Citizen Participation and Public Petitions Committee
Wednesday 8 October 2025
15th Meeting, 2025 (Session 6)

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

Introduction

Petitioner	Lynne McRitchie
Petition summary	Calling on the Scottish Parliament to urge the Scottish Government to stop the planned downgrading of established and high-performing specialist neonatal intensive care services across NHS Scotland from a level three to a level two and to commission an independent review of this decision in light of contradictory expert opinions on centralising services.
Webpage	https://petitions.parliament.scot/petitions/PE2099

1. The Committee last considered this petition at its meeting on 11 September 2024. At that meeting, the Committee agreed to write to the Minister for Public Health and Women's Health. The Committee also agreed to undertake a visit to explore the issues raised in this petition.

2. The petition summary is included in **Annexe A** and the Official Report of the Committee's last consideration of this petition is at **Annexe B**.

3. The Committee has received new written submissions from the Minister for Public Health and Women's Health, Bliss Scotland and Monica Lennon MSP, which are set out in **Annexe C**.

4. On 8 September 2025, the Committee visited University Hospital Wishaw to meet with the Petitioner, families and staff to explore the issues raised in the petition. A note of the visit is at **Annexe D**.

5. Written submissions received prior to the Committee's last consideration can be found on the petition's webpage.

6. Further background information about this petition can be found in the SPICe briefing for this petition.

7. The Scottish Government gave its initial response to the petition on 11 June 2024.

8. Every petition collects signatures while it remains under consideration. At the time of writing, 3,717 signatures have been received on this petition.

Action

9. The Committee is invited to consider what action it wishes to take.

Clerks to the Committee
October 2025

Annexe A: Summary of petition

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

Petitioner

Lynne McRitchie

Date Lodged

14 May 2024

Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to stop the planned downgrading of established and high-performing specialist neonatal intensive care services across NHS Scotland from a level three to a level two and to commission an independent review of this decision in light of contradictory expert opinions on centralising services.

Previous action

A petition against the proposal has over 20,000 signatures.

Numerous communications to MSPs from concerned parties.

Jackie Bailie MSP brought forward a motion to debate this issue in the chamber on 20th September 2023.

Meghan Gallagher MSP also extended this debate to support the petition to stop downgrading of specialist neonatal services in NHS Lanarkshire during Member's Business on 20th September 2023 in Scottish Parliament.

Background information

These plans would affect services across Scotland, including specialist neonatal units in University Hospital Wishaw which is award winning, Ninewells in Dundee and Victoria Hospital in Kirkcaldy.

The centralisation of neonatal services to three units in Glasgow, Edinburgh and Aberdeen could place additional stress on expectant parents and premature babies. Clinical whistleblowers have said that the decision to downgrade these facilities could endanger the lives of vulnerable babies and place remarkable strain on families.

There is a particular focus on retaining services at University Hospital Wishaw (Neonatal unit of the year 2023). Downgrading this unit would mean that NHS Lanarkshire, Scotland's third largest health board, that serves a population of 655,000 people, may lose a high-functioning service for babies/families which would have a potentially disastrous knock on effect on services in NHS Greater Glasgow and Clyde, NHS Lothian and NHS Grampian.

Annexe B: Extract from Official Report of last consideration of PE2099 on 11 September 2024

The Convener: For our next petition, which was lodged by Lynne McRitchie, we are joined by a galaxy of talent—[Laughter.] Mr Ewing, please.

Lynne McRitchie is not with us today but there are supporters of the aims of the petition in the gallery. We are joined by Jackie Baillie MSP and Richard Leonard MSP. I cannot remember, Richard, whether you have been to one of these shindigs before or whether this is your first appearance. Did you come once before?

Richard Leonard (Central Scotland) (Lab): I have been once before in relation to the treatment of young footballers.

The Convener: That is right; I recall it now. Welcome to you both.

The petition calls on the Scottish Parliament to urge the Scottish Government to stop the planned downgrading of established and high-performing specialist neonatal intensive care services across NHS Scotland from level 3 to level 2 and to commission an independent review of that decision in light of contradictory expert opinions on centralising services.

Neonatal units operate at three different levels: level 1 units provide special care, for example tube-feeding and intravenous antibiotic therapy; level 2 units provide specialised and high-dependency care, including assisted ventilation and short-term neonatal intensive care; and level 3 units provide the full range of medical neonatal medical care.

Following a review of maternity and neonatal services, the Scottish Government published a report entitled “The Best Start: A Five-year Forward Plan for Maternity and Neonatal Care in Scotland”, which recommended that a new model of neonatal services should be designed to accommodate the current levels of demand, with a smaller number of intensive care neonatal units.

The British Association of Perinatal Medicine’s framework recommends that neonatal intensive care units should admit at least 100 very low-birthweight babies a year and undertake at least 2,000 intensive care days per year. The perinatal group recommended the retention of three NICUs and that the remaining units be downgraded to level 2 neonatal units. As part of that change, the scope of the practice carried out by level 2 units will be wider than the previous level 2 definition.

The Scottish Government accepted the recommendations of the report, and work is under way to implement the new model of care. The Minister for Public Health and Women’s Health’s response to the petition states that the intention with the new model of care is that mothers in suspected extreme pre-term labour will be transferred before they give birth to maternity units in the hospitals that have neonatal intensive care units. The submission states that those units will have expanded capacity. It is noted that it will not always be possible to transfer mothers before they give birth, and in those cases the specialist neonatal transfer service, ScotSTAR, will transfer those babies in specialist ambulances. The submission states that consultation will take place with families during the implementation phase.

I should say that Monica Lennon has joined us for this petition as well—I neglected to mention her earlier, as she was already sitting at the table. I invite Jackie Baillie to make some comments.

Jackie Baillie (Dumbarton) (Lab): Thank you, convener. I do not know whether the collective noun is a suite of MSPs. I thought of a posse of MSPs, but I like your description even better: a galaxy of talent. We will settle for that, convener, thank you very much.

We are joined in the public gallery by Monica Sheen and Colleen Murphy, and by Alfie, who is probably the most well-behaved baby that I have ever seen. They have come specifically in support of this petition and they are joined in that support by many others who simply could not be here today. I also convey apologies from Mark Griffin. You will know that he has experience of the neonatal unit. He had another meeting, otherwise he would have been here today.

Thank you for the opportunity to speak to this petition. I am not sure whether this is the first time that there have been so many MSPs engaged in the same subject at committee, but it shows how important the issue is. The number of signatures collected on the public petition and the Scottish Parliament petition is also significant.

My colleagues and I will set out a number of reasons why the proposed downgrading of Wishaw neonatal unit is unsafe. As you have said, the rationale for downgrading Wishaw and keeping three units open in Glasgow, Edinburgh and Aberdeen is set out in the Scottish Government's demand and capacity modelling of NICU services. However, the data that was collected for that report on which these critical decisions are being made is, frankly, inconsistent. Different timeframes are used throughout: sometimes data taken over a year is compared to data taken over three years, and there is no rhyme nor reason to it. I understand that the exercise was rushed but it is so arbitrary.

The review that was initiated by the Scottish Government, which we welcomed, acknowledged that the data was flawed, but nothing has been done about it. Therefore, people are proceeding at pace to implement proposals that we know are based on flawed data. I find that astonishing, given that this Parliament and the Scottish Government assert that decisions are all evidence based. They appear to have fallen at the first hurdle here, and there is little wonder that people have very little confidence in the report and its implementation.

The report also fails to give consideration to maternity capacity. There is no analysis or consideration of workforce requirements. Although the report states that workforce data has been collected, the results of the analysis are not included. I have no idea why you would not put such a significant element into the report. I will come back to staffing in a minute.

In 2017, the Scottish Government published the "Best Start" report, which stated that three to five neonatal units should be developed, supported by something like 10 to 12 local and special care units. That is fine. Since then, however, the Government has simply fixated on developing only three. There is no explanation why the number is not five or four. It is our contention and the petitioner's contention, based on the

data and the volumes of people being cared for, that there should be four units in Scotland, and that Wishaw should be one of them.

Wishaw neonatal unit is the third busiest neonatal unit in Scotland. The critical mass of neonates exists within the central belt area. We know that Wishaw neonatal unit accepts the highest number of in-utero and out-of-utero babies, which clearly shows the skill set and the capability in the unit. There are transfers from other board areas all the time. Wishaw was named the best service in the UK last year, information that clearly has been ignored by the Scottish Government.

My colleagues will explain that there are real concerns from staff and patients that level 3 neonatal units in Glasgow and Edinburgh are already facing staffing pressures and will not be able to cope with demand once Wishaw is downgraded. I recently uncovered statistics that show that health boards across Scotland, in particular in the central belt, with the knowledge of the Scottish Government, have cut paediatric and maternity vacancies. Let me stress that the numbers are not frozen, they are not still there; they have simply been cut from the complement of what was required. I therefore worry about safety due to the lack of staff. The staff shortages will also add to pressure on neonatal services and force mums and premature babies to be transferred not to Glasgow or Edinburgh but to Aberdeen. We are talking about the very sickest babies, and just think about the distance that that would involve.

There is clearly appetite and scope for Wishaw neonatal unit to remain in place alongside units in Glasgow, Edinburgh and Aberdeen as part of the best start strategy. I would be grateful if this committee would take this petition on—because I know that you have run with petitions before—and invite the minister or the cabinet secretary to explain why the Scottish Government is ignoring the evidence and putting at risk the safety of mothers and babies at Wishaw.

The Convener: Thank you, Jackie Baillie. I should say that we, too, welcome Alfie. The tones of the committee members were soporific and he was very quiet earlier, but I notice that he has become very animated since you were speaking, Ms Baillie. I do not know what the moral conclusion from that might be.

Jackie Baillie: They were sounds of approval, convener.

The Convener: We have a few minutes each for Monica Lennon and Richard Leonard to speak. We have a fixed amount of time, so please be mindful of that.

Monica Lennon: Thank you, convener. I appreciate that this is my second appearance at the committee this morning.

I will reinforce Jackie Baillie's comments about safety. That issue has to be paramount in the minds of everyone. I am here as a Central Scotland MSP. Lynne McRitchie, who lodged the petition on behalf of the Wishaw Neonatal Warriors, is a constituent of mine, as is Monica Sheen, who is here today.

I do not want to repeat the comments that Jackie Baillie has made, so I will move on to the lack of meaningful public consultation and take my lead from what Fergus Ewing said with regard to a petition that the committee addressed earlier. He talked about the importance of having the confidence of the people who you seek to serve

and your local communities. When the Scottish Government got around to doing some consultation, beginning on 21 June this year, people had only 17 days to submit comments. People with lived experience, such as Lynne McRitchie, Monica Sheen and many others, were told that they had to summarise their comments, with a limit of 500 characters, in an online document. There are families whose babies, sadly, did not survive and others who have life-changing conditions, and it is unfair to ask them to summarise their experiences in a few hundred characters.

As well as the issues that Jackie Baillie has raised about the inconsistency and inaccuracy of the data and the way that evidence has been presented, I note that we have not had meaningful consultation, so there is no public support or public buy-in for the change. The proposal is not only flawed but has been built on very shaky foundations, which will put at risk the lives of Scotland's most premature, smallest and sickest babies, and their mums.

It is no exaggeration to say that there is a real sense of betrayal across Lanarkshire. As Jackie Baillie said, Wishaw is a much celebrated and award-winning neonatal intensive care unit that is highly respected across the UK. We often say in Parliament that we need to learn more from good practice. This is exceptional practice. The staff are upset, not for their own sakes but because they have very close relationships with the families, who they continue to care for long after babies have left the unit.

10:30

I will briefly touch on the young patients family fund, which is in place for parents of babies who have to be cared for outwith their community. Colleagues will know that that is a reimbursement system, which means that families can apply for their expenses after they have incurred the expense. It is good that that is in place, but many families, particularly those in Lanarkshire, where poverty is sky high at the moment, do not have money for hotels and accommodation and to buy extra food and pay for childcare. That needs to be looked at, too, because the Government has not costed the proposal in that regard and we do not know how much any of it will cost.

Lynne McRitchie, who is not able to be here today, has done a great deal of work in her own time. She is mum to Innes, who received care at Wishaw. In an earlier comment she said:

"I cannot imagine how we would have felt if we had then been told that best case scenario was to transfer to Glasgow to receive that care. It adds a whole new level of stress and trauma into what is already a horrific experience for parents and families."

We know that, because of capacity issues, many of our families in Lanarkshire could end up in Aberdeen. That is a long, long way from home.

The Convener: I encourage you to sum up now.

Monica Lennon: In conclusion, we fear that, if the issue is left in the hands of the Government, with its flawed data and lack of meaningful consultation, we will have a very dangerous outcome. I know that it is not entirely in the gift of the committee, but I urge the committee to bid for a committee-led debate. You have Labour talent here

today but there are many more owls in the Parliament. We have had a members' business debate on the issue led by a Scottish Conservative member and others have asked questions. There is cross-party support—that is important to know. We cannot play politics. If we truly want the best start for all of Scotland's babies, at the very least we have to pause this process before a terrible mistake is made.

The Convener: Thank you. I am interested to hear whether Richard Leonard passes the Alfie test, because he was very quiet during Monica Lennon's evidence on this occasion. Welcome again, Richard. I am happy to hear your contribution to our discussion.

Richard Leonard: I will get straight into the points that I want to raise. First, the recommendations that led to the proposals to downgrade Wishaw neonatal unit have not been subject to a robust or thorough equality or human rights impact assessment. That is an issue in relation to parents and families but also in relation to babies, because they, too, have rights under the United Nations Convention on the Rights of the Child—a right to life, a right to survival and a right to development—and that has not been properly taken into account.

Secondly, the clinical advice that has been used to justify the decision is now five years old. Thirdly, neither the current minister nor her predecessors have ever visited the Wishaw neonatal unit to speak to the staff there to get their expert view. Fourthly, as Jackie Baillie and Monica Lennon have mentioned, the concentration of the provision of these intensive care resources will bring about capacity and resilience issues. It is extremely difficult to understand the feasibility of families from central and southern Scotland having to go to Aberdeen, which will have one of the proposed three centres.

There has been centralisation of these services in other parts of the UK, but there has not been any proper evaluation of those that could be factored into any decisions that the Scottish Government takes. ScotSTAR and the Scottish Ambulance Service will be significantly affected by the changes and they have not been fully involved in the process. There has been no assessment of the impact on their services.

Finally, this is an issue in Lanarkshire and in Wishaw but there is also an issue about how we provide these services across the whole of Scotland. That is an issue for every member of this committee and every member of this Parliament. We simply ask this committee to take up some of these issues in relation to the extent to which the assessments have been made, the impact on staff, the impact on capacity, the impact on resilience and the impact not just on human rights but human lives.

The Convener: Thank you. I have been enjoying and reflecting on the evidence that has been given by the three of you. At the risk of creating panic among the clerks and my colleagues, I propose that the committee visit the neonatal unit in Wishaw for ourselves to see what we can discover and to bring attention to the issue. Do colleagues have any other suggestions?

David Torrance: I agree with your comments. Could the committee write to the Minister for Public Health and Women's Health to ask whether clinicians and staff at neonatal intensive care units were consulted before the decision to centralise

services was taken; whether the Scottish Government has considered the impact of the distance between home and hospital on the wider family, particularly other children, and what steps it is taking to mitigate any impact; whether she is confident that ScotSTAR has sufficient resources to respond to all transport requests following the introduction of the new care model; and how the new model will affect care for high-risk babies not born at a hospital with a neonatal intensive care unit, between birth and transfer to such a unit?

The Convener: I also suggest that we invite the relevant members who have been involved in the petition to accompany us on our visit. We could liaise with them about people we might see in order to draw some direct attention to this issue. Are members content with those suggestions?

Members *indicated agreement.*

The Convener: Thank you. I hope that we can don something with this petition and make some progress on if. We can speak again in an effort to progress that.

That brings us to the end of our consideration of new petitions this morning. Before we move into private session, I acknowledge that, although this committee has been fortunate to win the Holyrood magazine powering change award previously, we were only one of the three nominees this time. Nonetheless, I pay tribute to the clerks for all the work that they do, which helped to support the nomination that we received. I know that committee members very much value the work that they do, and we know in our hearts that, if we are being nominated, it is as much because of the work that they do on our behalf as the representations that we make.

Annexe C: Written submissions

Minister for Public Health and Women's Health written submission, 11 October 2024

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

Thank you for the opportunity to respond to the petition noted above.

In addition to my letter to the committee dated 11 June 2024 I would like to respond to the points raised within your letter of 25 September 2024.

The Best Start: A five Year Forward Plan for Maternity and Neonatal Care was published in 2017. It sets out a future vision for maternity and neonatal care which focuses on putting women, babies and families at the centre of maternity and neonatal care to ensure they receive the highest quality of care according to their needs.

The Best Start report was the result of a Strategic Review of Maternity and Neonatal Services in Scotland. The Review was chaired by an NHS Chief Executive and conducted by clinical experts, NHS service leads, academics and service user representatives. It examined choice, quality and safety of maternity and neonatal services in consultation with service users, the workforce and NHS Boards, and supported by analysis of current evidence.

Within the published report The Best Start recommended that Scotland should move from the current model of eight Neonatal Intensive Care Units (NICU) to a model of three units supported by the continuation of current NICUs redesignated as Local Neonatal Units (LNU's).

I think it is important to reiterate the reason why the Best Start expert report recommended this change, and therefore why we are moving forward with it.

The recommendation was based on evidence that outcomes, including survival, for the very smallest and sickest babies are best when they are cared for in units with high volume throughput (defined as care for more than 100 very low birthweight babies a year) and where there are collocated specialist services (such as neonatal surgery). This evidence is widely supported, and now forms the basis of professional guidance published by the British Association for Perinatal Medicine (the professional body for neonatology and a specialist society of the Royal College of Paediatrics and Child Health), and the majority of existing service models in other parts of the UK are aligned to this.

Based on the number of very low birthweight babies that are born in Scotland the Best Start Programme Board determined that three units would be a sustainable model for Scotland. I think all parents across Scotland would expect us to act in the interests of the best evidence and deliver services that improve the chances for the very smallest and very sickest babies.

You asked how clinicians and staff at neonatal intensive care units were consulted before the decision to centralise services was taken. The recommendation to move to three Neonatal Intensive Care units was made in the Best Start report published in 2017. The recommendations of that report were accepted by Ministers when it was published, and this was communicated to the Scottish Parliament at that time.

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 (highlighted above). 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. In addition, the Scottish Health Council led a programme of service user engagement across all NHS Territorial Boards, which were supplemented with bespoke service user events. Over 600 staff and 500 service 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.

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. The members of the Perinatal Sub Group were appointed based on the organisations they represented, not the Boards they were from (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, a leading charity representing neonatal families).

The petition that you have received has a particular focus on the neonatal unit in Wishaw. It may be helpful to note that Lynne Clyde, Head of Midwifery at NHS Lanarkshire, was a member of the Perinatal Sub Group representing Heads of Midwifery and involved throughout the options appraisal process. In addition, Heather Knox, at that time Chief Operating Officer for NHS Lanarkshire initially chaired the Perinatal Sub Group 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.

So in summary, a range of neonatal and maternity clinical voices were represented both in the development of The Best Start report that made the recommendations to move to three neonatal intensive care units, and in the development and undertaking of the Options Appraisal process that determined where those units would be located.

You asked about the impact of the distance between home and hospital on the wider family, particularly other children, and what steps are being taken to mitigate any impact. We continue to prioritise parents as key partners in caring for their baby and have facilities on neonatal units so that parents and siblings can be with their baby as much as possible. This is in line with the Best Start ethos of keeping mothers and babies, and families together as much as possible with services designed around them.

As a key part of the next phase, Scottish Government has consulted with families on implementation of the proposals, so that we can take account of their concerns when the pathways and processes for the new model of care are designed, and it is important that we hear the voices of those families to input into design of service delivery.

A survey was conducted through Citizen Space, Scottish Government's online consultation hub, to gather and consider the views of interested stakeholders on the new model of neonatal care and what matters to them. This process has been supported and input sought by HIS and Bliss the charity for neonatal families.

The survey was launched on Citizen Space on 21 June 2024 and asked 20 questions (7 open and 13 closed).

The survey received 434 responses. Of these, 428 were from individuals and 6 from organisations.

To supplement the survey, the Scottish Government conducted focus groups to interrogating key themes to emerge from the quantitative research study. The focus groups explored three themes: mental health support, financial support, and communication.

The results of the survey and focus groups are now being shared to support implementation.

Analysis of the responses will take place to determine an action plan to target areas of public concern and how these can be mitigated.

We have a number of measures already in place to support families who have babies in neonatal care including:

- Providing accommodation for parents to stay on or near neonatal units;
- Roll out of the Young Patients Family Fund (formerly the Neonatal Expenses Fund) to support families with the costs of travel, accommodation and food whilst their baby is in neonatal care;

- Provision of accommodation for parents/carers on or near the neonatal unit.

and

- Repatriating babies to their local neonatal units as soon as clinically possible.

You asked about ScotSTAR resources to respond to all transport requests following the introduction of the new care model. The Scottish Government commissioned detailed modelling work from RSM UK Consulting LLP to inform planning for transition to the new model of care. Their work involved engagement with both operational and strategic stakeholders, including ScotSTAR to validate data, generate and test planning assumptions and their report was published on 29 May 2024 and can be accessed at New Model of Neonatal Care – RSM UK Consulting - Report

Following the modelling work that RSM UK undertook we asked the Regional Chief Executives to develop implementation plans to deliver the new model of care, and as part of this to engage with the Scottish Ambulance Service and ScotSTAR on capacity. I am aware that the regional planning teams have met with ScotSTAR as part of their planning process, and capacity is an ongoing part of discussions moving forward with implementation.

Finally, you asked how the new model will affect care for high-risk babies not born at a hospital with a neonatal intensive care unit between birth and transfer to such a unit.

If it is identified during the pregnancy that there is a high risk of the baby (or babies, in multiple pregnancies) needing specialist intensive care after birth – for example for an identified heart or surgical problem – then all antenatal care will be planned with the input of a specialist maternity team, and with an expectation that the woman will be transferred to a maternity unit in a hospital with a NICU on site when it is time to give birth. This is the model that is in operation now across Scotland, for example in relation to neonatal surgery, which is only available in three units in Scotland, and pathways and protocols are in place to transfer mothers before they give birth.

If a pregnant woman goes into extreme pre-term labour, or looks like she is going to, depending on the timing of this, she will be transferred by ambulance to a maternity unit in a hospital with a NICU on site, if it is safe to do so, to give birth to the baby there. In the case of an unexpectedly unwell baby or, if there is no time to transfer the woman before a preterm birth, the baby will be born in the nearest hospital and given immediate short-term intensive care on site to stabilise the baby, before being transferred to a NICU by the specialist neonatal transport service ScotSTAR when it is safe to do so.

Experience of operating this model of care in Ayrshire and Fife has shown that this works well, with the vast majority of mothers in suspected pre-term labour being transferred prior to birth. The Scottish Perinatal Network has a programme of work underway to support all Boards in Scotland to strengthen processes and pathways to

ensure extremely pre-term babies are born in units with an alongside Neonatal Intensive Care Unit.

Babies receiving care in one of the three intensive care units will be transferred back to their local neonatal unit for ongoing care as soon as possible.

I would like to also provide clarification to the committee regarding a point that was raised on 11 September 2024.

Since my appointment and the announcement of the location of the 3 specialist intensive care neonatal units for highest risk babies in Aberdeen Maternity Unit, Edinburgh Royal Infirmary and Queen Elizabeth University Hospital in July 2023, I have met with families and clinicians from across Scotland, including in the University Wishaw Hospital.

On the 9 Nov 2023 I attended a meeting at the Scottish Parliament with Wishaw neonatal campaigners and elected representatives. On the 26 Feb 2024, I visited Wishaw General neonatal unit and met with staff to discuss the new model of care. On the 21 May 2024, I met Fulton McGregor, Wishaw Campaigners and former Wishaw Clinicians.

In addition, on 7 February 2024, I visited Ninewells neonatal unit in Dundee to award them with the Bliss Baby Charter gold award. In order, to gain additional clinical insight into the new model of neonatal care, on 22 August 2024 I visited NHS Greater Glasgow and Clyde Neonatal unit within Queen Elizabeth University Hospital and on 1 October 2024, I visited the New Royal Infirmary neonatal unit to see the work of the clinical teams and discuss the new model of neonatal care.

I am aware the prior to the announcement of the three units, my predecessor Maree Todd also had the opportunity to attend the neonatal units to meet with staff and families.

I hope this information has provided additional reassurance to the committee that we are looking all areas highlight as part of the implementation process so we can provide the best care in Scotland for our neonatal babies.

Yours sincerely,

Jenni Minto MSP

Minister for Public Health and Women's Health written submission, 1 September 2025

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

In addition to my letters of the 11 and 27 October 2024 I would like to provide the Committee with an update prior to the scheduled visit to the University Hospital Wishaw on the 8 September 2025.

We have continued to be proactive in listening to the concerns of both the clinical teams and the public throughout Scotland and what is clear from the clinical community is an agreement that the new model of neonatal care will give the smallest and sickest babies in Scotland the best chance of survival.

As noted in my written submission a range of neonatal and maternity clinical voices were represented both in the development of The Best Start report that made the recommendations to move to three neonatal intensive care units, and in the development and undertaking of the Options Appraisal process that determined where those units would be located.

The recommendation was based on evidence that outcomes, including survival, for the very smallest and sickest babies are best when they are cared for in units with high volume throughout (defined as care for more than 100 very low birthweight babies a year) and where there are collocated specialist services (such as neonatal surgery). This evidence is widely supported and now forms the basis of professional guidance published by the British Association for Perinatal Medicine (the professional body for neonatology and a specialist society of the Royal College of Paediatrics and Child Health), and the majority of existing service models in other parts of the UK are aligned to this.

Based on the number of very low birthweight babies that are born in Scotland the Best Start Programme Board determined that three units would be a sustainable model for Scotland. I think all parents across Scotland would expect us to act in the interests of the best evidence and deliver services that improve the chances for the very smallest and very sickest babies.

Over the course of this year we have continued to work with the Regional Chief Executives and NHS Boards to implement this service change.

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 of which £6.5 million has been provided to NHS Greater Glasgow and Clyde and NHS Lothian for implementation of the new model of neonatal intensive care (£3,570,400 to NHS Greater Glasgow and Clyde and £2,873,051 to NHS Lothian since 2019). We are discussing providing similar support for NHS Grampian. This funding is focused on supporting Boards through the transition process.

The three NHS Regional Chief Executives, who are leading implementation for the North, East and West regions, established a Task and Finish Group in March 2025. The Group’s membership comprises of the NHS Regional Chief Executives, Regional Planning Directors, SG officials and service leaders bringing working knowledge and understanding of current services, to lead delivery of the work.

The remit of the group is to oversee and support national action and coordination required for delivery of Regional Implementation Plans to be undertaken

collaboratively across regions to identify the practical steps that are possible to take to deliver the evidence-based model.

An update was provided to the NHS Scotland Executive Group in July 2025 noting that the Task & Finish Group had met on two occasions and is progressing:

- A Financial Plan to assess the cost requirements for neonatal cot and maternity capacity, with recommendations for transfer of resource between Boards, through collaboration between the 3 NICU Board Finance Leads and Regional Planning Directors.
- Mechanisms to provide assurance that the new model is achieving quality outcomes and delivering care as local to the mother and baby as possible.
- Overseeing the implementation trajectory.

The next meeting of the Task and Finish Group will take place on the 19 September 2025.

As previously outlined, Scottish Government commissioned Consulting firm RSM UK Consulting LLP to undertake detailed modelling work to fully map the capacity requirements across the system to inform capacity building and implementation of the new model. Forecasts incorporated demographic changes, incidence trends, flow of babies between units and operational assumptions.

The principles underpinning the changes to neonatal intensive care are supported by the Scottish Executive Nurse Directors (SEND) and by the Directors of Midwifery. However, concerns were raised about the implications of this change for maternity services. The Directors of Midwifery highlighted that additional data and evidence gathering was required for maternity services to inform maternity capacity implementation planning.

SEND, in support of the Directors of Midwifery, recommended that the Scottish Government undertake national-level data collection to understand the impact of the neonatal care remodelling on maternity services. This work is underway and will report to SEND, Directors of Midwifery and Regional Planning Chief Executives. The report will summarise the data provided by NHS Boards to the Scottish Government to inform consideration of maternity capacity requirements under the New Model of Neonatal Care.

Support for families who will be affected under the new model of neonatal care is also ongoing and we continue to prioritise parents as key partners in caring for their baby and have facilities on neonatal units so that parents and siblings can be with their baby as much as possible.

I have met with Bliss the charity for neonatal families and discussed the variations of access to the Young Patients Family Fund (YPFF) and accommodation resources within Boards. In order to mitigate these inconsistencies SG officials have worked with the YPFF leads within Boards and updated Terms and Conditions have been developed to provide clarity.

Furthermore, I look forward to supporting Bliss in October 2025 when I present Forth Valley Neonatal Unit with their Bliss Baby Charter gold award.

The Scottish Perinatal Network has continued with their programme of work underway to support all Boards in Scotland to strengthen processes and pathways to ensure extremely pre-term babies are born in units with an alongside Neonatal Intensive Care Unit. Babies receiving care in one of the three intensive care units will be transferred back to their local neonatal unit for ongoing care as soon as possible.

In addition, the Scottish Perinatal Network has developed an information webpage to allow families to access vital information on the unit they may be attending to assist in eliminating any uncertainty for families.

Previously you asked how the new model will affect care for high-risk babies not born at a hospital with a neonatal intensive care unit between birth and transfer to such a unit.

In the case of an unexpectedly unwell baby or, if there is no time to transfer the woman before a preterm birth, the baby will be born in the nearest hospital and given immediate short-term intensive care on site to stabilise the baby, before being transferred to a NICU by the specialist neonatal transport service ScotSTAR when it is safe to do so. This is a well established model that operates currently across Scotland in our Local Neonatal Units such as Forth Valley Royal, Royal Alexandra Hospital in Paisley and Raigmore in Inverness and in our Special Care units in St Johns, Dumfries and Borders.

ScotSTAR has now created a short video to support families, explaining what's involved in a neonatal transfer and answers commonly asked questions. It is also a helpful source of information for staff who have not experienced neonatal transport.

I hope this information has provided additional reassurance to the Committee that we continue to look at all areas highlight by the committee in October 2024 as part of the implementation process so we can provide the best care in Scotland for our neonatal babies.

Yours sincerely,

Jenni Minto MSP

Minister for Public Health and Women's Health

Bliss Scotland written submission, 23 September 2025

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

About Bliss Scotland

Bliss Scotland is the leading Scottish charity that champions the right of every baby born premature or sick to excellent neonatal care, experience and outcomes. We achieve this by improving care, giving voice to babies and supporting parents to be partners in care.

Background

There are 14 neonatal units in Scotland, eight of which were Neonatal Intensive Care Units (NICUs). In 2017, the *Best Start: A Five Year Forward Plan for Maternity and Neonatal Services in Scotland* included the recommendation to reduce the number of NICUs in Scotland to three.

In July 2023 the Scottish Government announced that the location of the three NICUs would be Queen Elizabeth University Hospital in Glasgow, Edinburgh Royal Infirmary, and Aberdeen Maternity Hospital.

Under this new model **no neonatal units will close**, with the remaining NICUs redesignated as Local Neonatal Units (LNUs). An estimated 50-60 babies across Scotland each year will be cared for in a different hospital under these changes. This will typically be babies:

- born <27 weeks gestation
- weighing less than 800g
- needing complex life-support.

This change is intended to improve the care babies receive, meaning that more extremely premature and extremely sick babies will survive and survive well.

Evidence for the new model of care

Multiple studies indicate that this model of care provides the smallest and sickest babies with the best chance of survival and quality of life. The EPICure 2 study in 2006 confirmed that NICUs with higher levels of activity had significantly better outcomes than smaller ones for babies born <27 weeks' gestation. Analysis from the UK-based Neonatal Data Analysis Unit published in 2014 showed that infants admitted to a high-volume neonatal unit at the hospital of birth were at reduced risk of neonatal mortality.

UK data is supported by international evidence. The French Epipage-2 study in 2011 revealed that fewer babies born 24-30 weeks survived to discharge in hospitals with lower volumes of neonatal activity. Survival without neuromotor and sensory disabilities at 2 years increased with hospital volume, from 75% to 80.7% in the highest volume units. Evidence from the US, Australia and other parts of Europe also supports this approach.

The new model is in line with UK-wide clinical guidelines set by the British Association for Perinatal Medicine (BAPM), which detail the activity levels required to sustain a NICU service, as well as best practice globally. Indeed, the recent Ockenden Review into services at Shrewsbury and Telford Hospital and CQC reports from Leeds Teaching Hospitals highlight the importance of operating within guidelines and in-line with the appropriate designation.

Bliss Scotland position

Around 5,200 babies are born needing neonatal care in Scotland every year, of which around 1,100 receive intensive care. This volume is far too low to sustain more than three NICUs in Scotland.

Bliss Scotland fully supports reconfiguration of neonatal services in Scotland and believes strongly that reorganisation of services is necessary to ensure the sickest babies have access to the care most suited to their needs.

Bliss Scotland has been involved throughout the process which led to decisions being made to centralise neonatal intensive care in Scotland, initially as part of the review group which contributed to the Scottish Government's Best Start report. We were subsequently members of both the Best Start Programme Implementation Board, and its Perinatal sub-group, until this programme formally closed in late 2025. Our role has always been to advocate for what is in the best interests of babies born premature or sick.

The current context

A Task and Finish Group (TFG) was established in 2025 to oversee and support the final stage of the transition to three NICUs across Scotland.

Bliss Scotland is concerned that progress is stalling. There has been a lack of clear communications about TFG priorities, work plan and progress to date. Ongoing concerns regarding resourcing have not been addressed, including adequate staffing at the designated three intensive care units.

We also share concerns of families, like the ones the Committee recently met with in Wishaw, who are worried about the impact of transfer to a unit further from home. To be successfully implemented, the new model must have funding to develop on-unit accommodation for parents in each of the three NICUs, and ensure facilities on neonatal units meet the needs of the families using them

Where will babies be cared for

For most babies who need neonatal care, this change should not affect where they receive care.

Most babies will be transferred in-utero and will be delivered at a hospital with a NICU onsite, minimising the chance of long-distance separation from their mother post-birth.
Babies will typically be cared for at their nearest NICU. For example, women at risk of extreme pre-term birth in Lanarkshire will normally be taken to Glasgow for their baby to be born. In certain cases of very specialist care, for example access to ECMO (extracorporeal membrane oxygenation), the only service in Scotland is in Glasgow, where babies requiring access currently – and in future – will need to be born or transferred.

We are concerned about the significant levels of misinformation circulating regarding where babies will be transferred to once the new model of care is implemented. Neonatal services aim to care for babies as close to home as possible, and the new model of care is based on this principle; including repatriation of babies to unit closer to home when they are well enough.

Practical support for families

The Young Patient Family Fund, and the availability and quality of family facilities on neonatal units, will be of increasing importance as neonatal care is centralised. Bliss Scotland therefore believes that much more can and should be done to enhance the support available to families.

Funding must be available to develop on-unit accommodation for parents in each of the three NICUs, and alongside this, the Young Patient Family Fund should be reviewed to ensure the costs that can be claimed align with current inflation levels, and to improve the ease of making claims.

Monica Lennon MSP written submission, 24 September 2025

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

I welcome petition PE2099 because I recognise the importance of specialist neonatal units to my constituents and people across Scotland. The proposed downgrading of the award-winning neonatal intensive care unit at University Hospital Wishaw raises serious concerns about the future care of premature and sick babies. These have not been adequately addressed by the Scottish Government.

More than 20,000 Scots backed the original online petition, and the parliamentary version has since gathered over 3,500 signatures. Each signature speaks to a family who dreads the prospect of their smallest, most fragile infant facing a longer, riskier journey when every second truly counts.

The Scottish Government announced this policy change in 2024 with limited engagement. A short consultation period in the middle of summer holidays and a UK General Election was not a designed with families in mind.

That truncated process amounts to tokenism, leaving families, clinicians, and local representatives feeling betrayed. Mothers from Wishaw Neonatal Warriors have experienced firsthand the lifesaving expertise of the unit and have made it clear that downgrading this award-winning service would be a devastating blow to their community.

Many parents simply cannot afford the upfront costs of accommodation near a distant hospital, and no retrospective fund can erase the stress of separation at life’s most fragile moment. Moreover, dismantling one of Scotland’s highest-performing Level 3 neonatal teams threatens staff retention across one of our most deprived health boards, undermining hard-won expertise and local trust.

I am grateful to the Committee for its diligent consideration of the petition and appreciate the recent visit to University Hospital Wishaw to see the firsthand how the NICU operates and meet with staff and families closely connected to it.

The Committee has already provided critical scrutiny and allowed more time for careful consideration of the proposal and the risk of unintended consequences. Given the concerns that campaigners have raised about the decision-making process, I believe that the Committee has an important role to play in preventing a

terrible mistake from being made. Based on the evidence taken, I would be grateful if the Committee would consider recommending an independent, multidisciplinary review be undertaken before Scottish Ministers reach a final decision.

This review should include robust travel-time modelling, a thorough cost-benefit analysis of family impacts, and a careful assessment of workforce sustainability.

Residents across Lanarkshire and beyond deserve evidence-led and transparent decision-making that takes account of all the likely impacts.

I reiterate my support for the petition and for neonatal intensive care to be retained at University Hospital Wishaw.

Annexe D: Note of visit to University Hospital Wishaw

Background

On 8 September 2025, the Committee visited University Hospital Wishaw to meet with the Petitioner, families and staff to explore the issues raised in petition PE2099: Stop the proposed centralisation of specialist neonatal units in NHS Scotland.

The petition is calling on the Scottish Parliament to urge the Scottish Government to stop the planned downgrading of established and high-performing specialist neonatal intensive care services across NHS Scotland from a level three to a level two and to commission an independent review of this decision in light of contradictory expert opinions on centralising services.

The Best Start Report recommended a reduction in the number of neonatal intensive care units from eight units, to three-five. It was then determined that the number of neonatal intensive care units would be reduced from eight to three.

The information gathered during this visit will help the Committee decide what action it wishes to take on the petition.

The Committee is grateful to those who shared their personal experiences and concerns about the proposed downgrading of Wishaw's neonatal intensive care unit (NICU) from a level 3 provider, to level 2.

A SPICe briefing on the issues raised in the petition is available on the petition webpage.

Meeting with the Petitioner and families with experience of neonatal care

The families who met with the Committee emphasised the importance of their stories being heard. One participant remarked that by contributing to the discussion, she wished to highlight the human aspect of the Scottish Government's proposed changes.

Impact on relationships

Social isolation

The parents pointed out that when their babies were in the NICU, the world continued around them. The participants emphasised that they were still required to pay bills, look after their homes and care for other children. The value of having support from family and friends during this time was emphasised.

Participants shared concerns that if mothers and babies are transferred for treatment in a unit further afield, the family could become isolated from their support networks. They felt that isolation from support networks and other children in the family could have a lasting impact on relationships and lead to poorer mental health outcomes for the parents.

Parent and baby separation

Families shared their personal experiences and emphasised the importance of being in close proximity to their babies, either as a patient in the same hospital or by living a short car journey away. They shared that being close-by allowed them to have the recommended early bonding experiences such as skin to skin and breastfeeding, as well as being present during medical emergencies.

While the plans state that efforts will be made to identify and transfer babies and mothers with high dependency needs before birth, participants stressed that often high dependency needs don't become known until an unexpected emergency during or after birth.

The participants raised concerns that under the proposed changes, mothers who require emergency medical care in Wishaw would be unable to travel with their babies to a level 3 unit, resulting in separation after birth.

Socioeconomic context and financial impact

Socioeconomic context

According to the Scottish Index of Multiple Deprivation 2020 there are several areas in North Lanarkshire which are amongst the most deprived, including in Motherwell which is immediately serviced by University Hospital Wishaw.

Participants felt that when making the decision to downgrade Wishaw's NICU, there was 'little to no consideration' of the socioeconomic deprivation and health inequalities of the communities serviced by NHS Lanarkshire.

Participants emphasised that preterm birth rates are significantly higher in areas of deprivation. The group noted that in the 2016 dataset used in the options appraisal, Wishaw had the 3rd highest number of neonatal admissions in Scotland.

The participants also explained that public transport links for low income families without a car are limited.

Costs

Families emphasised concerns about the financial impact on families transferred to an NICU further afield than Wishaw.

The Young Patients Family Fund provides reimbursement for costs incurred by the primary carer or sibling of a young inpatient receiving hospital care. While participants could see the value in the Young Patients Family Fund, they felt that it was not sufficient to cover the needs of families.

Under the Fund, the primary carer can claim back for one return journey per day to the hospital. However, participants stated that this does not adequately support parents with other responsibilities throughout the day, such as school pick-up for other children.

The hospital may provide meals or meal tokens free of charge. Any cost of other meals can be claimed up to £8.50 per eligible visitor, per day, through the Fund.

Claims can be made on a weekly basis and payments are provided as reimbursement of costs already incurred. The participants highlighted the

socioeconomic context for many patients in the NHS Lanarkshire Health Board area, stating that it will not always be feasible for parents to incur costs for reimbursement at a later date.

Options appraisal

The participants stated that while they support the recommendations of the Best Start Report and agree with the data and evidence related to improved outcomes, the group has serious concerns regarding the options appraisal and the decision making process.

Scoring

The participants believe there were significant inconsistencies in the scoring of the units. Following a review of the report and ranking, the group determined that the future of the units was determined by the scoring process. However, it was felt that the use of incorrect and out of date information regarding the services available at each unit caused a wide disparity in the scoring. The group also noted that the data collection took place without appropriate guidance to ensure a standardised system of scoring.

The group recognised that a small range of disparity in scoring would be expected based on individual interpretation of the data provided, likely linked to background/experience of the scorer. However, the participants felt that the range of scores raises significant concerns about the process.

Consultation and engagement

The participants emphasised that there was a lack of engagement with users of the service. They stated that no consultation took place with parent groups, political representatives, members of the Health Board or staff and experts within Wishaw's NICU.

The participants shared that the Scottish Government's engagement with Bliss, a charity for babies born premature or sick, involved collecting generic information from the charity rather than undertaking meaningful, direct engagement with its service users.

The participants questioned how a decision on neonatal services could be made without thorough consultation with families.

Meeting with staff from Wishaw's neonatal intensive care unit and NHS Lanarkshire

The Committee met with staff from the neonatal intensive care unit (NICU) in University Hospital Wishaw and staff from NHS Lanarkshire. The participants echoed concerns raised by the families, including –

- socioeconomic context in Lanarkshire
- isolation from support networks in the community
- the impact on other children in the family
- lack of consultation with families

Support and access to services

The staff group emphasised the value in families being close to home and established support networks when mothers and/or babies require medical care.

The group also noted that moving parents away from their local GP can impact on access to support, including access to mental health services.

Options Appraisal

The staff at Wishaw reviewed the Options Appraisal Report and concluded that they are not in agreement with the proposed changes to services provided by Wishaw's NICU. The staff group believe the plan is flawed and not in the best interests of service users in NHS Lanarkshire.

Transparency and representation

It was felt by the staff group that the outcome of the review was pre-determined, with a lack of transparency and openness throughout the process. This view was also shared by the families who met with the Committee.

The group shared that NHS Lanarkshire was not represented, resulting in a lack of joint informed decision making. It was noted that the Perinatal Subgroup included those with affiliations to NHS Greater Glasgow and Clyde, NHS Lothian, NHS Tayside, NHS Grampian, NHS Forth Valley and NHS Highland.

The participants also highlighted that the Scottish Ambulance Service was not involved in the review, even though there would be an increased resource requirement for the transfer of babies to level 3 units.

Data

Health Boards were asked to collate and review clinical data for the purposes of modelling for the options appraisal. The staff group shared concerns about this exercise, including a view that the pre-determined outcome of the review influenced the framework for this exercise. The group has been unable to receive information about the rationale for moving to three units, rather than four or five.

The group highlighted that there was no uniform approach to the extraction and review of data across Health Boards, which they believed was likely to cause discrepancies in the information provided.

Staff also felt that there should have been a longer period of time available to collate and review the data. The timeframe for this was under four weeks, including over the festive period, with some nil returns from other Health Boards. The group expressed the view that the data collection exercise should have taken place over several months.

Training and knowledge assessment

The group noted that the report did not mention an assessment of the skills, training and knowledge already embedded in the units. They highlighted that NHS

Lanarkshire has a neonatal trained consultant workforce, with a large cohort of experienced Advanced Neonatal Nurse Practitioners.

The group pointed out that Wishaw has a higher numbers of infants at <27 weeks' gestation being admitted to the unit than in the Royal Hospital for Children in Glasgow. It was noted that with the smaller staff size, exposure to premature infants is higher per individual staff member which results in staff having more frequent experience with high dependency cases, even if the number of cases is lower when compared with larger units.

Impact on staffing and existing services

The group shared informal reflections from colleagues in the early adopter units who believe they are already deskilling by working at level 2 rather than level 3. The group noted that transfer between units is a convoluted process, then raised concerns about babies receiving level 2 care whilst waiting for transfer in a unit that previously had the skill and experience level to provide level 3 care.

It was noted that the staffing impact of taking midwives and specialists off the unit to transfer mothers and babies has not been considered.

The group also believe there will be notable impact on the recruitment and retention of staff in NHS Lanarkshire as a result of the proposed changes.