NHS
Lancashire and South Cumbria
Integrated Care Board

Level 3 ICU care at Furness General Hospital

Listening to communities report

December 2025

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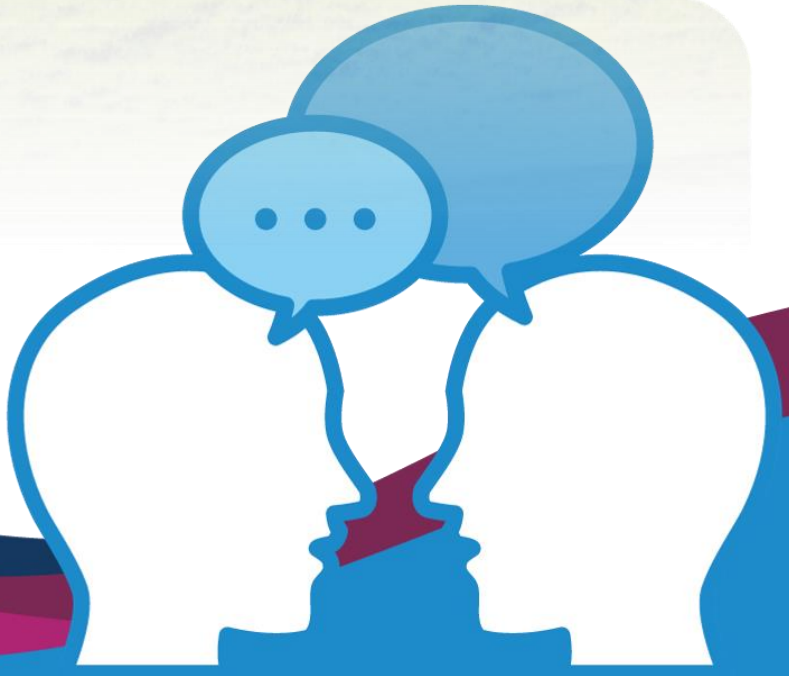

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Acknowledgements

We would like to thank Healthwatch Westmorland and Furness for hosting our drop in events and helping to promote engagement, the venues that allowed us to hold events, and everyone who took the time to engage and share their views.

Introduction

The ICB has a duty to involve patients and the public as set out in the NHS Act 2006 (as amended by The Health and Social Care Act 2012 and subsequently the Health and Care Act, 2022) which lays down duties in a wide variety of areas on NHS England and on ICBs. These include duties to improvement in quality of services, to reducing inequalities, and to public involvement and consultation.

This report documents the ICB's engagement with local communities regarding the future of Level 3 Intensive Care Unit (ICU) services at Furness General Hospital (FGH). The engagement was prompted by the temporary suspension of Level 3 ICU care at FGH in September 2024, due to longstanding staffing challenges. Since then, critically ill patients have been stabilised at FGH and transferred to the Royal Lancaster Infirmary (RLI) for Level 3 care. Independent clinical reviews in 2025 supported this interim model as the safest option.

The findings from this engagement are required to inform the pre-consultation business case (PCBC), which will guide the ICB's decision-making and contribute to the NHS England service change assurance process. This report aims to ensure that the voices of patients, staff, and the wider community are heard and addressed as part of a transparent and robust process.

Executive summary

This report presents the findings from the NHS Lancashire and South Cumbria Integrated Care Board's (ICB) engagement with local communities regarding the future of Level 3 Intensive Care Unit (ICU) services at Furness General Hospital (FGH). The engagement was prompted by the temporary suspension of Level 3 ICU care at FGH in September 2024 due to longstanding staffing challenges, with critically ill patients being stabilised locally and then transferred to the Royal Lancaster Infirmary (RLI). Independent clinical reviews in 2025 supported this interim model as the safest option.

An engagement process was undertaken between October and November 2025, including public meetings, drop-in events, direct submissions and online feedback. In addition to 13,000 signatures on a petition led by the MP for Barrow-in-Furness and 2,000 letters of objection, we received over 250 other written responses (emails, letters, social media comments) and over 400 people attended the public meetings and drop-in sessions (200 of these were attendees at Michelle Scrogham MP's public meeting). The aims were to gather feedback on the proposal, suggested alternatives to consider and issues to mitigate against, and also to help reduce misinformation on the subject.

The overwhelming majority of participants expressed strong opposition to the permanent removal of ongoing Level 3 ICU care from FGH, citing concerns about patient safety during transfers, the adequacy of local healthcare provision amid population growth, and the impact on health equity for rural and industrial communities.

Key themes raised included:

1. **Patient transfer and travel**: Deep anxiety about the safety and timeliness of transferring critically ill patients, especially given local transport challenges.
2. **Local development and Barrow Rising**: Concerns that Barrow's growing population and industrial profile require the highest level of local ICU services.
3. **Recruitment:** Worries that downgrading ICU services will worsen recruitment and retention and calls for more innovative staffing solutions.
4. **Concerns over data accuracy and transparency**: Distrust of the data used to justify the change, with calls for clearer, more accessible information and independent review of the data.
5. **Equality and accessibility**: Fears that the proposal would create a two-tier system disadvantaging rural and deprived areas.
6. **Staff concerns:** Reports of low morale and a lack of meaningful staff involvement in decision-making.
7. **Transparency, decision making and trust:** A strong desire for the ICB to show full compliance with the legal duty to involve, genuine consultation, transparent communication, and publication of impact assessments.
8. **Financial and local services:** Concerns that the closure of the Level 3 ICU is driven by financial motives rather than clinical needs, amid criticisms of spending priorities and fears around impact on other hospital services and potential further cuts.

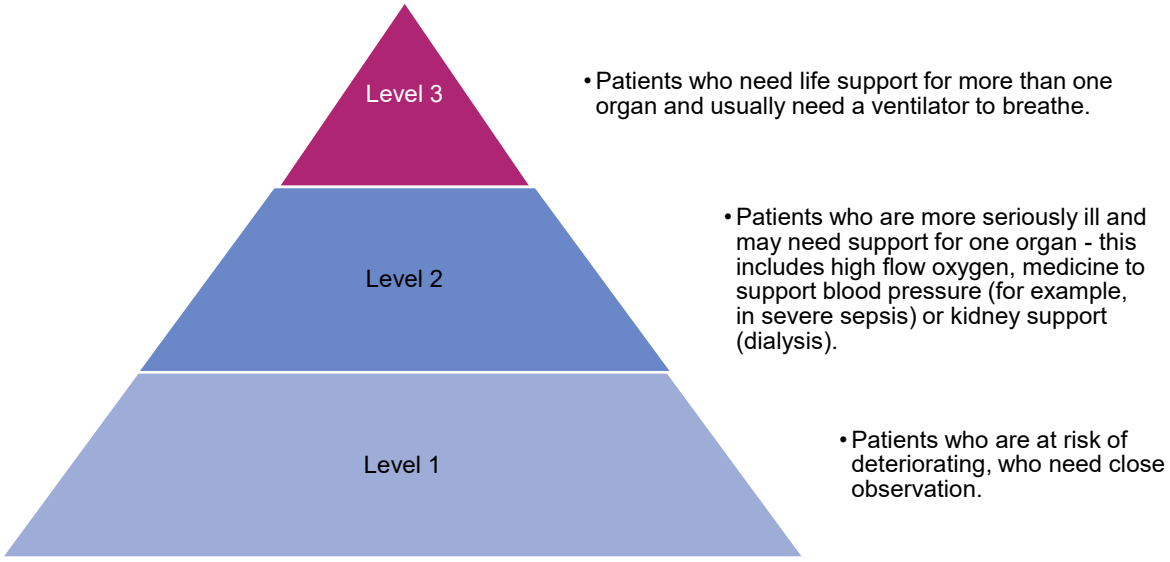
The public suggested a range of alternative solutions, including innovative recruitment, rotational posts, collaboration with local industry, establishing a tele-ICU model, and improved risk assessment and contingency planning. There was also a clear call for a full public consultation and for all options to be robustly examined and transparently communicated.

In summary, while the rationale for the proposed change is understood by some, there remains strong opposition and a lack of trust in the process. The ICB will need to ensure

robust scrutiny, transparent data analysis, and meaningful involvement of both staff and the public as the process moves towards decision-making and potential formal consultation.

The situation

Intensive/critical care (provided on an Intensive Care Unit - ICU) is classified in terms of 'levels':



At FGH, which is located in Barrow-in-Furness in South Cumbria, medical staffing in the ICU has been a concern for many years and has been identified as unsafe with just three consultants covering an eight-consultant rota. This is despite numerous attempts by University Hospitals of Morecambe Bay NHS Foundation Trust to recruit.

In September 2024, the difficult decision was taken to only admit Level 1 and Level 2 critical care patients to the critical care unit at FGH. As an interim measure any Level 3 patients have been stabilised at FGH and then transferred to the ICU at the Royal Lancaster Infirmary (RLI) or to other tertiary centres for ongoing care. Patients who require Levels 1 and 2 critical care continue to be treated and cared for at the hospital in Barrow-in-Furness.

Since the service was suspended, 58 patients requiring ongoing Level 3 critical care have been transferred from FGH once stabilised (up to 31 October 2025). None of these patients experienced any harm or worsening of their condition because of the transfer. Four of these patients were transferred to tertiary centres as they would have been prior to the temporary suspension. Patients requiring Level 1 and 2 critical care have continued to be treated and cared for at FGH.

At the request of the ICB, in May 2025, a review was carried out by the Lancashire and South Cumbria Critical Care Network. In July 2025, a review was carried out by the North West Clinical Senate. Both reviews concluded that the decision made in September 2024 to initiate a ‘treat and transfer’ model was clinically correct and in the best interests of patient safety. They also agreed that the numbers of people needing Level 3 ICU care are low and falling. Even with projected increases in the population the need for a Level 3 ICU would not be there.

Following the publication of the reviews, the ICB has indicated that the preferred option is to make this temporary suspension permanent to maintain a safe and sustainable service for the patients of South Cumbria.

The ICB has a duty to involve patients and the public as set out in the NHS Act 2006 (as amended by The Health and Social Care Act 2012 and subsequently the Health and Care Act, 2022) which lays down duties in a wide variety of areas on NHS England and on ICBs. These include duties to improvement in quality of services, to reducing inequalities, and to public involvement and consultation.

In September 2025, the ICB made a commitment to ensure a robust process of engagement was carried out that would feed into the NHS England service change assurance process and inform a pre-consultation business case. This was reiterated at a meeting of the Westmorland and Furness Council Health and Adults Scrutiny Committee on 24 September 2025.

In October 2025 the engagement activity began with its first phase known as pre-consultation engagement. This report outlines the methods of engagement and the feedback received.

It was not a formal consultation but will inform the process that could eventually lead to one.

Picture 1: Public meeting at Nan Tait centre, 8 October 2025

Methods of engagement

This report has reviewed feedback received from the two levels of engagement opportunities that people have used.

Direct submissions

These incorporate feedback, comments, or input received directly from individuals or organisations. These are personal to the people sending them who have taken the time to specifically provide their views.

These have included:

MP letters

The MP that covers Barrow-in-Furness has engaged with the ICB through meetings and conversations. They have also expressed their concerns in the form of letters direct to the Chief Executive of the ICB.

Members of the public or organisations

The ICB has received comments and letters from members of the public either by direct email or post, comments made on the ICB website or emails to generic team inboxes (e.g. patient experience or communications).

Petitions

In August 2025, Lancashire and South Cumbria ICB received a petition from Michelle Scrogham MP signed by 13,000 individuals who oppose the proposals to permanently suspend Level 3 intensive care at FGH and to treat and transfer Level 3 patients to RLI.

"I call on NHS England to reject the proposal from NHS Lancashire and South Cumbria to turn the temporary downgrading of the Critical Care Unit at FGH into a permanent arrangement."

The ICB consider petitions to be an important mechanism for local people to have a voice on local matters and represents the expression of the views of the people who sign it. To ensure that the voices are heard appropriately, and to avoid the danger of listening only to active groups, this petition will be viewed as one piece of evidence and information which contributes to an overall picture of public opinion and the consideration of proposals for any clinically-led service change process.

Signed letters of objection

A letter of objection was prepared by a community group set up to campaign against the proposal. It has been delivered to NHS England directly so, although we know it objected to the proposal and how many people signed it, we do not know the exact content or concerns raised within it. However, the campaign group has been vocal in their concerns at meetings and so we expect the letter to express these same concerns. Given the number of letters that the group have informed us they have, this feedback has been included in our analysis.

Social media comments

The ICB posted on social media to promote the engagement events listed in the following section. Some people chose to reply or comment to those posts with their views. Updates on the Level 3 critical care at FGH have also been posted by the ICB and UHMBT and received a number of comments.

These were noted and included in this report.

Facilitated engagement

This includes feedback gathered through events or activities organised by the ICB communications and engagement team.

Webpage

LSC Integrated Care Board :: Furness General Hospital critical care service.

A dedicated webpage was created in September 2025 to share information about the proposals, engagement events and to answer the most frequently asked questions.

The Frequently Asked Questions section is updated regularly as more questions are received at the engagement events. People are directed to the webpage as the source of the most up to date information.

Although people do not leave comments on this page, it is a source of information and the number of people visiting the page shows the level of interest in the information itself.

The webpage has been visited 2,873 times since the start of the public engagement period - 1 September 2025.

Public meetings

Five public meetings were held. To ensure attendees could have any questions answered, with Executives from both the ICB and UHMBT present.

Event	ICB representatives	UHMBT representatives
Wednesday 8 October – Barrow in Furness	• Prof Jane Scattergood, Acting Chief Nurse • Andrew Bennett, Director of population health	• Scott McLean, Chief Operating Officer and Deputy Chief Executive • Shawn Anderson, Divisional General Manager, Surgery and Families Division • Sarah Maguire, Divisional Head of Nursing for Surgery and Families • Dr Rachel Markham, Consultant in Anaesthetics and Intensive Care Medicine
Friday 10 October – Millom	• Andy Knox, Interim Medical Director • Jane Cass - Director of Partnerships & Collaboration	• Sarah Maguire, Divisional Head of Nursing for Surgery & Families • Shawn Anderson, Divisional General Manager, Surgery and Families Division

		• Zoe Eddleston, Clinical Service Manager for Pain and Anaesthetics • Dee Houghton, Deputy Chief Operating Officer • Danny Bakey, Divisional Director Surgery and Families Division
Thursday 16 October – online	• Prof Craig Harris, Chief operating officer • Andy Curran, Associate medical director	• Scott McLean, Chief Operating Officer and Deputy Chief Executive • Shawn Anderson, Divisional General Manager, Surgery and Families Division • Sarah Maguire, Divisional Head of Nursing for Surgery and Families • Danny Bakey, Divisional Director Surgery and Families Division • Lynne Wyre, Interim Chief Nurse
Wednesday 22 October – Ulverston	• Andy Knox, Interim Medical Director • Prof Jane Scattergood, Acting Chief Nurse	• Dr Helen Skinner, Chief Medical Officer • Shawn Anderson, Divisional General Manager, Surgery and Families Division • Sarah Maguire, Divisional Head of Nursing for Surgery and Families • Dr Rachel Markham, Consultant in Anaesthetics and Intensive Care Medicine • Danny Bakey, Divisional Director Surgery and Families Division
Thursday 30 October – Barrow in Furness	• Prof Jane Scattergood, Acting Chief Nurse • Jayne Mellor, Director of Acute commissioning, diagnostics and pathology	• Dr Helen Skinner, Chief Medical Officer • Shawn Anderson, Divisional General Manager, Surgery and Families Division • Sarah Maguire, Divisional Head of Nursing for Surgery and Families • Sabah Munshi, Divisional Chief Medical Officer (surgery, critical care)

At the meetings a presentation was given lasting approximately 30 minutes. An hour was then utilised to answer questions and hear the views of the attendees.

During the presentation, the solutions being considered were presented and attendees were invited to present their ideas for consideration. Considerations discussed were:

1. Continue with current operating model of a Level 1 and 2 service at FGH which also stabilises Level 3 patients and then transfers them to RLI.
2. Keep the change as it is at the moment on a temporary basis whilst continuing to recruit suitable staff with the aim of reinstating Level 3 care at FGH as soon as it is safe to do so.

3. Rotate the workforce between RLI and FGH.
4. Cease Level 3 services at RLI and retain Level 3 critical care at FGH.

Following the events, an evaluation questionnaire was sent to all attendees asking for their feedback. This will be used by the ICB communications and engagement team to develop future events. It is worth noting that the majority of attendees felt the information was clear, and they were happy with the opportunity to ask questions and the usefulness of the discussions. The feedback and comments made is included in the analysis in later sections of this report.

Member of Parliament for Barrow and Furness, Michelle Scrogham MP, also held a public meeting on Saturday 18 October. The ICB were invited but due to short notice and other commitments the ICB was unable to attend. Her office has been kind enough to share the points raised in that meeting with the ICB and they have been included in this report.

Drop-in listening events

The drop-in sessions were designed to be an opportunity for people who could not attend the meetings to visit engagement team members without the need for pre-arranged appointments.

This allowed for informal conversations on a one-to-one basis. Questions were answered if it was possible to do so but all questions and views were noted and logged.

Members of the engagement team were based at the Healthwatch Westmorland and Furness offices on 7 and 14 November and at FGH on Wednesday 12 November.

The sessions were held in the afternoon up to 4pm to allow time for people picking up children from school to attend.

These were promoted through a press release to the local press which was published in the North West Evening Mail on 8 November 2025.

A poster was also produced which was sent to 29 organisations including supermarkets, community groups, citizens advice bureau and leisure centres for display. It was not confirmed whether these venues did display the posters.

Prepared by: Nathan Skelton, Communications and engagement manager

Responses

The idea of making this change permanent is clearly emotive and contentious within the local communities that are served by FGH.

The table below shows the number of responses we have received or the number of people attending events.

Engagement method		Number of responses/people
MP letters		2
Concerns/enquiries from members of the public/organisations		121
Complaints from members of the public/organisations		11
Petitions		13,000
Signed letters of objection		2,000
Social media comments - ICB		73
Social media comments - UHMBT		50
Public meetings	Barrow 8/10/2025	57
	Millom 10/10/2025	5
	Online 16/10/2025	12
	Ulverston 22/10/2025	32
	Barrow 30/10/2025	70
Michelle Scrogham MP public meeting		200
Drop in listening events	Barrow 07/11/2025	6
	Furness General Hospital 12/11/2025	2
	Barrow 14/11/2025	20

Key themes and issues

The overwhelming response was one of disagreement with the proposal. Many found the subject very emotive having lived experience of the ICU, others were worried about the future and how the proposal might affect them or their loved ones if they ever needed the ICU. Some were more passionate about Barrow-in-Furness as a whole and not wanting to see changes to their local services. The common themes that arose are summarised below:

1. **Patient transfer and travel**
    - There is deep anxiety about the safety of transferring critically ill patients from FGH to Lancaster.
        - People were particularly worried about the A590 being the only main route to and From Barrow in Furness.
        - The reliability of ambulance services and contingency planning for road closures or adverse weather are major worries.

    - They said the A590 is often blocked making it difficult for transport including ambulances to pass.
    - They suggested such delays could make travel times much longer (often up to two hours).
    - Even though it was explained that the ‘treat and transfer’ model is safe and used for transporting other patients, people were not willing to accept that Level 3 critical care patients were not at increased risk.
- Questions are raised about how the system would cope during major incidents, mass casualty events or another pandemic, given limited ambulance availability and transfer options.
    - People expressed concern that contingency plans relied heavily on the air ambulance which is a charitable organisation and therefore their availability is not guaranteed.
- Families fear the emotional and financial burden of travelling long distances to visit loved ones, with particular concern for vulnerable groups such as the elderly and disabled.
    - Although the offer of support in these circumstances was explained people still felt that this was unnecessary pressure for people.
    - There were many emotive comments about patients suffering as a result of the transfer, with one citing that their loved one was transferred to and from Lancaster multiple times in a short period as they deteriorated and recovered.
- People did not agree that learning from other Trusts in rural areas was appropriate since other hospitals, such as those in Cornwall, were served by multiple transport links and main roads and motorways.
- People felt that a postcode lottery is being created with those in some areas being left without necessary services.

2. Local development and Barrow Rising

- Barrow is experiencing rapid growth in population due to industrial expansion (e.g., BAE Systems), which increases healthcare demand and risk of industrial injury.
- People wanted to know what planning had been done to accommodate the additional people expected to move to the area and to account for local tourism.
- People were very passionate about their area and were strongly against Barrow-in-Furness being treated as though it was a small cottage hospital.
    - They felt many services had been lost over the years and although they acknowledged investment in maternity, they felt that the hospital was still being downgraded.
- There were calls for more open collaboration between BAE and other local industries.
    - Particularly around understanding the population increases expected in terms of the number of older generations that may accompany families moving to the area.
    - Also, around what local industries have done to incentivise recruitment and make the area appealing for new employees.
- Other points included the claim from the NHS that people moving to the area are unlikely to need Level 3 ICU care. People argued that it is impossible to predict who may need the service as although older people are more likely they are not the sole users of the service.

- Barrow's role in national defence and industrial activity makes local ICU provision strategically important. People felt that removing ICU Level 3 from FGH could undermine safety for local workers and national interests.
- People said that removing Level 3 ICU from FGH contradicts national policy objectives on health equity, especially for rural, coastal, and industrial areas. National workforce plans emphasise the need to support recruitment and digital infrastructure in such regions.

3. Recruitment

- Staff and public alike are worried that recruitment efforts were not aggressive or creative enough, and that promised incentives (such as a £30,000 bonus) were not delivered.
    - There were calls for innovation when working with other agencies around recruitment to learn from those that have been successful.
- There is a perception that the downgrading of ICU services will make it even harder to recruit and retain skilled staff, not just in ICU but across other departments.
- Staff are concerned that losing Level 3 ICU will lead to de-skilling, especially for nurses and junior staff, and will impact other services such as paediatrics and surgery.
- There are worries about the ability to maintain clinical competence and provide opportunities for career progression if Level 3 ICU is lost.
- There are also concerns that losing Level 3 provision will lead to fewer Level 1 and Level 2 consultants wanting to work at FGH thereby raising doubts about the longevity of those services.
- Suggestions include using the new University of Cumbria campus in Barrow to "grow our own talent" and create a training hub, as well as considering rotational posts and creative recruitment solutions, including partnerships with local industry (e.g., BAE Systems).

4. Concerns over data accuracy and transparency

- There is significant distrust regarding the data presented by decision-makers.
    - Multiple comments suggest that statistics used to justify changes were 'cherry-picked' for periods of lowest patient numbers, making them misleading.
    - Members of staff attending the events said the figures presented did not match their experience.
- Several questions were raised about the origin and availability of supporting data.
- There were calls for figures to be presented in a way that would help understanding, indicating that current data presentation is not accessible or clear to stakeholders.
- There is some criticism that data used by the Clinical Senate was collected only in the summer, which does not provide a proper picture. It is suggested that data should be collected over three years for a more accurate analysis.
- There was also concern that the data only looks at the electoral register, not the transient population (such as shipyard workers and Lake District tourists), which could skew the analysis.
- Some contributors disputed the narrative around patient throughput and outcomes for different sites, stating that they do not recognise the data being presented and suggesting that it is either false or badly interpreted.

    - Suggestions included that the number of people being admitted to Level 3 ICU was misleading and that number of bed days in the unit should be included in analysis of the data.
- It should be noted, however, that much of the anger was based on some information being misleading. Those attending the one-to-one drop-in sessions did comment that they felt more assured at the detail although they were still not happy with the situation.

5. Equality and accessibility

- The proposal is seen as creating a two-tier system, with rural areas and those experiencing deprivation being unfairly disadvantaged compared to cities.
- People questioned the catchment of ICU and sharing provision. Some commented that ICU should be moved from Lancaster in order to increase provision at FGH citing that those living in RLI's catchment could more easily travel to other ICUs in Preston or Blackpool.
- People highlighted perceived inequities: North Cumbria has two hospitals with Level 3 ICU, while South Cumbria will have none. This was described as a 'postcode lottery' and fundamentally unfair.
- There was a strong narrative that South Cumbria is treated as a 'poor relation', receiving inferior services compared to other regions.
- The decision is seen as undermining the principle of equal access to healthcare for all, regardless of geography.
- Questions were raised about whether the original Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) are available for public viewing, and whether staff within the Trust have been able to view them.

6. Staff concerns

- There are reports of staff agreeing with public concerns but feeling unable to speak out due to fear of repercussions.
    - Staff have reported feeling threatened, with some saying they were told they could be sacked if they spoke out about the proposals. This has created a climate of fear and low morale.
- Staff feel their concerns are not being listened to or consulted, and that frontline staff are not being included in the decision-making process.

7. Transparency, decision making and trust

- There is strong distrust of the data, with claims that statistics were cherry-picked and the decision-making process is opaque. The public demanded independent review, genuine consultation, and publication of contingency plans, clear protocols, and equality and risk assessments.
- There is a general sense of distrust towards leadership and the decision-making process. There were calls for clarity on the ICB's statutory responsibilities and the legal process that must be carried out.
- Attendees repeatedly called for independent review of the data and genuine public consultation, expressing frustration at the lack of openness and accountability in the decision-making process.
- There was a general feeling that the decision has already been made and that it is based on finance and cost-cutting. People felt the engagement process was a tick-box exercise that would have no real impact on the outcome.

- Attendees criticised the reactive nature of engagement sessions and the lack of proactive communication. There is a call for clearer messaging, less jargon, and more involvement of patient voices in decision-making.
- People felt that there had been a lot of misinformation or that information had not been communicated properly. There is widespread misunderstanding about the scope of the proposed changes. Many believed the entire ICU was closing, which caused significant distress, but people did report feeling more reassured once this fact had been explained.

8. **Financial and local services**
    - Several people questioned the financial motives behind the closure, suggesting it's a cost-cutting exercise rather than a decision based on clinical need.
    - There was criticism of spending priorities, such as funding for engagement teams or new facilities (e.g., prayer rooms), while essential clinical services are cut.
    - Some people felt the closure of Level 3 ICU critical care is linked to a broader pattern of service reductions in the area, with fears that other departments (maternity, paediatrics, surgery, A&E) may follow.

Suggested solutions

During the engagement, people were presented with four considerations and also provided with the opportunity to present their own solutions to the issues.

1. Continue with current operating model of a Level 1 and 2 service at FGH which also stabilises Level 3 patients and then transfers them to RLI.
2. Keep the change as it is at the moment on a temporary basis whilst continuing to recruit suitable staff with the aim of reinstating Level 3 care at FGH as soon as it is safe to do so.
3. Rotate the workforce between RLI and FGH.
4. Cease Level 3 services at RLI and retain Level 3 critical care at FGH.

From the comments made it is felt that the preferred option from the public perspective is option 2 above. However, some people suggested option 3 and option 4 would be more equitable and realistic given the challenges with recruitment. They recognised that this would be an issue for people in the Lancaster / Morecambe Bay areas but suggested that those living in RLI's catchment could more easily travel to other ICUs in Preston or Blackpool.

The solutions put forward from the public and staff are as follows:

1. **Innovative recruitment:** Calls for more proactive and creative recruitment strategies, including advertising roles more widely, offering incentives (such as the previously mentioned £30,000 bonus), and learning from other hospitals that have successfully recruited staff.
2. **Rotational posts:** Suggestion to introduce rotational consultant posts covering the Trust's full footprint, enabling a local service and increasing understanding of the area's needs.
3. **Working with other Trusts:** Suggestion to consider a buddy-up system with other hospitals to share expertise and resources.
4. **Collaboration with local industry:** Proposals to approach local employers like BAE Systems for sponsorship or support in attracting and retaining medical staff.

5. **Training and development:** Calls for more creative solutions such as “growing our own talent” by leveraging the new University of Cumbria campus in Barrow, establishing FGH as a training site, and providing incentives for training with a commitment to remain with the trust.
6. **Tele-ICU model**: Strong support for establishing a tele-ICU link between Furness and larger hospitals (Lancaster or Preston), which would allow consultant oversight remotely from the current three consultants, reduce transfer risk, and keep critically ill patients closer to home. This model was presented as both clinically effective and cost-saving compared to ongoing patient transfers. It was also hailed as an innovative solution that would be at the forefront of ICU development.
7. **Dedicated ambulance provision**: Calls for reinstating or ensuring a dedicated critical care ambulance for transfers, with clear service level agreements (SLAs) and contingency planning for multiple simultaneous emergencies.

Other suggestions focussed on the process and what the ICB should do to ensure a robust decision-making process and build trust.

1. **Risk assessment and contingency planning:** Calls for robust risk assessments, especially regarding patient transfers, major incidents, and the impact on other services if Level 3 ICU is permanently removed from FGH.
2. **Addressing inequality**: Highlighting the need to consider the impact on vulnerable groups, such as those with disabilities or low incomes, and to ensure equitable access to critical care.
3. **Empathy and full understanding of the local need**: Some suggested that ICB commissioners should shadow the ICU transfer to experience it firsthand as well as spend time in the area so they can fully understand the concerns people have about isolation and lack of services.
4. **Improved communication and transparency:** Repeated demands for clearer, jargon-free communication about changes, more proactive engagement with staff and the public, and publication of key documents such as the QIA, EIA, risk assessments and full option appraisals.
5. **Public consultation:** Strong advocacy for a full public consultation on the proposed changes, with transparent sharing of data and decision-making processes.

Conclusions

Those who have engaged in this pre-consultation engagement period have been strongly against the proposal to permanently close Level 3 ICU care at FGH. Although we found that in explaining the rationale for the proposal, some had a better understanding as a result of the engagement.

In order to build trust and display transparency, the ICB should ensure the service change process is followed in a robust and open way allowing for scrutiny of that process at all stages.

The ICB should consider including members of the public as patient representatives or local ambassadors in working group meetings where options and data is discussed. As well as involving staff at all levels with working knowledge of the department. Work must be done to widely engage staff from FGH and include them in developing solutions to the issue. This

must address the concerns raised of staff reporting being deterred from speaking on the subject.

The data and recruitment process have been challenged by the public and members of staff working in the department. It is important that any processes are explained and concerns fully addressed and communicated, ensuring openness and transparency.

All of the options presented including those suggested during the engagement (listed above) must be fully examined. If any are discounted, full analysis leading to the decision to discount them should be made publicly available for scrutiny and understanding.

In the future stages of decision-making, information should be shared in full, with detailed explanations of what is in scope and what basis decisions have been made. This must be presented in a way that is easy to understand and is free from jargon with any technical detail explained.