

Meeting of the LHCH Council of Governors
held on Tuesday 2nd December 2025 at 13:00
LHCH Conference Room & Microsoft Teams

Present:

David Flory	Chair
Michelle Beaver	Staff Governor – Registered and Non Registered Nurses
Dr Jonathan Kendall	Staff Governor – Registered Medical Practitioners
Ian Ferguson	Public Governor – Merseyside, Lead Governor
Ray Davis	Public Governor – Cheshire – MS Teams
Vivienne Robertson	Public Governor – Cheshire
Dusty Rhodes	Public Governor – North Wales – MS Teams
Dorothy Price	Staff Governor – AHP, Technical and Scientific
Peter Humphrey	Public Governor – Merseyside
Margaret Roberts	Public Governor – North Wales – MS Teams
Sharon Faulkner	Staff Governor – Registered and Non Registered Nurses
Elaine Holme	Public Governor – Merseyside
Terence Comerford	Public Governor – Merseyside – MS Teams
Michael Carney	Public Governor – Merseyside
Clare Sumner	Staff Governor – Registered and Non Registered Nurses
Catherine Collingwood	Public Governor – Cheshire
Lynsey Jackson	Staff Governor – Non-Clinical
Keith Wilson	Staff Governors – Non-Clinical
Richard McLean	Nominated Governor – Liverpool City Council
Kim Crowe	Public Governor – Merseyside
Karen Higginbotham	Nominated Governor – Liverpool John Moores University

Attendees:

James Sumner	Chief Executive
Daniel Scheffer	Group Chief Corporate Affairs Officer and Company Secretary
Hollie Holding	Deputy Group Company Secretary
Claudette Elliott	Group Non-Executive Director – MS Teams
David Gilburt	Group Non-Executive Director
Mike Eastwood	Group Non-Executive Director
Su Rai	Group Non-Executive Director – MS Teams
Jonathan Mathews	LHCH & BG Executive Managing Director
Ruth Gaunt	Executive Office Manager & Corporate Governance Lead (Minutes)

Apologies:

Jackie Bird	Group Non-Executive Director
Sarah Walker	Group Non-Executive Director
Peter Wareham	Public Governor – North Wales – MS Teams
Neil French	Nominated Governor – University of Liverpool

Core members	Apr	May	Jun	Jul	Sep	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Terence Comerford									✓			
Peter Humphrey									✓			
Ian Ferguson									✓			
Michael Carney									✓			
Elaine Holme									✓			
Kim Crowe									✓			

Catherine Collingwood									✓			
Ray Davis									✓			
Denis McAllister									NA			
Vivienne Robertson									✓			
Margaret Roberts									✓			
Dusty Rhodes									✓			
Peter Wareham									A			
Keith Wilson									✓			
Clare Sumner									✓			
Lynsey Jackson									✓			
Jonathan Kendall									✓			
Dot Price									✓			
Michelle Beaver									✓			
Sharon Faulkner									✓			
Karen Higginbotham									✓			
Wendy Caulfield									NA			
Richard McLean									✓			
Neil French									A			
Present (✓)	Apologies (A)	Representative (R)	Non-attendance (NA)									

LHCHCoG25/26_01	Patient Story The patient story described feedback from an individual who had undergone a Transcatheter Aortic Valve Implantation (TAVI) procedure in order to avoid future complications. They reported that from the pre-op where everything was explained clearly and providing reassurance, to the hospital experience, the care was described as exceptional. The staff were attentive, friendly, and professional, making the patient feel calm and supported throughout. The procedure went as expected, recovery was smooth, and follow-up checks confirmed success. The patient left feeling reassured and grateful, praising LHCH as outstanding and highly recommending the experience to others considering TAVI. The patient story highlighted highly individualised care and was described as powerful and a model for collaborative discharge planning and cross-site working, emphasising the importance of individualised care and teamwork. The story also underscored the significant contribution of non-clinical, patient-facing staff, such as porters, to the overall patient experience.
LHCHCoG25/26_02	Introduction and Chair's Welcome Apologies & Declaration of Interest 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.
LHCHCoG25/26_03	Minutes of the Council of Governors (in public) meeting held on 16th September 2025 The minutes of the Council of Governors meeting held on 16th September 2025, were reviewed for accuracy and approved by the Council of Governors. Ian Fergusson (IF) suggested that it would be beneficial to Governor if draft minutes were sent out soon after meetings in order to review the minutes while the discussion is still fresh.
LHCHCoG25/26_04	Rolling Action Tracker <u>Action 1</u> – Explore sharing staff stories alongside patient stories at future CoG meetings. <u>Update</u> - Complete - Staff stories added to the CoG cycle of business.

	<u>Action 2</u> – Jonathan Mathews (JM) and James Bradley to discuss the business case for a specialist simulation training with the Charitable Funds Committee. <u>Update</u> - JM confirmed that the simulation centre business case, previously requested by the charitable funds committee and discussed in October, is being prepared by Mary Liley, Head of Fundraising. The case, valued at £1.1m for capital outlay plus associated revenue costs, will go through the governance process and is scheduled to return to the January 2026 Charitable Funds committee. An update is expected after that meeting.
LHCHCoG25/26_05	Any Urgent Matters Arising No urgent matters arising to discuss.
LHCHCoG25/26_06	Chairs Briefing David Flory, Group Chair, thanked Governors who attended the Governors' Workshop on the University Hospitals of Liverpool Group (UHLG) Strategy 2030 event held on 26th November 2025. DF highlighted the relevance of the patient story given significant external changes across the Liverpool system, including national, regional, and at Integrated Care Board (ICB) level, creating regulatory and contractual demands. DF emphasised the pressure within the Cheshire and Merseyside system and the constant requirement for updates, noting consultancy involvement. Despite these challenges, the core focus remains patient care and community support. Council of Governors meetings provide an opportunity to review organisational progress, risks, and achievements. DF stressed the importance of financial sustainability, governance integrity, and transparency during times of change, reassuring Governors of the Board's commitment to maintaining control and ensuring accountability. The CoG meetings seek to clarify current developments, explain their rationale, and reinforce engagement and communication as changes occur, ensuring they benefit patients while managing intended and unintended consequences.
LHCHCoG25/26_07	Chief Executive Report James Sumner (JS), Chief Executive Officer provided the Chief Executive report and highlighted key areas of note. IF noted that PwC are heavily involved in writing the business case and questioned who has the final decision of what goes into the business case to put forward. JS advised that the business case is being developed further to a request from NHS England and will focus primarily on clinical benefits for patients rather than financial savings, as joining 5 organisations together offers limited cost reduction. Patient impact carries the highest weighting, while financial considerations are much lower. The final decision rests with the Boards from the statutory organisations involved. JS and DF attended the LHCH Grand Awards last Friday. The event showcased outstanding clinical care through numerous presentations and JS was delighted to witness the recognition of LHCH staff excellence for the first time. There have been significant leadership changes at Cheshire and Merseyside ICB, including Liz Bishop becoming Interim Chief Executive, which is positive given her local knowledge. Further senior leadership changes are ongoing but not fully announced. The ICB faces a major financial challenge, with around 92% of this year's deficit already spent, making recovery difficult. Planning for next year is critical as financial pressures will tighten further. The 3 organisations are working together to align assumptions. Current efforts focus on interpreting NHS medium-term plan guidance issued recently, though clarity on planning remains limited.

JS advised that the strategy development work builds on last week's governor session and focuses on shaping the future approach for the 5 organisations currently operating within the Liverpool Adult Acute Service Providers (LAASP) programme. The emerging strategy is based on population needs and aims to address outcomes and challenges through 3 key care models. These include an acute specialist environment to integrate services, earlier diagnosis and treatment planning for patients, and an integrated community care offering that works closely with GPs and other providers. These models are designed to deliver better outcomes and a more joined-up approach to care.

JS updated governors on a key aspect of the LAASP programme which related to Clinical Reference Groups (CRGs). The CRG working on a single cardiology service was highlighted as providing a compelling case for creating improved pathways across Liverpool. The proposed approach would cover prevention of cardiovascular disease, acute & emergency care and rehabilitation, ensuring patients receive timely and appropriate treatment. While there is some financial benefit from reducing waste and duplication, the primary driver is improved patient outcomes. This proposal forms a major part of the business case and will be progressed as one of the key opportunities for the city.

IF questioned if this integral part of the business case must be signed off before proceeding. JS advised that this can be started now, however progress is currently limited due to separate statutory organisations, digital clinical systems, and financial ledgers, which create significant barriers. While there are logical improvements that could have been implemented over the past decade, these obstacles have prevented action to develop a single cardiology service. The current opportunity is to overcome these barriers by consolidating decision-making under a single body.

IF asked if one of the primary elements of the business case will be removing barriers to enable improved clinical pathways, with the designated centre of excellence taking the lead. JS noted that progress on certain initiatives have been hindered by organisational separation and competing interests, particularly around financial flows. Decisions often stall due to shifting resources between Trusts, even when changes would improve patient care. These barriers highlight the need for single policies, unified digital systems, and consolidated financial structures to enable collaboration and better services.

IF asked how organisational barriers will be overcome in order to make this happen. JS advised that a key example of past barriers is the vascular aortic case presented to the recent Annual Members Meeting, where progress stalled due to financial disputes between organisations, despite clear clinical benefits. Historically, separate Trusts charged premiums on business cases and operated like competitors. This approach is inefficient and costly. The business case currently being developed for NHS England will clarify outcomes and enable a more directive approach. Once agreed, it should remove many of these barriers and allow clear leadership on service delivery. JS emphasised that evidence shows these changes improve patient care, so there is no justification for delay.

Elaine Holme (EH) raised concern about effectiveness of communication due to the large number of people involved and asked how messages can be cascaded clearly. JS highlighted that over the past 18 months, 5 organisations have been pushed to work together under a single financial position, which has created challenges and negative messaging. JS noted that the situation is now improving as clinical models begin to emerge, making collaboration more meaningful. Communication should focus on positive clinical outcomes rather than compliance with NHS England directives, as that approach does not engage staff. Clinicians must lead this messaging through the

Clinical Reference Group. The goal is to inspire staff by showing what can be realised to improve patient care.

Keith Wilson (KW) noted his opinion that many staff do not feel adequately recognised and have faced significant uncertainty over the past 8 months. Despite understanding the need for business cases and organisational priorities, the core of care comes from staff and KW highlighted the importance of addressing their concerns and ensuring fairness during this period of change.

JS acknowledged that communication could have been better as the focus for the past 18 months has been on directives from external bodies and financial compliance, rather than positive clinical developments. Staff have mainly heard about business cases and group models, which has caused frustration and uncertainty, including misconceptions about redundancies. The business case is not a financial solution but a tool to present clear, coherent future plans that will improve patient care and address long-standing estate issues. JS stressed the need to shift messaging towards the benefits for staff and patients, using tangible examples rather than financial jargon, and committed to improving communication as the organisation moves into a more positive phase.

Linsey Jackson (LJ) questioned if there is an opportunity for input from people beyond clinicians when exploring collaboration across other Trusts. JS confirmed that there is the opportunity for wider input beyond clinicians. The process began with the Clinical Reference Group focusing on major clinical priorities such as cancer, cardiology, and women's services, where significant risks remain. Once the business case concludes at the end of December 2025, it will trigger work to build new capabilities over the next 12–18 months. These include embedding a strong quality improvement culture and leveraging commercial expertise.

LJ praised the award-winning cardiac arrest care but noted challenges with patients suffering hypoxic brain injuries post-arrest, as the centre lacks on-site neurology. This causes delays, extended bed occupancy, and bottlenecks in patient flow. JS confirmed subject to approval by NHS England, the Walton Centre NHS FT will join the group, with integration targeted within 12 months from April 2026. A high-level business case is being developed to secure NHS England approval, covering estate, digital technology, and organisational alignment. Once approved, a 5-year programme will enable specialties to address issues and deliver rapid improvements in patient care.

It was suggested that messaging be communicated in layman's terms. JS explained that until recently, communication was limited due to uncertainty over whether the business case would involve 3 or 5 organisations, with conflicting messages. A recent meeting with NHS England's CEO and Chair confirmed the need for a business case relating to all 5 organisations. This clarity now provides a mandate to communicate confidently, but previously, messaging was withheld to avoid confusion caused by frequent changes.

IF questioned the confidence of the decisions made remaining unchanged over the next 3–6 months. JS noted that the instruction to adopt a group model was driven by 6 or 7 key individuals from NHS England and regional leadership, most of whom have since left. New leaders at both national and regional levels questioned the approach and considered changes. This led to another prolonged period of uncertainty. Clarity has been received in the past 10 days, with senior NHS England and regional leaders aligned and, for the first time with agreement on the start date and the business case endpoint. It has been extremely challenging due to lack of a clear mandate and shifting opinions. The direction is now set and is unlikely to change.

	David Gilburt (DG) reiterated the importance of providing staff with clear, straightforward messages rather than management jargon. During the NED Governor visit undertaken earlier in the day, there was a discussion about establishing a cardiology service for the city, which sparked strong enthusiasm and commitment from clinical staff who were passionate and eager to make it happen. The Council of Governors received the update.
LHCHCoG25/26_08	LHCH & BG Hospital Leadership Team Update • LHCH SOF • National Inpatient Survey Jonathan Mathews (JM), Executive Managing Director summarised the strategic oversight summary. The update reflects the position at the end of quarter 2 (September 2025). The dashboard includes historical data for improved context, following a Board request earlier this year. <u>(i) Operational Performance</u> - performance remains strong. Notably, the organisation has improved its standing in the national oversight framework, moving from 4th to 3rd place nationally. Standards and performance are at their highest level, with a clear ambition to progress towards the top position. Elective activity is broadly in line with plan and exceeded plan in September 2025. The focus is on surgical activity within medicine and surgery. The main cancer performance issue is the faster diagnosis standard, which is off track due to the small sample size. However, the cancer clinical lead reviews all breaches to ensure no patient harm. From a quality perspective, cancer care is being managed effectively, and assurance remains high. Diagnostic performance has improved significantly since the start of the year and is now fully compliant, with support from Liverpool University Hospitals NHS FT (LUHFT) colleagues. CT and MRI capacity is managed collaboratively across Liverpool, with weekly discussions on mutual aid to maintain compliance. The dashboard incorrectly shows “failed”; however, the position has been compliant for several months. The majority of long waiters are in surgery, specifically the mini-mitral and Adult Congenital Heart Disease (ACHD) pathways. Currently, the Trust has around 40 patients breaching the 52-week standard, with none at 65 weeks. This includes patients from England, Wales and the Isle of Man. The aim is to reduce this number to zero by year-end (March 2026), though staffing constraints make this challenging. Work is ongoing to achieve the target. Operational performance now includes indicators on health inequalities, with 6 data points currently available as this is a new measure for the financial year. Work is underway to understand definitions and develop appropriate interventions. A smaller working group has been formed following a recent Hospital Management Board discussion to address this area and improve pathways. <u>(ii) Productivity</u> - data shows some fluctuations in patient-initiated follow-up (PIFU), diagnostic Did Not Attend (DNAs), and risk-stratified overdue follow-ups, which the team is working to improve. While the national PIFU target is 5%, LHCH has set a lower target because many patients are appropriately placed in surveillance clinics rather than PIFU. Efforts are ongoing to determine the right balance and address these areas effectively. Avoidable cancellations have increased, mainly in surgery, due to changes in bank rates and other factors impacting staff. This is a significant challenge given current

pressures across Cheshire and Merseyside, but work is underway to reduce cancellations over the coming months.

A deep dive into risk-stratified follow-ups this quarter has led to revalidation of current data, and the latest dashboard shows these numbers starting to decline. The focus remains on managing capacity effectively while ensuring patients are appropriately prioritised.

(iii) Quality of Care – quality of care remains strong overall, with a particular focus on sepsis, antibiotic targets and reducing falls. One area of concern is the loss of the mental health Service Level Agreement (SLA) with Mersey Care NHS FT, which has highlighted the need for specialist provision on site, as there is currently no Trust delirium lead. This issue is being actively addressed.

EH questioned the broader implications for the organisation beyond addressing delirium. JM explained that in order to manage risk, the team explored additional support options, including Broadgreen and LUHFT. While the risk is considered low due to patient numbers, quality standards need reinforcing. Plans include reviewing the SLA, seeking support from colleagues, and considering appointing a delirium lead. Staff support remains through occupational health and psychology services.

(iv) Finance - the year-to-date financial position shows a surplus of £4.2m, in line with plan, with a forecast surplus of £9.4m by year-end. Income shortfalls are linked to lower demand from Wales, private patient gaps due to additional sessions and consultant uptake, and the lung cancer screening project. The screening programme is new, so uptake rates are uncertain; assumptions were made in the business case, and work is ongoing to achieve sustainability and deliver the best outcomes.

Cost improvement remains the biggest focus across the group and all sites, with efforts concentrated on closing gaps in surgery and corporate areas. Driving these programmes to completion is critical to achieving financial targets. A question was raised about confidence in achieving this year's cost improvement targets, noting that it has been some time since the Trust last met its cost improvement goal. JS advised that the Trust has not achieved cost improvement targets on a recurrent basis but has met them non-recurrently. This year's plan will continue to be executed using both ongoing and one-time strategies, such as balance sheet changes and working together with colleagues from different divisions.

At the start of the year, annual planning included built-in flexibility to offset cost pressures during the year. If targets are not met, non-recurrent measures can be used to cover gaps centrally, reducing the impact on clinical divisions and allowing cost management without full divisional burden. Annual planning has now started, following the same process as before, with a focus on setting an appropriate risk reserve alongside income targets. This reserve helps manage cost inflation during the year.

JS noted that while many organisations face declining cash balances year-on-year, LHCH began the year in a stronger position and has maintained surpluses, largely due to high tariffs. For now, cash reserves remain stable, but the outlook is uncertain given significant commissioning constraints.

(v) Research - performance shows strong progress, with the latest dashboard indicating an 82% achievement against target. While a few indicators remain off track, detailed analysis will follow after the Research Committee meets in December, with further updates expected in the new year.

(vi) LHCH Escalated Risks - the organisation has adopted the new Group 5x5x5 risk framework, with site-level management of risks scoring 10+ (Serious) and escalation of 12+ (Significant) risks to the group Assurance and Risk Committee (ARC). Key

risks include financial balance in Surgery, Safe management of Aortic Surgery patient care, Surgical cancellations due to ageing infrastructure and ACHD service reputation due to workforce capacity.

A major challenge is the need to refurbish or rebuild surgical theatres, with an estimated cost of £40m. Current portacabins cost £120k annually and are not fit for purpose. The ideal solution is a purpose-built theatre suite, but funding within capital limits would take 7 years, so alternative approaches, including commercial partnerships, are being explored.

The ACHD service continues to face workforce capacity challenges. To address this, a new consultant will join next week, and recruitment is underway for a nurse consultant, which should help to strengthen the service and mitigate current risks.

(vii) Site Updates - JM emphasised the need to improve staff engagement and communication. Despite challenges, the organisation remains highly rated, top hospital in the North West for inpatient survey and 3rd nationally in NHSE rankings. Current pressures include industrial action impacting on staffing coverage and morale, alongside implementation of consistent C&M rate cards. There has been low flu vaccination uptake, around 40%. Plans include encouraging vaccinations, progressing the simulation centre business case, and addressing communication gaps around palliative care and patient flow.

Previous Board discussions highlighted the Trust's lower bed occupancy, 75–80% compared to the ideal 85–90%, prompting plans to close 9 beds in quarter 3/quarter 4. This aligned with conversations on supporting palliative care services in Liverpool, but implementation was delayed due to ICB governance issues, causing communication challenges. A decision is expected this week, with staff debriefs planned. The key focus moving forward is improving communication across the organisation, as some messages have not landed effectively despite increased briefings. Despite these challenges, performance metrics and standards remain strong, but engagement is critical amid significant system and local changes.

A query was raised about whether the closure of Maple Suite is directly causing increased bed pressures, given there are now 3 bed meetings each day, or if this is due to seasonal winter pressures. JM advised that the recent bed pressures were caused by a combination of factors; the closure of Maple ward coincided with the highest critical care acuity, leading to surgical cancellations and increased ward demand, compounded by delays in the palliative care commissioning decision. Efforts are underway to open capacity, which should ease pressures. Lessons learned include the need for earlier decisions on scaling back elective sessions and managing non-elective peaks more proactively.

Clare Sumner (CS) echoed concerns about the current bed meeting process, noting it feels overwhelming and reflects the challenges of adapting to change. While staff were initially positive about supporting the palliative care ward, repeated changes and delays have created fatigue and a sense of instability, leaving staff nervous and uncertain about who is in control, which is making engagement difficult.

JS noted that several Maple staff volunteered to support the palliative care service as they believed it was the right thing to do, but subsequent delays and reversals have created uncertainty, fuelling rumours and frustration. Information gaps have worsened the situation. The key challenge is managing communication effectively, ensuring decisions are only shared once confirmed through Board and senior leadership channels, reducing speculations.

Clarification was sought on whether closing Maple Suite entirely was under consideration or just speculation. JM confirmed that during flow reviews it was agreed

	that 9 beds could be closed. Maple was identified as the most suitable site for palliative care. This shaped the decision for the Trust to close 9 beds this financial year to support palliative care plans, with arrangements to open the service accordingly. Questions were raised about whether the palliative care ward would be run by the Royal. JM clarified that governance decisions by the ICB and Care Quality Commission (CQC) require commissioning through LUHFT, not directly with LHCH. Palliative services will be managed by the palliative service group due to medical provision requirements. However, staff who volunteer for this service will remain LHCH employees, with no change to their contracts. Concerns were raised about potential fragmentation if services move from Maple to other locations, questioning whether the organisation can maintain its identity. KW expressed a personal view and warned that if this happens, it could worsen significantly unless steps are taken to prevent it. JS emphasised the need to avoid rigid thinking about ownership. The priority should be creating opportunities for LHCH to grow, such as moving out of temporary spaces into better office facilities. JM highlighted the need for strategic estate planning, noting there are 19 wards on site, with 17 currently open in varying configurations. The focus should be on unlocking the potential of these wards to support cardiology pathways and broader ambitions. JM stressed the importance of avoiding siloed thinking, especially when other hospitals face A&E pressures while some wards remain closed. Effective engagement with clinical teams is key to optimising ward use, including the palliative care ward, to benefit patients across Liverpool and align with wider strategic goals. IF acknowledged JM's comments and the importance of improving communication and sought clarification on what decision regarding Maple is expected this Thursday. JM explained that the ICB executive meeting will confirm commissioning of the beds on LHCH site, as formal approval is still pending. JM stated that if the decision is negative, the Trust will work with staff on managing a smaller bed base. JS expressed frustration that staff have worked hard to resolve issues, only to face uncertainty over funding, leading to stalled progress. JS noted this challenge extends beyond palliative care, with wider recruitment freezes across Cheshire and Merseyside. Despite these difficulties, JS remains optimistic that the new Chair and leadership of the ICB will stabilise the situation and drive better decisions. A question was raised about the reasons for staffing issues. JM explained these include changes in bank rates, vacancies in specialised roles such as surgery, perfusion, Operating Department Practitioner (ODP), and Consultant sickness. These factors have increased pressure over recent months. Recruitment for roles such as ODPs, scrub and perfusion is challenging and requires long-term solutions, though some initiatives are underway to address these gaps quickly. The Council of Governors received the update.
XX25/26_09	LAASP 2030 Strategy Update Discussed during the Chief Executive Report.
XX25/26_10	Engaging the External Auditor to Supply Additional (non-audit) Services Policy Daniel Scheffer (DS), Group Chief Corporate Affairs Officer and Company Secretary confirmed that the policy has undergone its scheduled three-year review and remains relevant with no changes required. The Council of Governors were asked to approve the policy for onward ratification at the LHCH Audit Committee in January 2026. The Council of Governors approved the policy.

XX25/26_11	Non-Executive Directors update DG expressed thanks to John Doyle (former Non-Executive Director) in both Charitable Funds Committee and Audit Committee meetings for providing a comprehensive and helpful handover. Charitable Funds Committee David Gilburt, Non-Executive Director provided the Charitable Funds Committee update. The Charitable Funds Committee met on 7th October and reviewed the funds position, noting an improvement compared to 12 months ago. The committee agreed to review dormant funds to ensure compliance and explore ways to utilise them. Funding was approved for a Cosmed cardiopulmonary exercise machine, additions to the da Vinci Robot, a simulator and a £38k training module. The committee requested clarity from the Finance Director on group-wide equipment purchasing to secure better deals, given multiple hospitals are buying similar robots. The next meeting is scheduled for 13th January 2026. It was questioned why funds remain dormant and DG explained that the funds are currently in an account earning interest. The review aims to determine their original purpose which may relate to equipment which is now redundant or causes which are no longer prioritised. The goal is to identify opportunities to bring these funds back into use. IF asked whether all 5 organisations will retain separate charitable foundations or merge into one. JS explained this depends on the future group model. Statutory organisations usually keep separate charities, and legacy funds must remain tied to their original organisations to honour donors' wishes. Consolidation could be considered if a full merger occurs, but no decision has been made yet. JM acknowledged challenges with signing off small expenses and explained that a decision was made earlier this year to prioritise larger causes, as charitable funds are depleting and fundraising cannot keep pace. This has affected funding for minor items. JM highlighted the inefficiency of managing multiple small budgets and petty cash for events and agreed the need for a more streamlined approach. JS highlighted inefficiencies in purchasing separate robotic systems, noting high costs and expensive consumables. JS shared that, due to the group's scale, clinicians from all 5 organisations negotiated with Da Vinci's European CEO for major discounts on consumables, a long-term plan for additional robots and funding for research. They also secured support to develop a robotics training centre, leveraging the group's collective activity. This outcome was seen as a positive step. Audit Committee David Gilburt, Non-Executive Director provided the Audit Committee update. The Audit Committee met on 7th October. The committee reviewed several audit reports, approved some losses and noted routine discussions. Updates were provided on internal audit reports, with the Mersey internal audit team slightly behind schedule but making progress, aiming to be back on track by January. DF noted that the organisation's audit arrangements are in good shape, reflecting strong management and governance through the Audit Committee, and emphasised the importance of maintaining this standard. Claudette Elliott (CE) emphasised the value of being involved in discussions for continuity, particularly regarding LHCH. CE highlighted the progress being made, the

	professionalism and focus of staff despite ongoing changes, and expressed gratitude for their commendable efforts. The Council of Governors received the update.
XX25/26_12	Non-Executive Director & Governors Engagement visits DS updated Governors on the new NED and Governor visiting programme. The first visit under the new arrangements took place today, with another scheduled for 16th January. Visiting programme dates for the rest of 2026 will be planned. Governors asked whether they could join visits to other parts of Broadgreen alongside LUHFT Governors, and this will be explored. A question was raised about the organisation's position regarding the Constitution in relation to the business case. DS advised that if NHS England approves the current business case, the Council of Governors will be involved in the next stage, but this case does not trigger those requirements. Future cases will require Governors' scrutiny, strategic alignment, and consultation. Design principles for corporate functions are being developed. Over the next 4–5 months, 3 statutory corporate services will be integrated into a unified structure, aiming for completion by April 2026. Alongside this, a strategic outline business case will explore clinical and digital opportunities and recommend the future organisational model. A detailed business case will later define the long-term corporate services framework for 5 organisations, emphasising culture, organisational development and staff engagement. The Council of Governors noted the update.
XX25/26_13	Lead Governor Update and Feedback from Network/Engagement Events IF, Lead Governor provided the Lead Governor update and feedback from Network/Engagement Events. IF suggested introducing more frequent short staff surveys to provide regular, quantifiable insights. This would complement existing forums and annual surveys, which take a long time to deliver results, ensuring leadership can monitor and respond to staff views more promptly. IF reflected on the Cheshire and Merseyside Governor meeting, finding value in hearing from fellow Governors and key presentations. The session highlighted significant challenges in regional health plans and the need to improve clinical pathways. A presentation reinforced the critical role of Governors in holding leadership accountable for Trust performance during the pivotal period of change. IF emphasised that maintaining strong governance and connection with patients is essential to avoid unintended consequences as major healthcare transformations unfold. IF attended the Patient Engagement Forum and was impressed by the dedication of staff and the positive feedback from patients. The forum also highlighted areas for improvement, which are largely within the trust's control, though some challenges exist in follow-up care for patients outside the area. IF emphasised the importance of continuing to recognise the outstanding work of staff. DF reaffirmed his commitment to maintaining current governance arrangements, emphasising that effective leadership and collaboration make the organisation stronger. A question was raised regarding the recruitment status for the governance-related post, as part of the ongoing governance process. DF advised that this is currently

	paused to allow for clarity on the organisation's direction. The focus is on reassessing the Board's composition and acting in a way that supports the approval and implementation of the business case. The Council of Governors noted the update.
XX25/26_14	Membership and Communications Sub Committee Dot Price (DP) advised that the meeting had been deferred with a plan to reconvene in the new year to focus on the 2026–27 plan and explore collaborative opportunities, including with the UHLG group. DP has expressed interest in representing LHCH in UHLG and joining their meeting but has not yet received a response. The expectation is to have further updates and a group meeting by March.
XX25/26_15	Any Other Business (v) <u>Respiratory</u> DP highlighted the need for more visibility of respiratory clinical pathways, noting that discussions often focus on cardiology. DP also sought clarification on whether Diana Lees' involvement in the Clinical Reference Group relates specifically to LAASP or to the wider hospital group. JS clarified that the Clinical Reference Group (CRG) is for LAASP, but many pathways, such as respiratory and cardiology, primarily involve LHCH and 3 other organisations. Respiratory is next on the CRG's agenda and will be reviewed in the same way as cardiology considering inpatient, specialist and community services to determine the best approach. Discussion focused on ensuring that any future decisions about service changes are made with full input from the staff delivering those services. JS emphasised that engagement will be integral to the process, citing upcoming cardiology planning as an example of collaborative working. This approach underlines the importance of staff involvement in shaping future pathways.

Date of next meeting: Thursday 5th March 2026