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Jackson Carlaw MSP
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6 March 2026

Dear Jackson Carlaw,

PE2099: Stop the proposed centralisation of specialist neonatal units in NHS Scotland

Thank you for your letter dated 27 February 2026 providing a comprehensive summary of the petition and the ongoing commitment of the Citizen Participation and Public Petitions Committee to address the concerns that have been raised. I was also pleased to see that the committee has noted the Best Start recommendation is to move from eight neonatal intensive care units to three which corrected the point raised by Meghan Gallagher in the committee hearing of the 14 January 2026.

I am reassured that the Committee is accepting of the clear clinical evidence that underpins the basis of the new model of neonatal care and that the recommendation made by the Best Start report will improve outcomes for the smallest and sickest babies of Scotland.

The Regional Chief Executives have informed me that the regional implementation plans and financial planning is well underway. There is consensus that implementation will be a managed transition through a phased approach, with clear timelines and milestones.

The intention is to have detailed financial and operational plans by the end of March 2026 submitted to the Task and Finish Group with the aim to complete implementation by the end of 2026.

The Chief Operating Officer recently wrote to the NHS Chief Executives detailing the Operation Priorities for 2026/2027. As we move into 2026/27, it is important that Boards have a clear and coherent operational steer for the coming year, whilst at the same time recognising where we are in the parliamentary cycle. The letter asks Boards to continue to support safe and high-quality maternity and neonatal services, including full implementation of actions from HIS maternity services inspections and to deliver the required changes to implement the new networked neonatal intensive care model, so that mothers and babies receive safe, high-quality care in the right place at the right time as a high-level operational focus for the year ahead.

I will address the areas of uncertainty that you highlighted in your letter, but I would like to reassure the committee that the Scottish Government has considered the impact this will have on families throughout the process ensuring the best start ethos of family centered care is at the heart of all we do. My utmost priority, and that of this government, is to ensure safe, effective and family centred care is being provided to the families of Scotland.

As the Committee has highlighted The Best Start emphasises parents as key partners in caring for their baby and aims to keep mothers and babies, and families together as much as possible in the crucial early weeks, with services designed around them as this priority remains.

As I have previously outlined we have a number of measures already in place to support all families with babies in neonatal care as follows:

- provision of onsite accommodation for families in all intensive care units.
- the Young Patient Family Fund,
- and by ensuring babies requiring intensive care are repatriated to their local neonatal unit as soon as clinically possible

But we know more can be done and we are working with Boards to ensure that the concerns are addressed.

I have been reassured that NHS Boards are committed to involve parents in decision making and providing care for their baby; to provide funding support and accommodation for parents to stay on or near the unit, facilities within the unit to encourage kangaroo skin to skin care, early support for breastfeeding and to develop clear information for parents.

With regards to the Young Patient Family Fund, I am extremely proud that Scotland is the only UK country to financially support families who have babies in Neonatal Care.

The Best Start report recommended the introduction of a nationally agreed policy for expenses for families of babies in neonatal care. The Neonatal Expenses Fund (NEF) was launched in Scotland in April 2018, with £1.5 million committed to the fund over the first twelve months.

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Following an evaluation of NEF in December 2019 numerous changes were made to NEF's terms and conditions. From 1 April 2020 parents were able to claim a contribution to reasonable overnight accommodation costs.

Merging the Neonatal Expenses Fund to create a single united fund, the Young Patients Family Fund (YPFF), was identified as one of the commitments the government would deliver within its first 100 days post-election, and we met this ambition with the launch of the fund on 26 July 2021.

YPFF allows the parents/carers and/or siblings (under 18) of a young inpatient to claim costs associated with hospital visits. This includes costs relating to travel, subsistence and accommodation.

Officials have continued to work with the NHS Boards YPFF leads to understand and reduce any inconsistences in order to provide families with a fair and reliable source of support.

In response to this in September 2025 the Terms and Conditions were updated to bring further clarity of the use of the fund in providing reimbursement to families who require offsite accommodation. The updated documents are now live on the website.

I am pleased to note in 2024/25 Health Boards reported YPFF supported the families of 7,469 young inpatients with 19,108 claimants benefiting from claims under the fund amounted to £3,111,953 of support.

Family Engagement

The clinical evidence that forms the basis of the new model of neonatal care demonstrates that we cannot ignore what is best for the smallest and sickest babies of Scotland but as the Committee and the petition has outlined, the impact on families is a key priority and in addition to the information provided in my submission of the 11 October 2024, I would like to reiterate and provide assurance that families have been fully consulted throughout this process.

Prior to Best Start Report publication in 2017 a Maternity and Neonatal Review Group was established and consisted of representatives from the key professional groups involved in managing and delivering maternity and neonatal services, representatives of the Scottish Government, staff side organisations, third sector representatives and academics working in maternal and infant health research.

The Review group established four Sub-Groups, bringing together over 100 professional and frontline staff from maternity and neonatal services, academics, the third sector and professional organisations, as well as service users.

Listening to the views of service users, staff and service providers was critical to the Review and an extensive engagement programme was undertaken in all of Scotland's NHS territorial Board areas.

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The Scottish Health Council also delivered a programme of public and service user engagement, across all NHS territorial Board, which were supplemented with bespoke service user events, to gather views from people who had used maternity and neonatal services. Over 600 staff and 500 services users contributed to the review process. The detail of this engagement is set out in Chapter 4 of The Best Start report. The recommendations in The Best Start were a triangulation of the evidence (also detailed in Chapter 4 and Appendix G), plus the views of staff and service users, brought together by the Review Group.

As I have outlined previously, the process of determining which units should be providing Neonatal Intensive Care was undertaken by an expert group, the Perinatal Sub Group of the Best Start Implementation Programme Board. This group included clinical leads and service user representatives, and the Committee have heard from the Chairs of the Perinatal Sub Group in the course of considering the Petition.

In December 2023 the Scottish Government outlined to the Regional Chief Executives the expectation of the implementation plans and these should include plans for communication and engagement with local service users.

Additionally, as the Committee has highlighted, The Scottish Government undertook a public consultation through the citizen space survey in order to consult with families on the proposals. As I clarified in my submission of the 11 October 2024 the survey was launched on 21 June 2024 and asked a total of 20 questions, 13 closed and 7 open, to allow respondents the opportunity to provide free and open text responses in relation to questions such as; what support would be helpful during a neonatal stay, what are the most important consideration that need to be taken into account when planning the new model and what feedback would you like to provide to SG on the new model.

The survey received 434 responses. Of these, 428 were from individuals and 6 from organisations. All responses were reviewed in full. The report was then published in March 2025 and we consequently shared the outputs of that consultation with Regional Chief Executives so that their concerns can be incorporated when the pathways and processes for the new model of care are designed.

I will ensure that Scottish Government policy colleagues who sit on the Task and Finish group will again reiterate the importance of proactive communication to both the families and staff that will be affected by this change and the findings of the citizen space survey noted that respondents preferred information on the new model of neonatal care to be communicated through social media (87% of respondents) and clinical staff (54%).

Furthermore, I would like to reassure the committee that listening to service users and hearing lived experience is a continued priority for Scottish Government. On 29 October 2025, the Cabinet Secretary for Health and Social Care announced the establishment of the Scottish Ministerial Maternity and Neonatal Taskforce. The Taskforce brings together clinicians, service leaders, professional organisations and third sector partners with a shared

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purpose: to ensure that every woman and baby receives safe, high-quality, and compassionate care.

The safety of maternity and neonatal services is an absolute priority to this government, and the Taskforce is an important part of our ongoing journey to deliver high-quality care to women in Scotland.

The second meeting of the Taskforce took place on Thursday, 26 February. Members of the Taskforce are carefully considering plans for engagement with women and families and engagement with the clinical community. The approach will continue to be developed at the next meeting later this month, however I anticipate that a broad range of service users will be engaged.

Public Misinformation

A concern that I have raised on many occasions is the ongoing misinformation presented to the public within the press, social media and, unfortunately, also within the Parliamentary Chamber and the fear and alarm that this misinformation could be causing is distressing.

I, along with my policy officials, have been proactive in providing accurate information to the public, press and fellow members both publicly and through media channels and correspondence to provide that reassurance and correcting any inaccuracies.

During corresponding with MSPs I have reiterated that as political representatives we have a responsibility to ensure that information that we are sharing is accurate and I have sought their support in ensuring harmful misinformation is not repeated.

In order to provide open transparency through the review of maternity and neonatal services, the best start report was published in 2017 and clearly outlined the background and clinical evidence for the new model of neonatal care with the evidence to support the move to three intensive neonatal units in Scotland.

In July 2023 when I announced the location of the three intensive care units this too was published on the gov.scot website. Bliss also provided supportive comms through a news release and through their social medial channels to alert families of the new model and what this would mean for families.

I was extremely grateful that the nurses from Ninewells neonatal unit themselves also publicly shared their views on this and have sought to reassure the local community that the information circulating on social media is incorrect and that they support the new model of neonatal care. It would be my expectation that other Boards also provide the same level of reassurance to families.

As the committee is also aware, Bliss also intervened last year to dispel the misinformation circulating in the media and to reassure families that the model we are moving to in Scotland is the safest and best possible model for sick babies.

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Consistent with this approach, later in my response I would also like to provide a response to some inaccuracies within the submission of December 2025.

Capacity Modelling

The committee has requested confirmation of the capacity modelling that is still to be complete prior to implementation of the new model.

I can confirm that all capacity modelling has now been completed, and Directors of Finance have confirmed that the finance modelling has made good progress.

As per my submission dated 11 October 2024 and 1 September 2025, the Scottish Government contracted healthcare planning support from RSM UK to undertake the detailed modelling and capacity planning work. The report was published in May 2024 to inform local implementation plans.

As the committee have highlighted, in addition to neonatal modelling, maternity capacity is essential to the development of the new model.

I can confirm that the RSM report outlined the anticipated additional impact of in-utero transfers on maternity services in the three NICU sites. However, the report concluded that these assumptions were based on limited information and should be tested further as part of more focussed review of local maternity unit capacity.

Concerns were raised with Scottish government and SEND regarding the limited maternity modelling information within the report.

As I updated in my last letter, the Scottish Government agreed to gather data using methodology developed in NHS Tayside relating to the care that was provided to women at 22 to 27 weeks gestation for singletons and 22 to 28 weeks gestation for multiples between 1 July 2024 to 31 December 2024.

Workload insights from the transferring units provided comprehensive detail aligned with levels of care of their current maternity workload for the cohort of women and this allows the receiving units to plan for the additional workload. The data gathered indicates the additional maternity care QEUH, ARI and RIE will need to deliver under the new model, further supporting more detailed service planning.

This process was concluded in October 2025 and this collective information was provided to Regional Chief executives and Regional Planners to inform maternity capacity in the three regions.

Finance

The Scottish Government recognises that funding will be required to support

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Boards to make the transition to a reformed maternity and neonatal service. As I informed Committee within my submission of the 1 September 2025, since implementation of Best Start commenced in 2017 Scottish Government has provided over £30 million of funding to NHS Boards to support implementation of the Best Start recommendations.

We have provided £3,570,400 to NHS Greater Glasgow and Clyde and £2,873,051 to NHS Lothian since 2019, a total contribution of almost £6.5m. We continue to discuss additional support required with NHS Grampian . This funding is focused on supporting Boards through the transition process.

In parallel work is underway to develop a cross-Board funding model to ensure receiving units are funded for the additional care that they provide.

The Neonatal Service Change Finance Sub-Group was formed to respond to the request from the Task & Finish Group to develop a financial strategy to support neonatal service change. This included assessing the anticipated costs of neonatal cot and maternity capacity changes, with recommendations for transfer of resource between Boards.

As noted above the next Task and Finish Group is on the 18 March and a further update is expected.

I would now like to take this opportunity to address some of the points raised within the submission of 17 December 2025 as they hold importance in further eliminating some concerns that the public require to be resolved.

1. Perinatal Sub Group Membership

The submission of 17 December 2025 states at the time of the options appraisal publication the membership did not include a representative from NHS Lanarkshire.

As I and chairs of the perinatal sub group outlined to the committee and the evidence hearings and in my submission of the 11 October 2024 NHS Lanarkshire was represented throughout the process but I would like to reaffirm to the committee and the petitioner the representation process.

The Best Start report was the culmination of the work of the Review of Maternity and Neonatal Services. The 24 members of the Review Group included representative clinicians who were drawn from 9 NHS territorial Boards, including each of the 7 Boards that host Neonatal Intensive Care Units (NHS Ayrshire and Arran, NHS Fife, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Lothian and NHS Tayside). The Review Group recommendations were informed by the work of the Sub Groups, including the Neonatal Models of Care Sub Group. The 22 members of the Neonatal Sub Group also included representatives of each of the Boards that host Neonatal Intensive Care Units. The full membership of both of these groups can be found in Appendix E and Appendix F of The Best Start report.

As part of the review, the Review team visited all 14 Boards across Scotland and met with teams from maternity and neonatal services.

Following the publication of the Best Start report, the Best Start Implementation Programme Board was established.

The Programme Board agreed to establish the Perinatal Sub Group with the responsibility to take forward the recommendations on Neonatal Intensive Care.

As the committee heard and I have also corrected in chamber, the members of the Perinatal Sub Group were appointed based on the national organisations they represented (for example Chair of the Scottish Neonatal Consultants Forum, Chair of the Scottish Neonatal Nurses Forum, representative from Heads of Midwifery, Scottish Ambulance Service and ScotSTAR and Bliss) and not their NHS Board to provide an objective view to an evidence based clinical approach.

Lynne Clyde, Head of Midwifery at NHS Lanarkshire was on the group representing Heads of Midwifery Group Scotland and was involved throughout the options appraisal process that determined the three neonatal intensive care units. Lynne retired and when the Perinatal Sub Group was reconvened after COVID was replaced by Dr Mary Ross-Davie, Director of Midwifery at NHS Greater Glasgow and Clyde who was then listed in the final draft of the options appraisal report.

Heather Knox, at that time Chief Operating officer for NHS Lanarkshire, initially chaired the Perinatal Sub Group in 2017/18 and sat on the Best Start Programme Board however stood down from chairing the Perinatal Sub Group before it actually undertook the options appraisal as she perceived a conflict of interest with her Lanarkshire role.

The options appraisal was based on data that was received from NHS Lanarkshire. Currently between 700 and 800 babies are admitted to neonatal care in NHS Lanarkshire every year. This change will affect around 1 to 2 babies a month (between 12 and 23 a year based on data from the last 7 years).

Members were appointed to the Review Group for the duration of the review (October 2015 to January 2017) and the Neonatal Models of Care Sub Group for the duration of that group (February 2016 – August 2016)

The Perinatal Sub Group of the Best Start Implementation Programme Board was convened in 2017 to take forward the Neonatal Intensive Care recommendation, and other Best Start recommendations. The Group concluded in December 2024 and the membership has changed over the lifetime of the group.

The submission also noted that The Scottish Ambulance Service and Maternity services was not represented. As the link within the submission shows at the time of the options appraisal publication the membership included;

- Allan Jackson, Clinical Lead, ScotSTAR Neonatal
- Kenny Mitchell, Scottish Ambulance Service
- Dr Mary Ross-Davie, Director of Midwifery , NHS GGC

2. Bliss Role

The petitioners submission refers to my reference to Bliss and their role throughout the process of Best Start and the Perinatal sub group so I would like to provide some clarity.

Following the publication of the Best Start, Bliss Scotland, represented by its Chief Executive, was asked to join the Best Start Programme Implementation Board, overseeing the implementation of all 76 Best Start recommendations.

Bliss Scotland's Chief Executive subsequently also joined the Perinatal Subgroup which was tasked with providing more in-depth input to the implementation of the recommendations relating to neonatal care.

Bliss Scotland's role on both groups was to advocate for what is in the best interests of babies born premature or sick in the context of the implementation of the agreed Best Start recommendations. Their focus was therefore on identifying how parents can best be supported to play a hands-on role in their babies' neonatal care, which we know is vitally important to babies and their families.

Bliss Scotland worked closely with the Scottish Government to develop the Neonatal Expenses Fund, now the Young Patients Family Fund, which provides financial support for travel, food and accommodation costs for all neonatal parents.

In addition, they supported Scottish Government in the development the parent information leaflet providing information for families on the new model of care, different levels of care and where care is provided, and what to expect in the event of the need to transfer mother and/or baby.

Once the decision had been announced about the locations of the three neonatal intensive care units, in July 2023, Bliss Scotland issued communication to the families of Scotland about the plans noting the decision had been made because evidence shows that outcomes for very sick and small babies, are better when these babies are cared for in a larger neonatal intensive care unit.

Thereafter, Bliss supported the Scottish Government public consultation, through providing input on the questions asked through the Citizen Space open consultation and subsequent focus groups.

I would like to have on record my thanks to Bliss for the support and input they provided on both groups until the formal closure of the Best Start Programme in December 2024 and their continued work to advocate for families in national policy.

3. Transfers/Handling

I understand the concerns of the petitioner around the transfer of babies and the considerable requirements for a preterm baby transfer.

The expectation remains that under the new model of care, mothers in suspected extreme pre-term labour will be transferred to give birth in hospitals that have neonatal intensive care units before they give birth (in-utero). Those maternity units will have expanded capacity to receive those women.

Where it is not possible to transfer mothers before they give birth, as has been established practice for many years, our specialist neonatal transfer service (ScotSTAR) will transfer those babies by air or by road in specialist ambulances equipped to care for neonates, accompanied by neonatal staff.

As I outlined in my 11 October 2024 submission, experience of testing the new model of neonatal intensive care showed that the vast majority of mothers in suspected pre-term labour were identified and transferred before giving birth.

I was pleased to note that in the recent SPBAND publication for July-September 2025, across Scotland 91.7% of births at 22-26 weeks gestation resulting in a live born baby occurred in a hospital with a neonatal intensive care unit (NICU) on site, this is higher than the same quarter in 2024 (86.1%).

4. Governance/ Implementation

It was noted in the 17 December submission that the author believed “local implementation groups were initially tasked with this, but when they struggled to reach safe processes for transfer of women and their babies, this was then directed to the Chief Executives to determine.”

Again, I would like to outline the implementation process that has been undertaken. When the announcement was made in 2023 a DL letter was issued to NHS Boards stating CEOs within each region should agree a nominated lead CEO to deliver this programme from planning to full implementation. It was requested that the nominated lead CEO should have

prioritised access to Regional Planning infrastructure & resources to full implementation and regional implementation groups were established by the host boards.

The health boards who host the NICU's were asked to submit detailed implementation plans to the Best Start Implementation Programme Board and the NHS Chief Operating Officer by end 2023.

As the Best Start Implementation Board came to end in December 2024, The task and finish group was established by the three regional chief executives in 2025 to oversee and support national action and coordination required for delivery of Regional Implementation Plans to implement the move to three Neonatal Intensive Care units across Scotland.

5. Glasgow Clinical Letter

As noted in the submission I am aware of the letter from NHS GGC clinicians to their Chief Executive and senior team with regards to the new model of neonatal care. The Chief Executive responded to the letter, and the senior team met with the clinicians to discuss the issues raised.

6. Mental Health and wellbeing

We are committed to ensuring equitable, coordinated access to mental health provision for women, infants and their families throughout pregnancy and during the postnatal period. This is why since 2019 we have invested over £26m in improvements to mental health services and support for parents, infants and families across Scotland. This has meant that all 14 Health Boards have expanded or have new Community Perinatal Mental Health services.

Recommendation 39 of The Best Start Report states that NHS Boards should ensure all neonatal staff can refer parents of babies in neonatal care to local psychological services. We are rolling out integrated Infant Mental Health teams and Maternity and Neonatal Psychological Interventions to provide support to both parents and infants at the times it is most needed. Currently there are 11 Health Boards with new Infant Mental Health teams and a further 3 in development as well as 10 Health Boards with expanded or new Maternity and Neonatal Psychological Interventions services and a further 4 in development.

All 11 Health Boards who have a neonatal unit report that neonatal staff are able to refer parents to local psychological services, and parents are offered this throughout their neonatal journey, including at discharge. Maternity and Neonatal Psychological Interventions (MNPI) teams exist in most Boards. One Board, which does not have an MNPI team due to size, instead employs a perinatal mental health midwife and a clinical psychologist. Psychosocial support is one of the principles of the Bliss Baby Charter, which all Boards in Scotland are registered for. More information about the Bliss Baby Charter is available in the chapter on implications for neonatal care

Additionally, we are also rolling out integrated Infant Mental Health teams and Maternity and Neonatal Psychological Interventions to provide support to both parents and infants at the times it is most needed.

Mental health in the perinatal period is included in the Mental Health and Wellbeing Strategy, most notably through the articulation of the life cycle approach. It is also included within the Delivery Plan in the action to continue to invest in and embed perinatal and infant mental health services at all levels of need so that women and families across all areas of Scotland have access to these services

Furthermore, in June 2025, the Scottish Government published the Perinatal mental health service specification, to advise clinicians and managers working in NHS inpatient and community perinatal mental health services of the principles of good practice in relation to the delivery of services.

The specification makes clear that staff working with women, their infants and families must have the knowledge, skills and attitudes which allows them to delivery safe, high quality, person-centred, respectful care. Sufficient workforce levels, professional mix and support for continuing professional development are essential to maintenance of a high-quality workforce.

Team members must be appropriately trained, based on recommendations in the NHS Education for Scotland (NES) Perinatal Mental Health Curricular Framework, and have acquired the knowledge, skills and attitudes necessary to provide specialist assessment and care for women with mental ill health, and their infants.

This framework sets out the different levels of knowledge and skills required by members of the Scottish workforce who have contact with mothers and their babies, to enable them to support mothers, babies and their families to have positive well-being and good mental health during the perinatal period.

The Scottish Government has also worked with NES to advance training on Perinatal and Infant Mental Health. Training in evidence-based approaches and interventions is delivered to staff across sectors and across practice types including informed, skilled, enhanced and specialist, as appropriate to their role.

This includes education and training within Perinatal and Infant Mental Health through e-learning modules which are available on TURAS, covering seven topic areas of essential knowledge. We have also worked with NES to create a specialist Perinatal and Infant Mental Health Learning Programme which allows NES to track the progress of staff in Specialist Perinatal and Infant Mental Health Services including Mother and Baby Units, Community Perinatal Mental Health Teams and Maternity and Neonatal Psychological Interventions.

Additionally, NES have also developed the National Trauma Transformation Programme which offers a range of trauma training modules designed to ensure those who care for

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women and families have learning aligned to their role within services. All NHS Boards are progressing staff to attend this training.

8. Accommodation

The Best Start (2017) recommended all neonatal facilities should provide emergency overnight accommodation on the unit for parents, with accommodation available nearby for parents of less critically ill babies. Boards are expected to include provision for this in their planning.

Every neonatal unit in Scotland has provision for families to stay overnight where required. All neonatal intensive care units and the majority of Local Neonatal Units and special care units have rooms on or near the unit, with other accommodation available nearby to allow parents to be with their babies. The majority of boards also provide support to allow siblings to stay to ensure families are supported to remain together.

Scottish Government also provides support to all families with babies in neonatal care to cover the costs of food, travel and accommodation as part of our Young Patients Family Fund. If hospital accommodation is not available, the Health Board will usually be able to book and pay for nearby accommodation for families in advance.

Outcomes

I understand the concern raised by the petitioner that the outcomes of the change to the new model of neonatal care will not be seen for many years. As we have outlined to the Committee the evidence that informed the Best Start shows that outcomes for a very small number of the smallest and sickest babies is improved when they are born and cared for in units with a high volume throughput of cases and where specialist support services, such as surgery, are co-located on the same site and therefore we are confident that these changes will give the best possible outcomes for the smallest and sickest babies. The numbers of babies affected will be very small, and Scottish Government evaluation of the impact of the change will consider long term outcomes for this cohort of babies.

In addition, the review of evidence that informed Best Start was carried out by Dr Anna Gavine, Dr Steve MacGillivray and Prof Mary Renfrew of the University of Dundee - Maternity and neonatal services: efficient evidence review. The evidence showed that outcomes for very low birth weight babies (VLBW) are better when they are delivered and treated in NICUs with full support services, experienced staff, and a critical mass of activity.

As the petitioner will have heard this evidence has been further underlined by updated publication of the British Association of Perinatal Medicine (BAPM) Framework for Practice in 2021, which sets out optimal arrangements for Neonatal Intensive Care in the UK.

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As Stephen Wardle of BAPM presented to the Committee, through his experience of the centralising of neonatal intensive care in England, outcomes and survival rates are improving over time, and when people have looked back at the care provided in larger units and compared it to smaller units, they found clear differences in outcomes.

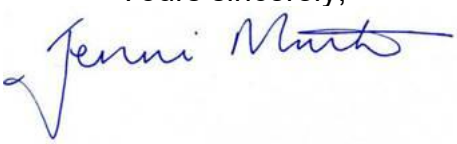
Stephen Wardle summarised, following centralisation in England, babies are now being delivered in the right place on more occasions, with more of the smallest and sickest babies, the ones most at risk, and those who are most likely to have poorer outcomes, now being cared for in centralised units, and that outcomes for those babies have improved.

In summary, planning for implementation of the new model has been commissioned to ensure service planning, organisation, and delivery follows the evidence base. Evidence illustrates that centralising the most specialist care for the smallest and sickest babies into fewer higher-volume centres will deliver the best possible outcomes.

I was struck by Stephen Wardle of BAPM's comment that "if we continue to provide care in lots of smaller units in an effort to avoid transfers, fewer babies will survive and there will be poorer outcomes", this cannot be ignored.

I understand the committees concern around work still ongoing during the implementation process however I would like to reassure that a managed transition approach to implementation, taking learning from the early adopters who have been working under this model since 2019, will allow safe and effective implementation to occur prior to the redesignation of units within Scotland.

Yours sincerely,



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