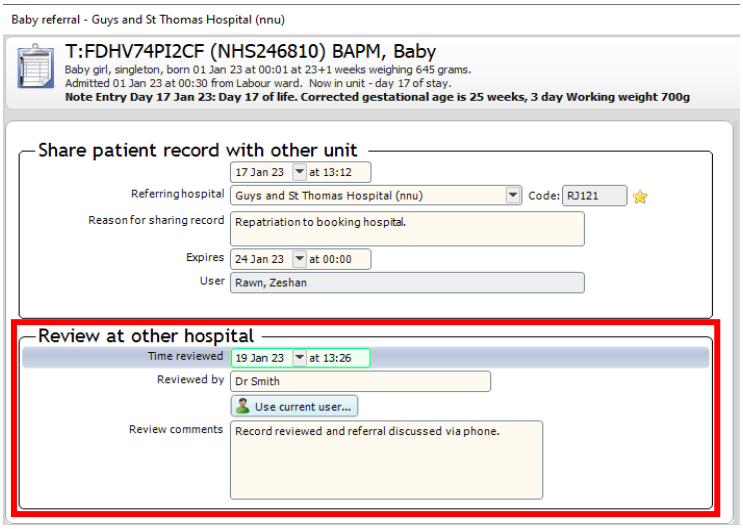
3. Accessing a Patient Record Referral



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

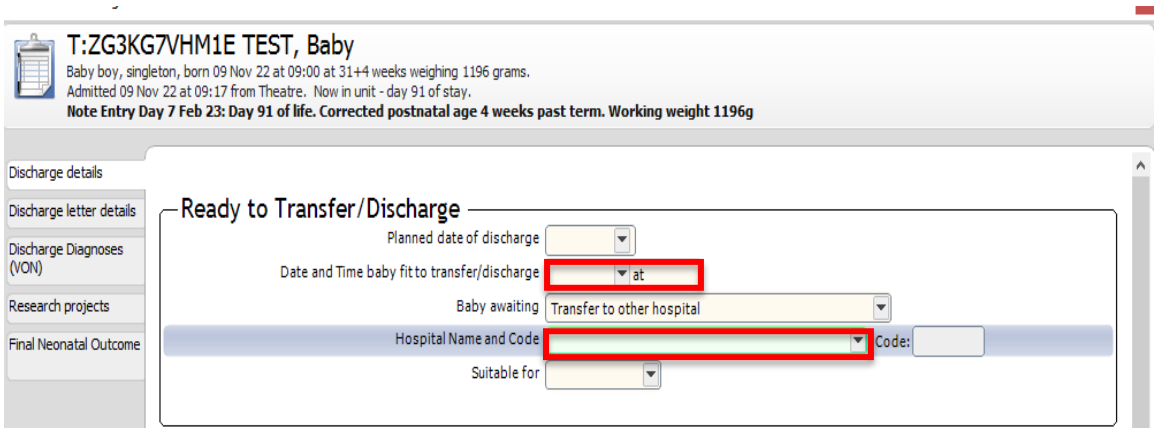
Double clicking on a patient from the list will open the patient record in Badgernet.

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***'.

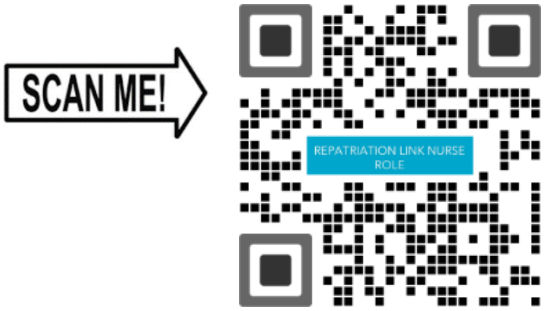


4. Accessing patient ready to Transfer/Discharge on Badgernet

1. Access discharge details tab from Discharges section of Badgernet.
2. Flag baby as fit for repatriation by selecting 'Transfer to other hospital' in the drop down 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.



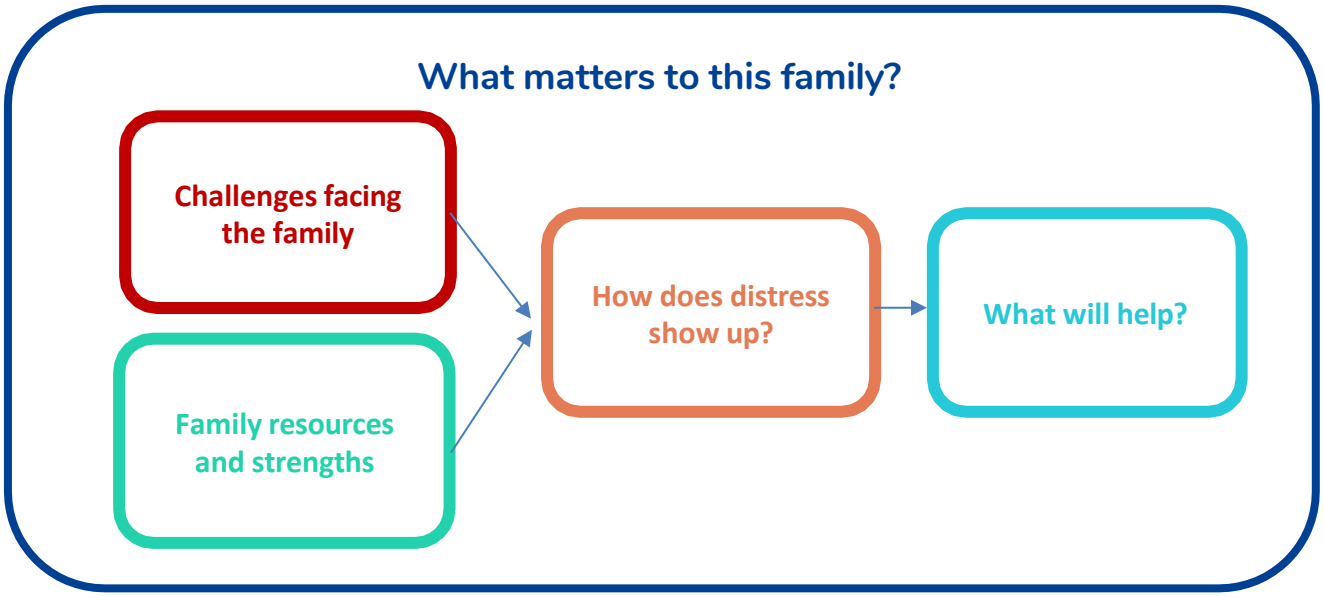
Appendix 2. Job Description



Appendix 3. Support for Families

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/

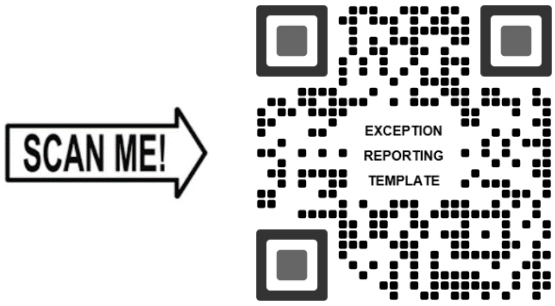
Holding **firm boundaries** about the need for repatriation, at the same time as **understanding and being sensitive and responsive to** the challenges for a family is the essence of **compassionate, trauma-informed approach** to repatriation.

Appendix 4: Good Practice Resources

Parental Resources

Repatriation Communication Proforma (NICUs & LNU/SCUs)

Exception Reporting Template



BAPM

Leading Excellence in Perinatal Care

This document was produced by the British Association of Perinatal Medicine (BAPM).

BAPM a membership organisation that is here to support all those involved in perinatal care to optimise their skills and knowledge, deliver and share high-quality safe and innovative practice, undertake research, and speak out for babies and their families.

We are a professional association of neonatologists, paediatricians, obstetricians, nurses, midwives, trainees, network managers and other health professionals dedicated to shaping the delivery and improving the standard of perinatal care in the UK.

Our vision is for every baby and their family to receive the highest standard of perinatal care. Join us today.

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British Association of Perinatal Medicine (BAPM)
is registered in England & Wales
under charity number 1199712 at
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