CPPP/S6/26/1/18

Citizen Participation and Public Petitions Committee
Wednesday 14 January 2026
1st Meeting, 2026 (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 10 December 2025. At that meeting, the Committee took evidence from:

    - Jenni Minto MSP, Minister for Public Health and Women's Health
    - Kirstie Campbell, Unit Head, Maternity, Neonatal and IVF Policy, Scottish Government
    - Danielle Le Poidevin, Neonatal Policy Manager, Scottish Government

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 Petitioner and the Scottish Government, 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 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, 22,244 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
January 2026

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 10 December 2025

The Convener: The first continued petition is the very important petition that we have been considering for some time, following our visit to University hospital Wishaw in September and our evidence session at our previous committee meeting. PE2099, which was lodged by Lynne McRitchie, calls on the Scottish Parliament to urge the Scottish Government to stop the planned downgrading—it is important to say that that is what it is—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 the decision in the light of contradictory expert opinions on centralising services.

We last considered the petition at our previous meeting, when we heard evidence from the British Association of Perinatal Medicine and then from the best start perinatal sub-group. I am delighted that today we are taking evidence from Jenni Minto, the Minister for Public Health and Women's Health, and her supporting officials Kirstie Campbell, unit head of maternity, neonatal and IVF policy, and Danielle Le Poidevin, neonatal policy manager. Minister, please invite your colleagues to join in when you think it appropriate, or they can signal to me if they would like to offer an additional contribution.

We are also joined by our colleague Clare Adamson MSP. I will invite Clare to join the questioning after the committee members have spoken, or, if she lets me know, we may bring her in on a key point. Minister, I know that you would like to make some opening remarks before we move to questions, so over to you.

The Minister for Public Health and Women's Health (Jenni Minto): Thank you for inviting me to provide evidence today. Addressing concerns about the new model of neonatal care is very important to me, so I am pleased to be here to talk about the petition. First, I will address a point made at the previous committee meeting and make it absolutely clear that no units are closing as part of the new model of neonatal care.

In 2023-24, around 4,500 babies were cared for in neonatal units. Just over 800 were admitted to intensive care. The majority of those babies need intensive care for only a short period—less than 48 hours. A small number need longer, highly specialised intensive care. For those babies, the complexity of that neonatal intensive care has increased, particularly for babies born at extremes of prematurity or with extremely low birth weights.

As the committee heard from Stephen Wardle of the British Association of Perinatal Medicine and Andrew Murray and Jim Crombie, the chairs of the best start perinatal sub-group, the clinical evidence shows that outcomes for the smallest and sickest babies are improved when they are born and cared for in a unit with a high throughput of cases, defined as at least 100 new, very low birth weight admissions per year and where support services are co-located.

That evidence underpinned the best start recommendation and also the professional guidance published by the British Association of Perinatal Medicine. As defined in the guidance and as highlighted by Stephen Wardle to the committee, local neonatal units will continue to provide a level of intensive care and be able to care for singleton births over 27 weeks' gestation, with babies receiving care in one of the three intensive care units being transferred back to their local neonatal unit for on-going care as soon as possible. The best start report—"The Best Start: A Five-year Forward Plan"—was based on evidence and a range of expert clinical opinion. The options appraisal that followed, as you heard from Jim Crombie and Andrew Murray, was objective, followed evidence-based criteria and was undertaken by an expert group comprising clinicians with service users represented by Bliss Scotland.

I was disappointed to hear at the last committee meeting that colleagues raised again that NHS Lanarkshire was not present within the process. I have corrected that point many times previously, and I am grateful to Jim Crombie for further clarifying to the committee NHS Lanarkshire's involvement in both the best start perinatal subgroup and the best start programme board. The members were appointed based on national roles that they represented, to provide an objective view to an evidence-based clinical approach. As the committee previously heard, having the right infrastructure in place is essential to support implementation of the new model and to optimise the parents' experience.

When I announced those changes in 2023, I asked the regional chief executives to lead on detailed implementation plans that described how they would build capacity in the three units before commencing any changes. The Scottish Government also commissioned detailed capacity modelling to inform those plans. In addition, work is under way with the regional chief executives' task and finish group to look at maternity capacity, financial modelling and cot capacity management. The best start report had family-centred care as one of its core principles. Among the earliest best start recommendations were the establishment of the neonatal expenses fund in 2018, now the young patients family fund, and the provision of accommodation on or near all neonatal units for the parents of the sickest babies. Other improvements include accessible psychological support services for parents, offered throughout their neonatal journey.

Since my appointment, I have been committed to listening to both families and clinicians from across Scotland, and I have seen at first hand the passion and commitment of the neonatal staff by visiting University hospital Wishaw, the Queen Elizabeth university hospital in Glasgow, and the new Royal infirmary of Edinburgh. I have also met with Wishaw neonatal campaigners and elected representatives on several occasions. I had the pleasure of presenting both Ninewells and Forth Valley neonatal units with their Bliss baby charter gold awards, recognising the care that those units provide and will continue to provide.

I also want to thank staff at Ninewells for their efforts in reassuring the local people that the new model is the right model. I want to put on record my thanks to all the neonatal nurses and consultants who do such a fantastic job in caring for babies and supporting families, and to thank Bliss for all its work for families at a time when they

need that support the most, and their work to advocate for those families in national policy. I recognise that families will be concerned about the change, but I want to provide reassurance that this decision has been made in the best interests of the very smallest and sickest babies.

I thank the committee for listening carefully to the evidence of those involved in the process, and for taking time to visit Wishaw university hospital.

The Convener: Thank you, minister. Let us start where we are all agreed. Any concerns that there were financial motivations have been dispelled to the committee's satisfaction. We are convinced from the evidence that we have heard that the best interests of babies have been at the forefront of the decision-making process. We are agreed on that point.

I also agree that there has been a certain amount of confusion and misinformation. I was careful to say at the start again that some units are being downgraded, and are not being closed. I will come to the detail of that.

However, where we are still wrestling is that there was the prospect of a reduction in the number of units at the full level of services, down to somewhere between three and five, and we landed at three. Concerns have been expressed about the geographical inconsistency of Glasgow, Edinburgh, Aberdeen and the south of Scotland, and all the way up to Wishaw, and therefore, the central belt being underprovided.

Another thing that impressed the committee was that we heard from the specialist services last week—those who had been involved in the decision—and there was a caveat to their support for their own recommendations. That caveat is that the capacity, resourcing and everything that is required to ensure that this model can work has to be in place. The committee, given that we are politicians of long standing, have all, from personal experience—not only in the field of health but elsewhere—been aware of similar initiatives for all manner of services, where, in the event, that did not prove to be the case. For the lives of very fragile newborn babies, not having everything in place right from the start would be a concern. So, there is the geographical issue and the question whether the resource will be in place.

The committee understands—although I have not seen the letter; Davy Russell will speak to it in a little more detail—that the clinicians at Glasgow have written asking for the proposal to be paused, because they do not believe that Glasgow has the capacity, that it is currently overstretched and therefore unable to take up the commitment that is being suggested that it would embrace. That rings alarm bells for us as a committee because it plays directly to our concern that the capacity will not be in place when this goes live.

I am sorry, that was a long preamble to my question. You said a moment ago that the changes would evolve when the capacity is in place. My initial questions are about the geography, the capacity, the resilience of the preparation for that capacity and when you think that it would be safe, given the concerns that are being expressed? If Glasgow is at full capacity, we would have that geographical issue that has been represented to us time and again of parents finding their baby separated

from them by being as far away as Aberdeen. When do you think that it would be safe to deploy the new model?

Jenni Minto: I will start by quoting from the best start report from 2017. It said:

> "It is proposed that three to five neonatal intensive care units should be the immediate model for Scotland, progressing to three units within five years."

That is the full quote. I am absolutely clear that we need to do this in the safest way possible, given that the intended outcome is to ensure the safety of and the best outcomes for the smallest and sickest babies.

The intention, from 2017, was always to phase the change, and that started in 2019 with two units, Crosshouse hospital in Ayrshire and Arran, and Victoria hospital in Fife. Ayrshire and Arran linked with QEUH, and Victoria in Fife linked with Lothian.

We made that first step and took learnings from that. I do not need to remind anyone in this committee that we then hit Covid, so there was a pause in the services. After Covid, as you have heard in evidence, there was a review to ensure that the circumstances were still the same. Again, that still supported the best start work.

In July 2023, I announced three new neonatal intensive care units. Last week, you heard evidence from Stephen Wardle about the model in England and the fact that, for the population size of Scotland and the number of babies, two units would be the appropriate number. However, because of the geography of Scotland—I think that Andrew Murray and Jim Crombie noted this—it was felt that a unit was needed in the north and Aberdeen was selected. That goes some way to responding to your question about geography.

I live on Islay, which is an island, as everyone knows. If these circumstances arose on Islay, the family would have to be helicoptered off the island. We have the Scottish specialist transport and retrieval service, ScotSTAR, which is both a helicopter and ambulance service, which is currently moving babies around between Wishaw, for example, and QEUH. That service has been set up for about 20 years. It is seen as a world-class service. We have hugely experienced neonatal staff working in that service giving the best support, treatment and care to families that require it. We have looked at the geography. We have looked at the central belt and also further north in Scotland. ScotSTAR and the Scottish Ambulance Service have been very involved in the work as it has progressed. Therefore, we have that support.

On capacity, you are absolutely right. My officials and I have been working hard on this question. We commissioned work to look at the capacity within each unit and the best model to support the move to three units. From my perspective, that is very important. That work spoke to the staff in each unit and took wider information, which was shared with the regional chief executives, who set up a task and finish group to move the work forward. It was never the intention to make an announcement on day 1 and have the change happen on day 2. There has always been an intention of incremental steps as we move towards the more concentrated neonatal intensive care units, which will have a throughput of around 100 babies each year, with the co-located additional services. It is important to recognise that.

I will hand over to Kirstie Campbell to talk about the clinicians' comments.

Kirstie Campbell (Scottish Government): The minister has highlighted the process that we have in place for implementation planning. Three regional chief executives have established plans in their regions for how they are going to implement the new model. As the minister highlighted, the expectation was not that we would be implementing everything on day 1 after the announcement was made; we always knew that there would be a period of implementation.

We commissioned the work from RSM UK that modelled the capacity required in each unit, and then we shared that with the regional chief executives. We set the expectation that their regional plans would identify how they will move from where they are now to the position in which they have the capacity to implement the model.

The task and finish group identified several pieces of work that needed to happen before we were able to move. That included doing some work on maternity modelling, looking at the maternity capacity in the units and recognising that, for the majority of the women, the expectation would be that the transfer happens while in utero. They would then give birth to their babies who need neonatal intensive care in the units they are moved to. We have therefore done some work on modelling the maternity capacity required.

We have also done some work on looking at the financial model that needs to be in place, so that the funding follows the babies. The Government has pump-primed the implementation in practice, and to date we have provided over £7.5 millionworth of funding to both Glasgow and Edinburgh and a small amount to Aberdeen, to support building the capacity that is required to start the move.

The process will always be incremental, as the minister outlined. We will start potentially with moving the smallest babies—the ones who are most at risk. When those babies are moved and the system is in place and is seen to be working, we will move forward with incremental change. The expectation is that we will be able to build capacity as we move forward with that change.

The Convener: Two questions follow from that. Can you illustrate for us, relative to the size of the current unit in Glasgow, the size of the new unit that you expect, and what you envisage the timetable of the transition being?

Kirstie Campbell: I can. That was outlined by the report that we commissioned from RSM UK. RSM UK set the expectation for an additional 10 cots in QEUH in Glasgow, an additional four cots in Edinburgh royal infirmary and an additional one and a half cots in Aberdeen maternity unit.

The Convener: Just for the completeness of the record, what is the existing capacity that those additional units are on top of?

Kirstie Campbell: The capacity flexes. I have to research in my folder for the precise numbers, but the capacity flexes across the units, because a number of intensive care beds can also be used as high-dependency beds. They will flex between the two in different cases. I can get the numbers for you later.

The Convener: That would be helpful. This is the guts of any reassurance about the capacity of the model to cope. What timeline do you imagine the model evolving over?

Kirstie Campbell: The timeline has moved since we started the implementation. We asked the regional chief executives to look at the timeline, the development that would be needed and how long that capacity building would take.

We had some experience from running the early implementer boards in Fife and Ayrshire, as the minister outlined. In those two boards, it took us a full year from start to finish to get the work from initial discussions through to actually starting to move the babies. Those units were at a significantly smaller level than the units we are now talking about, so the current task is much bigger.

It is fair to say that we are behind schedule. Much more work has been required, and I mentioned some of the work around maternity modelling and financial modelling, which has taken a bit longer than we expected. The expectation is that, once the work begins, we should be able to conclude it within a year to 18 months.

The Convener: If I am looking at this in political chunks, is it right that sometime in the first half of the next parliamentary session, which begins in May 2026, you would expect the transition to have been completed?

Kirstie Campbell: I would expect that, yes.

The Convener: That is helpful, and members may come back on that issue as we progress.

Before I bring in Davy Russell, I have one final question that I think it would be helpful to understand. Minister, can you set out what types of cases will be handled by each level of the national service?

Jenni Minto: There are three levels under the BAPM structure. The national intensive care units are the ones that we are talking about for the three areas: Glasgow, Edinburgh and Aberdeen. They will care for the smallest and sickest babies— those who are those born under 27 weeks and with a body weight of less than 800g. Those are the babies we are talking about—babies who need additional care, sitting beside co-located surgery and other neonatal support.

I should say that decisions to move babies are very much taken from a clinical perspective. Clinicians would decide whether a baby should move.

There are then local neonatal units, which support babies of up to 1,500g. Those units provide all levels of care for singletons greater than 27 weeks and multiple births greater than 28 weeks, and for babies requiring perhaps a short period of intubated ventilator support—a level of intensive care that was highlighted last week by both Andrew Murray and Jim Crombie.

The special care units provide care for babies of 32 weeks' gestation and upwards, and some may care for babies of greater than 30 weeks of gestation. Again, that depends on local geography—as we know from Mr Ewing's questions last week, that is a key thing within Scotland. Those units will also provide care for babies with

additional care needs who do not meet either the intensive care or the high-dependency care criteria.

Those are well-known categories in neonatal practice, and Scotland is following the BAPM guidelines in moving in this direction.

Davy Russell (Hamilton, Larkhall and Stonehouse) (Lab): You mentioned ScotSTAR transfers. Obviously, the role of ScotSTAR will significantly increase when we move down to three units. Does ScotSTAR have the capacity? In your financial modelling, have you built in any costs for ScotSTAR to increase its capacity to manage the increase in demand?

Jenni Minto: You are absolutely right that ScotSTAR is key to ensuring the right support. As I highlighted earlier, ScotSTAR has been operating for 20 years. It is a well-recognised model of providing transfer between hospitals for the smallest and sickest babies. As I said earlier, ScotSTAR and the Scottish Ambulance Service, which operates ScotSTAR, have been involved in the best start work right from the start, and that is very important.

Any modelling that is required will be done. As Kirstie Campbell noted, the work is happening on a financial basis. One of the directors of finance, who is part of the task and finish group, is looking at the work from a once-for-Scotland approach. If the capacity of ScotSTAR needs to increase, that will certainly be built into our approach to ensure that babies are transported in the safest, most careful way, to ensure the best outcomes for them.

Davy Russell: Based on your answer, I think that you are telling me that it has not been done yet.

Jenni Minto: I am sorry if I have given you that impression; that was not the intention.

All the capacity work is being done now, and it is important that it is done. We have been very clear that it needs to be done carefully. I am aware that some of the evidence that you heard last week was that the modelling had not been done. That is exactly the work that we have asked the task and finish group to do, to ensure that we have the right services to provide the right care for the babies.

Davy Russell: You mentioned that the original report was done in 2017 and that, after the Covid period, you reviewed it again to make sure that it was the right way forward. Did the same people review it, or was it done independently?

Jenni Minto: It was reviewed by the initial group—the experts who were basing their decisions on expert evidence, which you heard last week. However, once I had made the decision and I was, rightly, being questioned by families and other clinicians, I asked the deputy chief medical officer to review it again to ensure that we had followed the right evidence and that the right results were coming from the report.

Davy Russell: As part of the review, Bliss has said—I read this last night—that it did not consult parents because it was not in their terms of reference.

Jenni Minto: Yes, I have read that as well.

Bliss is an advocacy group to represent generally people who have experienced this type of care. To help progress the move to three neonatal intensive care units, I asked for—and in June last year we ran through Citizen Space—a survey of patients and parents who had experienced neonatal intensive care to ensure that their voices were heard. We also ran a number of focus groups. As I indicated in my introductory remarks, I have also met with parents and with patients and their parents in neonatal units in Scotland to hear about the care that they are getting.

I am confident that that voice is listened to. I have also been very clear in the task and finish group that the importance of listening to the patient's voice is recognised to ensure that it is heard clearly.

Davy Russell: Yet the parents' groups that I have heard from—and we had a chat with them— say that you are listening but are still just carrying on regardless.

Jenni Minto: I would be remiss if I were not following the expert clinical advice that you heard last week, which is clear that the smallest and sickest babies get the best outcomes if they are treated in neonatal intensive care units that have a greater throughput. I find that a really awkward phrase to use when we are talking about babies, but it means a greater number of babies going through the system to ensure that the clinicians, the nurses and everybody else in the units looking after the babies are of the right standard to get the best outcomes for the babies.

I have visited Wishaw, Ninewells and other neonatal units in Scotland. As I indicated in my opening remarks, the staff are fantastic, and I respect and have great confidence in the work they are doing. However, it would be remiss of me as the Minister for Public Health and Women's Health not to listen very clearly and read very closely the evidence from other experts, clinicians and also BAPM.

Davy Russell: Obviously, there will be more transportation and logistics involved when transporting mothers and babies. When a transfer has to take place, will it be the general ambulance service or will they need to make their own way to the units?

Jenni Minto: I have been very clear that ScotSTAR will transfer the babies. The decision about whether the mother can travel with the baby depends on the health of the mother. My understanding of the layout of a ScotSTAR ambulance is that the mother would have to sit for the duration of the journey, which might not be appropriate for her own health, so separate transportation decisions as to the safest and the right way for a mother to be transferred would be needed. It may be by ambulance, but it may also be by private car.

Davy Russell: I hear every week in my casework that the Scottish Ambulance Service is stretched—that is me putting it mildly—and this change is going to put more pressure on the Ambulance Service. Do you have any plans to increase its capacity?

Jenni Minto: ScotSTAR provides a separate ambulance; it is not a general ambulance. ScotSTAR ambulances are key ambulances designed specifically for neonatal baby transfer.

The Convener: Sorry to interrupt, but I think that Mr Russell's point is different.

As we were talking about a moment ago, I would be interested to know if there is an expectation that the ScotSTAR service will need to be augmented in some way, irrespective of the initial planning that is going on. Is there such an expectation? However, I think that Mr Russell's point is that if the general ambulance service is called on to ferry the mother and that journey was from, say, south of Wishaw to Aberdeen, the ambulance is going to be out of the system for quite some time, in an environment when we already know that there can be very long waiting times for ambulances.

There is a concern. You also said the transfer could be by private car, so I accept that there could be other options, but the current environment is not one that a mother or somebody contemplating being in this position might feel reassured by.

Jenni Minto: You are absolutely right, convener. I cannot imagine what it would be like for any family to be in this situation, which is why I am trying to be completely candid with you. The baby would be transferred by ScotSTAR, and the mother would be too, if she were able. If that was not possible, we have to recognise the pressures that are on the Scottish Ambulance Service just now and the transport would be organised to mitigate any issues on availability of ambulances to support the mother's transfer.

The Convener: Sorry, Mr Russell. I interrupted.

Kirstie Campbell: May I add something? When women require to be transferred by ambulance, it will largely be from an obstetric unit to another obstetric unit. We have clear protocols in place, which have been developed by our Scottish perinatal network and published in the last few years, to outline exactly how to transfer women by ambulance from an obstetric unit to another obstetric unit, and the priority that those calls have to take within the system. That guidance has been developed, recognising that we are going to need it for the new model, and it has been published.

Davy Russell: Yes, but my original point was that, if that is the case and that transfer is the number 1 priority, there must be strain on the system somewhere else. If this is going to be used a lot more, some people will be waiting a lot longer for other things.

Kirstie Campbell: The numbers will be low. We reckon that about 50 to 60 women a year will need to be transferred under the new model. The expectation is that the vast majority of women will be transferred from the hospital that they are in to the nearest intensive care unit. The long transfers should be rare, if not negligible in terms of distance travelled. There will be very rare occasions, for example, when there is a high number of multiple births and babies need to travel a little further, but that has happened so rarely over the past 10 years that it would not factor into planning.

Davy Russell: The convener mentioned the letter from the neonatal consultants in Glasgow. Do you have that letter?

Kirstie Campbell: I have seen that letter, yes. The letter came in, I think, about 18 months ago. At the time, we discussed it with the regional chief executive who was leading the implementation. The regional chief executive at that time was also the chief executive of the Greater Glasgow and Clyde NHS Board, Jane Grant. She assured us that the issues raised in that letter were being accounted for in the regional plan that they were putting together.

Davy Russell: Why was it not brought to the attention of this committee until now? It was not you who told me; it was somebody else. I think that the letter is relevant, because they are expert people as well.

Kirstie Campbell: They had concerns about the process of building capacity within the QEUH and how that would be managed. They also had concerns about capacity within their own unit at that time—they were clinicians at the Princess Royal maternity hospital, which will be changed to a local neonatal unit under the new model. Some of the concerns were local concerns that were addressed by NHS Greater Glasgow and Clyde, and some were taken into the regional planning process. It was some time ago and, as we understand it, the issues have been considered within the regional plans.

David Torrance (Kirkcaldy) (SNP): Good morning. What work has been carried out on how to identify women who could be in this situation and should be transferred before they give birth?

Jenni Minto: Thank you for that question. I think that you heard some evidence from Stephen Wardle about that last week.

From the work that we did with Crosshouse in Ayrshire and Arran sending patients to Glasgow and the Victoria in Fife sending patients to Lothian, it was clear that the best outcomes are if the mother can travel while the baby is in utero. That should be picked up in the visits that mothers-tobe have with their maternity staff. They will be put on one of the different pathways for expectant mothers and that would be taken into account. There will be certain areas that will require the maternity staff to ensure that they recognise whether a mother is likely to give birth early.

Kirstie Campbell: The Scottish perinatal network has put together a piece of guidance in anticipation of requiring really strong, clear guidance on the identification of expected pre-term labour. That guidance has also been published and shared widely around the Scottish clinical community. A number of elements have been put in place ahead of us making this move to help support clinicians across the country, to make sure that this is done safely and done well.

David Torrance: On family-centred care, how would you respond to the point that families at the moment do not receive enough financial or care support? Considering the distances that will now be involved, what financial help will the Scottish Government put in place for families who will have to travel those huge distances?

Jenni Minto: I refer to Bliss's involvement in the best start programme. Right at the start, they made the point very clearly that if you have a baby who is in intensive care for some time, it can be financially draining on the family. Accordingly, one of the

requirements of best start was to set up the neonatal family fund, which provided money for families in this situation, whether for food, accommodation or travel. That was covered. We have since extended that to the young patients family fund, which ensures that support is available for families in those circumstances.

I visited the people who organise the YPFF in QEUH, and for people who deal with expenses and finance, they were some of the most caring people that I have met, because they recognise the impact—the pressures and the stresses—that such circumstances can have on families. They ensure that all the staff in neonatal wards are aware of the YPFF, but also make visits themselves, and will support families in completing the application forms for the funds. That can be done on a weekly basis or at the end of a stay. The regularity with which the funds arrive is entirely up to the family. The fund is most important and I commend Bliss for its work to ensure that it was included in our recommendations.

Bliss was very positive on not only the finance side but around psychological support for families in this situation. Psychological support can be provided either on the wards or by the third sector, including by Bliss.

David Torrance: How would you respond to claims that the new model relies heavily on the third sector to provide that care?

Jenni Minto: Generally, I think that our health service can only benefit from support from the third sector. The operational improvement plan, the population health plan, and the strategic review framework all point to a need for much more holistic healthcare. That includes both the primary care that we get in our general practitioner surgeries and from opticians and pharmacists and so on, and the acute care in our hospitals, as well as a wraparound, if I can describe it like that, from the third sector, providing a different type of support that it is very good at.

Kirstie Campbell: To add to what the minister has said, people will be aware that the recommendation came from the best start report, which we published in 2017. Improving neonatal intensive care was among the fundamental premises of the best start report, but there was a whole package of improvement recommendations around neonatal care that we have been putting in place ever since.

Improvements to neonatal units across Scotland include the development of transitional care, which sees mothers and babies kept together in a maternity ward, rather than babies being taken off to a special care baby unit as would have previously been the case; the addition of sevenday neonatal community care, allowing parents to get their babies home earlier with support in the community so that they can they can receive the care that they need at home; and a range of other things, including the young patients family fund, which was previously the neonatal expenses fund that the minister highlighted.

Another thing to highlight is that in Scotland we have been moving forward with the implementation of the Bliss baby charter. Bliss has developed a set of standards for all neonatal units and we have been supporting neonatal units in Scotland to implement the criteria within the charter to provide the best care for families. It covers a range of things that make it easier for families to be with their babies in

neonatal care, including providing food and accommodation. Parents are recognised not as visitors to neonatal units but as partners in the care of their baby. That fundamental ethos and that change to a familycentred care approach has been a core part of implementation and Bliss, one of our leading charities as the minister outlined, has been instrumental in helping our units to move forward with that package of measures.

The Convener: Can I pursue that a little further in the context of my meetings with parents in Wishaw? The parents spoke about the situation that might develop for other parents post the implementation of these changes. We are talking here about families in extremis because we are talking about the sickest child. One parent said that his wife was left in a life-threatening state after the birth of the baby and that, had the new model been in place, he would have been left with an invidious choice, with his wife and child being not at the same hospital but potentially one being in Aberdeen and one being in the local hospital. There are also siblings in the family. In listening to those people talk about the family-centred care package, I noticed that those other responsibilities do not seem to necessarily be accommodated within the thinking of those who are offering support.

Does yet more work need to be done on what is provided within family-centred care? Clearly, it might be that accommodation and travel costs are covered but parents may have other children and there could be a need to provide emergency childcare to support that family in those circumstances. That does not seem to be part of the package at the moment. I think that when parents said that they did not feel supported enough, they felt that although there are provisions to meet some of the emergency financial pressures that they were faced with, there is not the comprehensive level of support that they felt would be helpful. In the conversations with parent groups, has that all been teased out? Could the provision be made as easy as possible to access in such circumstances for families in extremis—and in an unplanned way, obviously, rather than a planned situation where people can anticipate that they might be going to be in a hospital further away from where they might have expected?

Jenni Minto: That is a fair point. I understand that the majority of boards allow siblings to stay on site with their parents. I recognise what you are describing. I cannot imagine what it would be like to be in that situation. I reflect on the nursing staff, the clinicians and the people that work for the YPFF who I have met and recognise how caring they are. Where possible, they will want to support families in these difficult, traumatic circumstances.

The Convener: I make the point.

Jenni Minto: You make the point.

The Convener: You referred to the phasing that has already taken place. What have been the outcomes of that? What has been the success rate in terms of mortality?

Jenni Minto: I cannot comment on mortality, but perhaps Kirstie Campbell can give more information.

Kirstie Campbell: When we introduced the phasing, our expectation was that we were testing the implementation of the model but we always knew, and we discussed this around the table in the perinatal sub-group, that we would not really be able, within that phasing process, to test the impact on outcomes because the number of these babies is very small, as you can imagine. They are very, very sick babies, the sickest babies in Scotland. Our expectation and what we have been building towards is that the evaluation process will need to take place over a much longer time period. To have a realistic assessment of the impact of the changes on these babies in terms of mortality, morbidity and other outcomes, such as their long-term developmental outcomes, we need a much longer process. We are looking at putting in place a full study that will analyse over a period of about 10 years how the changes impact the children.

The Convener: In essence, have confidence in the model that we are pursuing and it is underwritten by the clinicians and others who have been involved in the design, the development and the recommendations that are being implemented, but it will be some time before we can absolutely determine that the decisions that were made were in fact the correct ones.

Kirstie Campbell: Absolutely. From the evidence that the best start decision was based on, it is clear that the expectation is that these babies will have improved outcomes, but because the numbers are so small it will take us a long time to be able to properly evidence the change.

Jenni Minto: I think that the committee heard evidence from Stephen Wardle last week about the change in the model in England and the improvements in outcomes there.

The Convener: I accept that that was the case. I think that we are getting to the end of this element but I want to allow you to reflect on one thing. I think that you touched on all the people in the group that made the decisions being there for their professional experience and judgment, rather than as representatives of their hospitals. When that final decision was made, however, there was a residual feeling in one or two of the other units that they potentially were not represented. In your own mind, have you discounted any sense of bias?

Jenni Minto: Yes.

The Convener: Fine. That is all that you need to say.

Clare Adamson (Motherwell and Wishaw) (SNP): I have just a couple of questions. As the convener said at the start, there has been a level of misinformation and I see the impact of that almost every day in speaking to constituents. We talked about service levels going from level 3 to level 2. Is Glasgow level 3 at the moment?

Kirstie Campbell: There are three units in greater Glasgow: the Queen Elizabeth university hospital, the Princess Royal maternity and the Royal Alexandra hospital in Paisley. The Queen Elizabeth university hospital and the Princess Royal maternity are both what we used to call level 3 units and will be neonatal intensive care units

under the new language. The Royal Alexandra hospital in Paisley is already a local neonatal unit.

Clare Adamson: I was getting to the question. We talked about downgrading, but is this not a realignment? As a local representative in Wishaw, I know that babies have to travel to Glasgow at the moment for co-located services, such as neonatal surgery. The experts told us last week that that was valid not just for neonatal surgery but also for paediatric pharmacy and anaesthesia and all those other expert areas that just do not exist at Wishaw at the moment. Is it appropriate to still be using level 2 and level 3 terminology? Should we be moving to a different terminology in the new model?

Kirstie Campbell: We want to align neonatal care in Scotland with the terminologies used across the UK, which is around neonatal intensive care units. The expectation is that there will be three of those. Currently, we have six neonatal units. There will be three neonatal intensive care units in Scotland.

I recognise that the terminology of “local neonatal units” is not entirely descriptive of what those units will do because they will provide intensive care for babies for up to 48 hours. Then we have the special care baby units, which are the level 1 units, and they provide care for babies at a higher gestational age.

Clare Adamson: I have a final comment for the committee. We have talked about the impact of neonatal care on families. Some of the employment law on where maternity leave legally kicks in should be looked at. I know that there is a fund for neonatal care but these disadvantaged children face immense challenges right from the start, as do their families, and I think that there should be some provision for more support from employers between the date of birth and what would have been the normal birth week. It is not only about the initial costs for families.

The Convener: Thank you for that. Consideration of areas of deprivation was part of the discussion that we had last week as well. Minister, is there anything that you or your colleagues would like to add? I think that we have covered all of the ground that was of central concern to the committee.

Jenni Minto: I would like to reiterate my thanks for the work that the committee has done in this area. Clearly, it is a very emotional area of healthcare and one that we really want to get right, so the questions that you have prompted in your evidence gathering have ensured that we have that covered in the work that we have been doing with the task and finish group and we are very appreciative of that.

The Convener: My final comment and reflection is that the petition is here because there are still people out there who are unconvinced and they can only be so because, for whatever reason, they have not understood the issues or they have raised concerns which may yet hopefully be accommodated or addressed. Communication is always very important in these matters and maybe work still needs to be done to offer the reassurance that people would want in advance of finding themselves in this situation.

Jenni Minto: Convener, I could not agree more with that final comment. I think that communication is incredibly important. The task and finish group is being clear about communicating within their sphere of influence, but I absolutely take that on board and think that it is a very fair point well made.

The Convener: Minister, thank you once again to you and your officials for engaging with us so constructively. We very much appreciate that.

Annexe C: Written submissions

Petitioner written submission, 17 December 2025

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

Firstly, I would like to thank the Committee for the time and dedication they have put into this petition.

The Minister for Public Health and Women's Health has stated that NHS Lanarkshire were represented as part of the decision-making process. While NHS Lanarkshire was part of the Best Start board, there was NO representation from NHS Lanarkshire as part of the Neonatal care options appraisal. Membership can be found here, (Maternity and neonatal services - neonatal intensive care plan: options appraisal - gov.scot)

It is also noted that the Minister for Public Health and Women's Health has also made reference to BLISS being tasked with gathering the views of parents. It has become clear that this was never in their Terms of Reference and was never their role.

The Best Start, the same document continually referred to by the Scottish Government, also states that “babies do best when parents are involved in care.” It also states, “prevention is at the core.” “.... reduce by a quarter the number of children with developmental concerns....” and “We are also committed to reducing the inequalities between the most and least deprived areas.”

“The future vision of maternity and neonatal services across Scotland is one where:

All mothers and babies are offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences.

Fathers, partners and other family members are actively encouraged and supported to become an integral part of all aspects of maternal and newborn care.”

Over and over again, we are being told that the decision to move to 3 NICU units is based on clinical evidence. The Scottish Government continues to cherry-pick the information contained in the report, focusing solely on the best clinical outcome, disregarding the statements above, and refusing to take a holistic approach to the best outcomes.

Evidence shows that extremely preterm babies should experience minimal handling, particularly in the first 72 hours. There are considerable requirements for a preterm baby transfer.

What are the time and financial implications of this?

How does this keep families at the centre, and an integral part of maternal and newborn care?

The Minister also referred to the parental focus groups. When these were held, the facilitator was clear from the beginning that they would only facilitate feedback on 4 questions around financial support, mental health support, access to information, and nothing else would be discussed.

It has also now been clarified that Bliss in fact did NOT consult with parents around the neonatal options appraisal, and they were present to represent parental views.

When the parents of the Wishaw Neo Natal Warrior group met with the Minister for Public Health and Women's Health, she stated on more than one occasion that (regarding moving to three level 3 units) "The decision has already been made" Supporting the argument that meeting with concerned parents was a tick box exercise rather than meaningful consultation.

The Scottish Government has agreed to the proposal detailed in the Options and Appraisal process, but it is clear that the health boards involved are struggling to find a way to implement the recommendations safely. I believe local implementation groups were initially tasked with this, but when they struggled to reach safe processes for transfer of women and their babies, this was then directed to the Chief Executives to determine.

Parents are not actively heard by SG.

NHS Lanarkshire, the Scottish Ambulance Service and Maternity services were not included in the Options and Appraisal process.

We keep being told the decision has been made, yet it is also stated that modelling is currently taking place to determine what that looks like. Surely the modelling should have been carried out first. From the evidence presented to the Committee, it is clear that on paper, the new model of Neo neonatal care looks to improve medical outcomes for the smallest and sickest babies, but in fact the NHS are unable to deliver this.

There are various mentions of parental involvement, family-centred care.... yet again, how the new model of care is going to be delivered fails. Due to the lack of capacity in maternity and the 3 proposed units, babies will be moved 100's of miles from home, their community, and their family.

The Scottish Government continue to prioritize the opinions of clinical experts at the cost of parental voice, family centred care, and mental health and wellbeing. In contradiction to the Best Start, which highlights the importance of family and parental voice and the importance of parental involvement and care in outcomes for the smallest and sickest babies.

I find it interesting that the letter from Glasow based consultants was not taken to the Committee, and wonder if this is a coincidence that the Chair at the time was also under Greater Glasgow and Clyde Health board.

Ms. Minto also stated that babies will have the best outcomes if transferred in utero, and different pathways are in place to ensure this. We know from data previously submitted to the Committee, that one third of babies were born in a hospital without

the necessary level of care from January-September 2024 (The Scottish Pregnancy, Births and Neonatal data Dashboard).

Ms. Minto also stated that she “Can't imagine what it would be like to be in this situation.” Families have tried time and time again to help her understand, but it has fallen on deaf ears, as “This decision has been made”

It’s extremely concerning that when asked about impact during the phasing period, that outcomes could not be gathered. How do the Scottish Government know this is going to work for Scotland? And indeed, as stated by Ms. Minto, we will not know the impact for a further 10 years. How many lives is the Scottish Government willing to destroy over the next 10 years whether it's due to infant mortality, lifelong physical and learning impact to babies being transferred, or mental health and wellbeing for mothers, fathers, families and communities.

A recent publication, “Life After NICU 2025: The lasting impact of prematurity” by the charity The smallest things found that: -

“Parents reported high levels of anxiety and worry in the months and years after leaving the neonatal unit. More than a quarter (28%) stated that they had been formally diagnosed with post-traumatic stress disorder (PTSD), with many more sharing that they had experienced flashbacks to their time in neonatal care alongside other distressing emotions.

➜ Anxiety (85%)

➜ Worry (79%)

➜ Guilt (76%)

➜ Flashbacks (67%)

➜ Grief (60%)

➜ Loneliness (56%)

➜ Intrusive thoughts (51%)

The Third Sector is mentioned as a key partner who offers support and accommodation to families. Will the already struggling Third Sector services receive any additional funding to provide the services needed to the families of the smallest and sickest babies?

Scottish Government written submission, 11 December 2025

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

At the meeting on 10 December, the Convenor asked about the numbers of beds in the three units that will be Intensive Care Units under the new model of neonatal care. The information below is taken from the Capacity and Modelling report

undertaken by RSM-UK to inform planning (information below taken from Pages 28 – 30 of the report).

Royal Hospital for Children, Glasgow

Modelling work recommends an additional 10 cots (or 12 if additional HDU and SC capacity cannot be located in Princess Royal Maternity or Royal Alexandra Hospital)

Current capacity is 50 cots, of which 30 are High Dependency and Intensive Care cots.

Edinburgh Royal Infirmary

Modelling work recommends an additional 4 cots

Current capacity is 39 cots, of which 17 are High Dependency and Intensive Care cots.

Aberdeen Maternity Hospital

Modelling work recommends an additional 1.5 cots

Current capacity is 34 cots, of which 15 are High Dependency and Intensive Care cots.