NHS
Northern England
Clinical Senate

# North Cumbria Review

# 15th and 16th December 2015

## 1. Background

The Northern England Clinical Senate has undertaken two formal reviews in North Cumbria in November 2014 and June/July 2015. Reports from these reviews, which focused on several high risk pathways, have been published and are available on the NHS Cumbria CCG website. It is not intended to repeat content in this third report.

Following the announcement of the Success Regime initiative for Cumbria and the development of a number of workstreams with named individuals to take forward plans, the Northern England Clinical Senate was invited by the Senior Responsible Officer (SRO) for the Proactive and Urgent Care Workstream to review early progress and thinking around acute medical admissions. The Terms of Reference for the review are included as Appendix 1.

A small review team was established comprising:

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|---|---|---|
| Dr Mike Jones | - | Consultant in Acute Medicine at County Durham and Darlington NHS Foundation Trust |
| Dr Robin Mitchell | - | Clinical Director for the Northern England Clinical Networks |
| Roy McLachlan | - | Associate Director for Northern England Clinical Networks and Senate, NHS England |

Biographies for the review team are contained in Appendix 2.

## 2. Review Process

Background information was collated by the SRO for the Proactive and Urgent Care Workstream and by the Executive Director of Strategy for North Cumbria University Hospitals NHS Trust. A two day programme of visits was planned to take place on 1st and 2nd December 2015; unfortunately due to external circumstances these dates proved impossible to carry out and a re-arranged two day visit took place on 15th and 16th December. A copy of the programme for this visit is included as Appendix 3.

The review team met with the following people:

David Stout, Proactive and Urgent Care SRO and Director of Transformation, Cumbria CCG
Dr Rachel Preston, Lead GP (Eden locality), Cumbria CCG
Dr David Rogers, Medical Director, Cumbria CCG
Dr Olu Orugun, Consultant Geriatrician with an interest in stroke and Site Clinical Director, WCH
Dr Joanna Cox, Consultant Geriatrician, NCUH
Dr Denis Burke, Consultant Gastroenterologist, Business Unit Director for Emergency Care and Medicine, NCUH
Julian Auckland-Lewis, Deputy Director of Transformation, NCUH
Dr David Lewis, Community Health Associate Medical Director, CPFT
Dr James Shawcross, Consultant Acute Care Physician, NCUH
Dr Jon Sturman, Consultant Anaesthetist and Clinical Director Intensive Care, NCUH
Dr Rod Harpin, Consultant Anaesthetist, NCUH
Dr Stephen Singleton, Director, Cumbria Learning and Improvement Collaborative (CLIC)
Dr John Howarth, Director of Service Improvement and Interim Deputy CEO, CPFT
Dr Debbie Freake, Executive Director of Strategy, NCUH
Dr Derek Thompson, Medical Director, NCUH
Dr Emma Farrow, A&E Consultant and Clinical Director for Emergency Care, NCUH
Dr Claire Summers, A&E Consultant, NCUH and Clinical Lead, WCH

## 3. Limitations

The focus of this stage of the review is given in the Terms of Reference and included below for completeness:

> "To provide constructive challenge and support to the consultant team in producing a consensus on proposals for medical staffing and supporting arrangements between Cumberland Infirmary, Carlisle (CIC) and West Cumberland Hospital as part of the Proactive and Urgent Care work stream of the Success Regime. The focus of the work will be acute adult medical pathways and associated services. To review proposals for keeping patients in appropriate settings outside hospital based pathways."

For ease of reference, the focus outlined above has been broken down to its constituent two parts and analysed over the next few pages. Additional themes from the review visit are then drawn together in the following section.

This report does not cover stages 2 and 3 of the Terms of Reference.

**4.1 To provide constructive challenge and support to the consultant team in producing a consensus on proposals for medical staffing and supporting arrangements between Cumberland Infirmary, Carlisle (CIC) and West Cumberland Hospital as part of the Proactive and Urgent Care work stream of the Success Regime. The focus of the work will be acute adult medical pathways and associated services**.

| Feature | Progress | What might be needed |
|---|---|---|
| There is strong agreement amongst stakeholders that as much care as can be safely delivered as close to home as possible is the foundation for the vision over the next few years. There is also agreement over the absolute urgency of continuing to address recruitment into vacant posts. | The emergence of the Success Regime appears to have had a positive effect in bringing stakeholders back to discussions about the future challenges. The approach to workstreams with designated individuals responsible for delivery is to be welcomed. A focus on integrating hospital based pathways with out of hospital care through this particular workstream is also welcomed. | The role of the Organisational Development workstream will be particularly important. There are still some tensions between health organisations and a focus on improving the culture and attitudes between Trusts and Commissioners will be needed. CLIC can have a very positive role in this work. |
| The 'Rubicon' approach is clearly at its very early stages and appeared not to be understood yet by all stakeholders. The approach appears highly relevant and could form the basis of a way to provide medical cover at WCH. | Very early stages and not widely or deeply understood. The phrases 'integrated care' or 'integrated teams' appear to be used to describe both internal (to NCUH) ways of working with acute admissions, and to refer to cross organisation/cross sector pathways being 'integrated'. | The more detailed modelling of medical rotas should be done as a system to help improve understanding of the Rubicon approach. Ownership needs to be shared across the Success Regime including specifically the clinicians who will be involved in developing and implementing this approach. Agreement on the definition of 'integrated' should be finalised. |
| The Trust's approach to creating integrated teams within the Emergency Floor at WCH is fully supported and welcomed by the Review Team. It is not going to be possible to recruit to a middle grade acute medical rota without substantive consultants being in post. Even with substantive consultants it may not be possible to recruit into the current middle grade rota. Therefore, creatively using other middle grade rotas and other clinicians flexibly would appear to be the only | Not all of the key players within the Trust are yet accepting the need for a radical approach to middle grade rotas. With additional support and training the review team believe this approach could work. | Training in decision making for the middle grade rotas to enhance their already existing technical skills. (It is understood that Health Education England has offered to help.) More detailed modelling is needed, very quickly. Workshops with all the key players present and participating, including colleagues from A&E. Potential blending of all posts at middle grade at WCH with a single resident rota with flexible working across sub-specialities/ departments. More detailed |

| Feature | Progress | What might be needed |
|---|---|---|
| solution. | | work is needed, very quickly. Review team would be prepared to help by continuing to support this work as within the scope of the review visit it was clearly not possible to meet an extended list of medical colleagues. |
| Investment in ACP arrangements. | Good progress maintained. | To continue. |
| Investment in ANP arrangements. | Substantial progress internally. A very strong initiative with close to 30 posts. | To consider further development. |
| Potential recruitment of a time limited 'Task Force'. | The potential to bring in a Task Force was highlighted explicitly by several colleagues during the review visit. | This proposal will need to be worked up in more detail including potential permutations if serious consideration is going to be given. Procurement route, specification, the period and impact on locums will need to be included. |
| Work in progress to understand likely activity levels and case mix at WCH. | | Complete the modelling with potential boundary changes and high risk activity being transferred to CIC. Whole system to agree impact of modelling. |

### 4.2 To review proposals for keeping patients in appropriate settings outside hospital based pathways

| Feature | Progress | What might be needed |
|---|---|---|
| Proposal to move to fewer, larger population based teams within Integrated Care Communities with a greater degree of standardised ways of working. | To be welcomed; early adopter sites are planned to be identified in early 2016. | Offer from review team to further review ways of working as they emerge. Proposal should be further developed if pilot metrics are satisfactory. |
| Passing of information between sectors appears to be less than ideal. Appears to be a degree of sectors re-doing assessments from other sectors. This may be inhibiting medium/longer term care planning. | No standardised approach – appears to vary between localities. | Re-visit use of electronic transfer of essential patient details between sectors/ organisations. Re-visit number of assessments being carried out for each patient. Develop shared approach to risk |

| | | |
|---|---|---|
| | | management – task for OD workstream. |
| High level proposals presented to review team regarding potential developments in some services outside hospital | The review team would acknowledge some radical solutions might be needed but were not convinced proposals are currently synchronised. | An assessment of the impact of the current proposals to be considered by the full system. The review team would offer to revisit the proposals as part of stage 2. |

## 5. Continuing Themes and Suggestions

Whilst the main focus of the Terms of Reference is on acute medical pathways and developing medical rotas and skills to manage these pathways, there are themes identified by the review team which might support the work of the Success Regime. Some of these themes continue from the first and second previous visits with subtle changes of emphasis as the workstreams of the Success Regime gain traction. The analysis of the themes below, therefore, is given in a spirit of constructive challenge which the review team hopes will support colleagues in delivering a continued, highly complex set of changes over coming years.

The items are grouped around:

- Vision
- Communication and Engagement
- Culture and History
- Recruitment
- Success Regime

### 5.1 Vision

The review team does not underestimate the scale of the challenge facing the (North) Cumbria health and social care economy. Compared to the previous visits there appeared to be a much more positive sense of vision developing for services in West Cumbria. WCH is emerging with the vision of having robust acute medicine services (with partial selection) and A&E services which link very strongly to other community and hospital based services, and this is a welcome change in emphasis. The sense of only transferring patients when absolutely needed, with an identified improved outcome for individuals, is coming through more consistently than on previous review visits.

It was noted that a visit is planned to Fort William in Scotland to understand how a small District General Hospital with features similar to West Cumbria has been able to deliver services for ill patients with similar service challenges. One of the review team, Dr Mike Jones, is well acquainted with the arrangements at Fort William and has already offered to facilitate further work if needed as Stage 2 within the Terms of Reference.

**Suggestion:** It is suggested that further definitional work be carried out on the detailed function of WCH and how the impressive new hospital fits in with the strategic direction of caring for people closer to home. There is a feel of 'dependency' on hospital services in West Cumbria, articulated to the review team several times by different colleagues as 'failure demand'. Redefining the role of community hospitals can only help this and the review heard this described as community hospitals potentially operating a 'step up' approach rather than a 'step down'.

## 5.2 Communication and Engagement

**Public** – the continuing initiatives to engage the public about the future shape of services was impressive. It is understood that relationships with the new community group – West Cumbrian's Voice for Healthcare – are developing well and the Clinical Director for the Networks and the Associate Director for Network and Senate have responded positively to a request by the Success Regime to do a workshop with Trades Union colleagues about the range of services that might need to be less local because of their specialist nature, and those which can be safely provided locally.

**Clinical** – it is understood that CCG GP Locality Leads are undertaking much closer liaison with the GP community in West Cumbria. From a hospital perspective the proposals around the Rubicon approach have received a mixed response ranging from strong support, support with caveats and some apparently entrenched opposition. In the time available it was not going to be possible to get groups of clinicians together to explore issues.

There also still seemed to be some reluctance to move towards broader application of cross site working which is a theme that has been brought up in previous meetings. The scale of the geographical distance between CIC and WCH clearly influences this but the review team were also informed of some fairly basic lack of communication about when colleagues eg in Rheumatology and Trauma/Orthopaedics would be on site at WCH and able to do in patient consultations. Addressing this will be an early priority for the new Medical Director and the review team would offer an early opportunity to meet him and the Executive Director of Strategy, for some informal, more detailed feedback on issues raised.

**Suggestion**: The review team would like to offer to be involved in any further workshop discussions with clinicians about the Rubicon proposals to provide further constructive challenge to moving forward. (Post visit note – two dates agreed in February 2016.) The review team would also like to offer to meet informally with the Medical Director and the Executive Director of Strategy at an early opportunity.

## 5.3 Culture and History

The review team were given several consistent insights into why (North) Cumbria finds itself in the current situation with a whole range of challenges. These insights were particularly valuable to the review team and provided an understanding of the different organisational cultures and tensions that exist. Six months on from the previous visit the review team heard about stakeholders being more open about their differences. It will be an important role for the future regime to manage these relationships into a more positive arena, with a particular role for the OD workstream.

**Suggestion**: If it is possible it may be worth having an open debate about organisational form. Examples are being implemented elsewhere under the new models of care approach and accountable care organisations which might offer benefits around simplification of accountability and risk.

## 5.4 Recruitment

This remains, rightly, the top priority for the North Cumbria health economy. The urgency is enhanced by primary care pressures emerging more explicitly. It is understood that neither of the senior academic posts with UCLAN have been appointed to, bringing an additional challenge. Whilst the need for this innovative approach is fully understood the review team did feel that getting stability back into service based posts was a greater priority. To this end

the exploration of a Task Force approach was seen as a vital opportunity to inject experienced clinical support whilst relationships with other stakeholders, including Health Education England (HEE), are explored again.

**Suggestion**: the review team would be happy to broker renewed discussions with HEE at the appropriate time.

### 5.5 Success Regime

The Success Regime was only launched in mid-September but it is clear from discussions that increasing the pace of cross organisational working is already having an impact. The offer remains for the Senate Chair, Vice Chair and Associate Director to meet at particular points with the Chair and Project Director of the Success Regime. The first meeting was very constructive and as it becomes much clearer what the outcome of the clinical assurance required by NHS England will be, there will undoubtedly need to be further visits of review teams though clearly not as large as the first two visits.

# CLINICAL SENATE REVIEW
# TERMS OF REFERENCE

**Title**
Review proposals for Acute Medical Pathways and associated services in North Cumbria University Hospitals NHS Trust

**Sponsoring Organisation**
NHS Cumbria Clinical Commissioning Group

**Clinical Senate**
Northern

**NHS England regional or area team**
Cumbria and the North East

**Terms of reference agreed by:**
Roy McLachlan
**on behalf of**
Northern England Clinical Senate
**and**
David Stout
**on behalf of**
Cumbria CCG
**Date: 11/12/2015**

**Clinical review team members**
**Robin Mitchell** – Clinical Director, Northern England Strategic Clinical Networks
**Roy McLachlan** – Associate Director, Northern England Strategic Clinical Networks and Senate, NHS England
**Mike Jones –** Consultant , County Durham and Darlington NHS Foundation Trust.

**Scope of the review**
Stage 1 – to provide constructive challenge and support to the consultant team in producing a consensus on proposals for medical staffing and supporting arrangements between Cumberland Infirmary, Carlisle (CIC) and West Cumberland Hospital (WCH) as part of the Proactive and Urgent Care work stream of the Success Regime. The focus of the work will be acute adult medical pathways and associated services. To review proposals for keeping patients in appropriate settings outside hospital based pathways.

Stage 2 – to arrange external expertise to demonstrate how a new model of care can work in an existing, similar environment.

Stage 3- To be determined at the end of stage 2.

**Timeline**
The review visit will take place on 15/12/2015 to 16/12/2015.

**Reporting arrangements**
The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report. Clinical senate council will submit the report to the sponsoring organisation.

**Methodology**
Information collated by the sponsoring organisation to be presented to the senate review team before the actual visit: including demographic data, organisational information, site maps, patient flows and any other information that the sponsoring organisation thinks will help the reviewers understand the issues surrounding the services under review.

Day 1 (15th December 2015)
Day 2 (16th December 2015)

**Report**
A draft report will be circulated within 10 working days from the visit to the review team and the sponsoring organisation for factual accuracy.
Comments/ correction must be received within [10] working days.
The final report will be submitted to the sponsoring organisation by the end of the first week in January 2016.

**Communication and media handling**
The arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation. It is noted that at this stage there is no intention to put any material from the review in the public domain because it is part of an iterative planning process.

**Resources**
Cumbria CCG 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.

**Accountability and Governance**
The clinical review team is part of the Northern England Clinical Senate accountability and governance structure. The Northern England Clinical Senate is a non statutory advisory body and will submit the report to the sponsoring organisation.
The sponsoring 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.

**Functions, responsibilities and roles**

**The sponsoring organisation will**

i. Provide the clinical review panel with relevant background information and potential proposals for change. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. Respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. Submit the final report to NHS England for inclusion in its formal service change assurance process.

**Clinical senate council and the sponsoring organisation will**

i. Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

**Clinical Senate council will**

i. Appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise.
ii. Endorse the terms of reference, timetable and methodology for the review
iii. Consider the review recommendations and report (and may wish to make further recommendations)
iv. Provide suitable support to the team and
v. Submit the final report to the sponsoring organisation

**Clinical review team will**

i. Undertake its review in line the methodology agreed in the terms of reference
ii. Follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. 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.
iv. Keep accurate notes of meetings.

**Clinical review team members will undertake to**

i. Commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review ( as defined in methodology).
ii. Contribute fully to the process and review report
iii. Ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. 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, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

**END**

## Biographies of Reviewers

### Dr Michael Jones, Consultant in Acute Medicine, County Durham and Darlington NHS FT

**Current Posts:**
Consultant and Clinical Lead in Acute Medicine
University Hospital of North Durham
Senior Lecturer University of Durham
Chair of Specialty Advisory Committee for Acute Internal Medicine
Member of Specialty Advisory Committee for General Internal Medicine
Member of Internal Medicine Board of JRCPTB
Director of Standards for Royal College of Physicians of Edinburgh
Education lead for Society for Acute Medicine
National Education Lead for Think Kidneys campaign in England
National lead for the Broad Based Training Programme in UK

**Previous Posts in the NHS:**
Consultant Physician and Clinical Lead in Acute Medicine Lothian Universities Health Division
National Clinical Lead for Medicine in Unscheduled Care Project in Scotland
Adviser in General Internal Medicine to Chief Medical Officer for Scotland
Deputy Medical Director Tayside Health Board
E-health Director Tayside Health Board
Project Lead for Unscheduled Care in Tayside
Clinical Group Director for Medicine and Cardiovascular Group 2001-2004
Associate Medical Director 1998-2001
Consultant Nephrologist 1992-1999
Lecturer in Medicine Aberdeen University 1985 –1992

**Roles outside of NHS:**
Dean and Director for Higher Specialist Training in the Royal College of Physicians of Edinburgh
Vice President of the Royal College of Physicians of Edinburgh
Secretary, Vice President and President of the Society for Acute Medicine (UK)
Chair of Specialist Training Committee of Academy of Medical Royal Colleges UK
Chair of Curriculum group for Acute and Internal Medicine in UK
Member of Education Committee of Academy of Medical Royal Colleges UK
Secretary of General Internal Medicine (G(I)M) Specialty Advisory Committee
Chair of the Joint Committee for Basic Medical training
Member of the Joint Committee for Higher Medical Training,
Member of Transitional Executive of Joint Royal Colleges Physicians Training Board
Assessor for Registrar Training for Royal College of Physicians in Ireland
External Examiner for International MRCP examinations
Reviewer for Scottish Medical Journal, Clinical Science and Nephrology, Dialysis and Transplantation.
Reviewer of book proposals for Blackwell Scientific
Reviewer of grant applications for the Medical Research Council and National Kidney Research Fund.
Member of the editorial board for the CPD journal for Acute Medicine and British Journal for Hospital Medicine

**Dr Robin Mitchell, Clinical Director, Strategic Clinical Networks**

Dr Robin Mitchell graduated in medicine from the University of Edinburgh in 1980. He undertook training in Anaesthesia and Intensive Care in Edinburgh and Leicester. In 1989 he was appointed as Consultant Anaesthetist in Durham, and subsequently undertook the roles of College Tutor and Clinical Director. He maintained a wide range of clinical interests including obstetric anaesthesia and intensive care medicine. He was a member of the project team for the development of the new North Durham Hospital, and was chair of the Durham and Tees Clinical Advisory Group for maternity and children's services in 2012-13. Dr Mitchell was Director of Medical Services for North Durham Acute Hospitals Trust from 1996 to 2000, and Executive Medical Director for County Durham and Darlington NHS Foundation Trust from 2010 to 2013. In 2013 he took up the role of Clinical Director for Northern England Strategic Clinical Networks. He has a keen interest in patient safety and service design.

**Mr Roy McLachlan, Associate Director, Strategic Clinical Networks and Senate**

Roy joined the NECN in February 2009 on secondment from Northumberland, Tyne and Wear NHS Trust where he was Chief Operating Officer. Prior to that he was Chief Executive of a number of NHS statutory bodies - NHS Trusts, a Health Authority and a Primary Care Trust. He has spent most of his managerial career working in the North East but started working in Scotland on the graduate scheme having completed an MA in French at St. Andrews University. He subsequently became one of the first NHS managers in the North East to undertake an MBA. Roy has been the Associate Director of the SCN since April 2013.

**Appendix 3**

## Success Regime – Proactive and Urgent Care

**Tuesday 15th December – Castle Inn and West Cumberland Infirmary**

| Time | Names | Location |
|---|---|---|
| 8.30am – 9am | David Stout, Proactive and Urgent Care SRO and Director of Transformation, Cumbria CCG | Dalton Room, Castle Inn, Bassenthwaite, CA12 4RG |
| 9am – 9.30am | Dr Rachel Preston, Lead GP (Eden locality), Cumbria CCG | Dalton Room, Castle Inn, Bassenthwaite, CA12 4RG |
| 9.30am – 11am | *No meetings arranged* | Dalton Room, Castle Inn, Bassenthwaite, CA12 4RG |
| 11am – 11.45am | Dr David Rogers, Medical Director and Deputy Chair, Cumbria CCG | Teleconference details-<br>FREEPHONE 0800 229 0275<br>MOBILE 033 0336 1396<br>CHAIR PIN (David) 492301<br>PARTICIPANT PIN 943020 |
| 11.45am - 12.30pm | TRAVEL | Castle Inn (CA12 4RG) to West Cumberland Infirmary (WCH) CA28 8JG |
| 12.30pm – 1pm | LUNCH | Provided |
| 1pm -2pm | Dr Olu Orugun, Consultant physician and Clinical Director of Medicine, North Cumbria University Hospitals NHS Trust (NCUH)<br><br>Dr Joanna Cox, Consultant Geriatrician, NCUH | Chief Executives Office, Management Suite, WCH |
| 2pm -3pm | Dr Denis Burke, Consultant Gastroenterologist, Business Unit Director for Emergency care and Medicine, NCUH<br><br>Julian Auckland –Lewis, Deputy Director of Transformation, NCUH | Chief Executives Office, Management Suite, WCH |
| 3.15pm – 4.15pm | Dr David Lewis, Community Health Associate Medical Director, Cumbria Partnership NHS Foundation Trust (CPFT) | Chief Executives Office, Management Suite, WCH |

**Wednesday 16th December – Cumberland Infirmary, Carlisle and Castle Inn**

| Time | Names | Location |
|---|---|---|
| 9am – 10am | Dr James Shawcross, Consultant Physician, NCUH | Seminar Room 1, Education Centre, Cumberland Infirmary, Carlisle (CIC) CA2 7HY |
| 10am – 11am | Dr Jon Sturman, Consultant Anaesthetist, North Cumbria University Hospitals NHS Trust (NCUH)<br>Dr Rod Harpin, Consultant Anaesthetist, NCUH. | Seminar Room 1, Education Centre, Cumberland Infirmary, Carlisle (CIC) CA2 7HY |
| 11.15pm – 12pm | Dr Stephen Singleton, Director of the Cumbria Learning and Improvement Collaborative (CLIC)<br>Dr John Howarth, Director of Service Improvement, CPFT and Clinical Lead | Seminar Room 1, Education Centre, Cumberland Infirmary, Carlisle (CIC) CA2 7HY |
| 12pm – 1pm | TRAVEL | CIC to Castle Inn |
| 1pm – 1.30pm | LUNCH | Castle Inn |
| 1.30m – 2.30pm | Dr Debbie Freake, Executive Director of Strategy, NCUH<br>Dr Derek Thompson, Medical Director, Northumbria Healthcare NHS Foundation Trust | Dalton Room, Castle Inn |
| 2.30pm – 4pm | Urgent Care Workshop involvement - table discussions | Budworth Hall, Castle Inn |
| 4pm – 5pm | Dr Emma Farrow, A&E Consultant and Clinical Director for Emergency Care, NCUH<br>Dr Claire Summers, A&E Consultant, NCUH | Dalton Room, Castle Inn |
| 5pm - 5.30pm | David Stout, Proactive and Urgent Care SRO and Director of Transformation, Cumbria CCG | Dalton Room, Castle Inn |