APPROVED

NHS GRAMPIAN

Minute of Meeting of the Population Health Committee
10:00 on Friday 18 July 2025
Via Microsoft Teams

Board Meeting
09.10.25
Open Session
Item 12.4

Present
Dr John Tomlinson, Non-Executive Board Member (CHAIR)
Mr Hussein Patwa, Non-Executive Board Member (VICE CHAIR)
Cllr Kathleen Robertson, Non-Executive Board Member
Cllr Ian Yuill, Non-Executive Board Member

In Attendance
Ms Shona Campbell, Interim Strategy & Transformation Manager (for Leigh Jolly)
Mrs Alison Evison, NHS Grampian Chair
Ms Kim Penman, Public Health Planning Manager
Mr Sandy Reid, Lead People & Organisation, Aberdeen City H&SCP (for Ms Fiona Mitchelhill)
Mr Dave Russell, Public Lay Representative
Professor Shantini Paranjothy, Deputy Director of Public Health

Paper Authors
Ms Louise Ballantyne, Head of Engagement (for items 9.1 & 9.2)
Ms Pamela Milliken, SRO Acute Pathways Integration (for item 10.2)
Ms Elizabeth Robinson, Consultant in Public Health (for item 7.1)
Dr Clare-Louise Walker, Consultant in Public Health Medicine (for item 8.1)

Minute Taker – Heather Haylett-Andrews

No.		Action
1	**Apologies** Apologies were received from: Ms Colette Backwell, Non-Executive Board Member; Cllr Ann Bell, Non-Executive Board Member; Mr Hugh Bishop, Executive Medical Director; Dr Adam Coldwells, Interim Chief Executive; Mr Stuart Humphreys, Director of Marketing & Corporate Communications; Ms Fiona Mitchelhill, Chief Officer Aberdeen City H&SCP; Ms Lynn Morrison, Director of Allied Health Professionals; Ms Judith Proctor, Chief Officer Moray H&SCP; and Mr Sandy Riddell, Non-Executive Board Member.	
2.	**Declarations of Interest** There were none.	
3.	**Chairs Welcome and Introduction** Dr Tomlinson opened by welcoming attendees and extended a reminder to give due consideration to the Committee's statement on equalities and health inequalities, throughout today's discussions. <u>Chairs Highlights</u>	

	• The National Population Health Framework is on the agenda today and he looks forward to the shared discussion at the Committee's development session on 12th September. • He outlined the revised assurance and escalation arrangements being implemented across NHSG Committees. While still a work in progress, he emphasised the importance of focusing on these changes and ensuring they are as effective as possible.	
4.	**Minutes of Meeting held on 2 May 2025** The minutes were approved as a true and accurate record of the meeting, subject to a correction ensuring consistency in the use of Councillor titles. All title inconsistencies have been corrected to the format 'Cllr [First Name] [Surname]' in the attendance list and 'Cllr [Surname]' in the body of the minute. This format will be used consistently from this point forward.	
5.	**Matters Arising** There were none.	
6.	**Committee Planning** **6.1 Action Log** Dr Tomlinson confirmed that all completed items will now be removed from the action log and amendments made on page 3 as follows: • Due dates for the first two actions will be amended to read '27/02/2026' • The third action will be marked 'completed' **The Committee noted the position of the action log at this point.** **6.2(a) Forward Planner** Mr Patwa asked for the rationale behind the topic of 'preventative spend', which is scheduled for discussion at the Committee meeting on 25 September. Ms Penman indicated that the Committee have previously discussed the topic of preventative spend within Public Health and noted that national work is underway, led by the Scottish Director of Public Health, to define and commission preventative spend. This complements local efforts already in progress. From an operational perspective, NHS Grampian is exploring how this applies regionally. Prof Paranjothy added that understanding preventative spend is a key element of the population health framework and will inform Grampian's broader transformation work. Kim Penman advised that the forward planner will be revised to include full strategic risk reviews every six months for the three risks overseen by the	**H Haylett-Andrews**

	Committee, following discussions with Sarah Duncan on strengthening the current approach. Additionally, the Child Health Strategy has been delayed, as the Children's Board opted to reassess its approach following a July workshop. Prof Paranjothy clarified to Dr Tomlinson that following reflection by the Children's board and feedback from the Population Health Portfolio Board, the current version of the draft strategy was considered insufficiently strategic and lacking a whole system approach. A revised, more integrated strategy will be developed. Mrs Evison suggested reflecting on whether the forward plan may need a slight shift in direction, given its connection to the Annual Delivery Plan and other emerging priorities. Dr Tomlinson noted that the priorities are expected to be refined and possibly streamlined, with an update to follow from the Chief Executives Team via Prof Paranjothy and Ms Penman. The upcoming development day will also play a key role in shaping this discussion. **The Committee noted the position of the forward planner at this point.**	
7.	**Public Health** **7.1 Health Improvement Framework** Ms Robinson provided an overview of her work to develop the Health Improvement Framework over the past year, to regain momentum lost during the pandemic. The framework is grounded in first principles, guided by tools like the population health framework. It's designed to help teams refocus strategically while respecting their distinct community roles, with strong support from both the Directorate and partnership teams. The goal is smarter, more effective collaboration across the system. <u>Questions and Comments</u> Dr Tomlinson referred to a point referring to the previous framework being too narrowly focused on personal approaches and highlights the need for a broader, systemic shift. He asked for elaboration of what the shift would look like in practice, and how would we recognise if it is actually happening? Ms Robinson indicated that currently, much of the Directorate Health Improvement Team's (HI) work is focused on individual support, e.g., smoking cessation and weight management services. However, given limited capacity, especially for obesity-related interventions, there is a need to shift toward broader, systemic approaches. This includes influencing policies around advertising unhealthy food and improving affordability and access to healthy options. While continuing targeted support for the most vulnerable, the team aims to use its expertise to advocate for meaningful, population-wide change. A report is due at NEPHA on food advertising, illustrating the team's growing role in shaping long-term public health outcomes. Dr Tomlinson would welcome future reports to clearly identify gaps, outline expected impacts and track whether our interventions are shifting outcomes	

as intended. Ms Robinson indicated there are already models that we can draw on that will allow us to model that shift over time.

Mr Russell sought clarity on the purpose of the report, its intended audience, and the next steps. Ms Robinson explained that the report is primarily aimed at the HI staff themselves, and more broadly at all NHS Grampian staff and health and social care partnerships (HSCPs), to help their understanding of the potential role of the HI team/associated workforce and framework. Mr Russell recognised that it is more about developing expertise than building capacity.

Mrs Evison shared her reflection that the HI Framework within NHS Grampian might be operating too narrowly and could benefit from being repositioned to better reflect collaboration across the broader system.

Ms Robinson agreed and indicated that this report is being shared with HSCPs and Integrated Joint Boards (IJBs) and soon with the Community Planning Partnerships (CPPs). She acknowledged the work needs to be embedded across the whole system, not just within NHS Grampian. While many teams are already engaged, we need to support them to build strength and confidence to take the next steps.

Prof Paranjothy built on Ms Robinson's point and believed the timing is right. The framework sets out how we can apply our expertise more effectively, support others doing public health work, and work collaboratively. We have had valuable engagement with staff and there is a strong appetite for change and are looking for direction and support, which this framework begins to offer.

Cllr Robertson enquired if the framework had already been approved or adopted by the IJBs, or are there still steps to take before we begin practical implantation? How can we support that process?

Ms Robinson reiterated that yes, the framework is being considered by the three IJBs, each of their strategic planning groups is at a different stage in reviewing it before eventually being brought to the full IJBs for decision-making.

Cllr Robertson highlighted the importance of a whole-system approach to child poverty, noting how simple measures like school breakfast clubs contribute to broader educational and wellbeing outcomes. Acknowledging the long-term nature of the project, she urged the use of international and generational insights to guide progress. Concerned by cuts to non-statutory preventative services, she is keen for the government to protect or fund them.

<u>Recommendations</u>

The committee:

- **Considered the opportunities that this framework will provide and where links require strengthening, drawing on the Committee members to assist with that**

	• **Reviewed and scrutinised the information provided in this paper and confirmed that it provided assurance that improvements to Health Improvement focus and practice is being made** • **Endorsed the framework for Health Improvement in Grampian as a way of taking forward a collaborative and coordinated whole system approach to health improvement** • **Requested an update at the next meeting detailing how this has progressed through the governance channels of the HSCPs and IJBs, to ensure the process is complete**	**E Robinson**
8.	**Creating Equity** **8.1 Vaccine Equity Deep Dive** Dr Walker delivered an in-depth presentation on NHS Grampian's Vaccination Equity Plan based on data and stakeholder input to address gaps in vaccine uptake. The focus was on deprived Scottish Index of Multiple Deprivation (SIMD) areas and ethnic minority groups - including Polish, Roma, Traveller, Bangladeshi, Indian, Pakistani, and African communities - where uptake was lower than average. <u>Comments and Questions</u> Mr Patwa raised the need for broader outreach - including from non-health services - to promote vaccination among communities not actively engaged with healthcare or on the vaccination pathway. He highlighted cultural hesitancy, particularly within ethnic minority groups during COVID, and asked whether qualitative evidence shows a shift in mind-set as a result of current outreach efforts. Dr Walker explained that while outreach efforts around vaccination equity are underway, they are still in the early stages. Mapping work is ongoing across different areas of Grampian to identify what is working and where gaps exist. She acknowledged persistent cultural beliefs and messaging challenges within some communities, particularly around vaccine safety, but no definitive shift in attitudes has been observed yet. Previous studies and collaborations have offered some insight, but most work so far has been preparatory - with hopes of more concrete evidence and impact to report in the future. Dr Tomlinson welcomed the deeper exploration offered by the discussion and emphasised the importance of identifying key strategic equity issues - such as vaccine uptake among ethnic minority groups. He called for targeted research to address questions like those raised by Mr Patwa and proposed that findings be embedded into the action plan. He also requested that future annual reports reflect this focus and highlight priority equity challenges that can drive meaningful change. Cllr Robertson pointed out that access and communication are key to improving vaccination uptake, especially in underserved communities. There are transport barriers to Elgin's vaccination sites and welcomes a shift to local health centres. Her concerns about MMR and rising measles cases,	

	she suggests aligning vaccination messaging with key moments like nursery enrolment, to boost awareness and uptake. Dr Walker explained that nurseries are being considered in vaccination planning, especially as the MMR schedule changes - the second dose will now be offered at 18 months instead of three years and four months. Younger children tend to have better vaccine coverage, partly due to easier access before nursery age and more opportunities before starting school. She also highlighted the importance of targeting young parents, noting likely gaps in adult vaccination due to lingering misinformation from the Wakefield controversy. Addressing both child and parent vaccination is key to improving uptake across Grampian. **Recommendations:** **The Committee were assured that the issue is being actively addressed and asked that future annual reports reflect the key strategic concerns identified.**	
9.	**Putting People First** **9.1 Public Involvement Team Annual Report (with Risk 3650 Update)** Ms Ballantyne outlined the Public Involvement Team's approach to mitigating Strategic Risk 3650 – Inability to reduce demand through citizen engagement and support the organisation's compliance with the Consumer Scotland Act 2020. She explained that despite limited staffing, efforts are focused on enabling broader engagement by training staff, offering toolkits, and transitioning the public involvement team into a more advisory and governance-based role. Their activities align with national guidance such as Planning with People and the Putting People First ambitions. To meet legislative duties, including those under the NHS Reform and Public Services Reform Scotland Acts - they plan to strengthen reporting through an annual summary, enhance future reports with infographics and metrics, and expand community-focused engagement. Appendix 2 reflects the team's diverse workload and long-term commitment to improving citizen involvement. Mr Patwa expressed appreciation for the comprehensive report prepared by Ms Ballantyne and her team. He then asked how they work to address and remove barriers to involvement, particularly for harder-to-reach groups, including deaf communities and others facing challenges in accessing information. He expressed interest in gaining greater clarity on the scope of these initiatives. Ms Ballantyne highlighted the ongoing challenge of reducing barriers to public engagement but noted that we continue to build connections with community partners. Current initiatives include lived experience panels, inclusion-focused roles, and expanded third sector and educational links.	

	She also flagged digital accessibility as a concern and indicated that connections are being built to eliminate more of those barriers in future. Mr Patwa suggested including trend data in future reports to help track engagement, both in terms of reach and repeat involvement. He highlighted the long-term benefits of understanding who and how many is being engaged. Ms Ballantyne confirmed plans to explore the use of a digital platform to collect demographic and engagement data, with the aim of incorporating this insight into next year's reporting. Mr Russell noted the team's impressive work despite its size and acknowledged that the report is presented as evidence of NHS Grampian's compliance with the Planning with People guidelines. Referring to a comment made by Dr Coldwells in a previous meeting around the pace of change being so fast that it is not possible to carry out engagement, he sought clarity on whether we need to start thinking about derogations to recognise that we are not doing that. Ms Ballantyne indicated that there has never been a time or project where the PI team have not provided engagement services within our statutory duties and shared details of resources that are utilised across health and public services as core business requirements for engagement, including: • Encouraging the use of VOiCE, a digital tool structured into three sections of engagement (planning, delivery and evaluation) that aligns with Planning with People guidance. It allows admin oversight of projects, stakeholder analysis, risk assessment and impact evaluation • Keeping website content up to date and accessible • Development of training resources She indicated that integrated pathway work which Dr Coldwells may have been referring to, much of the work has focused on establishing a single governance system, creating one vetting system but we have worked closely with all relevant stakeholders, including comprehensive engagement with staff - affected by waiting times, and GPs involved in referrals etc. When the project reaches the stage where public input can influence outcomes, meaningful engagement with service users and potential future users will take place. Dr Tomlinson indicated the importance of considering how we collect this information. He acknowledged that, given current capacity and workload, it would be unrealistic to expect perfection across all areas. Instead, suggesting it would be more reassuring to present an honest and realistic picture of where things stand - even if that includes areas for improvement, rather than aiming to show everything as flawless.	

	He emphasised the need to understand both our ability to deliver and the actual impact of the changes being made. Highlighting that impact, he noted, would be a valuable part of the overall assurance process.
	
	Mrs Evison acknowledged the strong evidence of the team's adaptability in managing multiple tasks despite limited resources. She was encouraged by a recent example, a letter from the Public Involvement (PI) team shared at a community council meeting which promoted the use of their services. While it is positive that awareness is growing, she noted that overall awareness of the PI team remains limited. She emphasised the importance of adopting a more integrated, whole-system approach to this type of work moving forward.
	
	Ms Ballantyne indicated that the team promotes its work across the system through Community of Practice sessions, and the Grampian Engagement Network, established several years ago, continues to serve as a platform for collaboration and sharing good practice. She also noted that all partnership areas now have their own engagement leads, creating new opportunities to engage and work more effectively across the system.
	
	Ms Ballantyne advised Cllr Robertson that she would contact the newly elected community councils again in November 2025.
	
	<u>Recommendations</u>
	
	The committee:
	
	• **Reviewed and scrutinised the information provided in the report and confirmed that they are assured that the work undertaken by the Public Involvement Team significantly contributes to:**
	  ○ **Mitigating Strategic Risk 3650 – Inability to reduce demand through citizen engagement.**
	  ○ **Representing evidence of NHS Grampian's compliance with Planning with People Guidance and Consumer Duty obligations as contained in the Consumer Scotland Act 2020**
	  ○ **Acknowledging the finite resource of the Public Involvement Team as a potential risk and key constraint given the anticipated volume of service change required to support reform and transformation**
	  ○ **Future reports must provide assurance by presenting data on evidence that activities are underway but also how they influence demand through broader system engagement and trend data to help track engagement reach.**
	
	9.2 Communication Messaging with the Public Progress Update
	
	The Committee noted the paper. Ms Ballantyne advised that she was representing the author in their absence and invited questions and comments from members.
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	Questions and comments Ms Ballantyne confirmed to Mr Patwa's question that she was unaware of any update in discussions with the Scottish Government since the paper was originally submitted to the Committee. Mr Patwa expressed disappointment that despite promising initiatives and strong collaboration among health boards, particularly those highlighted from NHS Grampian, there appears to have been limited national support or coordinated response from the Scottish Government. He welcomed the publication of three policy products but noted a lack of clarity regarding next steps, suggesting the work feels unresolved and emphasised the need for a cohesive national framework to support local messaging and ensure alignment across boards. Mr Russell asked for clarification of section 2.3 around the desire to move from hospitals to community care, as it seems to contradict that the public perceived as a closing of community facilities. Ms Ballantyne indicated there is ongoing communication efforts across various forums, including messaging on acute indicated pathways, wider reform initiatives, and public campaigns such as 'Know Your NHS' and 'We Need to Talk'. She emphasised the range of work underway to improve the system and ensure coordinated messaging that reflects the breadth of activity across different areas. Ms Ballantyne advised she would seek clarification on section 2.3 and provide an update. Dr Tomlinson replied, building on Mr Patwa's comment, that due to the upcoming Parliamentary election, there is unlikely to be further national progress on this issue in the immediate term. The need for consistent and effective public messaging to support service redesign and shape expectations has been raised over several years and remains a critical element of the transformation agenda. There had been concern about whether there is sufficient national appetite to pursue this work at present. He suggested the matter could be considered further within the development session in September and potentially escalated to the Board, as it may not be appropriate for the Committee to act unilaterally. Mr Patwa queried the Committee's endorsement of a proposal that is widely acknowledged as unlikely to progress, highlighting a potential disconnect between supporting its intent and recognising the current lack of feasibility. He suggested that this issue may warrant further discussion to determine an appropriate way forward. Ms Evison agreed that future actions should be considered after such discussion, and proposed the matter be taken offline for further consideration. Recommendations: **The committee:** • **Noted the position of the ongoing activity described within this paper, which includes work to influence national messaging as well as develop and deliver local and regional communications to support strategic programmes of working**	**L Ballantyne**

	• **Agreed that an escalation is required** **Escalation** **Issue:** Endorsement requires demonstrated national commitment, which is currently insufficient. **Escalated to:** Mrs Evison, NHSG Chair and Dr Coldwells, NHSG Chief Executive **Responsibility:** Dr Tomlinson, PHC Chair	**J Tomlinson**
10.	**Strategy, Governance & Performance** **10.1 Population Health Portfolio Board Assurance Report** The committee acknowledged the report, and Ms Penman noted that the paper requires no additional explanation other than it provides a summary of the discussion and actions taken at the previous Population Health Portfolio Board meeting, and how these have shaped the items now presented to this committee. **Recommendations:** • **The Committee reviewed and scrutinised the information provided in this paper and confirmed that it provided assurance that the Portfolio Board has robustly scrutinised the reports and considered cross-system implications and actions** **10.2 Strategic Risk Register Change and Innovation (Risk 3006)** The Committee noted the paper. Ms Milliken noted that while she was not the report author, she was prepared to take questions and refer any outstanding matters to colleagues following their return from leave. Ms Milliken noted the Strategic Change Board's central role in addressing the identified risk but acknowledged that assurance remains limited as key controls and the route map are not yet tested. She stressed the need to prioritise improvement resources across programmes, informed by recent oversight and the KPMG improvement plan. <u>Questions and Comments</u> Mr Russell pointed out that the report focuses on the workings of the Strategic Change Board and wondered whether there were other mitigations and improvements made to respond to the risk; and where those were identified. Ms Milliken explained that improvement activities and resource prioritisation are managed within individual programmes and directorates, the Strategic Change Board provides overarching oversight to coordinate and prioritise resources across the whole organisation. She highlighted the need to ensure	

that core actions are aligned with strategic objectives, noting that the forthcoming route map is intended to support this system-wide approach.

Mrs Evison noted that the report requires close reading to understand how the proposed controls will mitigate the identified risk. She suggested that future reports to the Board in August should offer greater clarity to provide assurance that the risks are being appropriately addressed.

Dr Tomlinson expressed support for the Strategic Change Board's involvement in addressing the identified risk, but noted concern around the feasibility of delivering all proposed actions. He stressed the importance of future reports, including those due to the Board and Integration Joint Boards; moving from broad ambition to concrete, achievable priorities.

Ms Milliken agreed and highlighted that the Strategic Change Board, working with the CET and route map, is helping define organisational priorities and align improvement resources accordingly. The need for governance and assurance mechanisms to ensure meaningful impact across programmes was emphasised by Dr Tomlinson and Ms Milliken.

Dr Tomlinson concluded by underscoring the importance of clearly articulating how priority actions will influence demand and meet strategic intent.

<u>Recommendations</u>

The committee:

- **Acknowledge that there is progress, assurance remains LIMITED and potential gaps in controls or mitigations are unclear.**
- **Recommends that the August board report provides specific details, particular its effect on demand.**
- **Confirms that a future report on this strategic risk is taken to a future meeting on a 6-monthly basis.**
- **Indicates that it would be helpful to understand how PAFIC has previously approached this, and share our own insights in return; perhaps supporting better alignment with the board's perspective.**

10.3 Strategic Risk Register Worsening Health (3131)

Prof Paranjothy introduced the paper and stressed the following points:

The committee has been regularly informed of progress of the range of controls applied to this risk since last year's update, examples include advancements in the Health Equity Plan and Joint Health Protection Plan.

The risk profile now reflects rising failure demand in health and care, with increased unscheduled bed use affecting planned care delivery. Waiting times have grown, especially for those in deprived areas who need more

	support. Limited preventative care capacity leads to more intensive and costly interventions. Following discussions with the Chief Executive Team, it was agreed that differential access and outcomes must be further embedded in our strategic risk approach. Related actions are now incorporated into both planned and unscheduled care improvement plans. This includes revised use of data to manage waiting lists and the Liberated Method to support high-intensity users in emergency care. Risk scoring was reviewed using NHS matrices, the level assessed as **high**, due to the Board's agreed minimalist appetite for health inequality risks. Although above appetite, the risk remains within tolerance. The assurance level is considered reasonable, reflecting the current pressures of failure demand. Controls are active, and new actions were introduced. Risk scoring will be revisited in six months once the effectiveness of these measures can be evaluated. <u>Questions and Comments</u> Mr Russell questioned whether **high** is sufficiently effective of the situation. Based on the data presented, he believed that is almost guaranteed that health outcomes will deteriorate, which might suggest the risk rating should be even higher. Prof Paranjothy emphasised that the strategic risk of worsening population health is long-term, and most controls, like the Joint Health Protection Plan and Health Equity Plan, are designed to work over several years. While foundational work is progressing as planned, the team is now introducing short-term actions (e.g. better use of data, waiting list management, and applying proven methods like the Liberated Method) that could yield immediate impact. These efforts are being incorporated into unscheduled and planned care improvement plans due to their interdependency with other high-rated strategic risks. The risk rating has been elevated from medium to high, reflecting both the seriousness of the issue and the need for urgent short-term mitigation to prevent further long-term deterioration. Mrs Evison queried whether Risk 3131 is formally recognised as a shared strategic risk across CPPs. She suggested that if so, it should be reflected as a control within the risk management framework, highlighting collaborative ownership and responsibility, potentially through the Equity Plan. Dr Tomlinson and Mrs Evison noted that making this explicit could enhance collaboration and focus. While the required actions are understood, implementation remains fragmented. There is a need to move from intent to delivery, embedding risk controls across planning structures such as CPPs, unscheduled care, and integration boards. The discussion emphasised that clarity on ownership and next steps is essential to progress.	

	Prof Paranjothy agreed with their assessment and indicated that parts of the puzzle have begun to assemble but some key pieces still being developed, and need to be brought together through the road map process. This risk is scheduled to be revised in six months' time, giving us time to observe how the roadmap progresses.
	
	Recommendations:
	
	The Committee:
	
	• **Reviewed and scrutinised the information provided in the paper and confirmed that it is seeing progress and asked for:**
	  ○ **A revised report to be presented in six months, incorporating insights from today's discussion and aiming to provide a clearer assessment of the assurance level.**
	  ○ **Agreed that the current assurance level for the risk be elevated from medium to high, with a further review planned in six months**
	
	10.4 Population Health Framework
	
	The Committee noted the report, and Professor Paranjothy confirmed ongoing work focused on two key priorities: prevention and a whole-system approach to healthy eating. Over the next two months, local engagement with HSCPs and CPPs will be carried out across the three areas to gather insights. These findings will be shared during the September development day, helping to shape direction and assess impact ahead of the planned six-month review.	

11.	**Date of Next Committee:** Friday 26 September 2025 at 10:00am virtually by Teams	