Clinical Guideline: East of England Paediatric Regional PCC Repatriation Guideline

Authors: Regional Repatriation Working Group

For use in: East of England Region Paediatric Departments including PICU

Used by: All paediatric medical & nursing staff

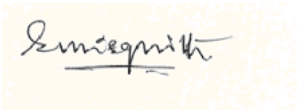
Key Words: Repatriation, IPC

Date of Ratification: September 2026

Review due: September 2029

Registration No: PCC-ODN-2026-3

Approved by:

East of England Paediatric Critical Care Clinical Oversight Group	
Clinical Lead Dr Ronald Misquith	

Ratified by the East of England Paediatric Critical Care Clinical Oversight Group:

Date of meeting	7 September 2026

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Introduction

The timely management of step down and repatriation of patients from PICU is vital to safeguard the limited regional paediatric critical care resources, especially during periods of operational pressure.

It is recognised that during time of surge, there will be a high volume of patients within both the referring and receiving hospital Emergency Departments and ward areas who may require inpatient beds. This may cause delays in stepping down patients from PICU, thus reducing capacity for accepting new patients requiring their services.

This guideline sets out a standardised approach for repatriating patients who have received Level 2 (L2) or Level 3 (L3) paediatric critical care within the East of England (EoE) PICU, ensuring continuity of the right care, in the right place while maintaining capacity for those who need specialist critical care intervention.

By fostering collaboration across the network, this framework will support equitable access, reduce delays, and alleviate the emotional and logistical burden on families.

It is also noted that some hospitals within the EoE may also receive repatriation requests from hospitals outside the EoE (London, East Midlands) and consideration should be given to these additional potential pressures on services.

Aims

- To improve access to and patient flow through PICU and ensure patients and their families are cared for as close to their home as possible when clinically appropriate and safe to do so.
- To provide a clear, consistent process for the repatriation of paediatric patients from CUH to local hospitals, ensuring safe and timely repatriations.
- To ensure delays in repatriations are escalated appropriately.
- To gather and report data on repatriations in the region.

Objectives

Expectation of delivery: All hospitals to accept repatriated patients in a timely manner. Whenever possible patients who are clinically fit for discharge from PICU should be transferred to their local CUH ward or District General Hospital (DGH) for ongoing care.

Collaborative working and communication: To ensure clear communication channels between the referring unit, the receiving unit, and families and carers.

Capacity Management: To ensure patient access to specialist paediatric critical care beds is not compromised. To reduce the need for clinically unnecessary transfers out of region of critically ill patients.

Timely Repatriation: To facilitate the safe transfer of care within **48 hours of notification (preferably 24 hours wherever possible)** once the patient is deemed medically fit for transfer and referral has been accepted. Where possible, a Clinically Fit for Discharge date (CFD) should be established early in the admission and shared with the receiving local hospital.

Documentation and data collection: PICU to document all repatriation referrals, including the time of referral, and to record any reasons for refusal or delay. The transfer team will utilise the regional STOPP tool documentation when completing a repatriation as appropriate.

Escalation Framework: To provide a robust escalation process for managing delays within the repatriation pathway. Internal Trust processes should form part of this framework.

Equity of provision: To promote equitable access to specialist and local resources across the network.

Efficiency of care: To minimise delays that may impact discharge planning and access to community or social care services, especially when patients are outside their home area.

Psychological support: To reduce the emotional and logistical burden on families and carers, who may otherwise need to travel long distances to visit and support their child. To reduce the burden on staff by being able to release commissioned beds.

Barriers to repatriation: To minimise delays to repatriation caused by barriers such as infection control, transport or staffing.

Data: To maintain a database of repatriation referral requests and delayed repatriations.

Patient complexity

The decision making behind repatriation may require additional discussion depending on the admission reason, or underlying patient condition. Complex and non-complex patients are defined below, to aid discussion and decision making for repatriation destination.

Criteria for noncomplex patients:

- Previously fit and well child, with full recovery anticipated.
- Inactive comorbidities unrelated to L3 admission
- Preexisting comorbidities can be managed by the child's local hospital.
- Active comorbidities have returned to baseline, with no new functional impairment.
- There is an adequate sedation weaning plan to prevent symptoms of withdrawal.

Noncomplex patients may be receiving oxygen therapy, high flow oxygen therapy for a short-term illness for example respiratory tract infection such as bronchiolitis, nasogastric/PEG feeding, and IV antibiotics.

Criteria for complex patients:

- Active comorbidities where care is shared/led by the tertiary centre
- New functional impairment, or function has not returned to baseline following L3 admission.
- Technology dependent children: Oxygen dependent (Define duration/levels).
- Non-Invasive Ventilation (Define duration/levels)
- Tracheostomy (+/- ventilation)
- Children requiring additional interventions: Temporary central line
- Palliative Care Plan
- New safeguarding concerns

Where patients fall into the complex patient group an MDT should be held to ensure a full handover, including escalation plan in case of deterioration post transfer.

A small number of patients being repatriated may have extremely complex conditions or have had protracted PICU admissions. A pre discharge MDT discussion may assist repatriation planning, however this is only necessary if these medical complexities will directly affect ongoing care. For the majority of repatriations, a comprehensive medical and nursing handover and discharge summary will be sufficient.

Where there is likely to be a need to help prepare DGH teams to accept a complex patient through ODN or other education, this needs to be identified early and the ODN education team informed so that they can plan and deliver this.

Infection prevention and control

Please refer to the full ODN Guidance for infection prevention & control and inter-hospital transfers document: EoE PCC ODN Infection Control Guideline - East of England
Referrals or repatriations should not be refused because of colonisation/ infection. Appropriate IPC precautions and prioritisation should be in place to facilitate patient flow. IPC challenges should be discussed with Trust IPC leads/teams or microbiologist in the first instance.

Screening swabs results

Screening swabs taken in other hospitals should always be accepted, including viral respiratory panel results for patients with respiratory symptoms (including SARS CoV-2 and Influenza) and documentary evidence of recent results should be provided by the referring unit. **There is no requirement for discharge screening before transfer.**

Use of cubicles / side rooms

- Routine isolation of children in cubicles when transferred from one hospital to another without a known or suspected infection risk is not required **however standard infection control precautions must be maintained.**

- Some children will require a cubicle, but others can be safely cared for in a ward area (this should follow an appropriate risk assessment and discussions with the medical/ID/IPC teams).

- In the case of infections spread by airborne route (e.g., measles, VZV, TB etc) it is necessary to care for children in cubicles / side rooms to prevent spread to other patients.
- In some circumstances, cubicles or side rooms may be required for specific reason such as end-of-life care, or other complex psychological / social or family concerns.

During periods of high prevalence of respiratory viruses, cubicles should be considered to reduce the risk of transmission of all viruses to the most clinically vulnerable, including children with:

1. Uncorrected congenital heart disease up to 2 years of age.
2. Chronic lung disease (bronchopulmonary dysplasia) or other lower respiratory tract pathologies necessitating home oxygen or long-term ventilation, up to 2 years of age.
3. Upper airways pathologies requiring ventilatory support, up to 2 years of age.
4. Severe neuromuscular conditions (i.e. SMA type 1) requiring night-time ventilatory support or regular use of airway clearance technologies (up to school age).
5. Significant immunosuppression e.g. - severe combined immunodeficiency (until immune reconstituted), post BMT: 1st 6 months post allogeneic BMT, or 1st 3 months post autologous BMT, post solid organ transplantation: in the 1st 6 weeks following transplant or on significant immunosuppressant treatment.
6. Newly diagnosed leukaemia during induction (1st month) or relapsed leukaemia (case by case decision based on intensity of treatment for relapse).

Children with the following conditions (NB important not to mix infections) may be cared for in an open ward / bay / cohorted area with careful IPC measures, depending on a local risk assessment and consultation with the local IPC team:

1. Infants under 6 months old (e.g., cohorting infants with bronchiolitis)
2. CRO (but not CPE) / MRSA / VRE / ESBL/C Auris positive on screening swabs or clinical samples

Managing children with bronchiolitis or viral induced wheeze

Refer to the RCPCH National guidance for the management of children in hospital with viral respiratory tract infections (2025). A flow chart for managing children is included in the guidance. National guidance for the management of children in hospital with viral respiratory tract infections (2025) | RCPCH

- Any locally available validated test should be used for respiratory infections prior to ward admission so that children can be admitted to a cubicle / cohorted as appropriate.
- Admission without virology results – infants with unidentified respiratory illnesses should be admitted to a cubicle. However, where cubicles are limited, to maintain patient flow and after a local risk assessment, it may be necessary to admit the child to a “respiratory cohort bay”. Consider setting up age appropriate, “bronchiolitis and / or “viral wheeze” bays.
- Admission with virology results – if cubicles are scarce, infants with identified respiratory illnesses may be cohorted in a bay according to the relevant viral infection (e.g., RSV, Flu etc.).

Viral respiratory tract infections - key points taken from:
National guidance for the management of children in hospital with viral respiratory tract infections (2025) | RCPCH
During periods of high viral prevalence and large numbers of children requiring admission to PICU, a child who requires repatriation from PICU to a local hospital should be given priority over an elective admission to facilitate flow into and out of PICU. Patient placement advice should be provided to the receiving organisation based on the respiratory virus, test results and other pathologies / clinical conditions.

Children being discharged to a general paediatric ward or repatriated to a local hospital from PICU do not require a negative viral result in order to step down onto a ward non-isolation area. Admission into a cubicle or cohort area is only required if the patient is still deemed infectious or there are other reasons for source or protective isolation.

During periods of high prevalence of respiratory viruses, local hierarchies and risk assessments should be applied for cohorting and use of cubicles to reduce the risk of transmission of all respiratory viruses to the most clinically vulnerable.

Immunocompetent children with respiratory viral infections can be de-escalated from a cubicle/cohort bay after a period of 5 days following the onset of their symptoms.

Children with influenza A or B who are either severely immunocompromised or require critical care management should remain isolated in a cubicle or managed within an influenza cohort bay for at least 7 days following symptom onset; seek local IPC or virology advice due to risk of prolonged transmission

Operational Delivery

The PICU consultant will make the decision that a patient is medically fit for discharge from PICU in consultation with other specialist teams as required. Once a patient is deemed stable and safe for transfer, referral to and agreement from local team should be made for repatriation within 24 hours whenever possible.

For internal stepdown of patients to CUH wards, guidance from the Paediatric Intensive Care Unit (PICU) operational policy should be followed.

To arrange repatriation of patients to a regional DGH:

- Clinical updates and bed confirmation should be discussed early to enable planning and timely acceptance once the patient is clinically stable.

- The PICU nurse in charge telephones the nurse in charge of the relevant ward to determine if any beds are available.

- Registrar to registrar referral, clinical handover and acceptance must be completed and the named accepting consultant recorded. Contact details can be found in Appendix 1.

- The referring unit must declare the patient's infection status at time of referral and provide any relevant test results. Where there are IPC challenges, advice should be sought from the IPC lead/team.

- Once the patient has been accepted for transfer and capacity at the local hospital has been confirmed an order for emergency same day transport should be placed on EPIC. It is the decision of the PICU consultant and NIC whether the patient will require a nurse escort or is safe to travel with a paramedic crew.

- The referring unit informs the accepting unit of the transport arrangements.

- If a nurse escort is not required, the PICU nurse who has been caring for the patient telephones the accepting ward and provides a comprehensive telephone handover to the nurse in charge.

- The PICU registrar prepares a discharge summary and the paediatric transfer document is generated on EPIC. Both documents are, printed out placed in a sealed envelope and taken with the patient to the DGH.

- Once transport arrives the accepting ward must be telephoned to inform the team that the patient has left and an expected time of arrival given.

- PICU will keep a record all repatriation referrals.

Escalation and Monitoring Procedures

In circumstances where repatriation cannot be achieved within the agreed timeframe, the following escalation steps must be implemented.

Both referring and receiving units are expected to adhere to the following actions regarding repatriation: -

- **Communication:** The senior clinician and nurse in charge from both referring and receiving unit must remain in contact to update on progress with the repatriation and discuss solutions/mitigations to the barriers. Contact details for escalation can be found in Appendix 1.

- **Capacity:** If repatriation has not occurred within 48 hours of bed request, then receiving hospital should consider means of creating surge capacity.

- **Internal Trust Escalation:** Both receiving and referring hospitals must escalate delays via their internal Trust escalation processes. If the local DGH cannot accept the referral, the patient should be added to the CUH repatriation list on EPIC and the patient flow manager and Children's services manager of the day informed.

- **Network Escalation:** The ODN Team must be notified of delays exceeding 24 hours from PICU. The ODN Team is available to support Monday-Friday, between the hours of 9am-4pm.

- **IPC Escalation:** If local IPC discussions cannot resolve barriers, escalate to the Deputy Director of Quality/IPC, Kaylash Juggernauth: 07725 490385.

- **Specialised Commissioning**: will be notified of pressures and delays as per the EoE Paediatric Critical Care Surge Plan.

- **Transport:** If the region is at OPEL 3 / PIC –CON 3 and there are transport challenges repatriating the patient, the referring unit should liaise with PaNDR. PaNDR are not commissioned to find beds but will assist where possible with conveyance to maintain Critical Care flow.

- **Data:** PICU will record all delays to requested repatriations. All delays in repatriation must be reported through respective internal incident reporting systems.

Local unit unable to accept at 24 hours from requested repatriation date/time

- Consultant and NiC from referring and receiving hospitals identify barriers and discuss options for mitigation
- Referring and receiving units escalate via internal Trust escalation processes
- If PICU at OPEL/PIC CON 3, with transport challenges for repatriation, PICU discuss with PaNDR
- If delay related to IPC issues, discuss with local IPC leads/teams
- PICU record delay on repatriation database

Local unit unable to accept at 48 hours from requested repatriation date/time

- PICU report delay to ODN
- Receiving unit review internal patient placement priorities including non-urgent elective admissions
- Receiving unit consider options for opening surge capacity
- If delay related to IPC issues has not been resolved locally, escalate to Regional IPC Deputy Director

Appendix 1: Referral and Escalation Contact Numbers

Hospital	Switchboard Number	Referral contact	Alternative contact 1	Alternative contact 2	Escalation contact
Addenbrooke's Hospital (CUH)	01223 805000	**PICU** Senior Sister/Charge Nurse 01223 217715	**PICU** Consultant of the Week *(via switchboard)*	**Ward** Paediatric Bed Manager 07540 693036	Senior Nurse of the Day (Paediatrics) 07707 293046
Bedford Hospital	01234 355122	Nurse in Charge Ext 732 *(via switchboard)* Paediatric Consultant Bleep 542 *(via switchboard)*	Ward Manager Ext 6367 / 5394 *(via switchboard)* Paediatric Registrar Bleep 744 *(via switchboard)*	Matron Bleep 126 *(via switchboard)*	Ward Matron Ext 6191 *(via switchboard)* Head of Nursing *(via switchboard)* Clinical Lead 07988 652862
Colchester Hospital	01206 747474	Paediatric Consultant Bleep 178 *(via switchboard)*	Paediatric Bleep Holder Bleep 953 *(via switchboard)*		Paediatric Acute Matron Bleep 635 *(via switchboard)*
Ipswich Hospital	01473 712233	Senior Paediatric Nurse Bleep 630 *(via switchboard)*	Paediatric Registrar Bleep 544 *(via switchboard)*		Paediatric Matron Bleep 515 *(via switchboard)*
James Paget University Hospital	01493 452452	Paediatric contact 01493 453193	Nurse in Charge (Ward) 01493 452010		Consultant / Registrar on Call *(via switchboard)*
Lister Hospital (Stevenage)	01438 314333	Paediatric Divisional Bleep Holder *(alert via switchboard)*	Paediatric Ward Manager 01438 284008		Paediatric Matron 01438 284812 (or *alert via switchboard)*
Luton & Dunstable University Hospital	01582 491166	Paediatric Ward Registrar Bleep 797 *(via switchboard)*	Nurse in Charge Bleep 717 *(via switchboard)* 07979 704898		Paediatric Consultant: • in hours ask for attending consultant (Ward 24/25); • out of hours ask for on-call consultant *(via switchboard)*
MSE - Broomfield Hospital (Chelmsford)	0300 4430001	Paediatric Registrar on Call *(via switchboard)*	Nurse in Charge (PAU) 07880 271451		Paediatric Hot Week Consultant *(via switchboard)*
MSE - Southend Hospital	0300 4430002	Paediatric Registrar on Call *(via switchboard)*	Nurse in Charge (Neptune) 07918 767554	Nurse in Charge (PAU) 07502 604905	Paediatric Consultant of the Week *(via switchboard)*
MSE - Basildon Hospital	0300 4430003	Paediatric Registrar on Call *(via switchboard)*	Paediatric Co-ordinator Bleep 6568 *(via switchboard)* 07586 980941		Paediatric Consultant of the Week *(via switchboard)*

Hospital	Switchboard Number	Referral contact	Alternative contact 1	Alternative contact 2	Escalation contact
Norfolk & Norwich University Hospital	01603 286286	Buxton Paediatric Consultant of the Week/On Call *(via switchboard)*	Paediatric Registrar / Tier 2 (Buxton Ward) *(via switchboard)*	Nurse in Charge (Buxton) Ext 6682 *(via switchboard)*	Paediatric Matron – Ext 7815 / 2368 *(via switchboard)* OR Nurse in Charge (Buxton) – Ext 6682 *(via switchboard)*
NWAFT - Hinchingbrooke Hospital	01480 416416	Lead Nurse Ext 3155 *(via switchboard)*	Ward Manager Ext 3162 *(via switchboard)*		DON for FISS Ext 3210 ***(via PCH switchboard)***
NWAFT - Peterborough City Hospital	01733 678000	Lead Nurse Ext 8414 (*via switchboard)*	Ward Manager Ext 8406 *(via switchboard)*		DON for FISS Ext 3210 *(via switchboard)*
Princess Alexandra Hospital (Harlow)	01279 444455	Paediatric Hot Week Consultant 01279 827173	Paediatric Matron *(via switchboard)*	Dolphin Ward Manager Ext 8701 *(via switchboard)*	Head of Nursing Ext 8513 *(via switchboard)*
Queen Elizabeth Hospital, King's Lynn	01553 613613	Paediatric Tier 2 (on-Call) Bleep 3305 *(via switchboard)*	Paediatric Consultant on Call *(via switchboard)*		Paediatric Consultant on Call *(via switchboard)*
Watford General Hospital	01923 244366	Paediatric Attending Consultant *(via switchboard - for medical handover)*	Starfish NIC / Ward Sister 07483 646657*(mobile)* 01923 217357 *(for nursing handover)*	Paediatric Matron 07974 495256 *(mobile)* 01923 244366 (*ext.*7487)	Deputy Director of Nursing 07779 925075 *(mobile)* 01923 217979 (*ext.*7979) Clinical Director, Children's Services *(via switchboard)*
West Suffolk Hospital	01284 713000	Paediatrician of the Week *(via switchboard)*	Nurse in Charge (Ward F1) 01284 713315	Ward Manager (Rainbow Ward) 01284 713390	Paediatric Senior Matron 01284 712808

Data collection (to be agreed and set up)

Referral data:
Medically fit for discharge date
Date/time of repatriation request
Patient date of birth
Patient NHS Number
Receiving Trust
Diagnosis / Reason for admission
Infection control status and any isolation requirements
Name of referring clinician
Name of accepting consultant
Date & time of extubation
Current respiratory support patient is receiving, if any
Complex/non complex
MDT required Y/N?

Delay data:
Medically fit for discharge date
Date/time of referral for repatriation
Reason for non-acceptance (staffing, IPC, transport, education, additional out of region requests for repat, other)
Outcome
Actual date/time of repatriation
Incident report completed Y/N?

References

National guidance for the management of children in hospital with viral respiratory tract infections (2025)
National guidance for the management of children in hospital with viral respiratory tract infections (2025) | RCPCH

CUH Paediatric intensive care unit (PICU) operational policy (July 2024)

Paediatric Critical Care GIRFT Programme National Specialty Report (2022)
Paediatric Critical Care - Getting It Right First Time - GIRFT

Contributors

With thanks to the East and West Midlands Paediatric Critical Care Networks for sharing their network documents.

With thanks to the Pan-Thames Paediatric Clinical Networks for sharing their version of the IPC guidance document.

With thanks to Kaylash Juggernauth, Deputy Director of Quality/IPC, EoE for support with IPC guidance.

Disclaimer

Exceptional Circumstances Form

Form to be completed in the **exceptional** circumstances that the Trust is not able to follow ODN approved guidelines.

Details of person completing the form:	
Title:	Organisation:
First name:	Email contact address:
Surname:	Telephone contact number:
Title of document to be excepted from:	
Rationale why Trust is unable to adhere to the document:	
Signature of speciality Clinical Lead: Date:	Signature of Trust Nursing / Medical Director: Date:
Hard Copy Received by ODN (date and sign):	Date acknowledgement receipt sent out:

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