NHS
North West
Clinical Senate

Furness General Hospital Level 3 Critical Care Service

NW Clinical Senate Review

Sponsoring Commissioning Organisation: Lancashire & South Cumbria Integrated Care Board

FINAL REPORT

Review date: 23rd April 2025

Chair's Foreword

Lancashire and South Cumbria Integrated Care Board commissioned the NW Clinical Senate to undertake an independent critical friend clinical review of options for the future delivery of a safe and sustainable critical care service at Furness General Hospital.

I would like to sincerely thank the clinicians, managers and commissioners who contributed to this review. Their passion and enthusiasm for serving their local community and wider population was clearly apparent to the panel. The conversations held during the review and the supporting materials received prior to the review clearly evidence a strong desire to ensure a safe, high-quality and sustainable service to the local population that offers the best care experiences and outcomes both for patients and their families.

I also offer sincere thanks to the review team who joined us to provide their time and advice freely. Thank you to members of the NW Clinical Senate for their ongoing support and commitment to the provision of robust independent and objective clinical advice.

The clinical advice and recommendations within this report are given in good faith and with the intention of supporting commissioners. This report sets out the methodology and findings of the review. It is presented with the offer of continued assistance to the Commissioners should it be needed.

Prof Martin Vernon
NW Clinical Senate and Review Panel Chair

Contents

1. Introduction

1.1. Lancashire and South Cumbria (LSC) Integrated Care System (ICS) is a collaboration of partners including the NHS, Local Authorities and the voluntary, community and faith sector.

1.2. Furness General Hospital (FGH) is part of the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) and provides a range of general hospital services to the residents of Barrow and the surrounding areas of South Cumbria, including a full Accident & Emergency Department service, Critical Care unit and Consultant led general acute beds. FGH also provides a range of planned care services including outpatients, diagnostics, therapies, day-case and inpatient surgery.

1.3. Until September 2024, the critical care service provided all three levels of critical care. From 23rd September 2024 this has been reduced to levels 1 and 2 due to a shortage of consultant workforce.

1.4. This review aimed to provide an independent critical friend clinical review of options for the future delivery of a safe and sustainable critical care service at Furness General Hospital.

1.5. The agreed review objectives focused on addressing the following questions:

1) Which of the two options most closely aligns with best practice as set out in national and other evidence-based guidance (i.e. resume a level 3 service or retain and level 1 and 2 service) to ensure the provision of a safe and sustainable service at FGH?
2) If a level 3 service were to be resumed, what would commissioners and the provider need to put in place to ensure the service is safe and sustainable?
3) If a level 3 service were not resumed, would any further mitigations need to be put in place beyond those that have been enacted since October 2024?
4) For the available options, have all key service interdependencies been robustly considered?

5) How do the options fit with the wider strategic alignment and direction of travel of the ICS?

1.5 A copy of the full Terms of Reference is included as Appendix 1.

1.6 The Clinical Senate Review Team members were:

NAME	JOB TITLE	ORGANISATION
Prof Martin Vernon	Chair and Consultant Geriatrician	NW Clinical Senate
Dr Martin Hogg	Deputy Chair and Consultant Clinical Oncologist	NW Clinical Senate
Dr Sara Barton	Consultant Acute Physician	Tameside General Hospital
Kelly Bishop	Assistant Director of Nursing and Urgent Care	Midlands and Lancashire CSU
Dr Irfan Chaudry	Critical Care Consultant and NW GIRFT Ambassador	Lancs Teaching Hospitals
Sally Fray	Consultant Nurse for Critical Care	Lancashire Teaching Hospital NHS Trust

1.7 Managerial and business support to the panel was provided by Caroline Baines. Head of NW Clinical Senate.

2. Methodology

2.1 A series of meetings took place during the period of January to April 2025 between representatives of the NW Clinical Senate (NWCS), the commissioners (L&SC ICB) and the provider organisation (UHMBT). During these discussions, the Terms of Reference for the review (appendix 1) and the desktop approach for the piece of work were developed and agreed. The assembled panel comprised subject matter experts from the NWCS council and assembly membership.

2.2 Provisional review information was provided by commissioners on 10th April 2025. Panel members reviewed this prior to the review which was undertaken on MS Teams on 23rd April 2025.

2.3 The review panel was joined for the first segment of the meeting by colleagues representing LSC ICB and UHMBT leadership teams who presented a detailed summary of the challenges to date and the options for future provision, as well as engaging with the panel in discussion and a question-and-answer session. The panel then met with a range of medical, clinical and managerial colleagues from a broad range of specialties, both critical care and interdependent services. Colleagues from L&SC Critical Care Network were due to attend but were unfortunately unable to due to staff sickness.

2.4 A draft summary report was sent to commissioners on 16th May 2025, with feedback received on 3rd June 2025. The final report was sent to commissioners on 5th June 2025 prior to ratification by NW Clinical Senate Council. This was done by exception following Chair's action to assist commissioners and avoid unnecessary delays in progressing work. At the time of writing, the report is scheduled to go for formal ratification by NW Clinical Senate Council on 8th July 2025.

3. Discussion

The sub-sections below contain summary panel advice in line with the review objectives. These are based on the panel's discussions and deliberations. They are not intended to capture the totality of the conversations.

Objective 1: Which of the two options most closely aligns with best practice as set out in national and other evidence-based guidance (i.e. resume a level 3 service or retain a level 1 and 2 service) to ensure the provision of a safe and sustainable service at FGH?
The panel fully agreed with the Commissioners that due to the demonstrated cumulative and historic issues encountered in maintaining a safe and sustainable designated level 3 unit (ICU) onsite at FGH, any proposal to resume the original level 3 service model to maintain an intensive care unit (ICU) at the hospital, without service change, would not, in the immediate, medium or long-term future achieve a safe and sustainable critical care service for the local population. However Intensive Care Society Guidelines for the Provision of Intensive Care Service (GPICS) (v2.1 2022) guidance highlights that sustaining a critical care service at level 1 and 2 without level 3 patients on site creates difficulty in attracting consultants in Intensive Care Medicine (ICM). This is fundamentally the issue for FGH which led to the closure of the ICU in October 2024. The panel advised that an anticipated impact of not regularly having patients with level 3 needs in sufficient numbers at FGH, will also be that providing a sustainable critical care service at level 1 and 2 supported by a consultant trained in ICM will be difficult and that the residual critical care service therefore risks not meeting the standards set out in GPICS guidance. The panel were however also in consensus that given the service profile and case-mix at FGH, and despite permanent closure of the level 3 ICU, the need to offer a service for stabilisation and transfer of patients with level 3 needs will persist at the hospital for the foreseeable future. GPICS guidance highlights that where hospitals

provide only level 2 beds accompanied by a stabilisation and transfer service for Level 3 patients, alternative models of critical care service support are needed.

The panel advise that this need must be clearly and urgently addressed through a well described interim and future service model. The panel were concerned by their discussions with FGH staff who clearly articulated the need for a service to support patients with level 3 needs but also expressed a lack of clarity about both the case for change and the present and future service model.

The panel therefore advise urgent engagement with FGH staff providing and utilising critical care services to provide clarity on the case for change, and to develop a collaborative approach to the development of an agreed and sustainable future model of care which meets the expected service standards aligned to GPICS guidance. This must set out the required workforce, infrastructure, network supports, service quality improvements and developments required to achieve long term sustainability for a level 1 and 2 critical care service which incorporates a safe and sustainable stabilisation and transfer service for patients with level 3 needs.

To mitigate ongoing staff uncertainty and reduce risk of further staff attrition in critical care and interdependent services, the panel advise that FGH staff more widely must be fully sighted on the approach to planning and implementation of a new critical care service model at the hospital together with realistic implementation timescales.

The panel were in consensus that neither of the current options for critical care services at FGH clearly describes the future service model which would be required to meet best practice standards as set out in GPICS guidance. In addition, the panel advise that the retention of level 2 beds accompanied by a stabilisation and transfer service for level 3 patients will continue to create significant workforce and organisational challenges if it is to meet these national service standards for quality and sustainability.

Current GPICS (v2.1 2022) guidance for smaller remote and rural critical care units specifies that network support to critical care units in locations like FGH must be in place to ensure they meet the following standards and recommendations:

1. The critical care service must be led by consultants trained in Intensive Care Medicine (ICM)
2. There must be always access to appropriate advice from a consultant in ICM
3. Dedicated daytime critical care must be provided by a consultant trained in ICM with no other commitments
4. There must be a doctor or Advanced Critical Care Practitioner (ACCP) with advanced airway skills resident within the hospital 24/7
5. There must be a 24/7 dedicated resident clinician on the critical care unit.
6. There must be structured handover between daytime and night-time staff supported by standardised policies for practice
7. Appropriate continuing professional development (CPD) must be supported by the employer and undertaken by all professionals who deliver intensive care.
8. Regional transport arrangements (road and air) must be put in place to allow timely, safe transfer of patients with an appropriate level of monitoring, staffing, and skills.

The panel advise that a supportive network structure incorporating the present and future critical care service at level 1 and 2 is essential for staff to feel confident in dealing with a deteriorating patient. It is imperative that remote and rural level 2 units should have immediate access to telephone or telemedicine advice from clinical professionals in a level 3 unit or retrieval service over secure means of communication, always (i.e. 24/7) providing advice and support from accredited specialists in ICM.

The panel were in consensus that the proposed approach to maintain a designated level 3 unit at Royal Lancaster Infirmary (RLI) is best placed to achieve this. However the panel also agreed that there is an urgent need for staff at both sites to understand the envisioned future service model, and for programme management and organisational development support to enable teams on both sites to work

collaboratively to ensure that the necessary infrastructure and sustainable workforce with appropriate expertise, skills and capabilities is in place to ensure patients with level 3 needs are safely and appropriately stabilised and transferred to RLI.

Summary

The panel supported the commissioner and provider conclusions that a level 3 ICU cannot be maintained in its current form at FGH and supported the case for permanent change to maintain only a level 1 and 2 critical care service at FGH, subject to defining the new service model for stabilisation and transfer of patients with level 3 needs.

The panel fully recognised that the previous level 3 service model was fragile and could not now be expected to meet national standards due to workforce and recruitment challenges leading to ICU service cessation in September 2024. They also fully recognised the multiple different attempts by UHMBT to attract and retain sufficient ICM accredited consultant numbers over many years without success. The panel were fully supportive of trust and commissioners for putting patient safety at the forefront of their decision-making and striving to provide a safe robust level 1 and 2 service rather than to continue attempting to sustain provision of a high risk, lower quality level 3 ICU service. The panel also recognised that from the information provided there had been no additional significant patient safety concerns following cessation of the ICU service at FGH.

In their discussion with staff at FGH the panel were however concerned about the apparent lack of a staff vision for how the new service model would be achieved. Of particular concern to the panel were the strongly expressed views of clinical colleagues we spoke to who clearly wished, and appeared to be actively working towards, reinstating a level 3 ICU. This suggested to the panel a disconnect between senior leadership and clinical staff narratives about critical care services at FGH which requires urgent managerial attention.

The panel advise that through a carefully redesigned service model and implementation programme working towards GPICS standards there are many

opportunities to mitigate the known risks to sustaining a critical care service at FGH. However, the panel also advise commissioner and provider caution in assuming that maintaining a sustainable workforce to provide a level 1 and 2 service with an accompanying level 3 stabilisation and transfer service to GPICS standards would be any less challenging than previously. In deriving learning from other remote sites delivering level 1 and 2 critical care with stabilisation and transfer services for level 3 patients, the panel also draw attention to, and fully recognise the particular challenge created by local geography which was repeatedly referenced by commissioners, providers and staff, noting the road transfer distance from Barrow to Lancaster (47 miles, equivalent to at least an hour's travel and frequently longer due to the nature of the roads). This can be expected to continue to have significant impacts on patient experience, workforce deployment and care continuity. The panel advise that safe, sustainable and effective management of the transport issues highlighted by FGH staff must be a key priority in developing a new network supported care model for stabilisation and transfer of patients with level 3 needs to Lancaster.

Objective 2: If a level 3 service were to be resumed, what would commissioners and the provider need to put in place to ensure the service is safe and sustainable?
As noted in objective 1, the panel were in consensus that a level 3 ICU cannot be sustained in either the short- or longer-term future at FGH, and that a new model of care should be developed as soon as possible to provide a sustainable level 1 and 2 critical care service accompanied by a sustainable and safe stabilisation and transfer service for patients with level 3 needs to meet GPICS standards. There are numerous similar critical care models in place elsewhere that could provide a blueprint for potential service options. These include those developed by the Northern Care Alliance in Greater Manchester and between Preston and Chorley in Lancs & South Cumbria. Key elements of successful stabilisation and transfer services for level 3 patients include adequately staffed and resourced facilities led by, and with continuous direct access to, consultants trained in ICM, resident ACCPs 24/7 with advanced airway skills, effective handover, trained confident and competent workforce with 24/7 remote access to senior clinical expertise and

efficient network supported transportation to facilitate timely and safe patient transfer.

Summary

The panel strongly recommends that:

- Commissioners and providers work with the critical care network and establish links with other remote and rural areas delivering similar services to GPICS standards to explore the best options to create a new remote service model that works effectively between FGH and LRI
- Clinical and managerial leadership work closely with existing critical care and anaesthetic staff across both sites and with key interdependent services at FGH, including paediatrics, and accident and emergency (A&E) to develop a care model which meet the needs of their patients and services, and which mitigates the further workforce attrition (for example the loss of senior A&E clinical staff reported to the panel)
- Clinical and managerial leads at FGH urgently engage with anaesthetic colleagues who reported to the panel their attempts to construct and re-establish a level 3 ICU service contrary to Trust decisions already made, and instead to harness their passion, creativity and commitment, to developing and implementing a new critical care service model which meets GPICS standards.
- Commissioners and providers consider bringing in expert external advice and support to assist in undertaking this work, given the panel's view that the scale of the challenge to implement a new care model exceeds that which might be achievable through a purely organisational development approach.

Objective 3: If a level 3 service were not resumed, would any further mitigations need to be put in place beyond those that have been enacted since October 2024?
As noted in objectives 1 and 2, the panel strongly advise that a successful future critical care service model for level 1 and 2 patients must also be accompanied by

a safe and sustainable stabilisation and transfer service that meets GPICS standards. The panel advise that complete absence of level 3 patients and provision at FGH can be anticipated to create significant challenges in sustaining level 1 and 2 services with significant anticipated adverse impacts on other key independent clinical services at FGH including A&E, surgery, and paediatrics. The panel therefore strongly advises against the complete loss of level 3 patients at FGH on the grounds that doing so risks degradation of other key service elements at FGH for which there would be no mitigations.

Despite managerial and clinical leadership assurances that stepping down the level 3 unit ICU has led to no adverse impact on scheduled care at FGH, operational management at RLI and prehospital pathways between the two, the panel has heard a very different view of impacts at FGH from conversations with some of the workforce, including A&E staff, surgeons, anaesthetists, nursing and AHP staff who expressed a number of concerns. These included losing care continuity for some patients, perceived adverse care experience impacts on some patients, professional concerns about de-skilling, wider workforce attrition, and training. While there have been no direct impacts on formal training identified at deanery or undergraduate level, staff reported an impact to alternative routes of specialist training such as colleagues who seek accreditation using the Certificate of Eligibility for Specialist Registration (CESR) route.

The panel accept that these views may not be supported by commissioners, Trust leadership data and key service outcome metrics, but nonetheless were concerned about the apparent narrative disconnect between clinical and managerial leadership and the wider FGH workforce that needs to be urgently addressed to ensure a new service model can be implemented with full workforce understanding and support.

The panel noted concerns about organisational culture in evidence submitted to the senate review and recommend that if the apparent narrative disconnect between commissioner and trust leadership and workforce is evidence of persistent organisational cultural issues, then these require urgent attention.

The panel noted that patients are transferred from FGH to RLI using the L&SC Critical Care Network vehicle wherever possible and if this vehicle is not available, then an emergency ambulance is used. The panel strongly recommend that access to this vehicle is sustained whenever possible both to ensure safe and timely movement of patients who require level 3 stabilisation and transfer particularly given the challenging geography as previously described between Barrow and Lancaster (47 miles and at least an hour's travel but usually longer). This should maximise positive outcomes for patients but also provide the best possible experience for patients, families, and staff.

Summary

The panel recommends that a new critical care level 1 and 2 service model at FGH must also fully meet the ongoing needs of level 3 patients for in situ stabilisation prior to safe and timely transfer in line to meet GPICs standards. In addition, the panel recommends immediate leadership engagement with FGH and RLI workforce to develop the new service model and to understand how this can optimally maintain care continuity. In this, the panel also recommends rapidly addressing the apparent narrative disconnect between leadership and workforce.

Objective 4: For the available options, have all key service interdependencies been robustly considered?
As noted at objective 3, the panel were concerned that not all the key service interdependencies and pathways at FGH have been robustly considered and engaged with when communicating the rationale for ceasing a level 3 ICU or in the context of engaging with the FGH workforce in developing a new critical care service model comprising level 1and 2 care and a stabilisation and transfer service for level 3 patients. They heard clear ongoing workforce concerns from a number of services including surgery, paediatrics, and A&E regarding their ability to provide safe services in the absence of a level 3 ICU. The panel also heard details of individual cases where staff perceived there were adverse care experiences for some patients with level 3 needs who were transferred to LRI but who could have

been better served by effective stabilisation and care level de-escalation enabling them to complete their care pathway at FGH without loss of continuity.

The panel were pleased but concerned to hear the patient and family voice in case examples from nursing staff who described instances of distressed patients and family when a patient must be transferred to RLI with the potential for longer-term adverse psychological impacts. In contrast staff also spoke positively about repatriation pathways back to FGH which were described as timely and efficient when patients were ready to step down from level 3 care at RLI.

During the review the panel were unclear whether commissioners or the Trust had fully considered the need for timely and responsive radiology diagnostic pathways to enable safe and appropriate assessment of patients with level 3 needs requiring stabilisation and transfer to RLI.

The panel were also unclear what consideration had been given to incorporating and developing sustainable critical care outreach services at FGH into a new care model based around an onsite level 1and 2 service incorporating a stabilisation and transfer service for patients with level 3 needs which meets GPICS standards.

The panel also identified in leadership and workforce discussions, concerns about maintaining nursing, medical and AHP staff training opportunities at FGH through exposure to level 3 critical care service delivery and that this may require spending time at RLI. The panel heard from nursing staff their concerns about losing level 3 competencies if not working with level 3 patients in the context of a service which must meet national standards. Consideration should be given as to how colleagues who want to retain these competencies are supported to do so, for example by working in rotation across the RLI unit.

Summary

The panel recommend that in developing a new critical care model at FGH, careful consideration be given to all interdependent services including diagnostic pathways, that clear service pathways for escalation and de-escalation are

developed and communicated and that processes are developed to maintain critical skills, capabilities and competencies among all workforce who require them across both FGH and RLI sites.

Objective 5: How do the options fit with the wider strategic alignment and direction of travel of the ICS?

The panel were not aware that there have been conversations across the wider Integrated Care System in terms of wider strategic alignment and direction of travel, for example with Lancashire Teaching Hospitals. Clearly there is close working with RLI, and this should be maintained and strengthened so that the two hospitals can provide a coherent, sustainable and high-quality critical care service to meet GPICS standards across both sites.

The panel were pleased to hear from executive colleagues that there have been no adverse outcomes to the 30 patients who have been transferred over the last six months (10 of whom would have been transferred even if there had been a level 3 unit at FGH due to their individual presentations and clinical needs) and no need to transfer patients beyond RLI.

The panel noted that commissioners and providers are well aware of concerns amongst the public and politicians if the level 3 unit (ICU) is not reinstated.

Despite these concerns the panel unanimously agreed that the decision to cease the level 3 ICU service at FGH was clinically correct and entirely focused on patient safety and service sustainability.

Furthermore, the panel recommends that a compelling, considered, and well-developed narrative must be prepared to assure concerned parties that patients requiring immediate level 3 critical care will continue to receive it at FGH through a future service model which meets GPICS standards. This should also describe how the previous provision could not meet these standards and was therefore not safe. The panel were struck by the powerful statement from one of the UHMBT

Executive team that *“it wasn’t what we would want for our friends and family so it’s not what we want for the public”*

The panel noted that the population of Barrow is predicted to rise significantly in the coming years due, in part, to the expansion at the BAE Systems plc site, but also that the predicted demographic changes are not amongst groups who are generally considered high users of level 3 critical care service (ICU) provision. It was noted that population modelling for future ICU demand shows a very small increase in need equivalent to considerably less than one bed which could be absorbed by an effective new critical care service model incorporating a level 3 stabilisation and transfer service.

The panel noted concerns have been raised that nature of business at BAE Systems plc means there is an increased need for a local ICU at Barrow. However, the panel were in consensus agreement with the commissioners’ conclusion that any such need would most likely arise from a major trauma incident, in which case patients would be taken to Preston or beyond, or from a nuclear incident, in which case critical care services at FGH would be unlikely to provide a viable operational response.

4. Conclusions

4.1 The panel were in consensus that a level 3 critical care service response to stabilise prior to transfer will always be required at FGH. The panel were supportive of the critical care service at FGH continuing to provide level 1 and 2 care accompanied by a stabilisation and transfer service to meet GPICS standards for patients with level 3 care needs at FGH in a networked model providing a level 3 ICU unit at RLI. This needs to be implemented as soon as possible.

4.2 The panel heard two contrasting perspectives from commissioners and trust managerial leadership (who do not support reinstatement of a level 3 ICU at FGH), and clinical and medical colleagues (who believe that it should be and appear to be actively working towards achieving this). The panel are in consensus that the optimum solution is to maintain a level 1 and 2 critical care service at FGH accompanied by a stabilisation and transfer service for patients with level 3 needs all of which must meet GPICS care standards.

4.3 The panel are in consensus that commissioners and providers must work closely together at pace, and in collaboration with staff at FGH and RLI to rapidly develop a network supported sustainable future critical care service model which meets GPICS standards

4.4 The provider should urgently engage with its workforce to set out the vision for future level 3 service delivery and develop options for the new network supported critical care model at FGH comprising level 1 and 2 care in situ and a stabilisation and transfer service for patients with level 3 care needs all of which meets GPICS standards.

4.5 Commissioners are advised to work with the L&SC Critical Care Network to explore how a level 3 stabilisation and transfer service that meets GPICS standards can be best provided at FGH. They should also engage with other

remote critical care services and expertise to identify how this can best be achieved for Barrow.

4.6 Where the future level 3 stabilisation and transfer service needs to move patients to RLI, the potentially adverse impacts on patients, families and staff experience must be recognised and addressed from the outset and mitigated wherever possible. Maintained access to the L&SC Critical Care vehicle for transfers, wherever possible, is vital to ensuring both positive patient outcomes and care experience for all concerned.

4.7 The panel are confident that the clinical workforce passion and enthusiasm combined with a shared vision, external advice and support incorporating the outputs of shared learning derived from effective models of care in other similar areas, and the input of the Critical Care Network will enable FGH to maintain a safe and sustainable level 1 and 2 designated critical care service accompanied by a stabilisation and transfer service for patients with level 3 needs delivered to GPICS standards.

4.8 The clinical advice and recommendations within this summary report are given in good faith and with the intention of supporting colleagues to provide the best possible services to the populations that they serve. The Senate wishes to extend an ongoing offer of continued support, guidance and advice should this be needed.

Appendices

Appendix 1: Review Terms of Reference

1. STAKEHOLDERS

Title: Critical care service provision at Furness General Hospital

Sponsoring Commissioning Organisation: Lancashire & South Cumbria (L&SC) Integrated Care Board (ICB)

Lead Clinical Senate: NW Clinical Senate

Terms of reference agreed by:

- Prof Martin Vernon (Chair, NW Clinical Senate)
- Caroline Baines (Senior Senate Manager)
- Craig Harris (COO and Director of Commissioning, L&SC ICB)
- Dr Andy Curran (Interim Medical Director, L&SC ICB)

Date: March 2025

Panel Chair: Prof Martin Vernon, Chair, NW Clinical Senate

Clinical Senate Review Team Members:

- Dr Sara Barton (Consultant Acute Physician, Tameside General Hospital)
- Kelly Bishop (Assistant Director Nursing and Urgent Care, Midlands & Lancs CSU)
- Dr Irfan Chaudry (Critical Care Consultant, Lancs Teaching Hospital and NW GIRFT Ambassador)
- Sally Fray (Consultant Nurse for Critical Care, Lancs Teaching Hospital)
- Dr Martin Hogg (Consultant Clinical Oncologist, Lancs Teaching Hospitals)

2. QUESTION & METHODOLOGY

Aim of the review:

To undertake an independent critical friend clinical review of options for the future delivery of a safe and sustainable critical care service at Furness General Hospital.

Objectives of the review:

1) Which of the two options most closely aligns with best practice as set out in national and other evidence-based guidance (i.e. resume a level 3 service or retain and level 1 and 2 service) to ensure the provision of a safe and sustainable service at FGH?

2) If a level 3 service were to be resumed, what would commissioners and the provider need to put in place to ensure the service is safe and sustainable?
3) If a level 3 service were not resumed, would any further mitigations need to be put in place beyond those that have been enacted since October 2024?
4) For the available options, have all key service interdependencies been robustly considered?
5) How do the options fit with the wider strategic alignment and direction of travel of the ICS?

Scope of the review:

In Scope:

- Critical care service at FGH

Out of Scope:

- Other services at FGH other than those with key interdependency with critical care
- Primary and community care services

Outline methodology:

The review will be conducted as a desktop review and include conversations with key clinical and managerial colleagues from L&SC ICB and UHMBT.

3. KEY PROCESS AND MILESTONES

Milestone	Timescale
Request for review (Chair's approval)	31/3/25
Agree final terms of reference	31/3/25
Any documentation for review submitted by commissioner and distributed to review panel	31/3/25
Review panel initial meeting and requests for clarification and/or further information sent to commissioners	w.b.7/4/25
Further information received from commissioner and distributed to review panel	w.b. 14/4/25

Milestone	Timescale
Review panel	23/4/25
Full report 1st draft sent to panel for checks	28/4/25
Panel submit final edits for submission	14/5/25
Final draft sent to commissioners for accuracy checks	16/5/25
Feedback on accuracy of report from commissioners	2/6/25
Final draft report completed	3/6/25
Ratification of final report by Clinical Senate Council	Council meeting 8/7/25
Final report provided by Senate to commissioner	9/7/25

4. REPORT HANDLING

A draft clinical senate report will be made to the sponsoring organisation for fact checking w.b. 19/5/25. Comments/corrections from Commissioners to be received by the senate by w.b. 2/6/25. The final report will be submitted by the Clinical Senate to the sponsoring organisation by 9/7/25 assuming the Clinical Senate Council ratifies it. The clinical advice and recommendations within the reports will be given in good faith and with the intention of supporting commissioners. The reports will be presented with the offer of continued assistance should it be needed.

5. COMMUNICATION AND MEDIA HANDLING

The Clinical Senate aims to be open and transparent in the work that it does. The Clinical Senate would request that the sponsoring commissioning organisation publish any clinical advice and recommendations made.

All media enquiries will be handled by the sponsoring organisation. Craig Harris will be the named lead, on behalf of the Sponsoring Commissioner.

The detailed arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation.

6. RESOURCES

The clinical senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

7. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the North Region Clinical Senates accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring commissioning organisation.

The sponsoring commissioning organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

8. FUNCTIONS, RESPONSIBILITIES & ROLES

The sponsoring organisation will:

1. Provide the clinical review panel relevant information, this may include: the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance, service specifications. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional, and local strategies and guidance (e.g. NHS Constitution and outcomes

framework, Joint Strategic Needs Assessments, and commissioning intentions). The sponsoring organisation will provide any other additional background information requested by the clinical review team.
2. Respond within the agreed timescale to the draft report on matter of factual inaccuracy.
3. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
4. Submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical senate council and the sponsoring organisation will:

1. Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.
2. Appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
3. Advise on and endorse the terms of reference, timetable, and methodology for the review.
4. Consider the review recommendations and report (and may wish to make further recommendations).
5. Provide suitable support to the team and
6. Submit the final report to the sponsoring organisation.

Clinical review team will:

1. Undertake its review in line with the methodology agreed in the terms of reference.
2. Follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
3. Submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
4. Publish lists of documents we are provided with, those which we request that are unavailable and those not provided to the review team.

5. Keep accurate notes of meetings.

Clinical review team members will undertake to:

1. Commit fully to the review and attend all briefings, meetings, interviews, panels, etc that are part of the review (as defined in methodology).
2. Contribute fully to the process and review report.
3. Ensure that the report accurately represents the consensus of opinion of the clinical review team.
4. Comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare any potential conflicts, to the chair or lead member of the review panel.

Appendix 2: Review programme 23rd April 2025

Venue: MS Teams

Time	Item	Lead / attendees
2.00pm-2.10pm	Welcome and intros	MV
2.10pm-3.00pm	Introductory presentation from commissioners and provider execs: What is the ask of the panel? What are the challenges / issues faced by the service? Followed by discussion	Andy Curran / Craig Harris / Jane McNicholas / Scott McLean
3.00pm-3.30pm	Conversations with medical workforce	Medics from CC / other relevant areas
3.30pm-4.00pm	Conversations with wider workforce	Nursing / AHPs / etc from CC / other relevant areas
4.00pm-4.15pm	COMFORT BREAK	
4.15pm-4.45pm	Conversation with CC Network	Senior managerial and clinical lead(s) from L&SC CC Network
4.45pm-5.45pm	Panel discussion	Panel only
5.45pm-6.00pm	Feedback to commissioners / providers	All