

minutes

Board of Directors (in Public) Item 1.3

Minutes of the Meeting of the Board of Directors held on 10th June 2025

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| Present: | David Flory James Sumner Joan Matthews Ben Vinter John Doyle Justin Ratnasingham Sarah Barr James Thomson John Doyle Jackie Bird Jonathan Mathews Jay Wright Claudette Elliott Rachael McDonald | Chair Chief Executive Director of Nursing, Quality & Safety Director of Risk & Corporate Governance Non-Executive Director Divisional Medical Director, Clinical Services Chief Digital & Information Officer Chief Finance Officer Non-Executive Director Non-Executive Director Chief Operating Officer Clinical Director of Research Non-Executive Director Deputy Chief People Officer |
| In Attendance: | Ruth Gaunt | Executive Office Manager and Corporate Governance Lead |
| Observers- Governors/ Staff/ Members of the Public: | Keith Wilson Dot Price Margaret Roberts | Staff Governor Staff Governor |
| Apologies for absence: | Nicholas Brooks Jane Royds Manoj Kuduvalli Tom Pharaoh | Non-Executive Director Chief People Office Medical Director Director of Strategy |

Action

- 1 **Welcome and Opening Matters**
The Chair opened the meeting and introduced those in attendance observing the meeting.
- 1.1 **Apologies for Absence**
Apologies for absence were noted as above.

DF advised that public and developmental Board meetings had been rescheduled to align with organisational requirements. The use of a scheduled Board Strategy day for a public Board meeting produced several apologies, however necessary capacity and capability was available to operate the meeting effectively.

1.2 Declaration of interests relating to agenda items

All meeting participants were asked to declare any interests in respect of items listed on the agenda. All participants confirmed that they had no interests to declare beyond those that may already be known and on Trust registers.

1.3 Minutes of the Board of Directors Meeting held (in public) on 29th April 2025 – for approval

The minutes of the Board of Directors meeting held on the 29th April 2025 (in public) were reviewed for accuracy and **approved** by the Board of Directors.

1.4 Action Log (Public) from Previous Meeting

The action log was reviewed, and the following action was noted as complete and removed from the action log.

- DIPC Quarterly Report Q4 - Annual report will include the year's progress. MK will also request the team provide trend data. To be discussed as agenda item.

All other actions were due for review at a future date.

1.5 Staff Story – Justine Brislen

Rachael McDonald introduced the staff story. Justine Brislen, former head of Learning & Development provided personal reflections of working for LHCH.

In July 2016, Justine joined LHCH, drawn by its outstanding reputation and a desire to advance her career by shaping its clinical and medical education services. Starting as a Clinical and Medical Education Business Partner, Justine since progressed to Head of Learning and Development. With a lifelong passion for helping others grow, rooted in early days as a student and qualified nurse. Justine has held various roles in education, including simulation and clinical skills and believes education is vital for patient safety and care. Justine took great pride in seeing colleagues thrive through learning. Justine would encourage others to the LHCH join without hesitation.

Joan M advised that the L&D team supports learning across all roles, promoting both specialty training and cross-specialty development. This builds confidence, broadens knowledge, and benefits the wider NHS.

JD inquired if learning from outside the Trust is encouraged. Joan M confirmed that regular peer reviews take place. Benchmarking and shared practice is shared across the critical care network.

JW suggested that as similar centres are absorbed into larger organisations, it would be a good time to review practices. There is value in exploring how others have adapted in order to guide LHCH future development.

RM stated that high staff turnover in ICU was noted a couple of years ago, particularly between one and two years of service. The team spoke to those staff members to understand why, and interestingly, many returned after gaining experience elsewhere, ultimately staying longer with LHCH in the long run.

DF noted initial impressions of the organisation were very positive, and over time, that has deepened into a strong sense of commitment and belonging among staff. People feel supported, valued, and part of something meaningful, an impression reinforced by consistently strong staff survey results and stories presented to the Board.

DF suggested individual staff attend the meetings going forward to provide interaction.

JR

The Board of Directors **noted** the staff story.

1.6 CEO's Report

James Sumner, CEO provided an update on a range of issues. The report was taken as read and JS highlighted key items of note.

The Cheshire and Merseyside system is facing significant financial challenges, with a large deficit and no fully agreed recovery plan, prompting a PwC-led review. While LHCH remains relatively stable with a projected surplus, broader system pressures, like reduced specialist commissioning, highlight the need for collaborative planning. Recent workshops with the five Liverpool trusts have shown strong alignment in strategy and values, with cardiology identified as a key focus for transformation. Despite ongoing financial strain, there is optimism in the collective approach, particularly through the LAASP programme and shared corporate services strategy, now branded as "Stronger Together."

Despite intense financial pressure across the system and ongoing scrutiny, such as rising staffing costs and PwC's review of Cheshire and Merseyside, there is a strong focus on delivering the LAASP programme as the most sustainable path forward. While individual organisations face challenges, collaboration is proving effective. Recent quality improvement work, like the radiology team's success in reducing diagnostic wait times, shows the power of shared learning. By sticking together and building on these successes, there is a good position to navigate the current pressures and deliver meaningful change across the region.

JS explained that PwC is supporting the 5 organisations in creating a unified 3-year plan, aligning with the NHS's shift away from annual planning. Working with the regional finance director Chris Adcock to ensure the approach matches national expectations. JT noted that the 3-year planning approach is especially valuable for infrastructure projects like theatres and Cath labs, where multi-year investment is essential. Moving away from short-term cycles and helps to ensure best value from long-term developments.

A detailed 3-year plan is needed, that clearly outlines: what benefits are expected from implementing consistent digital technologies, what would be gained from harmonising corporate services, and which specialties offer the

greatest opportunities. Once that programme is defined, there will be a very strong case for moving ahead

CE noted the importance of staying focused while understanding the daily pressures Executive colleagues face. Supporting each other provides confidence around prioritisation.

JT noted that things felt noticeably different over the past six weeks, especially with the increased ICB turnaround demands. In previous years, pressures were discussed without being directly affected, but now LHCH are clearly part of the process. It's important to recognise that, while also acknowledging the strong productivity work maintaining the underlying surplus position, not only about cost control, but about being more efficient and effective.

JS noted a good example of ongoing partnership challenges is the vascular input into the aortic service. While initial discussions focused on high costs, more recent conversations have revealed the true system-wide cost is much lower. If finances are treated collectively rather than charging each other, better services could be developed without unnecessary barriers. It shows that when clinicians collaborate without financial or bureaucratic obstacles, real progress is possible.

JR advised that the aortic team and radiology team will provide a presentation to the next Operational Board showcasing how they have optimised imaging before appointments, reducing unnecessary scans and associated reporting costs. Impressively, they have achieved a drop in scan requests for aortic surveillance patients, even as national demand continues to rise. It is a great example of sustainable, patient-focused improvement. JW agreed there is a major issue in the city with repeated tests like ECHOs and CTs, especially in ACS patients, wasting resources. A city-wide education approach, not just within specialist centres, can help fix this and will be a clear cost saving and better care.

JB noted assurance from the reports around strength in the Trust's quality and safety systems. These need to keep delivering value in different ways, and while that foundation is already in place, focus must continue maintaining it.

DF explained that despite the strong financial management, the Trust faces the same challenge as others in Cheshire and Merseyside: being part of an overfunded yet overspending system. Achieving sustainability will require significant, rapid change, and new system leaders are now working to address this. Focus should remain the role in addressing both local and system-wide challenges. While increased funding for the area would be welcomed, it would also bring greater scrutiny and less time to resolve existing issues, making the contribution to system solutions even more critical. Focus must be on actions that support long-term service and resource sustainability.

The Board of Directors **noted** the update.

2.1 Learning from Deaths, Quarterly Report, Q4 & Annual Report

Justin Ratnasingham, Divisional Medical Director, Clinical Services presented the learning from deaths report.

JR highlighted the well-established process for evaluating all deaths, beginning with a screening and followed by an in-depth review when necessary. Since February 2025, a new Chair has led the Mortality Review Group, prompting changes to its composition, including the addition of a regular trainee representative and greater nursing integration.

Any deaths with identified learning points are linked to the governance process, with findings fed back through audit days and a closed via an action log system. Recent reports have highlighted a recurring theme: delays in escalating care to senior medical staff during patient deterioration. In response, a formal critical care escalation policy has been implemented.

JS questioned assurance around Early Warning Scoring. Joan M confirmed that monthly audits are fed back to the divisions and form part of the resuscitation committee report.

CE noted assurance around continual dialogue between clinicians and families, in particular families who require additional support.

JR explained that the Mortality Review Group includes multidisciplinary members and engages in detailed discussions. At the conclusion of these deliberations, they assess the likely cause of death and the degree to which it may have been avoidable. However, it's important to note that this process involves a degree of professional judgment, it is not always possible to assign a precise percentage to the avoidability of a death. Deaths are also presented at audit days.

The number of deaths remains consistent with previous years, and the Trust continues to meet national standards.

JB inquired about the QA process, having identified 44 cases for discussion based on specific criteria, would other deaths be reviewed to identify examples of good practice that could support audit or learning. JR confirmed that there is an ethos of learning from all deaths. All patients receive a mortality screen. Learning is raised at the MRG.

The Board of Directors **noted** the report.

2.2 Safeguarding Annual Report and Deprivation of Liberty (DoLS) update

Joan Mathews, Director of Nursing & Quality presented the Safeguarding Annual Report and Deprivation of Liberty (DoLS).

The 2024–25 Safeguarding report highlights key achievements and sets priorities for 2025–26. Governance has been strengthened through a new Safeguarding operational group feeding into the committee structure and QSEC going forward. Training compliance is high at 95%, and 28 DoLS applications were made, mainly for delirious patients.

The Safeguarding lead reviews referrals with clinical staff to find safe alternatives. Many cases are managed internally with measures like one-to-one care or close observation for confused or delirious patients.

Liverpool ICB monitors safeguarding KPIs, with regular meetings between their lead and LHCH to ensure progress. Safeguarding training, including Prevent and RAP (Recovery and Action Plan), is actively promoted, with two Prevent referrals made last year, one accepted and one investigated for concerning behaviour.

Mental health support is under review, as referrals to Mersey Care have been low, prompting outreach to neighbouring hospitals for shared resources. Crisis team contacts remain available, including rare section 136 cases.

There is currently one Safeguarding Lead in post, and recruitment is underway for a second team member. They handle high volume of work, especially related to delirium.

LHCH has signed up to the NHS Sexual Safety Charter and will host a four-day training event with ICB leads to raise awareness.

Overall, it has been a strong year for safeguarding, with continued focus on patient safety and staff training.

JD requested information regarding priorities for 2025–26, how they will be phased and how highly they are ranked in importance. Joan M confirmed that the safeguarding lead is connecting with local hospitals to understand their priorities, which often focus on frailty, unlike LHCH focus on delirium. The safeguarding lead is working to align efforts and prioritise implementation, including staffing, to ensure LHCH can contribute effectively.

JD noted that when visiting the intensive care unit, discussion took place around the importance of night-time lighting, and staff mentioned that improved lighting could help reduce delirium. Joan M advised that the critical care manager is leading initiatives around lighting to support patients with delirium, collaborating with other organisations.

Joan M informed the Board that Security staff have received education on delirium and mental health, and included this in MET calls to ensure fast, appropriate responses. These changes are improving patient care and aligning with wider NHS developments.

DF inquired if the Trust have effective information sharing in place, not just across multi-agency partners, but also within different parts of the NHS. Joan M confirmed that the safeguarding lead works closely with colleagues, including those at LeDeR. The report highlights focus on patients with complex and enhanced needs. Collaboration with external partners, such as the local authority, is key to supporting these patients effectively. There is good awareness when people reach out for help or protection, the team explore their needs through questions. Information is then shared appropriately, either within the organisation or with the local authority, depending on the situation.

The Board of Directors received **assurance** that appropriate safeguards are in place to protect adults and children in LHCH in line with national and local directives, and legislation related to safeguarding adults and children.

2.3 Infection Prevention and Control (IPC) annual report 2024-25

Justin Ratnasingham, Divisional Medical Director, Clinical Services presented the IPC annual report.

The ongoing surveillance programme for monitoring and reporting on health care associated infection (HCAI) has continued and indicates that overall, Trust attributable infections have remained relatively low. There is a comprehensive audit programme which has demonstrated that standards have remained high. An assessment against NHS standards provides assurance that the Trust is fully compliant with the majority (51) of standards related to infection prevention and control, with only 3 standards with partial compliance. 2 of these relate to the fact that they are reliant on external providers (Occupational Health and Laboratory services) and 1, related to antimicrobial prescribing, which is a new standard that has not yet been fully explored. A substantial amount of evidence is available to support the assessment.

A surgical site infections (SSI) group has been established in the Trust, with bi-monthly meetings with multi-disciplinary membership. The group oversees an audit programme and ongoing action plan. The rates of the more severe infections i.e. those that are not classed as superficial, has decreased over the previous 2 years. A review is completed for all these patients to identify any issues or learning which are fed back to the relevant areas and via the surgical audit days. A drop in pre-surgery decolonisation compliance led to a multi-disciplinary review, resulting in actions to include staff training and increased monitoring.

In order to continue to maintain progress and reduce the risks of HCAI a forward plan for 2025/2026 will be developed and progress against this plan will be monitored throughout the year by the Infection Prevention Committee.

DF enquired if concern is raised regarding C-Difficile cases. JR confirmed only 1 case has been identified. Joan M advised that antimicrobial resistance is more common in the community than in hospital settings. Early detection and control in hospital admissions help keep rates low. JW noted that while consultant microbiologists are a limited resource, the involvement of the specialist nurse has been key in maintaining low rates, making their role especially valuable. JB suggested that reason infection rates remain low is bed occupancy which stays around 82–85%, this being a level few organisations maintain. This balance is crucial, and it is important the Trust sustain it, as higher occupancy could lead to different outcomes.

The Board of Directors **noted** the report.

2.4 Medical Examiner Annual Report

Justin Ratnasingham introduced Dot Homan, Lead Medical Examiner Officer who attended the meeting to present the Medical Examiners report.

JR informed the Board of Directors that the medical examiner process, statutory since September 2024, has reduced coroner referrals. While some confusion remains about when to refer, the process is running smoothly with no major concerns.

DH explained that Doctors are becoming more familiar with the medical examiner system, reducing unnecessary coroner referrals. Clear guidelines, developed with Liverpool coroners, help determine when referrals are needed. Death certificates are only signed after family discussions, ensuring transparency and satisfaction, feedback is positive.

Joan M advised that DH is the first to speak with families after a patient's death and works closely with the Medical Examiner team to escalate concerns. Her compassionate approach is key, and the ME process has grown well within the organisation.

DH advised that the team support families after sudden out-of-hospital deaths, offering them the chance to meet the team involved later if they wish. Many take this up through PALS, while others find comfort just knowing the option is there.

The Medical Examiner service is well established at LHCH and is able to fulfil its statutory duties, working closely with HM Coroner's offices, LHCH bereavement services and clinical teams within the Trust.

DF requested expansion on the confusion amongst medical and surgical staff around the necessity for when a coroner's referral is mandated. JR explained that during the process following a patient's death, there can be confusion, especially if the cause of death isn't clear. In such cases, doctors may prefer to refer the case to the coroner to avoid uncertainty or future scrutiny. While this can lead to unnecessary referrals, it helps prevent errors like issuing an incorrect death certificate. DH advised that Doctors are adapting to the new process where the medical examiner conducts the main review. They can still recommend a referral to the coroner, and many such referrals are still made, after which the coroner decides on the next steps.

JS noted that the report describes how new doctors are receiving training and inquired if existing medical staff are also being trained. DH confirmed that training takes place during audit days together with adhoc training.

The Board of Directors **noted** the contents of this report.

3 Targets and Financial Performance

3.1 Strategic Oversight Framework – M1

Jonathan Mathews, Chief Operating Officer explained that the SOF is summarised by drive and watch metrics agreed at the beginning of the year and subsequently have changed as required.

The organisation is in a strong position as of month one, with refreshed dashboards reflecting new indicators for the financial year. Since some indicators are new, six data points are needed before meaningful analysis is possible. These updates align well with earlier meeting discussions.

Operational Performance - elective activity was below plan, particularly in surgical areas, which have been identified as a risk. However, RTT, diagnostics, and cancer performance are currently meeting targets. Risks remain but are actively managed. There is focus on reducing DNA rates and overdue follow-ups to improve productivity and better utilise resources.

Health inequality KPIs are now part of the performance section. Having this data is crucial, but equally important is understanding the trends and determining the actions that follow.

As approaching the final 2 months of the quarter, it is important to note that recent cancellations in critical care and surgery as of May are not yet reflected in the report. This serves as an early warning, and the team are actively working on mitigation plans and strategies to recover the financial impact.

JB noted that dashboard shows an average bed occupancy of 74%, which seems low and inquired if this suggests there are more beds than needed. JM advised that the Trust likely have too many beds for a seven-day model, but during the workweek, the issue is more about bed placement. Critical care capacity is being reviewed, exploring ways to consolidate ward beds to improve efficiency, also supporting private patient activity which mainly takes place during the weekend. The Director of Nursing and the Deputy Director of Nursing are working on that flow piece aligning with quality and safety.

Joan M advised that the work is still in early stages, focusing on mapping patient pathways. While overall bed occupancy appears to be around 75%, weekday levels often exceed 80–90%, driven by unexpected admissions that impact critical areas like ITU and CCU. These fluctuations, especially from emergency cases, affect surgical flow and capacity, making it challenging to maintain consistent occupancy levels.

JM advised once the financial position and plan has been finalised, this will allow the team to address the occupancy issue.

Quality of Care - falls remain stable, and complaint numbers are low. MK will present an updated SHM and KPR report to the Board in September, following a recent review. Notably, a previously reported never event has now been retracted after discussions with commissioners and is no longer classified as such. This change occurred after the report was written.

JS noted that the radiology reports metric issue has been resolved and inquired when the corrected data is expected to appear on the dashboard as it is currently showing an inaccurate position. JM confirmed that the updated data will be incorporated into the September report.

Finance - month1 financial position is on track in terms of the £597K surplus. A detailed financial report will follow. JM noted this year's 7% CIP target is a significant increase from last year's 2.8%, presenting a major challenge. However, with strong governance in place, there is confidence in managing this. Key focus areas include patient flow, reducing unnecessary tests, private patient services, and a thorough workforce review.

People - voluntary turnover is declining, and vacancy control is now well embedded across the organisation. All roles, including clinical ones, are reviewed weekly by the Executive panel. While there have been some early challenges around interpretation and risk management, the process has been positively received by divisions. Sickness levels remain broadly stable.

Research - for the first time, research indicators have been included in the SOF, to include four key metrics. This will be developed further over the year.

Operational Risk - risk reporting is now included in the report, with five current risks highlighted. While this complements the upcoming detailed risk report, there are slight differences due to timing of data capture. Overall, it provides a solid overview of the Trust's risk position, showing an understanding of key risks, working to mitigate them where possible.

BV informed the Board of Directors that risks have been included in the SOF report as a trial, alongside the standard Board risk report on the agenda. BV requested the Board's feedback on whether to continue this dual reporting or fully integrate risks into the SOF. The team are also working on aligning reporting timelines and updating risk scoring to the new 5+5+5 model by September. DF suggested that placing the red-rated risks at the front of the risk assessment helps the Board focus more effectively on the most critical areas.

JS advised that the SOF report is strong in terms of content, but the reliability of some metrics is limited due to insufficient data points in the SPC charts. For example, the appraisal metric shows an alert, but with only five data points, making it hard to assess whether it is truly out of control. To improve confidence in trend analysis, SPCs should be based on a longer data history. Overall, the report is well presented, but consistency in SPC usage needs attention in the final version. JM advised that some metrics have been adjusted to show just one data point while the dataset is built up, while others retain a six-month retrospective view. JM to review the charts to improve consistency across the SPCs. JM

3.2 Finance, Month 1

James Thomson, Chief Finance Officer presented the Finance Report for month 1, 2025-26. Currently reporting on plan, surplus of £564,000.

JT highlighted some income underperformance in Welsh contracts and private patients activity, creating slight pressure in month 1, which could pose a risk if it continues. On the positive side, pay is underspent year-to-date, and bank and agency use has dropped, reflecting tighter vacancy controls.

As of month 1, 37% of the CIP target has been met, mainly through corporate schemes. A new governance structure has been introduced to manage the risk, with increased scrutiny across divisions. As of last week, the return to NHS England showed 41% achievement, and 54% of schemes are either achieved or close to sign-off, aligning with expectations for June.

Over the course of the year, the CIP includes a stretch target that begins from month 6, as part of the planning process. This is built into the programme and is profiled to reach £2.6 million by mid-year.

As of month 1, the overall position remains stable, with a healthy and improving cash flow. It is also positive to note that the capital programme has started and is progressing on track.

JS noted the planned reduction of 40 WTEs, but also vacancies for the targeted lung intervention work, which haven't been recruited yet. JS questioned whether these unfilled roles are masking a future headcount issue once they are filled. JT confirmed that the Trust is currently 48 WTE below plan. Once those positions are filled, the numbers will adjust. This is a similar position for digital staff, working to rationalise the establishment level that comes with this, collaborating with Trusts across LAASP to optimise the model. The Trust may not recruit to the full digital establishment, as some posts will be shared with other organisations.

CE inquired how divisions are responding to targets. JM advised that targets have been set similarly to last year, with milestone-based reviews that may trigger support meetings if needed. Surgery remains a key concern due to unresolved elective and non-elective activity, and corporate services—especially facilities, estates, and capital, face significant financial targets despite being small teams. The focus is on supporting surgery and finding collective solutions in corporate areas, with collaboration across UHLG.

The Board of Directors **noted** the financial position of the Trust for month 1.

4 Governance and Assurance

4.1 Board Assurance Framework

Ben Vinter, Director of Risk and Corporate Governance presented the Board Assurance Framework.

The Trust's performance continues to be heavily influenced by external factors and the broader operating environment, as highlighted during the meeting. Divisions are being asked to deliver more with fewer resources, which is a core challenge at present. Within this context, 3 key areas remain above trajectory and outside the Board's agreed risk appetite: operational delivery, the financial plan, and the digital agenda. The first 2 have already been discussed, and the 3rd will be discussed in the private Board meeting.

The report is provided for assurance. The Board of Directors were asked to consider and support the stated position.

JD questioned how substantial assurance has been classified in the report. BV noted the approach to the Board Assurance Framework has always focused on whether the controls and processes are functioning effectively, rather than solely on scoring delivery against objectives. BV suggested this be explored further outside of the meeting and at Audit Committee. Auditors have previously supported this perspective.

Reporting provides transparency to the Board, highlighting issues and reporting on the effectiveness of controls, without implying full assurance across all areas.

The Board of Directors **approved** the opening BAF for 2025/26.

4.2 High Risk Report (>15)

Ben Vinter, Director of Risk and Corporate Governance presented the High-Risk report.

The high-risk report summarises key organisational risks. Currently, there are 4 high-rated risks concerning clinical letters, surgical plan delivery, the surgical corridor, and perfusion capacity.

The Board were asked to note that the overall risk profile has shifted in the recent period, with several digital risks downgraded due to improved controls and actions. This report is presented for assurance, and the Board were asked to note the updates.

JS noted that the completion date for the surgical corridor was April and questioned whether it had been completed. JM advised that the work has been completed, but it has not yet gone through the governance process via Capital and Operational Board to formally confirm the reduction in risk.

BV stated that it may be helpful for the Board to note, as previously discussed, the surgical corridor risk is a recurring, cyclical issue by nature. Therefore, the current approach should be seen as a temporary measure rather than a permanent solution.

JT highlighted that the Surgical Division independently raised the risk to the financial balance. This wasn't prompted externally; rather, the division identified and escalated the concern themselves through internal discussions. It reflects their ongoing risk monitoring and their judgment that the situation now warrants Board level of attention.

SB informed the Board of Directors that 2 digital risks previously rated at 16 have now been reduced to 12, which is why they no longer appear on the report. It is important for the Board to note that these were distinct backup-related risks that have since been mitigated. Additional infrastructure risks are currently under review and will be added to the risk register in due course.

The Board of Directors **noted** the content of report and received **assurance** that the Trust has systems and processes in place for the identification, management and escalation of risks.

4.3 Complaints Process Annual Report

Joan Mathews, Director of Nursing & Quality presented the complaints process annual report.

The report outlines complaints activity from April 2024 to March 2025. In this time frame 21 formal complaints were received, compared to 40 the previous year. This reduction has prompted some questions and discussions about

the underlying reasons, whether this change reflects a positive development or highlights potential issues. The report outlines actions taken.

In terms of informal concerns and contacts, there has been a slight increase, along with some changes compared to the previous year.

Of the 21 formal complaints received, 12 were partially upheld, 8 were not upheld, and 1 was fully upheld. Each case is reviewed thoroughly with colleagues to ensure quality and consistency in responses. Strong emphasis is made on scrutinising how complaints are handled and whether responses are fair, comprehensive, and aligned with expectations.

Of the 21 formal complaints, 10 were graded above low severity based on the complaints policy, which defines low as non-complex issues. 9 were graded medium, and 2 were high. The team tailor response times depending on the complexity of each case, either adhering to standard timeframes or negotiating with the complainant if more time is needed. This helps manage expectations and maintain transparency. Page 3 of the report shows complaint numbers by division and subject matter.

1 case referred to the Parliamentary and Health Service Ombudsman (PHSO), currently under investigation. Initially, the complainant declined monetary compensation, but they have since changed their mind. The request is now being processed.

The PALS team effectively manages informal concerns before they become formal complaints. A past trend involved queries about waiting lists, but with the urgent planner and better communication, those concerns have decreased. Patients can now track their status and feel reassured their needs are being monitored.

The report outlines the response process for both formal and informal complaints. This is managed by a small but active team, primarily led by Laura Allwood, with support from the divisions. Laura works closely with colleagues through the MEO and MRG processes, ensuring all complaint responses are well-coordinated and consistent.

One reason for the downward trend in formal complaints is the open clinic approach across all clinical areas. Supported by matrons, divisional heads, nurses, and ward managers, these clinics encourage patients and families to raise concerns directly. Most issues, often related to food, care, or parking, are addressed immediately. Concerns that require further attention are handled informally and confidentially, with Laura coordinating any that escalate to formal complaints. For bereaved families, the team also reach out to understand how they would like the team to proceed. Overall, this proactive engagement helps resolve issues early, reducing the need for formal complaints.

JB inquired if any complainants go directly to the Parliamentary and Health Service Ombudsman (PHSO) after receiving the Trusts response, without giving the organisation the chance to resolve the issue first. Joan M explained that the team follow up with patients until all concerns are addressed, including meetings if needed. Once all options are exhausted, they are advised that they can contact the PHSO. In 2 recent cases, the

PHSO did not uphold the complaints or proceed with full investigations but sought resolution. No further concerns were raised.

CE stated that the report reinforces the importance of maintaining consistent communication with patients, both during their care and afterward, so they feel heard and supported, even when they are dissatisfied. This is key to providing assurance and building trust.

JS highlighted that it is remarkable that only 16% of complaints relate to communication, much lower than the usual 50–80% from other organisations. This suggests LHCH may be doing something particularly effective, perhaps through early family engagement or how complaints are categorised. This is an area worth exploring and sharing with others.

The Board of Directors received **assurance** that the complaints process, and procedure is robust and monitored for effectiveness in line with the NHS and Adult Social Care Complaints Process. Sharing of learning from each complaint review, being disseminated within the appropriate divisions and teams.

5 Board Assurance

5.1 BAF Key Issues Reports and Approved Minutes

5.1.1 CMAST CiC:

- **Summary report for meeting held on 2nd May 2025**

The Board of Directors **noted** the summary report.

5.1.2 LAASP Joint Committee

- **Summary Report from meeting held on 17th April 2025**

The Board of Directors **noted** the summary report.

5.1.3 Integrated Performance Committee

- **BAF Key Issues for meeting held on 22nd April 2025**
- **Approved minutes for meeting held on 17th February 2024**

The Board of Directors **noted** the BAF key issues and approved minutes.

6 Legality of Board Documentation and Decisions

Board members confirmed that the conduct of the meeting and decisions made by the Board, to the best of their knowledge, complied with the law.

7 Evaluation of Board Meeting

The Board of Directors confirmed that it was satisfied with the process, agenda and papers.

8 Date and Time of Next Meeting

Tuesday 24th June 2025, EO Accounts Approval
Tuesday 23rd September 2025

9 Resolution to exclude the Public

The Board of Directors resolved to exclude the public at this point by reason of the private nature of the business to follow.

DRAFT