Minutes of a meeting of the Norfolk Community Health and Care NHS Trust Board held in PUBLIC on 19 March 2025 at Woodlands House, Norwich Community Hospital.

Members: Lynda Thomas Graham Nice Sarah Buchan Laura Clear David Crawford Steve Crowe Carolyn Fowler Caroline Kavanagh John Kennedy Njoki Yaxley Matthew Winn	 Trust Chair Deputy Chair Chief Information Officer Deputy Chief Executive, Director of Strategy and Transformation Non-Executive Director Non-Executive Director Director of Nursing and Quality Medical Director Non-Executive Director Non-Executive Director Chief Executive
Non-voting: Rob Mack Sue Crossman	 Director of Community Health and Social Care Operations Associate Non-Executive Director
In attendance: Liz Cooke Vicky Brooke Emma Lunny	 Director of Human Resources Associate Director of Communications and Marketing Deputy Director of Finance and Performance
By invitation: Emmanuel Ynalvez Frank Asamoah Oluwaseyi Akinwumiju	
Apologies: Andrew Hopkins	 Director of Finance and Performance
New declarations of interest:	None

25/15	**Welcome and Apologies for Absence**
	Lynda Thomas welcomed all to the March 2025 Board meeting in public, acknowledging this to be the final meeting in this format. Lynda welcomed Sarah Buchan to her first Board meeting, and Emma Lunny as deputy for Andrew Hopkins.
25/16	**Hearing from our internationally recruited colleagues**
	Emmanuel Ynalvez, Frank Asamoah and Oluwaseyi Akinwumiju joined the meeting to share their individual experiences as internationally recruited staff.

	In summary, key reflections from the Board discussion: • Two of the nurses referenced not having any medical cover after 5pm – if this is the case, there should be an escalation process in place. • Exit interviews for internation staff are vital for the Trust to learn from their experiences. • There is a need to prepare wards/teams to be ready to receive an international student – clarify expectations. • Focus on development for those we are supporting through to registration. • Acknowledged there is much to learn from our international colleagues. • Noted the process has evolved quite a bit, but there is more to be done. Lynda Thomas thanked Seyi, Frank and Emmanuel for joining the meeting, and Carolyn Fowler for organising the session.
25/17	**Minutes of the previous meeting**
	The minutes of the meeting held on 15 January 2025 were agreed as an accurate record. All matters arising were either complete or on track.
25/18	**Chief Executive's Report**
	Matthew Winn presented his report. In summary, it provided an overview on national policy and initiatives, local issues in our system and communication activity to deliver our strategic ambitions. The following key points were highlighted: • Finances adrift in getting balanced plan across the system. Reminder that changes made in one organisation can impact on others. • Staff survey – fair results but there are certain areas we need to work on. There is some work across the Trust planned as well as more specific work in different areas. Leadership and management support needs to be key – Group Board will oversee action plan for improvements. • Emergency preparedness – it was noted that whilst we are in a much better position, we're not there yet. • Dissolution of NHSE and ICBs cost reducing programme and staffing reductions. Need to look at what this means – unclear at present however there is talking across the system to find a starting point. David Crawford questioned whether NCH&C were using the AI tool available for predicting falls as there was no reference to this. Sarah Buchan will follow this up. David also mentioned the positive feedback received for the digital library. In response to a question on how the NHS England news had been received, Matthew noted the messaging had been extremely blunt and inaccurate in what they were trying to change which brings instability. John Kennedy thanked Matthew for an interesting report and raised the correlation between the staff survey and Pulse survey and whether high workload and low morale were starting to produce cracks. Matthew confirmed there were plans being agreed to tackle potential issues which will be shared with Board. Need to look at how we make changes to support staff within our means and without increasing staff numbers. Sue Crossman flagged the issue about reductions/savings not realising reinvestment in the NHS.

	Graham Nice noted the report contained some good, positive information. Graham requested a report to a future Board meeting showing what support is being given to managers to allow them to support their staff as learning from the past when planning for the future will be key. The Board noted the report.
25/19	**Financial Plan 2025/26**
	Emma Lunny presented this report as an updated plan to the Board for review and final approval. The plan has been discussed and approved at the March meeting of the Finance and Performance Committee. In summary, this plan will be incorporated into an CB consolidated plan as well as being submitted to NHS England as the Trust's standalone plan. While the Trust is planning for a balanced financial position, other organisations within the system are finding it highly challenging to identify ways to deliver balanced plans with what they deem to be an acceptable level of financial and clinical risk. A system financial planning workshop in mid-February indicated potential efficiency / saving opportunities of £199m and a total system deficit of £84m. This continues to represent a financial risk for the Trust, which may see pressure to increase the size of the efficiency programme in 2025/26. Matthew Winn highlighted there is likely to be some shock coming at the end point, with a request to help out with system figures. Following robust discussion, the Board approved the proposed financial plan and agreed delegated authority for the Chief Executive and Director of Finance and Performance for any changes if required.
25/20	**Integrated Analysis**
	The Board received this report detailing an analysis of operational performance, quality, people and finance data. Key highlights from this and the Committee Chairs' reports: • Pressure ulcers continue to sit below the national benchmark which is a testament to the hard work of the teams. • Work continues to ensure the learning from the recent Regulation 28 is embedded and where required, processes changed. • Ongoing work looking at NDS assessments. Considering potential pilot in Children's services around a 'one stop shop'. • Current year position in finances is on track. • All clinical policies are up to date for the first time. • Deep dive undertaken into 10 elements of quality. • Looking at staff survey results in great detail. 67% of staff responded. • Sickness figures remain high. • Congratulations to the Willow team. The project came in on budget and a project closure report and lessons learned report will be produced. Graham Nice went on record thanking everyone involved in making this happen, noting that we now have a unit we can be proud of. Board discussed the report and agreed that there were no additional actions arising from the performance report and Committee Chairs' reports.
25/21	**Board Assurance Framework**
	The Board received this report and noted the format of the report would be changed effective from the next meeting. The report needs to be reduced in size and annotations removed – looking at one page per risk and one page summary.

	John Kennedy noted the BAF had been scrutinised in Audit Committee, in particular challenging closed risks, in particular staff experience; recruitment and retention; cyber security; and community capacity. Matthew Winn confirmed the Board Assurance Framework would be presented in a new format at the next Board meeting. Board noted the report and agreed that it represented a fair and accurate view of the strategic risks facing the Trust and how they were being mitigated.
25/22	**Building Trust Programme**
	Matthew Winn presented the following documents for discussion, noting and approval: • Draft Business Case – required for submission to NHS England as part of our journey to create a new organisation. Once evaluated by NHS England, a successful outcome will give us approval to proceed to a Full Business Case. • Group Governance Manual – this manual provides a comprehensive summary of the corporate governance framework for the Group Board and its committees. The manual will be subject to regular review and update throughout the coming year. • Fit and Proper Person Test Framework Policy – the purpose of this framework is to strengthen and reinforce individual accountability and transparency for Trust Board members. • Partnership Agreement – this agreement has been developed for collaboration between Cambridgeshire Community Services NHS Trust and Norfolk Community Health and Care NHS Trust for the purpose of joint working arrangements. The Board noted and approved the documents.
25/23	**Patient Story**
	Patient JS joined the meeting via MS Teams, accompanied by Julie Smith and Kimberley Savory. Following an accident in September 2022, the patient had a prolonged stay in the Norfolk & Norwich University Hospital (20 weeks) due to the surgery required. During his time in the acute hospital, the patient contracted sepsis twice. In November 2023, the patient met the NCH&C IV team. Whilst at home, the patient contracted sepsis for a third and fourth time, necessitating a return to the acute hospital. Post sepsis, the patient returned home and was again cared for by the IV team. The patient noted the care in the acute seemed organised and integrated. The patient noted it was a harder experience in the community due to dealing, for example, with the different IT platforms which resulted in delays in access to medicines. The communication between community providers due to the different IT platforms was challenging. The patient thanked Kimberley Savoury and the IV team for their care, and Julie Smith for her visits and signposting him to mental health resources and helping maintain his mental health. He also thanked Graham Nice for his visit. In addition, his thanks to the physio team and in particular, Jess Belmonte, were noted. The patient identified come potential operational improvements: • What three words application – what three words need to be known whilst the patient is still in the acute and then shared with the community providers. This would allow for the location of the patient to be identified more quickly. • Blood processing – the patient noted the challenges staff have in dropping off blood whilst out in the community. This causes delays as staff are taking time to travel to

various locations to drop off the blood and physically handing the blood over. Is there a way this could be streamlined to be more like a 'drive thru' service?

- Discharge letters – the patient had multiple discharge letters. Is there a way of having an app on a smart phone for these which would allow them to be multilingual, without the need to print. The app would hold the patient details and could even hold the 'What Three Words' and could be used as a communication tool, with service contact details.
- The patient reported he had had an allergic reaction to antibiotics (Red Man syndrome). The nursing team were very proactive in finding out what was happening, phoning GPs, pharmacies, team members for advice. On reflection, the patient wondered if this was the best use of staff time, or whether there could be a single point of contact to deal with these issues. The time spent with any potentials with the current patient impacts the appointment times for subsequent patients.

The patient thanked everyone who had supported him to recovery and was glad for the opportunity to relate his experience.

Julie Smith related that the patient had a really good professional relationship with the IV nurses, noting the importance of this to a patient. The patient was keen to get his life back and meeting with Graham Nice helped in the process. Confidence building has helped the patient through the recovery stage. Julie felt it had been an honour to work with this patient.

Kimberley Savory reported on two issues of concern: 1) the geographical area covered by the service is large and therefore travel time between appointments is substantial. This is in spite of the fact that patients are grouped geographically to minimise travel time. Kimberley highlighted that blood drop offs can be problematic, for example, out of hours a blood drop off may have to be taken from a patient in north Norfolk to the NNUH. The nurse then has to drive from the NNUH to another patient, therefore the more time that is spent travelling means the less time there is to spend with patients. 2) the other issue raised by the patient was the Red Man syndrome. The team do not have a specific contact at the NNUH to approach for advice. Each patient has their own speciality and their consultant and it can take time to find the specific contact within other areas, as well as difficulties with acutes acknowledging that the patient is still under their care. The acutes should be monitoring the blood results, infection markers, antibiotic levels of the patients. Kimberley felt it was difficult to find staff to take responsibility for discharged patients.

Matthew Winn noted that a lot of time would be taken to get the issue of antibiotics resolved by contacting many different people and it would be beneficial to have a single point of contact. Matthew questioned whether there was learning available from other teams within the Trust.

Kimberley responded that the IV nurse led service is a very standalone service which operates very differently to the community nursing teams as the IV patients have to be seen every day for their treatment. She added that the IV nurses undertake work for virtual ward as their nurses are not upskilled to do IV work. The IV nurses have been helping other nurses to get signe3d off with IV competencies. The issue is virtual ward does not have regular IV therapy patients so the nurses don't practice the skills often enough to build confidence. The IV team will go to inpatient units to undertake iron infusions when required as these are not done in patients' homes. Kimberley agreed there are some alignments that could happen between other community nursing teams but highlighted the more tasks the IV therapy team do with the inpatient units means the less time there is to help with the acute workload.

	Lynda Thomas thanked the patient and staff for attending the Board meeting and wished the patient all the best for a continued recovery.
25/24	**Close of meeting**
	There being no other business raised and no questions from members of the public and staff, the meeting in public was formally closed.