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I am writing to inform you of changes being made to the way neonatal intensive care is delivered in Scotland, as part of the implementation of The Best Start (2017).

The Chair of the Best Start Programme Board wrote to you in May 2022 signalling the remobilisation of The Best Start programme. As indicated in that letter, the Scottish Government and the Best Start Programme Board committed to moving forward with implementation of the new model of neonatal intensive care described in The Best Start which will consolidate care for the smallest and sickest babies in three neonatal intensive care units, in line with evidence that this will deliver the best possible outcomes (see Annex A).

The Best Start Programme Board submitted a report detailing the outcome of their options appraisal and testing process to Scottish Ministers (link to Options Appraisal Report below). Ministers have approved their recommendation that the neonatal intensive care units in Scotland should be located in the following areas:

- Royal Hospital for Children, in the Queen Elizabeth University Hospital, Glasgow
- Aberdeen Maternity Hospital
- Simpson's Centre for Reproductive Health in Edinburgh Royal Infirmary

It's important to note that no neonatal units in Scotland will close as a result of the proposed changes. This is about ensuring the smallest and sickest babies are born where they can readily access the very specialist care and services they may need.

The new model will see Scotland moving to a networked model of three neonatal intensive care units (NICU) working alongside local neonatal units (LNU) and special care units (SCU), supported by transitional care and community care services. This aligns with existing service models across the UK. Units identified as LNUs within this new model of care will continue to deliver aspects of intensive care, however, the smallest and sickest babies will be cared for in one of the three identified neonatal intensive care units (NICUs), until such time as they can be moved to a unit nearer to home.

To underpin the new model of Neonatal Care, the Best Start Programme Board have also approved the guidance 'Criteria to Define Levels of Neonatal Care Including Repatriation within NHS Scotland: A Framework for Practice', linked below which sets out details of the different levels of neonatal care.

In order to support health boards to move forward with detailed implementation planning, the Scottish Government will commission healthcare planning expertise to undertake national capacity and modelling work. CEOs within each region should agree a nominated lead CEO to deliver this programme from planning to full implementation. The nominated lead CEO should have prioritised access to Regional Planning infrastructure & resources through to full implementation.

I ask for your support to engage with this work and to include your regional strategic planners. I will set out further detail on the ask of relevant health boards once that contract is in place in the coming weeks.

The health boards who host the Units named above should submit detailed implementation plans to the Best Start Implementation Programme Board and the NHS Chief Operating Officer by end 2023, with the expectation that the National model is fully rolled out by 2025. These plans may be submitted jointly through Regional Planning Chief Executives. When I set out arrangements for the planning and modelling work noted above, I also intend to set out the expectations around what we hope to see in implementation plans, including engagement with local service users. The Chair of the Best Start Implementation Programme Board will monitor all regional implementation to ensure delivery of the national approach and will meet Ministers to update them on progress.

A number of resources are available to support local planning conversations, including:

- The Report of the Perinatal Sub-Group - Neonatal Intensive Care
- Options Appraisal Report;
- Criteria to Define Levels of Neonatal Care Including Repatriation within NHS Scotland: A Framework for Practice;
- Information for Expectant Parents leaflet;
- Financial support to assist with the cost of travel and food for families is available via the Young Patients Family Fund - mygov.scot.
- Q & A attached at Annex B.

Thank you in advance for your continued support in Best Start Implementation.

Andrew Watson
Director for Children and Families
The Scottish Government

ANNEX A

The Best Start and Proposed New Model of Neonatal Intensive Care

1. The Best Start, published in January 2017, outlined a new model of neonatal service provision which suggests care for the smallest and sickest babies is consolidated to deliver the best possible outcomes; emphasises parents as key partners in caring for their baby and; aims to keep mothers and babies together as much as possible, with services designed around them.

2. The recommendations for the new neonatal model of care are underpinned by strong evidence that population outcomes for the most premature and sickest babies are improved by delivery and care in units looking after a "critical mass" of these babies. They include:
    - That access to on site paediatric, surgical, laboratory and radiology services is beneficial for the most preterm babies
    - That parents are partners in care, involved in decision making and care delivery
    - That mothers and babies should not be separated unless essential for care of one or other.
    - That early discharge and ongoing care is in the interest of families
    - That parents should receive clear information
    - That kangaroo mother care and breastfeeding are essential to high quality care.
    - That a skilled workforce is essential in units of all designation.

3. The wider package of recommendations include recommendations to minimise separation of families, including:
    - Providing accommodation for parents to stay on or near neonatal units and facilities within the unit to encourage kangaroo skin to skin care and early support for breastfeeding;
    - Development of Transitional Care;
    - Roll out of the Young Patients Family Fund (formerly the Neonatal Expenses Fund); and
    - Community neonatal support to facilitate early discharge.

4. The Best Start recommends that Scotland should move from the current model of eight Neonatal Intensive Care Units (NICU) to a model of three units within five years supported by the continuation of current NICUs redesignated as Local Neonatal Units (LNU). These Local Neonatal Units will continue to provide a level of neonatal intensive care, but the care for the most preterm and sickest babies receive specialist complex care in fewer NICUs, while returning babies to their local area as soon as clinically appropriate. To support service redesign, formal pathways between these units were recommended, to ensure smooth transfer and repatriation processes.

Evidence to Support the Change in Model of Care

5. This recommendation is aimed at the most premature and sickest of babies and is based on a review of evidence (carried out by Dr Anna Gavine, Dr Steve MacGillivray and Prof Mary Renfrew of the University of Dundee and published alongside The Best Start). The evidence showed that outcomes for very low birth weight babies (VLBW) are better when they are delivered and treated in NICUs with full support services, experienced staff and a critical mass of activity (expert recommendation defines this as care for a minimum of 100 VLBW babies a year).

6. This evidence has since strengthened with the publication in 2021 of the British Association for Perinatal Medicine (BAPM) Framework for Practice, which sets out optimal arrangements for neonatal intensive care

Options Considered and Advice

7. The Best Start Implementation Programme Board was tasked with taking forward implementation of the recommendations within Best Start. The Programme Board set up the Perinatal Sub Group to take forward the Neonatal Intensive Care work, including an options appraisal process to identify the final three units. The Group draws its expertise from consultant neonatologists, neonatal nurses, the neonatal transport service, has midwifery and obstetric representation and is chaired by a medical director and health board deputy chief executive. The linked report from the Perinatal Sub Group details the full group membership and sets out the following:

    - The context, evidence base, and governance structure;
    - The options appraisal process, including the testing phase and post-covid review;
    - Risks and issues identified; and
    - Conclusions and recommendations.

8. On conclusion of the options appraisal process, the Perinatal Sub Group has recommended that the three neonatal intensive care Units in Scotland should be located in Queen Elizabeth University Hospital in Glasgow, in Edinburgh Royal Infirmary and in Aberdeen Maternity Hospital.

9. The Perinatal Sub Group report makes the following recommendations:

    - **That the outcome of the options appraisal process is now concluded and Ministers are invited to agree to the recommended final three units and that detailed modelling and phased implementation planning can now be commissioned.**
    - **Those three Neonatal Intensive Care Units for Scotland should be located in the Queen Elizabeth University Hospital in Glasgow, Edinburgh Royal Infirmary and Aberdeen Maternity Unit. The new model of neonatal intensive care should now be fully implemented on this basis, with consideration given to phasing roll out over the next two years.**
    - **The smallest and sickest babies should be born in maternity units collocated with a Neonatal Intensive Care Units where possible. That care should be delivered in the unit closest to their home and babies should be repatriated to their Local Neonatal Unit as soon as clinically appropriate.**
    - **Based on historical patient numbers, of the three units recommended as NICUs, the unit in Aberdeen is currently admitting the fewest babies with birth weights <1500g. Even with the planned changes to service Aberdeen is very unlikely to reach the benchmark of 100 of these babies per year, the number considered necessary to demonstrate improved outcomes. The subgroup does however recognise the geographical advantages for women of having a unit located in the North and recommends that enhanced monitoring and opportunities for shared learning and skills maintenance be considered for that unit.**

- **NHS Directors of Finance should be commissioned to develop a recurrent cross boundary flow of funding that sees a transfer of resource so that the funding follows the mums and babies.**
- **Transformational change funding should be identified to bridge any gap in funding to support capacity building in the final three Units until, until a sustainable funding model is in place.**
- **The Best Start Programme Board should drive development of this sustainable funding model.**

10. In addition the Perinatal Sub Group have led development of a Neonatal Criteria Framework and parent information leaflets to support implementation of the new model of neonatal care.

Service change implications

11. The Options Appraisal Process was rigorous and the outcome largely predicated on co-location with other key services (such as neonatal surgery). No neonatal units will close, and neonatal care will continue to be delivered in all locations, and numbers of babies affected by the changes will be less around 50-60 babies a year (from an annual birthrate currently around 48,000), and these babies would have their care stepped back to their local neonatal unit as soon as possible.

12. The ethos of the Best Start is to individualise care around the needs of women, their individual circumstances and their family circumstances. Family centred care will maximise the opportunity to establish the building blocks for strong family relationships, and for confident and capable parenting. This can help to mitigate the impact of inequalities and deprivation and their long term health and other consequences for families.

13. We would expect these proposals to help reduce existing inequalities, by improving outcomes for the very smallest and sickest of babies, given that we know that very premature babies born to minority ethnic mothers have poorer outcomes.

New Model of Neonatal Intensive Care – Q and A

Q:What are the timescales for implementation of the new model?
A:We are planning on the basis that the full model should be implemented by 2025.
Q: How will we be able to accommodate all of this extra activity on the Unit?
A: The Scottish Government is working with regional chief executives and strategic planning leads to undertake modelling and capacity work to help develop local implementation plans which should specially set out how the Units will aim to manage the estimated additionality. It's important that the whole multidisciplinary team are involved in developing local plans, including maternity staff.
Q: Who will be responsible for develop and implementing plans to transition to the new model?
A: Regional chief executives will be responsible for providing quarterly reports on progress to the Best Start Programme Board and Scottish Government. Regional planning leads will be responsible for driving forward implementation within and between Boards. It's important that the whole multidisciplinary team are involved in developing local plans, including obstetric and maternity staff.
Q: What if a baby of <27 weeks is born out with an intensive care unit?
A: As is current practice, clinicians are expected to stabilise and provide care for babies until it is deemed safe to transfer them to the appropriate location.
Q: How will the Scottish Government monitor implementation?
A: The Best Start Implementation Programme Board will be responsible for monitoring implementation. Where issues or delays arise in relation to implementation are identified, these will be escalated as appropriate to the NHS Chief Operating Officer to further understand any identified issues and identify possible solutions.
Q: How will I maintain my skills?
A: The report from the Perinatal Sub-Group on the outcome of the options appraisal process identified skills depletion as a key concern for those units no longer categorised as a NICU. This is based on the expectation that small and sick babies will continue to be delivered unexpectedly out with NICUs and that some babies in local neonatal units and special care units will deteriorate in smaller units and then need stabilisation and transfer. However, LNUs will continue to deliver intensive care and care for babies from 27+0 weeks that need stabilisation and treatment, so both nursing staff and medical staff will continue to have experience in delivering these aspects of intensive care.
The Scottish Government will work with the Scottish Perinatal Network and NHS Education for Scotland to take forward a number of actions to ensure that appropriate learning and development opportunities are available for staff impacted by the changes.