NHS
Lancashire and South Cumbria
Integrated Care Board

Integrated Care Board

Date of meeting	**1 February 2023**
Title of paper	Operating Model for the Lancashire and South Cumbria Integrated Care Board and Provider Collaborative Board
Presented by	Kevin McGee and Kevin Lavery
Author	Ruth Carnall and Paul Gray
Agenda item	9
Confidential	No

Purpose of the paper

This report was commissioned to consider the relationship between the Lancashire and South Cumbria Provider Collaborative Board and Integrated Care Board.

Executive summary

Colleagues recognised that this formed only one part of the work that was needed to develop the whole system. Also, to make progress on developing the newly formed relationships we decided to work together via a workshop. This inevitably means that a report such as this can seem out of date because actions agreed at the workshop are already changing the way in which people work. Nevertheless, for the record, we have provided below a summary of our recommended next steps.

1. It would be helpful to set out an approach and a timescale for producing a health strategy and within that a strategy for transforming clinical services.
2. There should be a small number of clear priority programmes which the PCB oversees. In future these need to sit within the overall ICB strategy. A short list was produced in the workshop which should form a start. An early opportunity should be taken to review progress since the workshop.
3. Rather than a purely generic operating model each programme needs to be clear about objectives, leadership, resources, and accountability.
4. The PCB should set a high bar for its activities making sure that all providers genuinely need to be involved. This avoids any tendency to refer difficult issues upwards. The PCB can also oversee programmes of work on behalf of all providers which do not involve the ICB.
5. The Joint Committee which has only recently been created is a sound vehicle for delivering decision making and oversight and should be supported by all parties.
6. The PCB needs a small standing team to support effective governance of its work. Individual programmes will require dedicated leadership and significant support. These requirements will vary over time.
7. Professional networks are valuable and can work alongside system leadership from the ICB. They should not form any sort of tier of accountability

8. This work only looked at the relationship between the PCB and the ICB. The operating model for the system must also consider the emerging role of place and key partners in primary care, local government, and other sectors.
9. The clinical transformation programme will be challenging and create conflict between providers. Given the scrutiny which is likely to arise the benefit of independent chairmanship should be considered by the PCB at that time.
10. The lead CEO role for the PCB works well and should be retained.
11. The clinical leadership requirement is extensive and is an urgent priority to consider. There are likely to be significant demands on the time and capacity of senior clinical leaders within the system and potentially a need to find colleagues from outside the system for support.
12. Whilst a good start has been made on culture and relationships more is needed, and you have already indicated a commitment to a longer-term OD programme. This should include the broader system but in addition those colleagues who attended the workshop should come together to review their progress.

Recommendations

The Board is requested to:

1. Note the contents of the report.
2. Approve the recommended next steps.

Governance and reporting (list other forums that have discussed this paper)

Meeting	**Date**	**Outcomes**
ICB Executive Meeting	24 January 2023	Supported the paper for the Board

Conflicts of interest identified

not applicable

Implications

If yes, please provide a brief risk description and reference number	**Yes**	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Privacy impact assessment completed			x	
Financial impact assessment completed			x	
Associated risks			x	
Are associated risks detailed on the ICB Risk Register?				

Report authorised by:	Kevin Lavery CEO

Operating Model for the Lancashire and South Cumbria Integrated Care Board and Provider Collaborative Board

1. Introduction

1.1 In October 2022 Lancashire and South Cumbria (LSC) Integrated Care Board (ICB) commissioned a programme of support to develop clarity about the respective roles of the ICB and the Provider Collaborative Board (PCB) in the ICS and to define the optimal operating model for the ICB and PCB.

1.2 The programme of work took place during November – December 2022. This report describes:

- The context and objectives of the work.
- The approach taken to deliver the programme.
- A summary of the outputs of a workshop with ICB and PCB leaders held on 19 December 2022 to discuss the priorities agreed for joint effort between the ICB and PCB and the operating model to deliver those priorities.
- Conclusions and recommendations.

2. Context and Objectives of the work

2.1 The context and purpose of the programme of support was set out by the ICB in October 2022 and is described in the following paragraphs.

2.1.1 The L&SC ICB was established on 1 July 2022. It was preceded by a pathfinder integrated care service operating as a shadow ICB for 18 months and a Provider Collaborative. Both delivered early wins for the system.

2.1.2 The L&SC system faces huge challenges, many of which are greater than ever before and go beyond those faced by health and care services across the country:

- The ICB was born in a pandemic with huge backlogs for planned treatment.
- Widening inequalities in a system with severely challenged regions – towns like Blackpool and Blackburn have some of the poorest health outcomes in the UK.
- The system is a poor performer. Overall, the system is SOF 3 with three of the five trusts in SOF 3 and in need of improvement. One trust is SOF 4 and subject to national intervention. Only one trust is graded at SOF 2.
- Historically NHS organisations have enjoyed real term year on year increases but the financial horizon for foreseeable future looks very constrained. Some tough decisions have already been taken to balance the budget and delivering it has significant risk.

- Nationally, high ambitions have been set with a clear focus on emergency care pathways, clearing the backlog for planned treatment, reducing hospital admissions, and improving the speed and effectiveness of hospital discharge. It is clear with an election on the horizon that immediate returns are expected, including rapid and sustainable improvements across quality, productivity, efficiency and use of resources measures.
- We are in the midst of a very challenging winter with urgent and emergency care systems being tested to the limit with expected record numbers of patients with Covid and flu and severe staffing shortages, all under the media microscope.
- And these challenges to be managed whilst still setting up the new ICB. It is also clear that NHS England will hold the ICBs to account for delivery.

2.1.3 Leaders in the ICS share an ambition to improve health outcomes, reduce inequalities and improve performance. There is a burning platform and many opportunities to secure a step change in quality, performance, efficiency, and effectiveness. The ICB wants L&SC to become a high performing system in short order. This means having a strong community focus with integration of health and care, investment in prevention and improved access to primary care, all delivered with a close eye on health inequalities. They also want to ensure that the five trusts are high performing, efficient and effective and work in perfect harmony.

2.1.4 A system level OD programme is being developed, which all partners are signed up to. This is a medium-term strategic work programme, but an urgent requirement was identified to address some immediate issues and challenges in the way that the ICB and PCB work together, which requires timely attention to enable the system to achieve its ambitions and work at pace. There is confusion over what system leadership really means. What is the role of the ICB and PCB? What powers should the ICB, and PCB have? How should the two work together in practice? What does optimal collaboration look like? How do we avoid duplication of effort, resources, and leadership? What is the role of the ICB vis-à-vis the Region?

2.2 In this context external support was commissioned to support the ICB and PCB on the following:

1. Establishing clarity on the role of the ICB and PCB
2. Advice on the optimal system operating model for the ICB and PCB, to include:
   a) leadership roles/responsibilities,
   b) programme and decision-making infrastructure (key forums/meetings etc)
3. What culture and processes need to be in place to create success?
4. How to avoid duplication of effort, resources, and leadership?

2.3 The work was intended to be jointly owned by the ICB and PCB and would involve:

- Examining the current, embryonic arrangements
- Looking at best practice elsewhere
- Recommending what needs to stay, stop and what we should do differently.

3. The approach taken

3.1 The aim was that the approach taken to the work would not only deliver the required clarity about the respective roles and operating model for the ICB and PCB but will also lay the groundwork for future system working.

3.2 Dame Ruth Carnall and Paul Gray were engaged to support the programme. The following methodology was adopted:

- Ruth and Paul interviewed senior leaders in the system and at regional level. The schedule of interviewees is included as Appendix 1 and covers:
    - Chairs and Chief Executives of NHS providers in L&SC
    - Executive and Non-Executive Directors of the L&SC ICB
    - PCB SROs and the PCB management team
    - Members of the Regional and National NHS England team

- These interviews were tailored to the individual, but for L&SC system leaders covered:
    - What works well that we can build on and what are the challenges
    - The key issues and priorities for the system to tackle
    - What are your thoughts on how these challenges might be met
    - Views of the role and distinctive contribution of the ICB and the PCB and other players in the system
    - What would make a good outcome for the workshop scheduled for December
    - With key regional leaders the interviews also sought to understand their views of the L&SC system.

- Meet key people nationally especially the team working on provider development and also those in advisory roles.
- Research approaches across the country to consider what has gone well and what has not worked.
- Attendance at the PCB development day in December
- Synthesis of this material to include some of the local case studies as the basis for a face-to face workshop to develop roles and the operating model
- Use the workshop output as the basis for a report with recommendations for the ICB and PCB to consider.

3.3 The interviews took place during November and December 2022, followed by a workshop held on 19 December 2022 for provider chairs and chief executives, and the ICB chair and executive team. A follow-up discussion was held with ICB non-executive directors in January, after which this report was prepared.

3.4 The next section describes the workshop, the discussions that took place and the conclusions that were reached.

4. System leaders workshop 19 December 2022

4.1 The chairs and chief executives of the five provider Trusts and the chair and executives of the ICB met in person on 19 December to work together on the roles and operating model for the ICB and PCB.

4.2 The workshop was designed to enable the group to:

- Reflect on the feedback from the 1:1 discussions and insights from elsewhere.
- Identify the priorities for joint effort between the PCB and ICB.
- Think through the respective roles and operating model for a subset of those priorities.
- Use that discussion as a foundation for the model of future working.

4.3 Each of these are discussed in the following paragraphs.

4.4 Feedback from the 1:1 discussions

4.4.1 The 35 or so interviews had highlighted the very significant amount of common ground that is shared by system leaders in L&SC, and the high degree of commitment to work together to respond to the huge challenges in the system. Despite the current and future challenges, there is optimism about the future. The extent of the common ground is not found in every system and provides a very strong foundation for the future.

4.4.2 Notwithstanding this, a number of key issues were raised through the 1:1 discussions which were grouped into four themes. In summary they related to:

- **Strategy and priorities:** highlighting the need to confirm the priorities for the ICB and PCB and to develop a longer-term strategy for health and for transforming clinical services
- **Delivery:** where frustrations had been expressed about the approach to delivering together so far and a desire to improve this in future
- **Structure and operating model:** which included different perspectives on the role and purpose of the PCB, the respective roles of the ICB and PCB, and the need to also consider the operating model in the context of the role of places and the contribution of primary care and local government.
- **Style, relationships, and culture**; with all partners wanting the ICS to succeed and emphasizing the importance of building trust and effective working relationships.

4.5 Agreeing the priorities for the PCB and ICB to work on together

4.5.1 Working in smaller tables the group discussed what the range of priorities should be for the PCB and ICB to work on together for the next 12 months. We noted that there are too many priorities at present and the aim was to identify the short list of areas where joint effort will be prioritised and

resourced to deliver clear objectives. It was fully recognised that this did not reflect the complete priorities of the system as a whole and that a full strategy was needed - and which will be developed in due course - but that this need not mean no progress can be made on some of the big changes which everyone recognises the need for.

4.5.2 Eight priorities for joint effort emerged through the discussion:

1) Elective recovery including design of hubs with agreement to the model by September 2023.
2) Clinical service redesign, beginning with vascular, stroke and urology.
3) Community services redesign with mental health.
4) Urgent and Emergency care pathway:
   - Redesign pathway to best practice.
   - Focus specifically on ambulance handover times.
   - Focus specifically on urgent mental health services.
5) Single pathology network.
6) Workforce capacity, planning and recruitment.
7) Single clinical information system.
8) Shared corporate service support in Finance, HR, and Procurement.

4.6 Clarifying roles and developing the operating model

4.6.1 Each of the identified priorities will require further work to refine and agree programmes and leadership. At the workshop we selected three priorities to use to help think about the future operating model and worked on those initially in mixed ICB/PCB groups and then reflected on the discussions in separate provider and ICB teams.

4.6.2 The three priorities selected to use as examples were:

- Elective care and the design and designation of hubs
- Vascular service redesign
- Community services considering how to work within place and across the whole system

4.6.3 The discussion about each example covered the following questions:

- Define the shared quality and financial objectives which require joint rather than individual action.
- What approach do we want to take to planning this programme of work?
- Who will do what – role of the ICB and PCB.
- What do we need from each other to successfully deliver the objective?
- How is accountability demonstrated and what happens when we disagree or get stuck?
- Where will we be in 6 months and 1 year?

4.6.4 Following the discussion in mixed ICB/PCB groups about these three examples, the provider and ICB teams reflected separately about what this means for the ICB and the PCB.

4.7 Actions agreed

4.7.1 At the end of the workshop the following actions were agreed:

- The first example discussed was the elective care recovery programme and the creation of hubs for the ICS. This had been a productive discussion and it was agreed that Kevin McGee would take this forward developing the programme proposed, for discussion at the delivery board and the PCB in January. This would include a proposal on resourcing and leadership.
- The second example discussed was the fragile clinical services, and specifically vascular surgery. It was agreed that Martin Hodgson would review the discussions held on vascular surgery and refine the programme to include timescales and resourcing/leadership requirements, being clear about how the PCB and ICB would work together. The other two specialties identified (stroke and urology) should also be reviewed in light of decisions about how to take forward vascular surgery with greater pace.
- The third example was community services redesign. Some work had been initiated by James Fleet and Sarah O'Brien on community services redesign. The discussion at the workshop highlighted confusion about how the emerging place-based leadership should dovetail with the PCB so that provider leadership could be engaged. James agreed to initiate a reset meeting with colleagues from providers to consider how best to take forward this work at ICB, PCB and place levels.
- Kevin Lavery and Kevin McGee agreed to review the longer list of priorities, confirming the final list and considering how each could be taken forward by the PCB in conjunction with other system players and incorporating that into the joint forward plan submission to NHS England.

5. Conclusions and recommendations

5.1 Significant progress was made in the workshop and as described above, there were some agreed actions to take forward. The full details of the workshop discussions are included in the workshop write up. We have reflected on the interviews, the workshop and subsequent discussions and set out our recommendation below. Perhaps though, the most important point would be to say that the operating model must evolve from continued discussion and development not just between PCB and ICB colleagues but with leaders across the whole system. Place leaders have recently been appointed and colleagues stressed the importance of ensuring that the operating model should encompass a clear statement about how place fits both with the whole system and the PCB. Local Government, Primary Care and other sectors were also not party to this initial programme which clearly needs to be rectified. This report is therefore only one contribution, made at a specific point in time in the development of the system.

5.2 In the feedback from the interviews and at the workshop we gathered our reflections and conducted discussions under four headings. So that the link is clear, we have set out our recommendations below under those same headings.

5.3 **Strategy and Priorities** - The ICB has been in existence only since July 2022. The PCB existed prior to that as part of the developing approach to integrated care systems. The ICB has in that short time substantially restructured and

recruited new leadership and in common with the rest of the country L&SC has faced an exceptionally challenging few months as the NHS and other public services have tried to recover from covid and prepare for the heavy operational pressures of winter.

5.4 This has not been an environment in which colleagues across the system could easily take the time to think strategically about the future. To make a profound impact on the particular health challenges facing people in Lancashire and South Cumbria (which includes some of the most deprived areas of the country) will take considerable time, effort and resource. In our workshop there was a clear recognition that the creation of the ICS was an opportunity to overcome the fragmentation of recent years and to really pursue a system wide health strategy. Work done previously shows that, as part of a whole population health strategy, major changes will need to be made to secure high quality safe and sustainable clinical services accessible to all, including:

- Urgent and emergency care.
- Investment in services in the community including for mental health services and to support frailty.
- Elective and cancer care.
- Centralisation of some specialist care.
- Effective clinical networks enabling access to services for remote or vulnerable communities.
- Significantly improved productivity across all services.

5.5 It will be impossible to focus across this whole range at the same time. Change will be controversial and require thoughtful engagement and consultation as well as significant leadership and resourcing including for the transitional costs of change. As the ICB matures into its role working with and through key partners this work will define its future success but right now the pressures of operational delivery dominate the time and attention of leaders.

5.6 Nevertheless, our advice is that it would be helpful to set out an approach and a timescale for producing a health strategy and within that a strategy for transforming clinical services. In the meantime, given the work that has already been undertaken by organisations within L&SC it ought to be possible to agree a short list of priorities, accepting that the major strategic review which is comprehensive and systematic will come later.

5.7 Some progress was made on this in the workshop on 19 December, where a long list of priorities was synthesised down to a shorter list. We recommend that this list is revisited and refined and that for each confirmed priority the ICB and its partners agree:

- The objective in measurable terms
- The programme of work required
- Respective role and responsibility of each partner including who will lead
- What resources are needed
- How accountability will be delivered

5.8 This would enable the PCB to make progress on some key priorities on behalf of the system with support and oversight as appropriate being provided by the ICB.

However, it remains essential that everyone understands how and by when a full strategy which is prioritised and resourced will be produced.

5.9 **Delivery** - In the course of our interviews, we heard a great deal about the objective of delivering significant efficiency and financial savings from bank and agency staffing which had been a source of frustration to everyone. We discussed how and why, despite the significant leadership commitment, what appeared to be low hanging fruit had failed develop the clear delivery model needed to succeed. We did not dwell too long on the specific lessons learnt from this because colleagues were satisfied that by the time of the workshop the programme had been secured and would now deliver. We considered how the lessons might be applied to other programmes for example shared approaches to procurement, HR, and finance functions.

5.10 The key to securing commitment lies in:

- Clarity about the objective and genuine agreement in detail
- An agreed programme of work with committed leadership
- Clear achievable timescales and milestones
- Accountability based on transparent data
- An approach based on mutual trust and openness with a joint commitment to succeed together overcoming obstacles together.

5.11 We saw that some of this was about structure and process, but a lot was about culture, style, and behaviour. Whilst the workshop made a start on working these through, there is more work to be done. The success of the Bank and Agency programme will be critical to giving people confidence that they can succeed together. Those lessons can be applied to other corporate programmes. It will be important over the coming months for the PCB to review progress considering both the absolute measures of delivery i.e., savings but also the development or otherwise of trust and mutual respect.

5.12 One issue raised in interviews was that of the potential for duplication of role between the Delivery Board and the PCB. It is not the role of the PCB to oversee performance of individual Trusts. The delivery Board is an ICB mechanism for reviewing performance and the accountability relationship is between the ICB and individual providers. We recommend that the PCB should be continually clear that there is no tier of accountability for performance which sits with them.

5.13 **Structures and Operating Model** - Views about the role of the PCB varied widely, ranging from those who saw it as a precursor to the establishment of a Group (i.e., a quasi-organisation) to those who believed it should be looser collaboration of providers coming together to oversee specific programmes of work on behalf of the ICB and providers. In this programme of work, we were asked to specifically consider the PCB, but many colleagues felt that this hampered the opportunity to consider how place should be a focal point for shared accountability and also that important representation from primary care and local government was absent. Nevertheless, when we reflected on the separate roles of the ICB and the PCB it was a productive discussion. We would draw out the following key points;

- Collaborative working is complex and time consuming because it requires organisations with differing pressures and priorities to align and commit to supporting a shared objective. Because of this the bar to working at PCB level needs to be high. Individual providers working

alone and indeed in place should have maximum autonomy consistent with the delivery of the ICBs overall plan.

- There are plenty of opportunities for providers to collaborate without needing an overarching governance. An example we heard about the proposed changes to mental health services for children and adolescents on which good progress was being made without the need to engage the whole PCB. It may be though that the two providers concerned will need support to engage primary care, and other parties in individual places.
- The ICB should lead on determining the overall system priorities for L&SC, undertaking this priority setting process in a collaborative way.
- The PCB should focus on a few significant priorities which have high impact. Those priorities should be agreed with and involve a mandate from the ICB. Each of the priorities should also have a programme approach and an SRO held to account for delivery of a clear programme of work.
- Prior to the workshop significant progress had been made by the PCB in developing a formal Joint Committee operating on behalf of all providers. We felt that this was a positive step and would provide sound governance for decision making.
- A lead CEO for the PCB is an effective way of maintaining a linkage between the ICB, its subcommittees and the individual providers and this arrangement is already appropriately established.
- Whilst a small and capable dedicated team is clearly needed to ensure good governance for the PCB, we do not recommend standing appointments of individual functional directors because of the risk that they could, over time, imply a hierarchy. However, professional networks are a common and effective means of ensuring good communication and sometimes a means of marshalling scarce resource. Finance, nursing and HRDs have long had professional networks, and these can happily co-exist with clarity of accountability between the ICB and providers
- Some systems have benefitted from independent chairmanship of their PCB. In L&SC it is clear that some very challenging decisions about the configuration of services will need to be taken in future, affecting all providers. For this reason, the PCB should reflect on whether independent chairmanship could provide a more secure and legitimate means of resolving the inevitable conflicts which will arise.
- A programme-based approach means that accountability through clarity of role and commitment of resource will not form a single operating model covering all issues but will vary according to the nature of the programme ranging from something which is provider initiated, managed, and resourced through to a major service change which requires independent input, ICB leadership and consultation and significant investment both from the PCB and also from the wider system.

5.14 One very significant issue which needs to be considered is how to secure dedicated clinical leadership capacity and capability. From the discussion at the workshop and the data we have reviewed it is clear that the clinical strategy will

require very challenging changes to the model of care for NHS services. This can only be led by committed clinicians especially doctors who are well supported to give their time. We did not discuss how practical this will be, but it needs urgent consideration. The possible establishment of a clinical leadership forum with external clinical input should be debated. Without this scale of change required is substantially at risk.

5.15 **Style, Relationships and Culture** - The PCB predated the establishment of the ICB, and the L&SC ICB had decided to set a new structure and to recruit substantially from outside for the most senior roles. Whilst this was recognised as positive as it differentiated the approach from what had gone before it had caused delay and also created tension. The ICB was clearly seen by some as wanting to establish its authority and whilst this might have been accepted as legitimate, it was evident that there was process of norming and storming well underway. That said, it was also clear that all parties want this ICS to succeed and want to tackle some of the long-standing issues that predecessor systems have failed to address.

5.16 Good progress was made in the workshop with clear actions agreed, named leads for some programmes and commitment to get together on a more regular basis to think about roles, responsibilities, and relationships. We were struck by the spirit of commitment we saw and the lack of defensive behaviour or visible protection of organisational status. We strongly felt there was a good basis for securing a shared success. We saw though that the very challenging nature of the changes needed to secure sustainable services would certainly test this sense of shared purpose.

5.17 The key issue will be how to avoid the workshop being a 'flash in the pan' at a time when the pressure of business as usual is so great. Also, only NHS providers and the ICB Executive team were in the room and the integrated care system leadership must include other key players. A system level OD programme is being developed. We recommend that providers across L&SC and place-based leadership should come together on a regular basis to take forward a programme of development. This programme needs to be grounded in the agreed priorities but offer opportunities on a regular basis for reflection on progress made which can be celebrated and lessons which need to be learnt. The open and honest dialogue which we believe has been started will continue to need support over the coming months.

6. Recommended Next Steps

6.1 The Board is requested to:

1. Note the contents of the report.
2. Approve the recommended next steps.

Dame Ruth Carnall
Paul Gray

21 January 2023

Appendix 1

System and regional leaders interviewed as part of the programme

	Name	Organisation	Role
1	Kevin McGee	Lancashire Teaching Hospitals	CEO and PCB Executive Lead
2	Paul O'Neill	Lancashire Teaching Hospitals	Chair (Interim)
3	Trish Armstrong-Child	Blackpool Teaching Hospitals	CEO
4	Steve Fogg	Blackpool Teaching Hospitals	Chair
5	Martin Hodgson	East Lancashire Hospital Trust	CEO
6	Mohammed *Shazad* Sarwar	East Lancashire Hospital Trust	Chair
7	Aaron Cummins	University Hospitals Morecambe Bay	CEO
8	Prof. Mike Thomas	University Hospitals Morecambe Bay	UHMB Chair and PCB Chair
9	Chris Oliver	Lancashire and South Cumbria NHS Foundation Trust	Interim CEO
10	David Fillingham	Lancashire and South Cumbria NHS Foundation Trust	Chair
11	David Flory	ICB	Chair
12	Kevin Lavery	ICB	CEO
13	James Fleet	ICB	Chief People Officer
14	Sam Proffitt	ICB	Chief Finance Officer
15	Maggie Oldham	ICB	Chief Planning, Perf & Strategy
16	Asim Patel	ICB	Chief Digital Officer
17	Craig Harris	ICB	Chief of Integration
18	Sheena Cumiskey	ICB	ICB Board non-executive
19	Jim Birrell	ICB	ICB Board non-executive
20	Jane O'Brien	ICB	ICB Board non-executive
21	Roy Fisher	ICB	ICB Board non-executive
22	Ibby Adia	ICB	ICB Board non-executive
23	Sarah O'Brien	ICB	Chief Nurse
24	David Levy	ICB	Medical Director
25	Richard Barker	NHSE	Regional Director
26	Darren Mochrie	NWAS	CEO
27	Becky Higgs		
28	Nikhil Khashu	NHSE	Regional Director of Finance
29	Kevin Moynes	ELHT (Director of HR and OD)	SRO - People
30	Pete Murphy	(BTH (Director of Nursing)	SRO - Nursing
31	Gerry Skailes	LTH (Medical Director)	SRO - Medical
32	Jonathan Wood	LTH (Director of Finance)	SRO - Finance
33	Tony McDonald	ELHT (Executive Director of Integrated Care)	SRO - Community Services
34	Gemma Stanion/Nicki Latham/Ed Parsons	PCB	PCB leadership team