Citizen Participation and Public Petitions Committee
Wednesday 26 November 2025
18th 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 8 October 2025. At that meeting, the Committee agreed to write to invite the British Association of Perinatal Medicine, Best Start Perinatal Subgroup and the Minister for Public Health and Women's Health to give evidence at a future meeting.

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 British Association of Perinatal Medicine has provided a written statement to the Committee ahead of the evidence session. The statement is provided at **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 available on the petition webpage.

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, 22,159 signatures have been received on this petition.

9. At today's meeting, the Committee will hear evidence from:

    - Dr Stephen Wardle, President, British Association of Perinatal Medicine

    and then from –

    - Jim Crombie, Co-Chair, Perinatal Subgroup
    - Dr Andrew Murray, Co-Chair, Perinatal Subgroup

Action

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

Clerks to the Committee
November 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 8 October 2025

The Convener: We suspend consideration of item 2 and resume item 1, which is continued petitions.

The final continued petition, for which we have been joined by the petitioners, is PE2099, which was lodged by Lynne McRitchie. 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 the light of contradictory expert opinions on centralising services.

We last considered the petition on 11 September 2024, when we agreed to write to the Minister for Public Health and Women's Health, and to undertake a visit to explore the issues raised in the petition. Since then, members of the committee have visited the neonatal intensive care unit at the University hospital Wishaw and have met the petitioner, families with experience of neonatal intensive care, Wishaw staff and NHS Lanarkshire staff. We thank those individuals who took the time to meet us. A tremendous number of people turned up; those of us in the committee who were present really valued the personal exchanges that we were able to have, not only with people who have been effected but with a considerable cohort of staff who also turned up to speak to us.

Hearing the perspectives and experiences of families with direct experience of neonatal care—some of which had happy outcomes and some less so, so it was a highly charged discussion—helped with our understanding of the issues raised in the petition. We are also grateful to the staff at NHS Lanarkshire and University hospital Wishaw for their work to arrange the visit, which was a first-class operational opportunity for us all. A note summarising the issues raised during the visit is available in the papers for today's meeting and has been published on the petition's website page.

Since we last considered the petition, the Minister for Public Health and Women's Health has provided two written submissions. The first submission reiterates that 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 and where there are collocated specialist services. The response states that the review team visited all 14 health boards and met teams from maternity and neonatal services. The Scottish Health Council led a programme of service user engagement across all national health service territorial boards in Scotland, which was supplemented with bespoke service user events. The submission states that more than 600 staff and 500 service users contributed to the review process.

The minister's most recent written submission notes that, although the principles underpinning the changes are supported by the Scottish executive nurse directors

group—SEND—and by the directors of midwifery, concerns were raised about the implications of the change for maternity services. The submission says:

“The Directors of Midwifery highlighted that additional data and evidence gathering was required for maternity services to inform maternity capacity implementation planning.”

It states that a national-level data collection is under way to understand the impact of the neonatal care remodelling on maternity services.

10:15

Bliss Scotland has provided a written submission that details its support for the new model of care and shares its view that the volume of babies born needing intensive care in Scotland is

“far too low to sustain more than three NICUs in Scotland.”

The submission shares concerns that

“progress is stalling”,

with a lack of clear communication about the task and finish groups’ priorities, work plan and progress to date. Bliss believes that

“Ongoing concerns regarding resourcing have not been addressed, including adequate staffing at the designated three intensive care units.”

I should say that there were issues raised in regard to Bliss by those who attended the visit that the committee held at the hospital.

Monica Lennon MSP is unable to attend the meeting this morning and has instead provided a written submission. The submission states that a

“truncated process amounts to tokenism, leaving families, clinicians, and local representatives feeling betrayed.”

Ms Lennon’s submission calls on the committee to consider recommending that an

“independent, multidisciplinary review be undertaken before Scottish Ministers reach a final decision”

regarding the future of neonatal intensive care services.

It is important to remember that the recommendation was not necessarily to have three NICUs; it was for a reduction in the number of service centres, and that it would have been perfectly possible for the award-winning unit to have been retained.

Meghan Gallacher had hoped to join us this morning for the consideration of the petition but was unable to do so. Jackie Baillie is still with us, and she would like to address the committee.

Jackie Baillie: I am going to attempt the impossible, which is to try to get the committee to keep the petition open. As you rightly pointed out, the Wishaw neonatal unit was the best neonatal unit in the country—not Scotland, but the whole of the

United Kingdom—in 2022. For some reason, the Scottish Government then decided that it should close.

You are quite right to reference an earlier report that was presented to the Scottish Government, which recommended that there should be three to five neonatal units to cover Scotland, instead of the seven or eight that we have now. Nobody disagrees with that. What we disagree with is that the Scottish Government opted to go for three units—one in Glasgow, one in Edinburgh and one in Aberdeen—and that Lanarkshire, the third-largest health board, which covers a population of 655,000 people, would have its neonatal unit removed. I have to say, in contradiction to what the minister contends, that the evidence was partial. There was no voice from NHS Lanarkshire sitting around the decision-making table, but there were representatives from Glasgow and Lothian.

The thing that we need to hold on to is that the Wishaw neonatal unit does not only deal with mums and babies from Lanarkshire; it deals with those covered by Greater Glasgow and Clyde, because the two Glasgow units that are currently there do not have enough capacity to cope with the mums and babies from Glasgow. Lanarkshire plays a key role for the whole of Scotland. It has been said that when the Wishaw neonatal unit closes and mums and babies cannot go to there, to Glasgow or, potentially, to Edinburgh, Aberdeen could be the default.

We think that there is not enough capacity in Glasgow to cope, so you would be putting the sickest babies in ambulances to make the two-and-a-half to three-hour journey to Aberdeen to be seen. It is entirely ridiculous, not just because of the risk, but because the sickest babies are likely to be in hospital for long periods. What happens to the mums and families who are rooted in their community in Lanarkshire? How do they spend time with the baby up in Aberdeen? That would be impossible and impractical.

It is not only the families who are very pragmatic in resisting these changes; it is the clinicians as well. The committee saw that very powerfully in its visit to the unit.

The solution, if I can posit one, is that we should have four units. It is common sense—it is not rocket science. I wonder whether we could invite the committee to write to the Government to suggest that it pauses any changes, that there should be a fully independent review and that it should consult the clinicians and the families affected in more than just a tokenistic way. Perhaps the committee could even invite the minister to come before the committee.

That would be a valuable conclusion to the committee's visit. To be frank, if we do not keep the petition open, the Government will downgrade the neonatal unit between now and May, and that will not benefit anybody.

The Convener: I am sure that when you said "you" would be putting people in ambulances, you were using "you" in the most general sense.

Jackie Baillie: Absolutely. Not you, convener—the Government.

The Convener: Not me personally. You make a number of salient and relevant points.

One of the parents whom we heard from in relation to the prospect of their baby being in Aberdeen said that the mother was left in a critical condition and was not going to be transferred with the baby, so what was he supposed to do? Was he supposed to stay with his wife, who was in a critical condition in Wishaw, or was he supposed to travel to Aberdeen, where the baby would be? He said that it would be a dreadful choice for any husband and father to have to make in those circumstances.

Davy Russell: I have an interest in this matter, as it is a constituency matter. I agree with everything that Jackie Baillie said. It is about not only the parents but the clinicians and the public. It is an emotive subject for citizens in Lanarkshire. My inbox is full every time there is mention of the unit closing. It is an emotive subject and needs to be looked into further. At minimum, the information needs to be reviewed.

The Convener: I do not think that there is any question but that the committee wants to keep the petition open. Before we make any further recommendations, I think that we need to take some evidence. I suggest that we invite the Minister for Public Health and Women's Health to give evidence on the matter, and that we invite the British Association of Perinatal Medicine's best start perinatal sub-group to the committee so that we can interrogate the process that led to the recommendation for three rather than four or five units. That seems to be the critical issue, as far as I can see. It would have been wholly consistent with the original report and recommendation for a fourth unit to be retained.

As Jackie Baillie said, this is an award-winning facility that provides support to such a large health board. Given all the issues that have been identified, those of us who visited the facility thought that the petition ought to be considered, and we are very sympathetic to its aims.

Fergus Ewing: I entirely agree that the petition should be kept open and that evidence should be taken from the minister, so I am entirely satisfied with that suggestion.

I want to make two points. First, if there are to be three units, that means that the whole of the Highlands, including Morayshire, Argyll and the isles will not have such a facility. We should reflect on that, because there are very strong feelings in hospitals there that face potential closure. That has been a very live issue, particularly in Wick and Elgin, over the years. My late wife was involved in saving the maternity unit in Moray many decades ago.

Secondly, I ask Jackie Baillie to clarify something, either now or, if she needs to get more information, later. You indicated that the performance of the Wishaw unit was the best, not just in Scotland but in the whole of the UK. I am interested to know, either now or later, but certainly before we take evidence from the minister, what the statistical evidential basis is for that judgment.

Jackie Baillie: I am capable of many things, convener, but that level of detail is not in my gift. I will be happy to provide the information later.

The Convener: That would be great—it may have been one of the issues that was raised when we were on the visit. I cannot specifically remember whether we were given detailed information in support of that position, but perhaps, together with the clerks, we can establish what the situation is.

It is also important that we make it clear that the petition is about the downgrading of facilities, not the closure of facilities. That could cause additional alarm to people, but the core aspect of the ask of the petition is about sustaining the specialist units.

We are content to keep the petition open. There is some further information that we want and, in the time that is left to us, we will seek to hold a further evidence session with the minister and those who have been involved in the consideration of the recommendations, so that the committee can interrogate them and, potentially, make recommendations for the future. Is the committee content to proceed on that basis?

Members *indicated agreement.*

Annexe C: Written submission

British Association of Perinatal Medicine written submission, 19 November 2025

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

Witness Statement from the British Association of Perinatal Medicine

The British Association of Perinatal Medicine (BAPM) is a professional association and registered charity. Established in 1976, BAPM aims to improve standards in perinatal care by supporting those involved to optimise their skills and knowledge, promote high quality, safe and innovative practice, encourage research, and speak out for the needs of babies and their families.

We are a membership organisation representing over 2,900 perinatal professionals and stakeholders including neonatal and obstetric doctors, nurses, ANNPs, midwives, managers, allied health professionals and parents.

We represent neonatal professionals working in all four of the nations of the UK including Scotland.

We have been asked to give evidence by the Citizen Participation and Public Petitions Committee (CPPPC) of the Scottish Parliament on Petition PE2099: Stop the proposed centralisation of specialist neonatal units in NHS Scotland including exploration of the evidence base that formed the Scottish Government's Best Start review.

BAPM is aware of the Best Start Review, a five-year plan published in 2017, with key stakeholder input, for the improvement of maternity and neonatal services in Scotland and its recommendations. We recognise that this report set out a vision for the delivery of high quality and safe maternity and neonatal services across Scotland over the next five years. It aimed to put the family at the centre of decisions so that all women, babies and their families could get the highest quality of care according to their needs.

The recommendations focus on designing a service that delivers better outcomes, facilitates family centred care and accommodates current levels of demand.

It recommended that Scotland should move to a model of three-to-five neonatal intensive care units (NICUs) in the short term, progressing to three units within five years supported by the continuation of local neonatal (LNU) and special care units (SCU). Best Start also recommended that formal pathways should be developed between these units, to ensure that clear agreements are in place to treat the highest risk preterm babies and the sickest term babies in need of complex care in fewer centres, while returning babies to their local area as soon as clinically appropriate.

This recommendation covers the care of the most premature and sickest of babies. It is based on evidence which shows that outcomes for very low birth weight babies

(VLBW), are better when they are delivered and treated in Neonatal Intensive Care Units (NICUs) with full support services, experienced staff and a critical mass of activity (defined as care for a minimum of 100 VLBW babies a year). This is in line with the framework for practice from the British Association of Perinatal Medicine (BAPM), published in 2021 and is in line with changes which have been largely implemented in England. It allows concentration of expertise and ensures optimal care for the smallest and sickest babies born in the right place with optimal perinatal optimisation[i].

The BAPM framework and other staffing standards have become standards contained within the NHSE Service Specification for Neonatal Intensive Care[ii] used for English NICUs.

The Current Petition

The petition which we have been asked to give evidence on aims to stop the centralisation of specialist neonatal units in NHS Scotland, and seems to be opposed to the Best Start review and its findings.

BAPM is strongly in favour of progressing with the Best Start review and its findings in order to optimise care of the smallest and sickest babies in Scotland. We support the centralisation of neonatal intensive care and the co-location of neonatal services with other paediatric services including paediatric surgery. These principles are described in our framework document[iii] (Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021))

Evidence for Centralisation of Neonatal Care

The recommendations in the BAPM framework for centralisation of neonatal care is underpinned by strong evidence. This shows improved outcomes for preterm babies in the UK when they are born and cared for at tertiary units with a high volume of activity compared with units providing a lower level of care and lower activity. The whole perinatal multidisciplinary team have the experience and expertise obtained through caring for a high volume of infants.

Data from the EPICure 2 study collected in 2006 were analysed to look at designation of unit and size compared to neonatal outcomes for babies <27 weeks[iv]. This confirmed that outcomes were not only better for babies cared for in neonatal units with a higher level of care but also that NICUs with higher levels of activity had significantly better outcomes than smaller ones. Of those babies born in hospitals with a NICU, the odds ratio of survival in hospitals with high versus medium activity levels was 2.71 (95% CI, 1.16 - 6.31) at 23 weeks' and 2.29 (95%CI, 1.30 - 4.02) at 24 weeks' gestation. The study defined high activity as more than 2000 respiratory care days (ventilation and CPAP combined).

Another large UK study extracted data from the National Neonatal Research Database (NNRD) on all babies born before 33 weeks' gestation in 2009-2011[v]. Infants born and admitted to a high-volume neonatal unit at the hospital of birth (defined as the highest quartile) were at reduced odds of neonatal mortality (odds ratio (OR) 0.70, 95% CI 0.53 to 0.92). The effect of volume on any in-hospital

mortality was largest among infants born before 27 weeks' gestation (OR 0.51, 95% CI 0.33 to 0.79).

The UK data are also supported by French data from the Epipage study which confirm that larger NICUs have improved outcomes when compared to smaller ones[vi]. Survival at discharge was lower in hospitals with lower volumes of neonatal activity (aOR 0.55, 95% CI 0.33-0.91). Survival without neuromotor and sensory disabilities at 2 years increased with hospital volume, from 75% to 80.7% in the highest volume units. After adjustment for other factors, survival without neuromotor or sensory disabilities was significantly lower in hospitals with a lower volume of neonatal activity (aOR 0.60, 95% CI 0.38-0.95) than in the highest quartile hospitals. Older international data from the US, Australia and Europe also support the UK data.

These principles resulted in the creation of neonatal networks in England to ensure centralisation to optimise the care of the smallest and sickest babies.

In February 2016 *Better Births* set out the *Five Year Forward View* for NHS maternity services in England[vii]. This report highlighted several challenges facing neonatal medical and nurse staffing, nurse training, the provision of support staff and cot capacity. It recommended a dedicated review of neonatal services. In response NHS England commissioned the Neonatal Critical Care Review (NCCR). This has been implemented with improvements in centralisation and resulting outcomes.

This is summarised in the NHSE document Implementing the Neonatal Critical Care Review[viii]. This document published in 2019, highlighted the fact that over a third of NICUs in England perform fewer than 2000 intensive care days per annum. It also highlighted the fact that several of the units with low volumes of activity were in close proximity and recommended reconfiguration of some of these services to lead to economies of scale, better staffing and less variation in admission rates, albeit at a cost of increased antenatal transfers.

The survival of babies born before 27 weeks is improved when this occurs in a maternity service with a Neonatal Intensive Care Unit (NICU). Survival is improved if NICUs look after at least 100 very low birth weight (VLBW) infants (<1500g) per year and survival is even better when born in busier units delivering >2000 intensive care days. All NICUs should, therefore, as a minimum, look after at least 100 VLBW infants and unless geographically challenging, should be performing >2000 intensive care days each year.

A similar situation, albeit with different geographical pressures appears to exist in Scotland. An options appraisal process has taken place and made recommendations about the numbers of intensive care units required and the designation of units[ix] using similar principles.

BAPM does not have a view about this designation process or the units selected but supports the principles of centralisation as described.

Post Natal Transfer

As described above, babies born below 27 weeks gestation should be born in a unit with facilities to provide intensive care in order to optimise their outcomes. In

addition, if they require transfer after birth to a NICU there is a higher risk of death or severe brain injury compared to those born and cared for in tertiary units[x]. As a result of this the antenatal transfer and delivery of all babies <27+0 weeks in a maternity unit with a co-located NICU is now recommended. Canadian data have also confirmed the benefit of antenatal compared to postnatal transfer with postnatally transferred babies <29 weeks' gestation having a higher odds of death (aOR 2.1 (1.5-3.0)) and cerebral palsy (aOR 1.9 (1.1-3.3))[xi].

Co-Location of Paediatric Services

In addition to the volume of activity undertaken by neonatal intensive care units, the co-location of other paediatric services is important. This is particularly important for paediatric surgery as a large number of newborn infants, particularly those born prematurely, require surgery in the newborn period and transfer in the newborn period may be associated with sub-optimal outcomes.

Necrotising enterocolitis (NEC) is a serious bowel condition which can affect babies born prematurely. This condition often requires surgical intervention at a time when babies are extremely small and requiring ongoing intensive care. The optimal care of infants with NEC requires joint input from neonatologists and paediatric surgeons and this can only be achieved if they are collocated and working together. If paediatric surgeons are not on site and a baby develops NEC they require transfer at a time when they are very unstable and at high risk of morbidity and mortality.

A significant number of babies are identified antenatally to have problems which will require surgery soon after birth and the joint management of these babies by neonatologists and paediatric surgeons is important to ensure optimal care.

Other babies have other significant conditions such as cardiac abnormalities, renal or neurosurgical problems which require the involvement of other specialists in their care. The care of these babies is optimised when specialists are collocated with the NICU.

Implementation of Best Start Recommendations

BAPM would like to see the review which was published in 2017 implemented in Scotland as soon as possible to optimise outcomes for babies. We recognise that some capital and revenue resources may be required for this implementation and we would support these resources being made available without delay so that implementation can occur.

BAPM also recognises the importance of families in the care that we provide[xii] and it is vital that families' views are considered. It is important that accommodation for families is available, particularly for those families who live a long distance from the tertiary NICU centres.

Dr Stephen Wardle

Consultant Neonatologist

President, British Association of Perinatal Medicine

[i] Perinatal optimisation. BAPM Website. https://www.bapm.org/pages/perinatal-optimisation-pathway
[ii] Neonatal Critical Care Service Specification. NHSE. March 2024. https://www.england.nhs.uk/wp-content/uploads/2015/01/Neonatal-critical-care-service-specification-March-2024.pdf
[iii] Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021) | British Association of Perinatal Medicine
[iv] Marlow N, Bennett C, Draper ES, et al. Perinatal outcomes for extremely preterm babies in relation to place of birth in England: the EPICure 2 study. Arch Dis Child Fetal Neonatal Ed 2014;99:F181–F188.
[v]Watson SI, Arulampalam W, Petrou S, et al. BMJ Open 2014;4:e004856. https://bmjopen.bmj.com/content/bmjopen/4/7/e004856.full.pdf
[vi] Thomas Desplanches, Béatrice Blondel, Andrei Scott Morgan, Antoine Burguet, Monique Kaminski, Bénédicte Lecomte, Laetitia Marchand-Martin, Jean-Christophe Rozé, Paul Sagot, Patrick Truffert, Jennifer Zeitlin, Pierre-Yves Ancel, Jeanne Fresson. Volume of Neonatal Care and Survival without Disability at 2 Years in Very Preterm Infants: Results of a French National Cohort Study. J Pediatr 2019 Oct;213:22-29.e4. doi: 10.1016/j.jpeds.2019.06.001. Epub 2019 Jul 4
[vii] Better Births. Improving Outcomes of Maternity Services in England 2016 https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf
[viii] Implementing the Recommendations of the Neonatal Critical Care Transformation Review. NHSE 2019 https://www.england.nhs.uk/publication/implementing-the-recommendations-of-the-neonatal-critical-care-transformation-review/
[ix] A Five-Year Forward Plan for Maternity and Neonatal Services Neonatal Intensive Care Options Appraisal Report. July 2023 Scottish Government
[x] Association of early postnatal transfer and birth outside a tertiary hospital with mortality and severe brain injury in extremely preterm infants: observational cohort study with propensity score matching Kjell Helenius, Nicholas Longford, Liisa Lehtonen, Neena Modi, Chris Gale, on behalf of the Neonatal Data Analysis Unit and the United Kingdom Neonatal Collaborative Helenius BMJ 2019;367:l5678
[xi] Reem Amer, Diane Moddemann, Mary Seshia, Ruben Alvaro, Anne Synnes, Kyong-Soon Lee, Shoo K Lee, Prakesh S Shah, Canadian Neonatal Network and Canadian Neonatal Follow-up Network Investigators. Neurodevelopmental Outcomes of Infants Born at <29 Weeks of Gestation Admitted to Canadian Neonatal Intensive Care Units Based on Location of Birth J Pediatr 2018 May;196:31-37.e1
[xii] Useful links for families | British Association of Perinatal Medicine