CPPP/S6/25/19/2

Citizen Participation and Public Petitions Committee
Wednesday 10 December 2025
19th 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 26 November 2025. At that meeting, the Committee took 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

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 Bliss Scotland and the Petitioner 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, 22,179 signatures have been received on this petition.

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

Action

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

Clerks to the Committee
December 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 26 November 2025

The Convener: The second item on our agenda is consideration of continued petitions. The first petition is PE2099, an extraordinarily important petition on which the committee has previously engaged and has undertaken a site visit to the neonatal intensive care unit in Wishaw, where we were pleased to meet the petitioner, Lynn 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 centralised services.

At our previous consideration of the petition, the committee agreed to take evidence from the British Association of Perinatal Medicine's best start perinatal sub-group, and the Minister for Public Health and Women's Health. We will hear from the minister at a subsequent meeting, but at today's meeting we will take evidence first from Dr Stephen Wardle, the president of the British Association of Perinatal Medicine, who joins us online, and then from members of the best start perinatal sub-group.

Good morning, Dr Wardle. I see that all the graphics on your background image have been reversed, so we are seeing all the text behind you the wrong way round. It is difficult to work out what it all says—those who are following the proceedings can puzzle over what it means.

We are also joined by our colleagues Clare Adamson and Monica Lennon. If there is time after committee members have asked their questions, I will invite both of them to put their questions to the witness.

Dr Wardle, is there anything that you would like to say by way of introduction?

Dr Stephen Wardle (British Association of Perinatal Medicine): Good morning. I am a consultant neonatologist and, as you have said, the president of the British Association of Perinatal Medicine, which is a professional organisation that represents perinatal professionals: doctors, nurses, allied health professionals, psychologists and pharmacists who work in neonatal services.

The Convener: This is an emotive subject—we can all understand that. Our job is not to ignore that, but to approach the issue in as professional and dispassionate a manner as possible in order to ensure that there is a proper opportunity to discuss the aims of the petition and that Parliament and the Scottish Government ultimately come to the right decisions.

What are the types of local and national factors and constraints that the British Association of Perinatal Medicine would expect to be taken into account when implementing its framework's recommendations? Are you confident that those have been adequately taken into account in the proposals that have emerged in Scotland?

Dr Wardle: In terms of the organisation of neonatal networks, there is some evidence that the centralisation of services improves outcomes. We know that the smallest and sickest babies who are cared for in larger, more centralised neonatal services have better outcomes than those who are not. In my written submission, I have documented some of the evidence behind that and the references involved. All that information, and the framework that was produced on behalf of the British Association of Perinatal Medicine, was taken into consideration in the best start review.

The centralisation of neonatal services in larger neonatal units that have all the right resources in terms of people, expertise, equipment and the wherewithal to be able to deal with the smallest and sickest babies helps to improve outcomes. That means that babies of 27 weeks and lower should all be cared for in neonatal intensive care units rather than local neonatal units or special care units.

Do I need to describe the difference between neonatal intensive care units and local neonatal units?

The Convener: It might be helpful if you could explain that on the record. The committee has gone through that previously, but it would not be unhelpful to hear it again.

Dr Wardle: The care that individual babies receive is divided into various levels, and individual neonatal units provide certain levels of care. The highest level of care is provided by neonatal intensive care units, which are the most complex, largest units. Those are the tertiary units that care for babies across a wider region and look after the smallest and sickest babies.

Local neonatal units tend to be smaller units at local hospitals. They care for babies who are born early—in general, babies from 28 weeks and above—but not the smallest and sickest babies. Special care baby units tend to be slightly smaller facilities that provide care for babies at higher gestations who do not receive any intensive care. In local neonatal units, short-term intensive care can be provided, but babies who need long-term intensive care are cared for solely at neonatal intensive care units.

As you will be aware, the British Association of Perinatal Medicine and associated services have defined levels of dependency and activity that a unit must be engaged in—that is, the number of babies who are looked after and the number of intensive care days that are provided—if it is to be designated as a neonatal intensive care unit or a local neonatal unit. Those levels ensure that the throughput for the larger neonatal intensive care units is sufficient in order to meet the criteria that we know help to improve outcomes.

The Convener: That is helpful. Although there is a pattern to them, a lot of our questions cut across one another and are relevant to various points. Obviously, we are going to discuss why we went from having eight units to having just three, following a recommended reduction to between three and five. However, following our visit to Wishaw, my question is: how does the framework aim to maximise the

experience of babies and parents—that is, the human aspect—alongside maximising clinical outcomes and cost-effectiveness?

The unit in Wishaw is an award-winning facility with highly experienced staff and is at a geographical point that is accessible for everybody in the south of Scotland. We know that some of the larger units that exist are turning people away because they do not have capacity, which raises the prospect that somebody from Lanarkshire could end up in Aberdeen.

In Wishaw, we spoke to a father who said that, following the birth of their child, his wife was left in a life-threatening situation and that, if the unit in Wishaw had not existed, he would have had to decide whether to stay with his wife, whose life was at risk, or stay with his baby, who might have been in Aberdeen. That would have been an awful choice to make. The human dynamic in such circumstances seems to be at risk.

As I said, there is an award-winning facility in Wishaw and, when we visited it, we saw that the quality of care that is provided is outstanding. To us, as laypeople, it seemed difficult to square the circle.

Dr Wardle: I understand all those issues. It is difficult to provide local services that are as specialised as they need to be in order to care for the smallest and sickest babies.

As I have said, the optimal way of providing the right level of care for those babies is by ensuring that care is centralised and that units are large enough to be able to care for enough babies to maintain expertise. That can be difficult, and the movement of mothers and babies as a result of centralising care is inevitable.

It is important to avoid the movement of babies as much as possible. Ideally, sufficient capacity should be provided in all of the units that are providing the intensive care. In any review of the designation of services, it is important that the neonatal intensive care units that will be enabled to take all of the activity have sufficient capacity in terms of staff and space to be able to care for those babies.

If all those things are provided, it should be possible to transfer mothers antenatally—that is, before birth—when a pre-term delivery is expected. That should avoid mothers and babies being separated. It might mean that care is provided slightly further away from home for some families. That means that the capacity has to be in the right places, so that those journeys are minimised as much as possible.

In the first stages of neonatal intensive care, babies are very sick and need lots of expert intensive therapies and treatment. Later in their care, many babies can be transferred back to their local units. It is a system that seems to work well when networks are well organised. If the right capacity is in the right places, it should be possible, in most instances, to anticipate when women are going to deliver prematurely and ensure that the smallest and sickest babies are born in the right place, where intensive care can be provided on site, so that the baby does not need to be transferred. Following that, when those babies have progressed and done well, they can be transferred to their more local units.

You also mentioned local expertise and the excellence of some units. It is important that expertise is maintained, and I appreciate that the approach that we are discussing can be difficult in some units that are providing a higher level of care, particularly if the change is seen as downgrading the care that is provided by moving the facility to a lower level. However, the changes are not about individuals. The issue is not about which individuals can provide the best care; it is about making sure that the right people are in the right place to provide the right care for the babies, and that that care is provided in large enough centres.

The Convener: It is not always the case that the outcome is a happy one. In the scenario that I mentioned, the baby could have been transferred from Wishaw to Aberdeen and, in the worst-case scenario, it might not have been possible for the father, who was also concerned about his wife, to be present in the event that things did not work out well. We are talking about considerable distances. You say that adequate capacity will be available in the larger units, but I do not know whether my parliamentary colleagues are terribly sure that that has been the pattern when other services have been centralised.

Dr Wardle: It comes down to how the services are commissioned. If the resources are available, it should be possible to commission sufficient space and capacity in the right places.

I agree that transferring women and babies very long distances is not ideal, and that is why the right capacity has to be in the right places. Unfortunately, outcomes are not always good, and provisions need to be in place to deal with those situations.

Davy Russell (Hamilton, Larkhall and Stonehouse) (Lab): You have said that travelling is not good for the baby, but you have also referred to appropriate capacity being available in the alternative unit. The nearest unit to Wishaw is Glasgow, which is at or near capacity. As a result, capital investment would be needed to increase capacity before there was any decision to close Wishaw. Is that right, or sensible?

Dr Wardle: I do not know the particular circumstances in Wishaw and Glasgow and what would be required to be opened to ensure sufficient capacity or, indeed, what the right capacity would need to be. Sometimes capacity just means having more nurses, or the right number of nurses, to look after a particular number of babies or to maintain a certain level of activity in a particular neonatal unit.

I am not aware of the exact circumstances in Glasgow that limit capacity at the moment. It could be that more nurses are required, or it might be that some capital investment needs to be made in order to have a larger space—I am not sure—but, ideally, all those things should be provided to ensure that capacity can be transferred.

David Torrance (Kirkcaldy) (SNP): Good morning, Dr Wardle. Does the proposed location of Scottish units raise any concerns about a disproportionate rate of transfers from areas of high deprivation?

Dr Wardle: High deprivation can lead to a higher incidence of prematurity and sometimes poorer outcomes. What do you mean by “deprivation”? Are you asking whether transferring might be more difficult in those circumstances?

David Torrance: In areas of deprivation, health is usually poor, so we will probably find more cases of premature babies being born and therefore more need for specialist units.

Dr Wardle: Yes, that is possible and, indeed, is often the case. Again, it goes back to capacity being in the right places and ensuring that there is sufficient capacity so that care can be transferred when required.

The distances that people travel need to be reasonable, too. The review has recommended the establishment, eventually, of three neonatal intensive care units and, as has been pointed out, Glasgow would be the closest to Wishaw. I do not know enough about the local circumstances but, as long as sufficient capacity is provided, it should be possible to manage the situation.

David Torrance: On that point about capacity, the central belt has the greatest population density in Scotland; indeed, the whole area of Lanarkshire and Wishaw has high population density. Would it not make sense to put the units where you have the highest population density, instead of people having to go to Aberdeen, Dundee or such areas?

Dr Wardle: I do not think that I can answer those questions. All those issues were reviewed in the options appraisal, but neither I nor my organisation took part in the review, so we do not have a specific view on that. However, the principles that were used were those recommended by BAPM on centralising care to improve outcomes.

The Convener: Davy, did you want to follow up on any questions?

Davy Russell: Just a couple, convener.

The review recommended the establishment of between three and five operational units. Obviously, Scotland’s population is 5 million. What, based on your expertise, would be the right number of units? Would it be three or five—or four?

Dr Wardle: That is a good question. Geography would certainly need to come into it, but I would point out that the size of the population, and the number of deliveries that occur in Scotland, are similar to those in a neonatal network in England. There are 10 such networks in England, and typically, each of those neonatal networks will have two neonatal intensive care units. Some have just one, while others have three or four. In general, though, around two neonatal intensive care units will be required for that size of population. As I have said, geography will come into this, too.

Davy Russell: What do you think would be a reasonable distance for a mother and baby to travel?

Dr Wardle: What is “reasonable”? Sometimes, mothers and babies get moved considerable distances. Ideally, when care is provided within networks, the distance is minimised. Some of the networks in England are large and require the transfer of

mums and babies over significant distances, but I do not think that there is any set distance, or time limit, for transfers.

The key thing is ensuring that capacity is in the right place and that transfers, particularly transfers of babies, are minimised. Mums need to be transferred rather than babies. We certainly do not make recommendations on distances, but organising care within networks helps minimise very long-distance transfers.

Davy Russell: How easy is it to identify mothers who might be prone to giving birth prematurely? Is there any methodology that you would use, or pre-work activity that you would do, to ensure that the mother is in the right place closer to the right time?

Dr Wardle: Yes, there is. Lots of work goes into that. This is really a question for an obstetrician, but there are tools to predict which mums are going to deliver early.

Sometimes, there are clinical factors, such as multiple births, that make early delivery more likely. Women who have had a previous pre-term birth are at higher risk of delivering early, as are some women who have problems with, say, their cervix. On most occasions, the obstetrician can predict when women are likely to deliver early. Some women just go into labour early, and that cannot be predicted, but as long as they can be transferred early enough in the process, it can happen in a safe and timely way.

Unfortunately, there are some women who go quickly, and unpredictably, into premature labour. In those circumstances, the baby needs to be transferred after birth, which, as I have said, is less than ideal and something we try to avoid. That is the purpose of organising care in networks and trying to ensure that mums are transferred rather than babies.

Davy Russell: Thank you.

The Convener: Maurice Golden, do you want to follow up on any of those points?

Maurice Golden (North East Scotland) (Con): I think that that would be helpful, convener.

Everyone will agree that there is already a degree of centralisation, given that we are starting with eight specialist units. However, the concern is the rationale behind all this and how we ensure not just the best clinical outcomes but the best patient outcomes.

I am interested in cases in which, as a result of closures, families might have to live apart and in the impact that that might have. Last month, The Courier reported on the case of Lois Cathro, whose triplets were born at 32 weeks, and all under 4 pounds in weight, at Ninewells hospital in Dundee. They received excellent care, but Lois said:

“Had the unit not been there, we could have faced an unimaginable situation.”

Is it conceivable that parents and families might have to make round trips of hundreds of miles between hospitals just to see their babies? What impact might that

have not just on their clinical care but on their overall wellbeing and, potentially, on future health and mental health outcomes?

10:00

Dr Wardle: Travel for parents is a big issue when care is centralised. It is important that, as well as providing the capacity to look after babies, we provide facilities for parents, too. That will mean help with accommodation for those parents who have travelled long distances, help with travel costs and help with things such as parking and food while their babies receive intensive care.

All those things need to be considered—and, I hope, provided where possible—to make the journey for those parents easier and more bearable. After all, having a premature baby is a considerably emotional and stressful experience. It is all about caring for babies as close to home as possible, so we need to avoid very long-distance transfers, and we should transfer babies back to their local unit, when that is possible, and based on their care. Hopefully, if all those principles are considered, we can optimise the experience for families and try to ensure that families, particularly those from deprived backgrounds, do not have to meet very high costs and avoid the stress and difficulties that can arise from having their babies being cared for at a long distance from their home.

Maurice Golden: Thanks for that answer, but you have highlighted, I suppose, the nub of the issue. It appears as though the arbitrary methodology behind closing units and reducing them down to three is almost setting mothers and very sick babies up to fail by building in that amount of travel from the outset. Huge swathes of Scotland, including the most deprived parts, will lose services if the closures go ahead. In your opinion, does this move need to be reconsidered?

Dr Wardle: I do not think that it needs to be reconsidered on that basis. Optimising outcomes is clearly the reason for centralising care in this way and for these recommendations being made. Providing appropriate care for parents and families will be key to all that.

The difficulty is that, if we continue to provide care in lots of smaller units in an effort to avoid transfers, fewer babies will survive and there will be poorer outcomes. A high level of resources is required to support the level of intensive care that is needed in a large number of smaller units and to provide the right staffing levels in all those places. It is not that centralising care is about saving costs—it is not. It is about improving outcomes. Trying to provide care in that many units would be difficult, because it is difficult to provide the right staff at the right level with the right expertise.

Maurice Golden: I am not a clinician, but clearly there is already a degree of centralisation. At the moment, we have eight units, and perhaps the number should be five or six. I know that the Princess Royal maternity hospital is already in Glasgow, so I would presume that, in that case, the effect on parents will not be so severe. However, it seems to me that the proposed move down to three units boils down to finances, which is deeply concerning. Can you assuage those concerns in any way?

Dr Wardle: I do not think that it is about that—our recommendations are not around finances; they are around improving outcomes. If we want the best outcomes for our babies and families, centralised care provides that. I do not think that it is around costs although, clearly, the costs need to be borne in mind. In a system in which resources are not endless, those things need to be taken into consideration. However, our recommendations are around improving clinical outcomes.

Fergus Ewing (Inverness and Nairn) (Ind): I understand the basic point that Dr Wardle is, quite fairly, making, which is that his views are driven by the desire to get the best outcomes. That is understandable. Where there are very low birth weight babies, that is extremely worrying for everybody. I was not in attendance during the visit that committee members made to Wishaw, but I understand that it was put to members that the process of centralisation in England was perhaps going to be revisited. Is that a false rumour, or is there substance to it?

Dr Wardle: No—there are no plans to revisit centralisation in England. In some networks, there is on-going review of the care that is provided and the designation of units, but there are no plans to revisit that type of centralisation. Providing care in operational delivery networks with centralisation of care for the smallest and sickest babies continues, and is planned to continue. I think that there are reviews in some networks to look at where the care should be provided, in the same way as care is being looked at in relation to the designation of individual units. However, there are no plans to revise that.

Fergus Ewing: Thanks for clarifying that.

In your written submission, you state that the recommendation is that

“Scotland should move to a model of three-to-five ... units ... in the short term, progressing to three units within five years”.

I represent the seat of Inverness and Nairn, which is in the centre of the Highlands, but the Highlands is roughly the size of Belgium. For example, the journey time from Wick to Aberdeen is four hours 41 minutes by car—it is 204 miles. I have absolutely nothing against my colleagues and friends representing the Wishaw area, but the journey time from Wishaw to Glasgow is 30 minutes, and the distance is 20 miles. I want to put that in perspective, because the geography of Scotland, once one leaves the central belt is, by and large, one of very sparse populations spread over enormous areas.

It is your clinical judgment that there should be a move to five units and then to three. What would you say to those who say that, if there is nothing in the Highlands, the nearest place is Aberdeen, which means that people who live in the more rural parts of the Highlands—you could make the same case for the south of Scotland and other rural areas such as the north-east, Argyll and the islands in particular—are second-class citizens when it comes to neonatal care? Specifically, in your deliberations, did you consider geographical justice, if I can make it into a rather short, if somewhat crude, phrase?

You can see what I am driving at. There are very strong feelings in places such as Wick and Elgin that maternity services should be retained there. Indeed, campaigns have been going on there for many years.

Dr Wardle: I can see the difficulty. I have already said that geography needs to be taken into consideration in these decisions. Scotland is unique—it is different from many areas of the UK—but it is difficult to provide very specialised care in remote areas and in small units in multiple locations. The situation is similar in other countries. A good example is Australia, where transfers need to happen over very long distances and from very rural locations. From a neonatal point of view, the key thing is to ensure that transport services are good enough. In Scotland, there is a well-developed transport system—the Scottish specialist transport and retrieval services system. It is important that the resources and the wherewithal are available, when necessary, to transfer babies over large distances from very rural locations. Transport that is properly resourced, equipped and available is the key to providing care to those women and babies.

The Convener: Fergus Ewing has a final thought.

Fergus Ewing: A final thought, indeed. In Canada, they have flying doctors precisely because of this issue; they have the same thing in the Australian outback, and our outback is the Highlands. What you are advocating is that health services in remote areas must have on-call contracts for helicopters or planes in order to transport, when necessary, the mother and baby to a centre of excellence to receive the specialist care that it is your advice is essential. Is that right—that that must be part of the service?

Dr Wardle: Yes, that must be part of the service.

Fergus Ewing: No ifs, no buts.

Dr Wardle: Yes. In order to provide care for those women and babies, the appropriate transfer facilities must be available.

The Convener: I would like to invite our colleagues who have joined us this morning to put questions to you.

Clare Adamson (Motherwell and Wishaw) (SNP): Thank you for the opportunity, convener. Good morning. I would like to recap some of what you said, Dr Wardle. You said that ICU care in neonatal units will continue in Wishaw and the other hospitals that currently provide that service.

Dr Wardle: The proposal is that Wishaw would become a local neonatal unit. Local neonatal units will provide intensive care on a short-term basis, which means for up to 48 hours. They will still look after babies born at 28 weeks and above, which is still considerably premature, but they will not look after the very smallest and sickest babies born at 27 weeks and below.

Clare Adamson: Wishaw does not have the facility for neonatal surgery; Glasgow does. How important is that, and how often is it required for the smallest and sickest babies?

Dr Wardle: It is really important to co-locate paediatric surgical care and neonatal intensive care, where possible. That does not mean that every single neonatal intensive care unit needs to have surgical care available, but a proportion of the smallest and sickest babies will require surgical input. I cannot give you an exact figure, but, off the top of my head, I would guess that between 10 and 15 per cent of extremely pre-term babies might require some sort of surgery. Where possible it is really important to provide paediatric surgical care and other paediatric specialists on the same site. It is possible to provide neonatal intensive care without surgical care on site, but when problems that require surgical input arise, those babies might need to be transferred, and that might be at a time when those babies are sick and unstable, so it is always better to avoid that situation, when possible.

Clare Adamson: I pay tribute to all the parents who have given evidence and to everyone who speaks so highly of the care that they have had in these units. I want to turn to the example that Mr Golden gave of triplets that were born at 32 weeks. He said that they weighed 4 pounds; I am sorry that I do not have the capacity to translate that into kilograms. Would those babies have fitted the criteria of the smallest and sickest, given that they were born at 32 weeks?

10:15

Dr Wardle: Babies at 32 weeks' gestation would be able to be cared for in a local neonatal unit. The type of care that those babies are likely to receive is short-term intensive care, and it is unlikely that babies born at 32 weeks would need more than 48 hours of intensive care.

Clare Adamson: Do you have any statistics that show what difference centralisation has made to outcomes and the survival rate in England?

Dr Wardle: I do not have data to answer that specific question on survival rates before and after centralisation. However, we know that outcomes and survival rates are improving over time, and we know from the data that I referenced in my written statement that, when people have looked back at the care provided in larger units and compared it to smaller units, they found clear differences in outcomes. It would be interesting to look at your specific question, but it is a little bit tricky to define a set time period when changes have occurred and when you might look at those sorts of changes. What we do know is that, in England, following centralisation, babies are now being delivered in the right place on more occasions. More of the smallest and sickest babies—the ones who we know are most at risk, who are most likely to have a poor outcome and whose outcome we know is improved by being cared for in a centralised unit—are now being cared for in centralised units.

The Convener: Monica Lennon, would you care to ask a couple of questions?

Monica Lennon (Central Scotland) (Lab): Yes, thank you, and thank you to the committee for all your work, and especially for the visit to University hospital Wishaw NICU.

Dr Wardle, thank you for your written evidence and your oral evidence today. To put that in context, are you able to explain for the committee's benefit whether you or

your executive committee members have visited the site at Wishaw or Glasgow, or indeed the other units that we are discussing today?

Dr Wardle: No, we have not. We have not taken any part in the review in Scotland. I am giving evidence based on our framework and our evidence that we have produced as an organisation, but we have not taken any part in any of the decisions or the reviews that have happened in Scotland.

Monica Lennon: Thank you for clarifying that. I ask because you made a number of important points about what should be in place for babies and families across Scotland in terms of the right resources, transport and capacity, and you cited the evidence that has informed your position in relation to centralisation. However, the evidence that we have as MSPs, especially those of us who represent communities in Lanarkshire, is that we do not have enough resources, we do not have the right transport and we do not have the right capacity. Do you accept and acknowledge that, today, the unit in Wishaw is not simply a local unit, because it serves a huge region of Scotland—as the convener set out at the beginning of the evidence session; that it is already serving as an overflow capacity site for NHS Greater Glasgow and Clyde, because the reality is that Glasgow already cannot cope; and that, by the Scottish Government's own admission, the modelling that has been done so far and which may already be out of date shows that at least dozens of babies from Lanarkshire will have to go to Aberdeen, which is a considerable distance by ambulance, when, as you said yourself, travel is not ideal and would put babies at risk? It would be most helpful if you could address those points.

Dr Wardle: I go back to the point about the right resources being in place to provide the right capacity in the right places. I cannot comment on local circumstances; I can comment only on the underlying principles.

Monica Lennon: Thank you—that is helpful. It reinforces what has been my position all along, which is that the decisions need to be informed by people who work in the local services and those who have used local services—they need to have a seat at the table.

Dr Wardle, you are a member of the British Association of Perinatal Medicine, and you clearly have the best interests of patients and your members at heart. Is it regrettable that no one from NHS Lanarkshire had a seat at the table and was able to ask questions and inform the decision, when clinicians from Glasgow and elsewhere were involved? To have robust decision making, should there have been representation from NHS Lanarkshire?

Dr Wardle: I cannot comment on how the review was organised and who was invited. It is important to have stakeholder review from all parties, but it is not for us to comment on who was invited.

Monica Lennon: Okay—thank you.

The Convener: Thank you very much, Dr Wardle. I hope that none of that seemed unduly testy. I realise that we strayed into various areas and, obviously, it is an emotive subject. However, I am grateful for the range of evidence that you have

supplied us with, all of which will help to inform the committee as we review the petition and consider our recommendations, or otherwise, as we go forward. I am very grateful to you.

Would you like to add anything, or are you content with everything that you have contributed?

Dr Wardle: I am happy with everything that I have contributed. Thank you for the opportunity.

The Convener: The graphics on your screen came around the right way eventually, so we can now see them without needing a scribe. Thank you very much for joining us.

I suspend the meeting briefly while we change witnesses.

10:22 Meeting suspended.

10:23 On resuming—

The Convener: We will continue taking evidence on PE2099, which is on stopping the proposed centralisation of specialist neonatal units in NHS Scotland. For the second evidence session this morning, I am delighted to welcome Jim Crombie, co-chair of the perinatal sub-group of the best start implementation programme board; and Dr Andrew Murray, co-chair of the perinatal sub-group. Are there two co-chairs, or are there other co-chairs who are not with us?

Dr Andrew Murray (Best Start Perinatal Sub-group): There were more co-chairs, but we are representing the panel today.

The Convener: Right—so we have two of the posse of co-chairs with us this morning. I am grateful to both of you for joining us. Would you like to make any opening remarks, or are you happy for us to move to questions?

Dr Murray: I am happy to move to questions.

The Convener: Fine. Thank you very much.

Could you give us clarity on the intention of the best start report with regard to the final number of units? Obviously, we have eight, and there was a recommendation to move to between three and five, and the recommendation ended up at three. The committee is concerned to know whether there is scope to move beyond that figure of three towards the five that was within the range of parameters that were discussed.

Dr Murray: The intention was to acknowledge that the way in which Scotland's services are currently set up is not in line with the best evidence. You have just heard that clearly from your previous witness. The level of evidence meant that we needed to look to change and reconfigure the services.

It very much came down to the fact that there has to be a critical level of expertise and activity in the units to ensure that we achieve the best outcomes, including on mortality. More babies will survive and we will get better outcomes if a critical mass

of activity and expertise in the units can be achieved. As you have heard, that is 100 births per year of particularly low-weight babies.

The best start programme was aware of that and set out in its recommendations that, because the units had been established in a more disparate way, we could not guarantee and assure ourselves that we were delivering the best services. Therefore, the recommendation was that we move to an evidence-based approach, which underpinned the reconfiguration. You have heard the evidence from the British Association of Perinatal Medicine. We should see our services through the lens of the figure of 100 very low-weight births and the number of respiratory ICU days to ensure that we can deliver the outcomes that the babies—the patients—deserve.

The Convener: What about the question whether there should be three, four or five units?

Dr Murray: Again, that was driven by the option appraisal and the data that we had. Your previous witness was clear that the number of births per year in Scotland would probably reach the threshold for only two such units in a network in England. We knew that we would need to use that data to drive the final decision making. As you know, the data is clear that, if we are committed to improved outcomes and reduced mortality, we cannot justify any more than three units.

On the move from five units, there has to be a transitional period. Your previous witness set out eloquently that there is a need to put in place resources, pathways and everything else that is needed to support successful implementation. The committee touched on inequalities. An equalities impact assessment needs to be put in place to underpin that and make sure that we get it right.

As one of the co-chairs of the sub-group, I envisaged a transitional period of having three to five units and then moving clearly towards the vision of ultimately having three units.

The Convener: I want to touch on something that Monica Lennon asked about and which came up quite a bit when we were on our visit. The review group included representatives from Glasgow, Edinburgh and Aberdeen, and, coincidentally, the three centres are to be in Glasgow, Edinburgh and Aberdeen. Lanarkshire was not represented. I understand that people from Lanarkshire were invited, but they took the view that, because there was a material interest, it might be prejudicial for them to take part, not realising that, in fact, it was potentially prejudicial for them not to take part. Notwithstanding their view of how that might have been interpreted, could that not have been challenged to ensure that the review group was more representative of all of Scotland, rather than just of the centres of excellence that ultimately benefited from the outcome of the review?

Jim Crombie (Best Start Perinatal Sub-group): That is a really good point. It is important to note that the review kicked off in 2018. In the period from 2018 to 2024, the chief executive of NHS Lanarkshire was involved, as was the head of midwifery at NHS Lanarkshire, Lyn Clyde. There is a need to ensure that the approach to something as important as this allows individuals to contribute, focus and use the data. As we moved forward with the programme, we felt that clinical expertise and

representatives from key clinical groups were informing the science of the issue, the decisions and the subsequent options appraisal, so that the outcome was predicated on evidence and on improving outcomes.

I heard a question about the exercise being finance driven. There were no finance representatives on the sub-group, and the criteria for the options appraisal did not include a financial criterion. The options appraisal was based on clinical outcomes, clinical co-locations and the availability of clinical expertise at the volumes that Dr Wardle has already briefed you on.

10:30

Davy Russell: Do you accept the potential for bias or conflict of interest in relation to the membership of the sub-group and the expert group?

Dr Murray: I do not. The members were a range of extremely experienced individuals. They were often in national roles because of their expertise, and there were also people from outwith Scotland. There was a clear attempt to get the right people with the right expertise to inform the decision making. From my perspective, there would not be any such potential.

The conversations that Jim Crombie laid out on the options appraisal were all about objective criteria. For example, you either have co-location of services or you do not. We went through a process of trying to build up that very objective picture. Subsequently, the decision making was reviewed by one of the deputy chief medical officers, I guess so that an integrity check was done.

I think that the integrity of the members of the group should not be impugned. Some of the members of that group were from health boards that are not part of the final three. There were individuals from Tayside—there were possibly individuals from elsewhere, if we were to review the whole list. As the co-chair, having been involved in a few national pieces of work, I got a sense of the clinicians' absolute commitment to achieving the best outcome for their patients. They were trying to do that as objectively and as transparently as possible.

Davy Russell: Dr Wardle mentioned that there is some evidence to back the reduction from eight down to three, but he did not say that there was a lot of evidence—he referred to the fact that he had never visited the sites and that it was more of a desktop exercise. Should the reduction be done in stages to see how it is working, rather than diving from eight to three?

Dr Murray: That is a good point. We tried to consider that, and there was the opportunity to do so with the pandemic. Just prior to the pandemic, we had set up early implementer sites so that we could test some of the thinking around the recommendation. That was about creating a wider network—Crosshouse hospital in Ayrshire linking to the Queen Elizabeth hospital, and NHS Fife linking to Lothian colleagues—so that we could try to problem solve what issues might arise.

On Dr Wardle's statement about the evidence, I think that the evidence is compelling. There are multinational studies from many highly thought-of centres that always come back to the point that unless you have enough experience to be

managing 100 of the sickest babies, you will not get the same outcomes and the mortality rate will be higher.

If that point did not come across clearly in the previous evidence session, I can say, certainly from our perspective as co-chairs, that we have a pretty copious evidence list that comes to that repeated conclusion, which is why we needed to pursue it.

Davy Russell: What efforts were made to communicate to the stakeholders—families and so on—the membership of the sub-group and the reasons for their appointment?

Jim Crombie: We ensured that we had representatives of patients' voices, if you like, as part of the neonatal sub-group. The chief executive of Bliss Scotland is part of the programme, and she informed a lot of our communication processes.

The membership and the remit were published—they were widely available—and we reported to the best start programme board, which, again, had further representation outwith Glasgow and Lothian. There was a series of communications, and we were transparent about the content of our work and our process as we moved forward. Bliss was immensely helpful in supporting that communication to wider users and so on.

The Convener: I have to say that, on our visit to Wishaw, everybody we spoke to was scathing of the contribution of Bliss.

Jim Crombie: I am not aware of that.

Dr Murray: I cannot comment on their view, I am afraid.

The Convener: People felt that Bliss was completely distant, and that what they got was simply a pro forma advancement of Bliss's view, without that having been subject to any direct engagement whatsoever.

Dr Murray: I am sorry, but I cannot comment on the individual relationship that Bliss had with that centre. We would need to see whether we have anything that would correspond to that view. We are happy to look at that, if it is an important point.

The Convener: Davy Russell, I apologise for interrupting your line of questioning. Please continue.

Davy Russell: No, I am fine, convener.

The Convener: Fergus Ewing would like to come in at this point.

Fergus Ewing: The witnesses have said that, as one would expect, careful consideration was given to the issues in arriving at the key recommendation that there should be three units, which would be in Glasgow, Edinburgh and Aberdeen. What consideration was given to Inverness?

Jim Crombie: The evaluation looked at all eight units, and the option appraisal criteria referenced key clinical elements of the provision, such as throughput, co-location on the site of expertise in, for example, paediatric surgery, which Dr Wardle referenced, and a number of other clear criteria that each of the units was matched

against. As we came out of the options appraisal process, it was clear that there was a margin between the three units that scored best and the other units. From a clinical evidence and clinical data point of view, it was clear that those were the three units to go for.

Fergus Ewing: I can understand that, with the specialisms that are present in the units in Glasgow and Edinburgh—I should say that my partner is a very senior anaesthetist with nearly 40 years' experience in the national health service—it makes sense that they would be two of the choices. I think that most people would agree with that, whatever part of Scotland they represent. However, I understand that the unit in Aberdeen—I have nothing against Aberdeen; it is all one country—is not expected to meet the recommended threshold of 100 very low birth weight admissions per year, which means that it is some way behind Glasgow and Edinburgh. Would it not have been possible to provide more specialist resource in Inverness in order to provide a degree of geographical equity? Without downplaying Aberdeen, could there not be a case for four units, given that, as I said to Dr Wardle, the travel time to Aberdeen from most places in the Highlands is about three to five hours—it takes a day from the islands—whereas the travel time from Wick to Inverness is about two hours and 20 minutes? That latter time is not great, but, from most places in the Highlands, it is quicker to travel to Inverness than to Aberdeen.

I am just looking at things from a geographical point of view. I appreciate that clinical decisions must trump everything else when there is a case of a baby who requires specialist care. However, would it not be possible to have four centres, one of which would be in Inverness, although that would require more resource to be placed in Inverness, more consultants to be situated there and more provision to be made available for emergency situations, if I could put it crudely like that?

Jim Crombie: It is a really complex question. There is an ambition to have all services available to everyone as close to home as possible, but the clinical evidence is very clear that, if you have units that are not consistently delivering a volume of specialist care at the level that we are talking about, the outcomes from those units will be less favourable than outcomes from the units that are delivering that volume of care.

You are correct that the Grampian unit does not deliver 100 births per year of those particularly low-weight babies. Our estimations of the actual activity around Grampian and the flow from Tayside suggest that the figure is around 80.

There was a point at which there was a proposal that there would be two units in Scotland, because that is what the volumes suggested should be the case. However, for the very reason of geography that you raise, we considered that we should be able to support a third unit.

Fergus Ewing: Finally, did you consider demographic trends? The point that I am making is perhaps not immediately obvious, but Inverness is the fastest-growing city in Scotland, and possibly the fastest-growing city in Europe. The population is increasing. I do not know whether it is because of the fresh air or something in the water, but, over the next 10 or 20 years, the population is due to expand more

rapidly than anywhere else in Scotland, not least because of renewables activity in the inner Moray Firth. Various figures have been put on it, but I think that the rise will amount to around 30,000 people over the next 15 years. That will substantially increase the pressure on Raigmore hospital, which is falling apart at the seams and needs to be replaced—there is no doubt about that.

If we are thinking strategically about Scotland, these decisions need to be made on a long-term basis, and that means that, surely, we cannot just isolate the Highlands. Paragraph 56 of your report, which covers risks and conclusions—I was going to quote from it, but it would take too long—specifically says that Aberdeen is fine because it negates the problem of long journeys from the north. I am very sorry, but no, it does not. I was surprised to see that comment in your report, and I wonder whether you might want to rephrase or recast it.

More important, is there not a case for looking again very carefully at the changing circumstances, demographic and otherwise, in the Highlands, which I think would offer a strong case for providing four centres and not three?

Dr Murray: We did not look at those projected demographics, but, after the pandemic, we took the opportunity to re-evaluate some of our data from all the centres to see whether any new trends were emerging. At that point, there was not anything that changed the decision making.

The information from the option appraisal process and the scoring has been made available to the committee. If you look at it, you will see that there is a significant difference between the Grampian scores and the Inverness scores, so it was not as if there was a close decision between having three centres and having four.

Fergus Ewing: That could be redressed, because there has been a shrinkage of consultancies—

Dr Murray: It was cut and dried.

The Convener: I should say that I do not think that Inverness is one of the eight units currently.

Maurice Golden, you were going to raise issues around this area. Do you want to pursue anything on the back of what Fergus Ewing has just asked about?

Maurice Golden: I have a question about the cut-off point. Clearly, throughput was one of the criteria used, and I appreciate what you have said about Glasgow and Edinburgh. However, the difference in the scores between the units in Aberdeen and Glasgow is 17 and the difference between the units in Aberdeen and Dundee is 29—following that, there is a bit more of a drop-off.

I wonder about the case for Dundee and Wishaw in terms of the wider package beyond clinical outputs. Clearly, an ambulance can get from Wishaw to the Queen Elizabeth hospital quickly, but if you are a parent from Lanarkshire or the south of Scotland who is trying to visit your very sick child in Govan, you can be stuck for hours on the roads around Glasgow, whether you go via the M74 or M8. How was that taken into account in the overall findings?

Jim Crombie: As Dr Wardle said, the premise of the decision making is to create facilities that offer the sickest babies—the lowest-weight babies—the best opportunity to survive and thrive. That was central to our thinking.

In terms of the implementation of the recommendations, the issue that you describe needs to be part of the process. The Scottish Government set aside funds to support families as part of the programme, and that was augmented later in the process in order to try to address the issue that you have identified. There is no doubt that, as you centralise services, you increase the distance that people will have to travel. There was recognition that the strategy would certainly have an impact, but that was outweighed by the absolute benefit of the sickest babies surviving and thriving.

10:45

Dr Murray: Just to add to the point about whether we could have made any compromise on that approach, there was a lot of discussion about the veracity of the evidence that I just outlined. We needed that conversation to take place, and we needed to provide a lot of assurance to respond to the question, “How could it be such a round number. That seems convenient, doesn’t it?” We looked at that statistically and had a range of experts who were able to contribute and explain. The consistency of the evidence internationally meant that any deviation from our ambition—the wider package as you chose to describe it—would mean poorer outcomes for babies and an increased mortality rate. We would not be able to countenance that as the group that was charged with driving up those standards and outcomes.

Maurice Golden: The report is the first step towards developing a new way to deliver such care, but it is partly predicated on having a support network in place so that its rationale can ultimately be justified. My concern is that the support network might not be in place. After you have reported, who is ultimately accountable for delivering on the report’s recommendations in order to make your rationale successful?

Jim Crombie: That is a really important question. When we completed our option appraisal, we wanted to offer additional support for the areas that would be affected by the implementation. We wanted our analysis of the numbers of women who would be transferred to the units to be reflected. As Dr Wardle said, the ambition is to move the mum with the baby still in situ, as that would be the safest transfer. That was our focus.

We procured external expertise to model the impact of our recommendations, so that it was explicitly clear what the flows would look like. I was clear that implementation was of such significance that it needed accountable officer-level leadership. Through the Scottish Government, we required each of the regions involved to designate a lead chief executive to oversee the implementation of our recommendations. I was clear that that offered the best opportunity for this clinically imperative model of care to be delivered. The accountability was clear in that structure.

Maurice Golden: Thank you.

Davy Russell: In the previous session, Dr Wardle said that transportation is key, whether it be air ambulances in the Highlands and Islands or just ambulances, as is the case here. We hear day in, day out about ambulance waiting times. Have you budgeted for enough ambulances? If a patient is going from Wigtownshire to Glasgow or wherever, it could take a vehicle and a couple of people out of the system for up to a day. Have you made arrangements to increase that capacity? Is that part of your business or is it somebody else's problem?

Jim Crombie: It is part of the implementation programme. The Scottish Ambulance Service is a member of the neonatal network and runs the specialist element of ScotSTAR, which is staffed by clinical experts.

Someone mentioned doctors getting on a plane and travelling. We are talking about highly expert clinicians and consultants who support the transport of very sick babies. They were fully involved in the discussions and were clear about the capabilities in play.

Davy Russell: It is the capacity issues that I am really talking about. My inbox is full of people who have waited X amount of hours for an ambulance. If you take somebody out of the system—for a day in some cases—that will be a bigger strain on capacity.

Jim Crombie: There is no doubt about that. We have to pay attention to the numbers, which require a level of specialist transportation. That was part of our modelling. As part of the implementation, each of the regions will work with the Scottish Ambulance Service—which is a national board, as you know—to look at the infrastructure requirements and what augmentations are needed to ensure that capacity is put in place.

Davy Russell: Okay.

David Torrance: Good morning. How do you respond to the criticism that the option appraisal exercise was weighed towards surgery, which does not adequately reflect the needs of most pre-term babies?

Dr Murray: As has rightly been said, co-location of surgery was in the criteria, as was co-location of other critical services. That was a question that I heard Dr Wardle pick up on. I am not a neonatologist, but he was able to give us an estimate of the numbers of very unfortunate babies who might come to require surgery. It is important that that was considered as a factor, but it was one of many clinical factors that were taken into account. You heard about the risks of transferring such surgeries to a specialist centre, which is why co-location was considered very desirable in the option appraisal.

Jim Crombie: As my colleague said, what we looked at in the option appraisal went much wider than surgery. We looked at the co-location of paediatric medical specialties, including respiratory, gastroenterology and ophthalmology, as well as cardiac, congenital, diaphragmatic hernia and abdominal wall conditions. We looked at a whole bunch of criteria, because, as Dr Wardle said, when the experts are co-

located on the campus, the ability to support vulnerable babies to survive and thrive is optimised. The exercise was focused only on surgery.

The Convener: I have found all the evidence that we have considered fascinating. For the sake of the petitioners, I will be pejoratively political. There is an idealistic argument that is based on the technical availability of services and the best survival prospects for children, and there is the reality that politicians come across on behalf of our constituents every day. The great transport network in the health service, which ferries children from the south of Scotland up to Aberdeen at the click of a finger when the need arises, is effectively unavailable when constituents are left waiting up to 18 or 24 hours for an ambulance to turn up to take them anywhere. The additional consideration is that they, in fact, will simply go to Glasgow in such cases. In a previous evidence session, I talked about a parent who had a critically ill wife and was concerned about whether, in his circumstance, he should have stayed with the critically ill wife if the child was not in Glasgow but at the other end of the country.

In a sense, the clinical directive has generated what it believes to be the outcome that will lead to the highest level of survival among the sickest babies. However, that is dependent on the infrastructure support behind it, which politicians have found does not always follow. At some point down the line, constituents will come to us with an experience that goes against absolutely everything that you have identified as the clinically designed outcome, because the practical reality will be that they will not have got the support that was necessary and they will feel that they lost a child in the worst circumstances because of it.

Jim Crombie: It is difficult to argue against that. There is no doubt that the impact on individuals and families should be a component part of our thinking—although I note the support processes that can be put in place.

You are anxious about the Scottish Ambulance Service, and I hope to reassure you by saying that it is part of the implementation process and comes under the overall review of the infrastructure. ScotSTAR is world class and is able to transport the sickest kids with rapid turnaround times. It is the envy of other countries. As has been said, the co-location of all the clinical services optimises the chance for the child.

I recognise the impact on the family, who may have to travel in a number of circumstances. The Scottish Government identified funds and processes to support families who find themselves having to travel by train or car, having to stay overnight and having to buy meals. All those things were identified when organising a fund to support families in those circumstances.

Dr Murray: The ambition has been described as idealistic, but we heard from Dr Wardle that other countries have been successful in this regard, including England. He caveated it, but he thinks that evidence about improved outcomes is starting to appear. We are going through a difficult implementation process, and I do not think that there is any doubt about the devil being in the detail as we try to ensure that everything is aligned to support the reconfiguration. We talk about the reality and about people experiencing difficulties as they go through the process, but our reality

could involve delivering an improved network and an improved system with improved outcomes, which I think is what we all want.

The Convener: I invite my two parliamentary colleagues to contribute a question.

Clare Adamson: This is about the ScotSTAR specialist transportation unit. I understand that those ambulances are used only for transferring the sickest babies, so they would not be subject to the other pressures on the Ambulance Service generally. What about a woman who is being transferred? If the baby is still in situ, would she go with ScotSTAR?

Dr Murray: My understanding is that ScotSTAR is only for the transfer of the babies—but I am happy to be corrected. It is staffed by anaesthetists.

Clare Adamson: So, a parent would not necessarily be on that transport with the baby at the time.

Dr Murray: Again, I would need to double-check that. I should know more about it, because our ScotSTAR experts were very clear. It is primarily used for a transfer of the baby in an intubated and safe environment. I think that parents have to follow, but I am not sure of the operational detail.

The Convener: With the lower number of specialist centres, would the call on the service not be considerably greater than is the current experience?

Jim Crombie: Not necessarily, because the premise is that women are identified as being vulnerable in terms of premature birth, and the women are transferred to the unit at the prenatal point. ScotSTAR would not be involved in that process.

The Convener: I meant the ScotSTAR service itself. At the moment there are eight centres, but if there were only three, might the call on that resource, for transferring people to just three centres that are further away, be greater than is case at present, when there are eight?

Dr Murray: I do not think so. You have heard that the ambition is to have early identification of the mothers, so that they are in the right place for delivery. That is one of the key principles to underpin the arrangements. There will be less movement and fewer emergency transfers taking place. We might find that having fewer centres actually works more easily because of the established relationships—but I am speculating.

Monica Lennon: I know that time is tight and that there are still more questions and answers, but for now I just want to get some clarification.

Mr Crombie, you said that, when your group was making the decisions, there was a recognition that the strategy would have impacts, although they were outweighed by the clinical benefits. Dr Murray, I heard you say that the work would now begin on undertaking the equality impact assessment. These issues have been looked at since 2018, and I am hearing today that work is now beginning to look at the equality impact assessment. There have been some nods to what the social, economic and financial impacts might be, as well as the clinical impacts and outcomes.

11:00

For the benefit of the parents who are sitting behind you and people who will be listening or who will read the Official Report and want to be assured that everything is being given due consideration, can you tell us what the impacts are and what evidence has been gathered to ensure that all the other issues—such as being more trauma informed and thinking about the health, wellbeing and life chances of the woman as well as the baby—are being given equal consideration?

Jim Crombie: You said that there were more questions than answers, so I am happy to clarify anything that I have not answered to your satisfaction. The prime responsibility of the sub-group was to offer a view on optimal provision of specialist care for the sickest and lowest-weight babies in Scotland. Using clinical evidence and clinical expertise from the membership of the sub-group, we formed a view that the research and the clinical expertise were pointing us to higher volume units, which means a smaller number of specialist units providing higher volume care, because there is evidence that the care in specialist centralised units will be optimised. We knew that that meant a reduction of access to specialist care from eight units to three, and we therefore recognised that there would be an impact on individuals and families.

The implementation process needs to look at finance. The Scottish Government identified finance; accommodation, because we need to look at how we are going to provide accommodation in these areas; and transport and access, because we need to consider these matters with the Scottish Ambulance Service and the ScotSTAR service. All those issues were identified and are part of the on-going implementation process. There is no getting away from the fact that implementation will have an impact, but I strongly believe that the evidence that we heard and saw—the clinical opinion that we sought—was explicitly clear: to offer our sickest babies the best opportunity to survive and thrive, this is the model of care that should be in place in Scotland.

Monica Lennon: I still do not understand the status of the equality impact assessment.

Dr Murray: That was a comment that I made. However, I stepped back as co-chair. The work has started to move into the implementation phase, and I would need to seek a statement for you from the current team that is supporting the work to try to encapsulate where we are against your requests.

Monica Lennon: I apologise—I thought that you were currently the co-chair. How many co-chairs have there been?

Dr Murray: There have been a few co-chairs. The pandemic got in the way and there was a protracted timescale, so I think that, ultimately, there were probably five or six of us. To give you some assurance, I think that all of us would regard ourselves as being at a very senior level, and we were asked specifically by the chair of the best start programme board, who had detailed conversations with us about what the roles would entail.

Monica Lennon: Your clinical expertise is valued and appreciated, but we have had five or six co-chairs, people with national experience and people from outside Scotland, but no one from Lanarkshire.

Jim Crombie: I think that I pointed out that Heather Knox, the then chief executive of NHS Lanarkshire, was involved in the early part of the programme, and that Lyn Clyde, who was head of midwifery in NHS Lanarkshire was involved in the programme.

Monica Lennon: But they have not made decisions. They said that they tried to do the right thing by trying not to prejudice decisions because they felt that they had an interest as one of the units, but it looks like there has not been consistency around other people's decisions.

Dr Murray: I am sorry to interject. I tried to give you some assurance that the option appraisal process is objective. It is a case of, "Are these services there or are they not?" As you can appreciate, when there is representation from all parts of the country, the difficulty is that there is lobbying that is not based on that evidence.

We were trying to create a high-quality process. Our colleagues in NHS National Services Scotland supported us through the whole process, so we have used an approved national methodology for all sorts of service redesign in order to make the process as objective as possible, and we would want to stand by that.

Monica Lennon: On the—

The Convener: You must draw your questions to a conclusion, Ms Lennon.

Monica Lennon: Thank you.

We have heard a lot today about the importance of high-volume provision in order to maintain the level of specialty. Everyone who I speak to is under the impression that the Wishaw NICU is high volume. It is already struggling to cope with the demand and it already services demand from Glasgow and elsewhere. What is it that the unit is doing wrong just now? We are hearing that we need to have the right people in the right place, but the unit is award winning and it is serving a huge population in Scotland and doing it to a very high standard, so what is broken about that? It seems to me that the unit works well. It needs more capacity, but why would we want to downgrade the unit, when it is already performing an excellent service to the people of Scotland?

Jim Crombie: I disagree with some of your descriptions. No one is suggesting much of what you said there. The unit provides a level of activity—there is no doubt about that—but we are looking at activity that is linked to the smallest and lowest-weight babies and those who require the highest level of intervention with the co-location of the services that support the on-going provision post-birth.

Dr Murray: The unit does not have the co-location of the services that would make the service more comprehensive to really achieve those better outcomes. As a resident of Lanarkshire myself, I have no doubt that the clinicians in the unit are very skilled and committed.

Monica Lennon: I will just make an observation on that, as I know that I need to hand back to you, convener. If co-location was a factor, it sounds as though the process was weighted against Lanarkshire right from the beginning, because that was one of the criteria that you mentioned. It sounds as though our local service had no chance with all these different co-chairs, and that is regrettable.

Dr Murray: The reason why that criterion was in the option appraisal is that the evidence base shows that 100 of these very low birth weight deliveries per year achieve better outcomes because of the co-location of services, so that had to feature in our option appraisal—that had to be the rationale for it.

The Convener: I will draw the evidence session to a conclusion, but thank you both very much for your concise and informed evidence.

These are highly emotional and emotive issues. I hope that at no time would you get the impression that the committee is anything other than respectful of your clinical experience and the experience that you brought to any review. However, in pursuing the aims of the petitioner, I often say that we are at a magnificent advantage in this committee in that we are not following any party's political election manifesto; we are following the aims of a petition that has been lodged by people who are concerned. Our job is to take that argument as far as we possibly can. I am very grateful to you both for your time. I will suspend the meeting briefly before we move to the next agenda item.

Annexe C: Written submissions

Bliss Scotland written submission, 4 December 2025

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

Bliss' role in the Best Start Programme new model of neonatal care
December 2025

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.

Context

We are submitting this document in response to the **significant misunderstanding, and misrepresentation, of Bliss Scotland's role in the Best Start implementation process, which is important to correct.**

This document has been shortened to comply with the requirements to submit evidence to the CPPP committee. If you would like to read the full document, please email josiea@bliss.org.uk

What was the original proposal to introduce a new model of neonatal care in Scotland?

In 2015, the Scottish Government announced it would undertake a review of maternity and neonatal services in Scotland. This review took 18 months, and incorporated a wide programme of engagement with service users, led by Health Information Scotland on behalf of the Scottish Government. Bliss was represented by our then Policy & Campaign Manager on the main review group (as one of 24 group members), and on the neonatal models of care sub-group (as one of 22 sub-group members). Both the main review group and the sub-group also included representation from Health Boards including NHS Lanarkshire, NHS Tayside and NHS Grampian.

The outcome of this maternity and neonatal review was the publication, in January 2017, of the *Best Start – Five Year Plan for Maternity and Neonatal Care*. Based on detailed review of the latest evidence and clinical best practice, this included the recommendation: *"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****."* The Scottish Government subsequently accepted the Best Start recommendations in full, and set up an Implementation Programme tasked with delivering these recommendations.

How was Bliss Scotland involved in the Best Start Implementation Programme?

Following the publication of the *Best Start*, Bliss Scotland – represented by its Chief Executive – was asked to join the Best Start Programme Implementation Board (as one of 24 members), which was tasked with overseeing the implementation of all 76 Best Start recommendations. Bliss Scotland's Chief Executive subsequently also joined the Perinatal Sub-Group (as one of 21 members), which was tasked with providing more in-depth input to the implementation of the recommendations relating to neonatal care. Bliss Scotland was represented on both groups until the formal closure of the Best Start Programme in December 2024.

Did Bliss Scotland seek to engage with families as part of their input to the Programme Board or Perinatal Sub-Group?

Bliss Scotland's role as part of Best Start Programme implementation was <u>not</u> to engage directly with families; indeed, the terms of reference for both the Implementation Board and the Perinatal Sub-Group prevented us from doing so, with specific requirements:

- *"to preserve the confidentiality of papers and discussions"*
- That members *"will not discuss or disclose any programme related management information without prior agreement from the Chair"*

In the discussions across both groups, **Bliss Scotland consistently put forward the importance of regular and ongoing communication with both families and neonatal health professionals**, and encouraged the Best Start Programme Team to develop a communications plan through which to do so; however Bliss Scotland was not in a position to initiate this communication directly.

Once the decision had been announced about the locations of the three neonatal intensive care units, in July 2023, Bliss Scotland continued to advocate very strongly across both groups for clear and regular communications with families about the plans, and for the Scottish Government to undertake rapid and direct engagement with families to shape implementation detail – **however Bliss Scotland was never tasked with undertaking this engagement directly**. When Scottish Government engagement did finally take place in June/July 2024, Bliss supported this through providing input on the questions asked through the Citizen Space open consultation and subsequent focus groups.

What did Bliss Scotland contribute through their input to the Programme Board and Perinatal Sub-Group?

Bliss Scotland's role on both groups was to advocate for what is in the best interests of babies born premature or sick, in line with our charitable mission, and in the context of the implementation of the agreed Best Start recommendations.

At Bliss Scotland we recognise the significant concern from families that the proposals will result in a small number of the smallest and sickest babies having to

travel further for their care, and the impact this will have on those families having to travel far from home and away from their support networks. Indeed, this is already the situation facing families in other parts of Scotland without a NICU. **A significant focus for us throughout the Best Start was therefore on identifying how parents can best be supported to play a hands-on role in their babies' neonatal care, which we know is vitally important to babies and their families.**

Bliss Scotland worked closely with the Scottish Government to develop the Neonatal Expenses Fund, now called the Young Patients Family Fund, which provides financial support for travel, food and accommodation costs for all neonatal parents. We have also advocated through the Best Start programme and wider campaigning for more dedicated parent accommodation on or near neonatal units so that families have somewhere to stay close by to their baby. In recent years we have also successfully campaigned for legislation which introduced a statutory entitlement to neonatal leave and pay for all employed parents through the Neonatal Care (Leave and Pay) Act, which came into effect in April 2025, enabling both parents to be at their baby's cotside throughout their neonatal stay.

What has happened since the Best Start Programme formally closed at the end of 2024?

Since the formal closure of the Best Start Programme at the end of 2024, Bliss Scotland has continued to push for progress with the implementation of the new neonatal model of care through a variety of means, including briefing parliamentarians for debates in the Scottish Parliament and through letters and meetings with officials and Ministers. We understand that a Task & Finish Group has been established with representation from the three NHS Scotland regions to finalise and take forward detailed implementation plans for neonatal reconfiguration.

At this point, we recognise that neonatal services in Scotland are not currently in a fit state for the final stage of reconfiguration to go ahead, with more progress needed at the designated three NICUs – in Edinburgh, Aberdeen and at the RHC in Glasgow – including investment in additional staffing and cots to be able to accommodate the additional capacity required. Bliss Scotland is disappointed at the lack of progress with implementation plans through 2025, and with the lack of transparency from the Task & Finish Group in how plans are progressing; including a lack of any timeline and milestones towards implementation.

Bliss Scotland continues to support the principles of centralisation of neonatal intensive care services in Scotland in line with the Best Start recommendations and with evidence and clinical best practice, but the right resources need to be in place to enable this to happen, including further workforce planning and capacity building. We are concerned that progress continues to stall in ensuring services are prepared to transition to the new model safely, and we continue to press the Scottish Government to invest the required resources to ensure this can happen in the coming months.

As referenced in our first submission to the Citizen Participation and Public Petitions Committee ahead of their meeting on the 8 October, we are also concerned about the significant levels of misinformation circulating regarding the plans. This misinformation has been heightened in recent months and we are increasingly alarmed and frustrated to hear repeated references – both in the media and directly from MSPs – to services closing down, the process and safety of transfers and drawing on family experiences which, given the gestations and clinical status of their babies, would not be affected by the planned changes.

These proposals are difficult, the concern around them understandable, and debate about how to implement them safely is vitally needed. **But that debate needs to be undertaken in a measured way and grounded in the facts**, rather than perpetuating misinformation in the way that we have seen in recent months, which only serves to generate fear and concern amongst the public.

Petitioner written submission, 4 December 2025

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

Although we are relating our concerns to Neonatal services in Wishaw and Lanarkshire residents, these changes will directly impact neonatal services all over Scotland and impact already stretched Maternity, Ambulance, specialist & GP services. While many may think “I don’t live Lanarkshire or I’m not having anymore babies so this won’t affect me” this change will have a wider spread impact.

Currently in Scotland there are 8 level 3 Neonatal Units that provide care for the smallest, sickest babies. The Scottish Government wish to reduce this to 3 which will be centralised in Glasgow, Edinburgh and Aberdeen, meaning 5 neonatal units, including Wishaw, will be downgraded. The theory behind this makes perfect sense as it sounds as if it will result in better care for the babies if looked after in units “more experienced” in looking after small, sick babies. However, the report itself acknowledges that Aberdeen is currently admitting the lowest number of these small, sick babies but a unit in the North will have geographical benefits. So is this the right decision for Scotland as a whole?

2 of the smaller health boards have already piloted this proposal with the smallest babies who now feed into Glasgow & Edinburgh. The numbers are fairly low as predicted for the smallest babies, however, when we add on the sickest babies, these numbers will inevitably increase.

So with these 2 and Scotland’s existing level 2 neonatal units already feeding into Glasgow and Edinburgh, where are Lanarkshire’s and the level 2 units that currently feed into Wishaw’s smallest, sickest babies going to go?

Glasgow does not have the capacity required in the current set up with Wishaw providing level 3 care. This is the case for available bed space and staff numbers to provide safe care. There is no space within the hospital to increase the number of bed spaces, and if there was, they do not have the staff.

In an ideal world, the pregnant mum threatening preterm delivery will be transferred to one of these centres before birth, accompanied by a midwife and using an ambulance. This is taking services away from the local area. We know both these services are already under crippling pressure.

If the baby is born in the ambulance, or born and then transferred, morbidity and mortality increase, resulting in poorer outcomes for the baby and additional trauma for everyone involved. This potentially increases the need for follow up specialist and GP services in view of the neurodevelopmental and mental health impact.

Paramedics do not have specialist training in pre-term or complex delivery. A standard ambulance does not carry the lifesaving equipment needed to support a pre-term or sick baby.

The Scottish Pregnancy, Births and Neonatal Dashboard from Public Health Scotland shows that in 2023, 100% of babies born between 22 and 26 weeks were born in a hospital that could provide level 3 care. Between January and September 2024, this drops to 69%.

Not the 100% as stated at the recent evidence gathering session attended by representatives form the Best Start Perinatal sub group and the British Association of Perinatal Medicine.

It was also stated that while there is no data, it is known that outcomes and survival rates have improved under centralisation. Without the data and evidence, how has this been assessed?

ScotSTAR was also heavily referenced but as confirmed by the question from Claire Adamson MSP, a woman being transferred pre delivery would not access ScotSTAR specialised service, it would be a standard ambulance.

Using Lanarkshire as an example again, it is the third largest health board in Scotland which covers a vast geographical area with increasing social deprivation. Lanarkshire women traditionally present late, perhaps for the previously specified reasons, so what does this mean for them? Potentially more births prior to or during transfer? Being displaced up to 3 hours and 150 miles away from their support network if they are in fact well enough to accompany their baby? Difficult decisions for partners who may have to choose between going with sick baby or staying with sick Mum? Having to choose between being isolated with their small sick baby and separated from older children? Small sick babies need skin to skin contact and breast milk so although this will be a difficult decision, the small sick baby will win. But at what cost?

There is a fund which can be accessed to buy food which provides £8.50 per day, with travel and accommodation will be compensated. This is however a reimbursement scheme so relies on families having the funds from the outset which with the current cost of living is challenging. Babies won’t always be going to their nearest unit due to capacity issues so there is the travel time and not just expense to consider. Parents must also consider time away from both your small, sick baby and family at home. Not everyone can drive and those who can may not have access to

a car or money for fuel. Mums who have had a caesarean section are advised against driving for 6 weeks. What are the public transport links like to these 3 hospitals? There is currently insufficient accommodation on the sites as well, which I imagine will operate on a first come first served basis and be prioritised for the families of the smallest, sickest babies who live the furthest away.

We are so focused on the smallest, sickest level 3 babies but what happens with the bigger, not so sick level 2 and 1 babies? These 3 centres will not be able to accommodate all of Scotland's smallest, sickest babies in addition so the bigger, more stable babies risk also being displaced from their booking hospital. A massive increase in workload for the specialist neonatal transport service which will potentially be shuttling babies all over the country to accommodate this, whilst on call for emergencies.

While everyone wants the best outcomes for the smallest and sickest babies, the delivery of the recommendations from the Best Start Options Appraisal cannot be delivered safely in the current climate within NHS Scotland.

When meeting me and representatives from the campaign group, The Minister for Public and Women's Health was very clear that "the decision had been made." Minutes for these decision making meetings do not exist.

This being the case, health boards are now being left to work out how this can be delivered safely, and in short, it can't.