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NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

# The future of Level 3 ICU services at Furness General Hospital

## Case for change

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## CONTENTS

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## CONTEXT / BACKGROUND

The Trust and the Critical Care Network have been raising concerns regarding the sustainability of medical staffing in the Intensive Care Unit (ICU) (also called critical care) at Furness General Hospital (FGH) for several years and have worked together closely to try to recruit new colleagues and retain those that do work within the unit. Unfortunately, this has been largely unsuccessful.

The situation became fundamentally unsafe in September 2024 when medical staffing within the unit fell to only three permanent Consultants out of eight funded posts. This led to rota gaps for sufficiently qualified doctors becoming increasingly frequent - often resulting in having to find ad-hoc overnight cover for that day by asking colleagues to work additional shifts, cancel annual leave or travel from another site. This severely affected the ability to provide safe and sustainable services. Therefore, a decision was made to temporarily suspend Level 3 (L3) services at FGH and operate a Treat and Transfer model with patients requiring ongoing L3 care being transferred to the Royal Lancaster Infirmary (RLI).

The decision to recommend the making of the temporary suspension of ongoing Level 3 ICU care at FGH permanent, is made on the grounds of safety. The primary driver, and the main issue is that national guidance says that to provide a safe and sustainable L3 service, requires a minimum of eight substantive consultants specialised in Intensive Care Medicine. At the time of the temporary suspension, the FGH ICU service had three in post, and despite multiple recruitment drives, it has not been possible to increase this on a permanent basis.

It is also important to note that even if there was a full rota, the number of L3 patients through FGH has been falling over successive years and created an increasing challenge to maintain clinical competence. It also impacts on the ability of the Trust to recruit and retain clinical colleagues to run the ICU to the required standard. Clinical units with lower patient volumes attract fewer colleagues due to perceptions of reduced workload, fewer career progression opportunities given the lack of experience and exposure to diverse cases, risks around skill erosion where colleagues may feel they are less able to maintain and enhance their skills as frequently as in a high-volume unit, and potentially lower overall impact on patient outcomes. These factors can make such units less appealing to healthcare professionals seeking challenging and impactful roles.

The safety of adult critical care transfers is evidenced both through data collected since the temporary suspension was put in place and national/international data where transfers are significantly longer than the 47 miles between Barrow and Lancaster. It's also important to note that being transferred to the RLI has not negatively impacted on patient outcomes to date.

The priority is to ensure the people of Barrow have the safest and best possible care available This is why the proposal is to operate a Level 3 'stabilise and transfer' service model with maintenance of a Level 1 (L1) and Level 2 (L2) ICU service at FGH.

In the absence of a sustainable ongoing L3 service, this proposed model has also been recommended by the North West Clinical Senate in their recent review, and by the Lancashire and South Cumbria Critical Care Network, who have advised that this model is both safe and pragmatic. Patients requiring L3 care are still expertly stabilised and are then safely transferred to a unit more able to deal with the ongoing needs of patients with multiple organ failure.

## EVIDENCE FROM THE NORTH WEST CLINICAL SENATE

Following the temporary suspension of L3 services at FGH in September 2024, the Lancashire and South Cumbria Integrated Care Board (ICB) commissioned an independent review by the NHS North West Clinical Senate to look at the safety and sustainability of the critical service at FGH going forward.

It was chaired by Professor Martin Vernon, with a panel of expert clinicians who reviewed the clinical evidence and considered presentations and submissions from clinicians, managers and commissioners.

The Clinical Senate review panel agreed with the ICB that due to the demonstrated cumulative and historic issues encountered in maintaining a safe and sustainable designated L3 unit onsite at FGH, any proposal to resume the original L3 service model to maintain an 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.

The NW Clinical Senate further added, however, that GPICS (v2.1 2022) guidance (Appendix E) highlights that sustaining a critical care service at L1 and L2 without L3 patients on site creates difficulty in attracting consultants in Intensive Care Medicine

(ICM). This is fundamentally the issue for FGH which led to the temporary suspension of L3 services in September 2024.

In line with current GPICS guidance for smaller remote and rural critical care units, the NW Clinical Senate recommended that:

1. The FGH service must be led by Consultants trained in intensive care medicine which necessitates close working relationships with the service at the RLI and the Lancashire and South Cumbria Critical Care Network
2. There must be always access to appropriate advice from a consultant in intensive care medicine available to colleagues at FGH
3. Dedicated daytime critical care at FGH must be provided by a consultant trained in intensive care medicine with no other commitments beyond critical care at FGH
4. There must be a doctor or Advanced Critical Care Practitioner (ACCP) with advanced airway skills resident within FGH 24/7
5. There must be a 24/7 dedicated clinician with critical care skills resident on the FGH unit
6. There must be structured critical care handover between daytime and night-time colleagues supported by standardised policies for practice within FGH
7. Appropriate continuing professional development (CPD) for critical care colleagues at FGH must be supported by UHMBT and undertaken for all professionals who deliver intensive care which requires close working between critical care services at FGH, RLI and across the L&SC Critical Care Network
8. Regional transport arrangements (road and air) must be put in place to allow timely, safe transfer of patients between FGH and the RLI with an appropriate level of monitoring, staffing, and skills

The NW Clinical Senate therefore advise that a supportive network structure incorporating the present and future FGH ICU service at L1 and L2 is essential for colleagues to feel confident in dealing with a deteriorating patient. It is imperative that they should have immediate access to telephone or telemedicine advice from clinical professionals in a L3 unit (i.e. the RLI) or retrieval service over secure means of communication, always (i.e. 24/7) providing advice and support from accredited specialists in intensive care medicine.

## EVIDENCE FROM THE LANCASHIRE AND SOUTH CUMBRIA CRITICAL CARE NETWORK

The Trust and commissioners further consulted with the Lancashire and South Cumbria Critical Care Network. The Critical Care Network was established in 2013. It is established with the aim of ensuring that patient requiring critical care receives safe and effective high-quality care.

In May 2025, the Critical Care Network gave a presentation to the Trust and the ICB which stated:

- FGH has faced over a decade of challenges in sustaining an Intensive Care Consultant workforce
- Current model: stabilisation and transfer of L3 patients to the RLI is safe, effective, and sustainable

- There is no evidence of patient harm from transfers; RLI has sufficient capacity

The Critical Care Network has highlighted that the ICU at FGH has significant staffing challenges:

- FGH lacks 24/7 Intensive Care Consultant coverage
- Heavy reliance on locums, bank, and additional duty sessions
- Consultants not consistently on specialist register or with required credentials
- Out-of-hours support remains limited on the FGH site

Historically, there has been a declining trend in advanced respiratory support cases at FGH. For example, from 1 April 2023 to 31 March 2024, 2.3 L3 patients were seen per week and from 1 April 2024 and 30 September 2024 this was 2.0 L3 patients per week. FGH has a lower L3 activity compared to similar units in other hospitals.

With such a low volume of patients, this has implications for colleague competencies. The more patients that clinicians review and treat, the more effective they are. This is evident in many evidence-based reviews and is particularly evident in critical care.

The Critical Care Network reviewed FGH ICU against the critical care standards, Guidelines for the Provision of Intensive Care Services (Appendix E), known as GPICS V2.1 (and V3 currently in draft) in relation to medical staffing and the NHSE Adult Critical Care Service Specification. It fails to meet many of these standards and specifications. It faces ongoing challenges with consultant presence, resident ratios, and 24/7 availability. In addition, it has faced challenges with out of hours cover, particularly the lack of a dedicated consultant with two Programmed Activities (PAs) in acute intensive care medicine (GPICSv3).

To enable any wider provision of L3 care at the FGH site, there would need to be a consistent and sustained workforce across both the Intensive Care Consultant and Senior Anaesthetist on-call rotas (over a 12-24 month period), appropriate direct clinical care in all job plans and assurance that the Senior Anaesthetist on call would be available to attend the ICU within 30 mins of a call. This would need evidencing through activity data of this senior anaesthetist over a 6-12-month period as they are covering all anaesthetic responsibilities across the FGH site. In addition, to maintain skills for all colleague groups, either rotation between both sites would be necessary or there would need to be a significant and sustained increase in L3 activity at FGH. To enable wider L3 provision to be undertaken at FGH, there would also need to be a dedicated resident 24/7.

The Critical Care Network concluded in its recommendations:

- Reinstating L3 admissions is not desirable or feasible in next 12–24 months.
- Current model of stabilisation and transfer is pragmatic and safe
- Recommend L2-only unit with fixed derogation period for training
- To deliver ongoing L3 care in the future would require further sustained improvement in medical staffing and increased activity

## OPTIONS APPRAISAL AND DECISION-MAKING PROCESS

The ICB and UHMBT have undertaken an options appraisal regarding the service which is set out in the table below:

| OPTION | APPRAISAL OF OPTIONS |
|---|---|
| Reinstate Level 3 | The Clinical Senate panel supported the commissioner and provider conclusions that a L3 ICU cannot be maintained in its current form at FGH.<br><br>The panel fully recognised that the previous L3 service model was fragile and could not now be expected to meet national standards due to workforce and recruitment challenges leading to a temporary suspension of L3 services in September 2024.<br><br>They also fully recognised the multiple different attempts by UHMBT to attract and retain sufficient intensive care medicine accredited consultant numbers over many years without success. |
| Stabilise and transfer (thus removing L3 at FGH)<br><br>**Recommended option** | The Clinical Senate panel supported the case for permanent change to maintain only a L1 and L2 critical care service at FGH, subject to defining the new service model for stabilisation and transfer of patients with L3 needs.<br><br>The panel were fully supportive of the Trust and commissioners for putting patient safety at the forefront of their decision-making and striving to provide a safe robust and L1 and L2 service rather than to continue attempting to sustain provision of a high risk, lower quality L3 service.<br><br>The panel also recognised that from the information provided there had been no additional significant patient safety concerns following the temporary cessation of the L3 ICU service at FGH.<br><br>The Trust continues to encourage RLI Consultants to work at FGH and the team at the RLI has recently agreed to work at FGH regularly to allow for more collaborative working and skill-sharing. |
| Proactively target recruitment to address the workforce gaps / challenges at FGH | UHMBT has evidenced multiple different attempts to attract and retain sufficient intensive care medicine accredited consultant numbers over many years without success. |
| Implement a rotational workforce approach across UHMBT | Requiring RLI colleagues to temporarily or permanently change their working base to FGH would require formal consultation and there has been limited desire from medical and nursing colleagues to move to FGH. |

| | |
|---|---|
| rather than by hospital location | There is also the risk that it would destabilise recruitment and retention at both sites - causing unacceptable patient safety risks for people across Morecambe Bay. This is a view shared by the Critical Care Network. |
| Cease Level 3 services at RLI and retain L3 at FGH | Ceasing L3 services at the RLI rather than FGH was considered but this was not deemed a viable option for several reasons:<br>• The RLI unit meets Guidance for the Provision of Intensive Care Services (GPICS) requirements in terms of senior and resident medical staffing<br>• The RLI unit is a training unit for the North West Deanery<br>• Requiring RLI colleagues to temporarily or permanently change their working base to FGH would require formal consultation and there has been limited desire from medical and nursing colleagues to move to FGH<br>• The numbers of patients requiring L3 care is higher at the RLI than it is at FGH. In 2023/24, the ICNARC data shows that there were:<br>o FGH: 395 ICU admissions in total. 148 of these were L3 - 124 of whom were ventilated<br>o RLI: 553 ICU admissions in total. 205 of these were L3 - 172 of whom were ventilated<br>• Between 24 September 2024 and 30 November 2025, there were 60 Level 3 ICU transfers to RLI from FGH<br>• Permanently moving L3 services to FGH would mean more patients have to travel to receive the urgent care they need<br>• There is also the risk that it would destabilise recruitment and retention at both sites - causing unacceptable patient safety risks for people across Morecambe Bay. This is a view shared by the Critical Care Network. |

## IMPLEMENTATION AND SERVICE MODEL PLANNING

It is important to note that other 'time critical' services at FGH like paediatric intensive care, neurosurgery and managing patients post stroke and heart attack have operated on a stabilise and transfer model for many years. With all these models, there have been very few issues relating to transfers, and the transfer process ensures patients receive urgent access to the specialist care they need 24 hours a day, seven days a week.

Moving critically ill adults to is accepted nationally as safe practice, with NHS England developing an Adult Critical Care Transfer services (ACCTS) service specification in 2021.

### Standard Operating Procedure

An Interim Standard Operating Procedure (SOP) titled 'Treat and Transfer of Critically Ill Patients' was developed in conjunction with the Lancashire and South Cumbria Critical Care Network when the service was temporarily suspended in September 2024. We have enclosed a copy of the SOP with this Case for Change.

This outlines the current stabilisation and transfer protocols, along with referral guidance. Any breaches of guidelines have been reported through the Trust clinical incident reporting system.

Following the announcement of the intention to make the temporary change permanent and the recommendations from the Clinical Senate and Critical Care Network on how to strengthen the process, the SOP is in the process of being reviewed with colleagues within the ICU team, leads from interdependent services, the Critical Care Network, the Clinical Senate and North West Ambulance Service NHS Trust (NWAS). The Trust's Clinical Lead for Critical Care is also part of a national group of critical care leads and a subgroup of leads involved in the reconfiguration of ICU services, and this work is supporting the review to ensure that it is safe, evidence based and in line with best practice.

Once the review is complete, the updated SOP will proceed through the usual Trust procedural document scrutiny and approval process and will be shared with all relevant teams and published on the Trust's Procedural Document Library when it is approved.

### Admissions data

Intensive Care National Audit and Research Centre (ICNARC) data is the most robust data available and is subject to national scrutiny. In terms of annual admission rates to the ICUs at FGH and the RLI, we are using 2023/24 data as this is the most representative timeframe as it predates the interim measures. In 2023/24, the ICNARC data shows there were:

- FGH: 395 ICU admissions in total. 148 of these were L3 - 124 of whom were ventilated
- RLI: 553 ICU admissions in total. 205 of these were L3 - 172 of whom were ventilated

Between 24 September 2024 and 30 November 2025, there were 60 L3 ICU transfers from FGH - mainly to the RLI. In the same period, there were 265 ventilated L3 patients at the RLI (including those transferred from FGH to the RLI).

As soon as patients can step down from L3 care, they are returned safely to FGH for their ongoing care.

### Medical recruitment / staffing

Due to the geographical location and longer distances from major cities, recruitment to specialist roles such as ICU Consultants is challenging for many trusts in Lancashire and South Cumbria.

Since 2014, the Trust has advertised for consultant or specialist anaesthetic posts covering the ICU department at FGH on 19 separate occasions and have tried a variety of methods, including engaging recruitment specialists and advertising in specialist medical journals such as the British Medical Journal (BMJ). The adverts have included posts covering FGH only, and joint posts covering the entire Trust to encourage rotation and attract more applicants.

Over the years, the Trust has also explored other options, such as:

- Attending national conferences such as the national Acute and General Medicine conference to attract new recruits. The costs to attend these events were significant and whilst they led to some interest in positions at FGH, none of this interest progressed to applications for vacancies
- Approving and investing in new staffing models
- Explored the potential to offer up to £30,000 as an incentive per Consultant on recruitment - in line with the NHS' Financial Incentives Framework. This was not taken forward as the evidence from other Trusts in the region and across the country was that the offer didn't help to attract any new candidates, and in fact, only served to destabilise current services
- Paying significant finders' fees to recruitment agencies to source locum Consultants and specialists to support the rotas
- Using external organisations to provide anaesthetic support to Theatre lists where appropriate to free up Trust clinicians to support the on-call rota
- Attempts to partner with organisations to create 'grow your own' programmes to develop more junior colleagues but this was not progressed due to the complex and differing needs of FGH in its geographical location
- Requesting mutual aid from local providers but this has not been possible due to pressures within their own services

Whilst the temporary suspension of L3 services has been in place, the Trust has continued to try to recruit to the vacant posts with targeted recruitment strategies by the medical workforce team and support from specialist recruitment agencies (incurring introductory fee costs of over £45,000).

Between September 2024 and September 2025, 17 potential candidates have been put forward as part of this work, but the majority were not suitable at Consultant or Specialist level to work autonomously. However, one Specialist doctor and two Locum Consultants in ICU were recruited on temporary contracts.

This enabled the implementation of a new working rota for medical staff in the ICU at FGH which has been in place since 5 May 2025:

- ICU daytime cover (8am - 6pm): Management of patients on the ICU is directed by a consultant, locum consultant or specialist in ICU. There are five doctors on this rota
- ICU out-of-hours cover (6pm - 8am): The ICU is covered by a Senior Anaesthetist, who also provides senior cover for obstetrics and anaesthetics. This is an eight-person non-resident rota, which is currently staffed by five senior doctors, along with locum doctors and extra duty shifts
- Anaesthetics daytime cover (8am - 6pm): A Senior Anaesthetist provides cover for anaesthetics, obstetrics and emergency calls from other acute areas of the hospital
- Resident On-Call Doctors: Two senior/middle-grade resident doctors are on duty at all times - one primarily covering ICU and anaesthetics and the other covering Obstetrics, with flexibility to interchange based on clinical needs. Transfer of L3 patients is carried out by this tier of doctors, along with an ICU nurse who is appropriately trained

One substantive consultant has since resigned but the Trust has recently successfully appointed a new CCT Consultant Anaesthetist who is due to commence work at FGH in March 2026.

Despite all these efforts and recent recruitment successes, the rota remains significantly unfilled meaning it is not possible to safely deliver a L3 service 24 hours a day, seven days a week.

A small number of colleagues and stakeholders have asked about exploring the use of ‘experienced specialists’, such as senior anaesthetists, to fill gaps on the Consultants rota.

Guidance for the Provision of Intensive Care Services (GPICS) v2.1 (2022) is the definitive reference source for planning and delivery of UK Intensive Care Services. GPICS is a collaboration between the Faculty of Intensive Care Medicine and the Intensive Care Society (ICS) and aims to improve the standards of care that critically ill patients receive and to reduce geographical variation. GPICS v3 is currently in the consultation stage and is expected to be ratified soon.

When they refer in this version of the guidance to ‘consultants in intensive care’, they also include doctors in the specialist grade - although these must have 12 years’ post graduate experience and six years’ experience in intensive care medicine with demonstrable maintenance and development of knowledge and skills. It will also recommend that they should be on the General Medical Council’s Specialist Register and be, or be eligible to be, a Fellow or Associate Fellow of the Faculty of Intensive Care Medicine.

The specialists on FGH’s ‘senior anaesthetist’ rota overnight are trained and skilled anaesthetists, but do not have specific recognised training in intensive care medicine so this would not apply to them.

This position has been confirmed with the Medical Lead for Lancashire and South Cumbria Critical Care Network who is one of the lead clinicians in the development of the revised GPICS guidance.

The real challenge for FGH is its geographical location and inability to recruit and sustain a workforce that can meet the requirements of adult critical care service specification and GPICS - despite years of trying.

### Medical training / ongoing skills development

All doctors on the Senior Anaesthetist rota require an average of one day per week working in ICU to maintain skills and meet national guidelines. Experience in managing L1 and L2 patients will continue at FGH, and doctors on this rota have been offered the opportunity to undertake regular sessions on the ICU at RLI. Consultants working in the ICU at the RLI have also agreed to provide reciprocal sessions in the daytime on FGH ICU to allow for more collaborative working and skill-sharing.

## Nurse staffing

Nurse staffing levels for ICUs are nationally set within the staffing recommendations for critical care - as identified in Guidance for the Provision of Intensive Care Services (GPICS) v2.1 (2022) and supported by all affiliated intensive care bodies.

There may be a requirement for a different nursing model if the temporary change is made permanent. This new model would align with national standards and guidelines for the agreed number of commissioned L1 and L2 beds. Within this model, there will be appropriate staffing to ensure the treat and transfer bay has the required skilled and competent nurses for the duration of the stabilisation and the transfer to a level 3 facility.

This may mean a reduction in the number of Registered Nurses and Clinical Support Workers required on the rotas within the ICU. The potential impact of this is unknown at this stage but if this is the case, the Trust's Organisation Change Policy will be followed and colleagues will be supported to find suitable roles within other areas of the hospital.

## Nursing training / ongoing skills development

It is important to note that both medical and nursing colleagues will continue to be exposed to caring for L3 patients as part of the treat and transfer model. However, as they will not be providing the ongoing L3 care they may have done previously, the Trust will ensure other processes are in place to enable them to maintain the relevant skills and experience, such as opportunities to rotate between the ICUs at FGH and the RLI and simulation training. This also provides the opportunity to train and develop less experienced nursing colleagues. Putting this approach into place for nursing colleagues would require formal colleague consultation as per the Trust's Organisational Change Policy.

There is also external training regarding critical care that will be prioritised to ensure that colleagues are able to develop skills. This will also hopefully aid recruitment and retention from a nursing perspective.

## Oversight of Treat and Transfer model

The management of the Treat and Transfer service would be overseen by the Surgery and Families Divisional Management Team, cross-bay Clinical Lead and cross-bay Matron. As a final decision about the future L3 model is yet to be made, the timelines are yet to be agreed. There may be some changes for colleagues who work within the unit and that will be implemented using the relevant Trust policy.

All critical care admissions are monitored by the NHS Directory of Services, which are updated twice daily by the nurse in charge of the ICU with weekday oversight by the Critical Care Network. Any concerns regarding appropriate location of patients are immediately escalated to the senior management team on duty, and any patient safety concerns are raised through the incident reporting system.

A cross-bay Critical Care Governance Lead is in post and rapidly reviews all patient safety incidents. Learning is escalated through divisional and Trust governance structures; and shared with the medical and senior nursing teams within the ICUs at FGH and the RLI quarterly governance meetings.

## IMPACT ON INTERDEPENDENT SERVICES

It is important to note that other 'time critical' services at FGH like paediatric intensive care, neurosurgery and managing patients post stroke and heart attack also operate on a stabilise and transfer model. With all these models, there have been very few issues relating to transfers - even in periods of bad weather or where there have been issues with roads.

The priority is to safely maintain all acute services at FGH including the Emergency Department (ED), surgery, paediatrics and diagnostics, and we are fully committed to ensuring their continued delivery. The Trust's three clinical Divisions are working closely together to ensure that any changes do not negatively impact on other services within the hospital.

Service development and recruitment strategies for the last nine months have been focused towards ensuring 24-hour availability of a senior anaesthetist, to protect the 'front door' of the hospital. Anaesthetists are highly skilled doctors who are trained in specialised interventions such as airway management, resuscitation and ventilation, as well as complex vascular access procedures, management of paediatric emergencies, and trauma patients. The medical rota that is now in place (detailed in point 2 above) provides immediately available senior anaesthetist support to resuscitate and stabilise acutely ill or deteriorating patients in any area of the hospital - including the ED, surgery, paediatrics, medicine and obstetrics.

Patients who require critical care will be admitted to the stabilisation bay within critical care at FGH. It is only those who require ongoing higher levels of care who will be subsequently transferred to RLI or elsewhere once they have been stabilised. If the decision is made to make the temporary change permanent, it will not impact on the Trust's ability to carry out any elective or emergency surgical procedures that took place at FGH previously. No routine elective procedures that require post-operative ongoing L3 care take place at FGH. If emergency surgery is required, this will continue to be carried out at FGH with the L3 Treat and Transfer model initiated if the patient requires ongoing L3 care.

In addition, since the implementation of the temporary suspension of L3 services in late September 2024, ICU nursing colleagues have been invited to work alongside the Critical Care Outreach Team at FGH. This team are on duty from 8am - 8pm every day and can identify and provide support for patients on the wards who are at risk of deterioration, implement timely management and facilitate appropriate escalation to ICU. The advantages of the Critical Care Outreach Team include:

- Improving oversight and monitoring of ward patients
- Early detection of deterioration of patients – helping to prevent them requiring a higher level of care
- Early escalation and intervention to prevent further deterioration or enable stabilisation prior to transfer to an appropriate area
- Retaining the skills of critical care nurses
- Empowering ward colleagues by providing education and support, leading to better patient care and more efficient use of critical care resources

## CONTINGENCY AND TRANSFER ARRANGEMENTS

Established transfer processes have been in place across the Trust (including FGH) and the North West for many years to transfer patients requiring specialist treatment for cardiology, cardiothoracic surgery, neurosurgery, trauma and paediatric intensive care. The Interim SOP - 'Treat and Transfer of Critically Ill Patients' - is enclosed with this report.

Adult Critical Care transfers are routine practice across many areas of the UK; and such transfers from FGH's ICU have been managed since September 2024 with no adverse events.

The unique nature of the A590 is recognised, however, it is unusual that adverse weather or other conditions precludes road transfer. As we have already stated, established and successful transfer processes have been in place for many years to transfer patients requiring specialist treatment. In the scenario that a road was not passible, a comprehensive risk assessment would be undertaken. If necessary, L3 patients can be managed for short periods in the stabilisation bay on the ICU until transfer can be safely carried out.

All patients who are transferred have a comprehensive assessment process, with documentation and review post transfer. This is a nationally mandated process. Since the temporary suspension of L3 services at FGH in September 2024, there have been no incidents of L3 patients deteriorating or having poorer outcomes because of the transfer from FGH to the RLI.

Work is underway with NWAS to monitor the impact of the increase in transfers from FGH to make sure there is no detrimental effect on ambulance response times across Lancashire and South Cumbria. Data from the temporary change will be used to allow modelling of any impact prior to any permanent change and conversations about mitigating any impact will be had with NWAS and their commissioners. This includes any increase in transfers from the site - including L3 transfers and early repatriations back to FGH from other sites.

Currently, any transfers to and from FGH are carried out by NWAS. However, the Critical Care Network is looking to procure its own transfer vehicle in the coming months, and the intention will be to use both the critical care transfer vehicle and NWAS to support transfers.

## HEALTH INEQUALITIES AND ACCESS

The ICB and the Trust understands that having a loved one transferred to another hospital - however close or far - will be difficult for families and remains committed to supporting them as much as possible.

The support required will be different for every family, so it is important that each case is assessed on an individual basis. Colleagues within the ICU and associated services are acutely aware of the difficulty for relatives when they are having to travel and will, where at all possible, accommodate their requests.

Some of the support the Trust can put into place for families of patients who have been transferred include:

- Flexibility on visiting times
- Ability to use the relatives' rooms overnight / for several days where required
- Covering the cost of public transport, including taxis where required
- As soon as patients can step down from L3, they are be returned safely to FGH for their ongoing care

This approach is a similar approach used in tertiary specialist healthcare providers and in the other services that operate similar treat and transfer models from FGH. Since the temporary suspension of L3 ICU services at FGH was put in place in September 2024, two concerns have been raised by members of the public - both in July 2025 regarding the intention to permanently cease L3 services. No concerns or formal complaints have been raised from patients that have been transferred since September 2024 or their families.

The Trust has undertaken a comprehensive Equality Impact Assessment (EIA) to evaluate how the proposed changes to critical care services at Furness General Hospital (FGH) may affect rural and deprived populations, particularly in Barrow and South Cumbria. The data shows that 35% of Level 3 ICU admissions come from the most deprived quintile, compared to 15% of the general population in the area. This indicates a significant over-representation of vulnerable communities in ICU usage. The EIA also highlights that older adults, people with disabilities, and those without access to private transport are disproportionately affected by the proposed treat-and-transfer model. These groups face increased challenges in navigating public transport, especially given the limited connectivity between Lancaster rail station and the RLI.

To address these concerns, the Trust has outlined several mitigation strategies:

- Transport support: Caregivers facing travel difficulties will be assessed individually, with support offered for public transport costs, assistance at transit points, and overnight accommodation at the ICU when needed
- Digital access: Nursing colleagues will facilitate FaceTime and other digital solutions to maintain caregiver contact, and the organisation is committed to providing data support where hardship is identified
- Continuity of care: Colleagues at FGH will maintain competencies in Level 3 care to ensure safe and effective patient transfers, supported by a critical care ambulance and SOP-driven protocols
- Colleague engagement: Measures such as positive leadership, opportunities to work at RLI, and regular communication are in place to maintain morale and strengthen inter-site relationships

These actions reflect the Trust’s commitment to minimising health inequalities and ensuring that service changes do not disproportionately burden patients and families in rural and deprived areas.

The Trust will continue to engage directly with patients and families to ensure any concerns or worries are resolved as soon as possible and any learning is taken forward to ensure the best possible service and experience.

## DEMOGRAPHIC CHANGE

Available recruitment data from BAE Systems suggests that an estimated figure of 17,500-30,000 people are likely to move to the area within the next ten years - including the additional workforce's partners and families. This has been included in various Team Barrow strategic documents and is based on estimates of the number vacancies BAE Systems anticipates will involve people relocating to Barrow and likely numbers of partners or dependents.

Whilst optimistic for the economic growth potential that this represents for Barrow, the Trust and ICB are cautious about this data as there is significant variation in the stated numbers, and there isn't a formally documented methodology for this as it's a high-level assumption and not supported by any detail to inform accurate clinical planning.

In December 2023, UHMBT was asked to rapidly develop an outline business case for estate changes in Barrow, to support the Team Barrow business case. To support this, a model on the likely population numbers was developed and included assumptions based on age profiles. To be clear, this model was developed very quickly with limited data and was specifically written to help understand which services at FGH may need capital investment in response to population growth. It suggests that the population growth is going to create pressures in primary care, community, maternity and emergency services. This would be driven by an increased demand from a younger working age population. The Clinical Senate review has indicated that the projected increases in the local population would not lead to an increase in Level 3 ICU demand.

Team Barrow has commissioned a formal set of projections. It is believed that these will be available imminently; however, this delivery date is dependent on the analytical team receiving updated data from the Office of National Statistics (ONS).

The Trust and commissioners have considered the projected population growth for Barrow but do not believe that it would impact on the demand for L3 services at FGH. This was also the view of the North West Clinical Senate panel (Appendix A) who noted that the predicted demographic changes are not amongst groups who are generally considered high users of level 3 critical care service (ICU) provision - the elderly, those with comorbidities, etc. The population growth is focused on economically active adults of a working age. Therefore, it is not believed that this would lead to an increased need for L3 services and would not make the unit any more sustainable than it currently is.

There have also been concerns about the nature of business at BAE Systems and how that leads to an increased need for a local ICU at Barrow. However, the North West Clinical Senate 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.

## ENGAGEMENT WITH STAKEHOLDERS AND COMMUNITIES

When the decision was made to temporarily suspend L3 services at FGH in September 2024 to protect the safety of patients and colleagues, the Trust shared this news across all its available internal and external communication channels. This includes direct communications with the media and key stakeholders, including NHS England, Healthwatch and the relevant Overview and Scrutiny Committees. Local MPs were also briefed in writing and verbally at the regular scheduled engagement meetings.

Four further updates were shared at the end of September 2024, November 2024, December 2024 and April 2025 to inform colleagues and stakeholders on the most recent position, including progress with the Clinical Senate Review and work with the Critical Care Network. These updates were also shared within regular stakeholder engagement sessions.

The Trust and ICB have worked together since September 2024 in reviewing and responding to concerns, questions and requests from the media, stakeholders and the public via various channels such as formal letters, media enquiries and comments on social media.

Following receipt and consideration of the independent review by the NW clinical senate and a review by the Lancashire and South Cumbria Critical Care Network, the ICB announced its intention to make the temporary suspension of ongoing L3 care at FGH permanent on the grounds of safety. Once this decision was agreed, the Trust and ICB held a joint stakeholder briefing followed by two face-to-face colleague engagement sessions on site at FGH on 15 July 2025. These sessions were followed up with written briefings to stakeholders and colleagues. The decision was then proactively announced via all available internal and external communications channels, including print, radio and broadcast media.

A specific information page has been added to the ICB's website - including latest updates and Frequently Asked Questions (FAQs) which are reviewed and updated regularly based on feedback.

### Colleague engagement

The Surgery and Families leadership team and relevant Executive Directors continue to engage directly with colleagues with the ICU service across the Trust and wider interdependent services, and relevant support is in place via Occupational Health, etc., for those that require it.

### Engagement with the Westmorland and Furness (W&F) Health Adult Scrutiny Committee (HASC)

Both the Trust and ICB have continued to engage with key stakeholders, including a strong commitment to working closely with W&F HASC and meeting with the local MP to discuss key issues and concerns.

On Wednesday 24 September 2025, colleagues from the Trust joined the ICB at a formal W&F HASC meeting in public in Barrow Town Hall. The meeting was attended by around 70 members of the public, including the local MP. The questions from the Committee were in areas such as the risks of transfer, geographical

location, the potential for RLI colleagues to move to FGH, the impact of the anticipated population growth in Barrow, reasons for the national shortage of ICU Consultants and how patients are kept safe whilst being transferred.

The ICB made the case that based on the interpretation of the legislation by both organisations, it was believed that the proposed change required a significant period of engagement but not public consultation because:

- FGH will still provide L3 care - providing immediate care and treatment of patients who need it. It is only if the patient requires ongoing L3 care, that they would be transferred to the RLI
- This treat and transfer model is used in other services at FGH and is nationally recognised as good practice and has been the model of care for many years in various other services at FGH including, paediatric, neonatal, coronary care, stroke, neurosurgery and plastic surgery
- There are a limited number of viable options to consult meaningfully on given the nature of the recruitment challenge, the low number of patients, and the clear advice and recommendations from external and internal clinical experts

Following some confusion between the Committee about whether they were recommending a full public consultation or engagement, the Committee voted and the agreed outcome was the recommendation that the ICB carries out a full public consultation and reports back to them before a final decision is made.

### Engagement with the local MP

The Trust and the ICB have maintained regular engagement with the local MP to discuss key issues and concerns.

Prior to informing colleagues about the proposal to make the temporary change permanent, the MP was invited to a briefing to ensure they was fully aware of and understood the plan.

There has been ongoing dialogue between the MP, the Trust, and the ICB, with regular engagement sessions taking place and the MP writing to both organisations formally on numerous occasions to share concerns and ask questions - all of which were responded to in detail. The MP has publicly expressed opposition to the proposal and has organised a petition, signed by approximately 12,000 individuals, which has been submitted to NHS England.

The MP’s concerns broadly align with themes raised during public engagement, including:

- Transport and travel implications
- Recruitment initiatives
- Future population modelling
- Alternative proposals for ICU provision at other sites
- Wider impact on the town and future recruitment across other sectors
- Planning for future emergencies, including pandemics

Additionally, the MP convened a public meeting during the period of ICB-led public engagement events. While NHS representatives were not present at the meeting, all questions raised were subsequently shared with the ICB and responded to in full.

## ICB-led public engagement programme

The ICB, supported by the Trust, held a series of engagement sessions across the Furness area during October 2025 in connection with the proposal to make the temporary change to the way patients receive ongoing Level 3 critical care at the hospital permanent. The sessions took place as follows:

- Wednesday 8 October in the Nan Tait Centre in Barrow-in-Furness
- Friday 10 October at Millom Community Hub
- Thursday 16 October via Microsoft Teams
- Wednesday 22 October in the Coronation Hall in Ulverston
- Thursday 30 October in the Nan Tait Centre in Barrow-in-Furness

The sessions explained the rationale behind the decision and offered the opportunity for the public to ask questions. In total, 175 members of the public attended the formal engagement sessions - out of 298 who registered to attend. Further drop-in sessions were hosted by Healthwatch during November, and 26 individuals attended these events.

Below is a summary of the issues raised:

- Recruitment initiatives - what had the Trust done to recruit suitable candidates, had they done everything they could?
- A590 and transport issues - what happens when the road is closed, are transfers safe?
- Assurance that both the Intensive Care Network and Clinical Senate are independent - concern that the Trust is part of the Intensive Care network and the senate may not be independent
- Staff rotation between units - could senior colleagues provide a joint rota to ensure both units at FGH and RLI were covered?
- Impact on families and loved ones - what support was there once a patient was transferred?
- Impact on wider recruitment and retention of skilled staff in south Cumbria - not having a L3 unit in the town may harm other recruitment to both other departments at FGH and other professions
- Future population modelling - and whether they included the possibility that people moving to the area may bring elderly relatives
- Questions around the treat and transfer model - detailed questions to assure the safety and resilience of the model
- Tone of ICB communications - concern that a decision had already been taken as the ICB were too defensive or supportive
- Concern finance had been put ahead of patient safety
- Learning from other areas - particularly Whitehaven
- How this might impact planning for future disasters or pandemics

A report from the engagement outlining the feedback has been developed and is enclosed with this Case for Change.