APPROVED

Board Meeting
14.08.25
Open Session
Item 12.5

NHS GRAMPIAN
Minute of Meeting of the Population Health Committee
10:00 on Friday 2 May 2025
Via Microsoft Teams

Present
Dr John Tomlinson, Non-Executive Board Member (CHAIR)
Cllr Ann Bell, Non-Executive Board Member
Mr Sandy Riddell, Non-Executive Board Member
Mr Dennis Robertson, Non-Executive Board Member (for Mr Patwa)
Cllr Kathleen Robertson, Non-Executive Board Member

In Attendance
Dr Adam Coldwells, Interim Chief Executive
Mrs Alison Evison, NHS Grampian Chair
Mr Stuart Humphreys, Director of Marketing and Communications
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
Ms Lynn Morrison, Director of Allied Health Professionals
Ms Susan Webb, Director of Public Health

Paper Authors
Mrs Roda Bird, Interim Equality & Diversity Manager (Item 10.2)
Ms Luan Grugeon, Strategic Development Manager (Colleague & Citizen Engagement) (Item 7.1)
Ms Lynsey Martin, Public Health Consultant (Item 10.1)

Minute Taker – Heather Haylett-Andrews

No.		Action
1	**Apologies** Apologies were received from: Ms Colette Backwell, Non-Executive Board Member, Mr Hugh Bishop, Executive Medical Director, Ms Fiona Mitchelhill, Chief Officer Aberdeen City H&SCP, Mr Hussein Patwa, Non-Executive Board Member/Vice-Chair, Ms Judith Proctor, Chief Officer Moray H&SCP, and Cllr Ian Yuill, Non-Executive Board Member.	
2.	**Declarations of Interest** Mr Robertson and Cllr Bell declared for transparency, in relation to item 7.1 PPF Annual Assurance Report, that they are Chair and member respectively of the NHS Grampian Charity.	
3.	**Chairs Welcome and Introduction** Dr Tomlinson opened the committee meeting by welcoming everyone with a reminder to take account of our statement on equalities and health inequalities as we go through the agenda. From our July Committee, there is	

	a new Assurance and Escalation recommendations process that will be utilised in every committee paper, with a focus on the associated strategic risk. We will endeavour to trial this new approach today. <u>Chairs Updates</u> • The National Population Health Framework is expected to be published in the spring (one of three reform papers). It is hoped we will review it at the July meeting with further discussion at our development event in late autumn. • We extend our heartfelt gratitude to Ms Webb, who is attending her final Population Health Committee meeting today. Her remarkable contributions across numerous committees have greatly benefited NHS Grampian. We congratulate her on her new appointment as Director of Public Health and Health Policy at NHS Lothian and wish her all the best. Prof Paranjothy will assume the role of Interim Director of Public Health, pending a new appointment and we look forward to working with her in this capacity. • Ms Haylett-Andrews will share the provisional dates for the 2026 Population Health Committee, welcoming the committee's review and feedback.	**H Haylett-Andrews**
4.	**Minutes of Meeting held on 28 February 2025** The minutes were accepted as an accurate record of the meeting (pending the following amendments) Page 6 - 'sexual promotion specialist group…' to be changed to 'sexual **health** promotion specialist group…. ' Page 11 - '(Dr Coldwells as vice chair of City CPP...)' to be changed to 'Dr Coldwells as vice chair of Aberdeenshire CPP...)	
5.	**Matters Arising** Dr Tomlinson pointed out for information that at the Board Seminar on 7th May, the work carried out since the last meeting on the route map and prevention, will be on the agenda.	
6.	**Committee Planning** **6.1 Action Log** Dr Tomlinson confirmed that all completed items will now be removed from the action log. **The Committee were content with the position of the action log at this point.**	**H Haylett-Andrews**

	6.2(a) Forward Planner **The Committee were content with position of the forward planner at this point.**	
7.	**Putting People First** **7.1 PPF Annual Assurance Report (inc. Strategic Risk 3650 Update)** Ms Grugeon provided an overview of the first-year progress in implementing Putting People First (PPF). She highlighted practical examples and positive feedback from stakeholders and staff who attended the Community Appointment Days (CADs) across Grampian (of which there have been 4). The report also updated on our strategic risk to reducing demand through citizen engagement, which remains high. While many actions in the delivery plan are complete or underway, progress has been challenged by limited team capacity and competing demands across the system. We are still in the early stages of our ambition to spread this as business as usual across the organisation and are now evaluating the broader impact, to assess whether these events lead to lasting behaviour change. Ms Grugeon also shared that we are in the final approval stages for charity funding, which will support further tests of change. The original application is being reviewed in active discussion with Lisa Duthie. <u>Questions and Comments</u> Mr Robertson indicated that he attended the CAD on Chronic Pain and commended Luan for the range of activities that were evident. He was encouraged by the high level of engagement and had been privy to hearing positive feedback (and continues to do so). He noted that the report does not reflect the ongoing, active discussions with Lisa and he understood that an updated project timeline and signed off Memorandum of Understanding was needed from Ms Grugeon before the monies can be released. Ms Grugeon concurred with his explanation, indicating that the report had been prepared prior to this updated position from the charity. Cllr Bell also shared her delight around the success of CADs and concurred with the positivity of feedback from people attending the Chronic Pain session. She was pleased to hear that a future CAD around Mental Health will be held in her area. Mr Riddell emphasised the need for a cultural shift across the organisation and with stakeholders, focusing on outcomes and real-life impact over systems and processes. He highlighted the importance of engaging seldom-heard groups and using feedback loops to build trust and drive widespread adoption. He emphasised the importance of leadership at every level, now and in the future. Despite resource challenges, he urged prioritising and investing in this approach to enable meaningful transformation.	

	Ms Grugeon explained that this is about advancing our current route map. While we have a high-level ambition in place, several key steps are already in motion to secure traction and leadership support across the system. This includes immediate work as well as planning for phase two, where we will integrate PPF, co-design, and prevention-focused approaches. To refine the details, workshops are being held in collaboration with Alan Cooper. Ms Webb added that the Chief Executive Team (CET) and colleagues are highly supportive of CADs, our chief officers expressed how impressed they were with them. Area Clinical Forum and Grampian Area Partnership Forum stressed the need for tangible short term outcomes, and CADs currently provide that. With charity funding secured, we can now create a real-time feedback loop, ensuring PPF is seen as the full programme, not just appointment days. Maintaining engagement with the CET and broader system is so important and finding the right balance is key. Dr Coldwells stated that he has instigated a regular slot in his team meetings to keep PPF tangible for the CET as business as usual. Ms Grugeon has been instrumental in ensuring this is not seen as an extra burden but as something embedded in daily practice. We have opted for a 'little and often' approach, revisiting this every month or six weeks. Engagement is strong, and as people familiarise themselves with it, it will continue to grow. Ms Robertson appreciated the outcome-focused approach, expressing the importance of showcasing achievements and suggested involving housing and benefit teams in discussions; perhaps introducing council-led housing pop-ups at CADs to enhance support. Ms Webb indicated we are leveraging network data lab insights to explore the link between housing and health, collaborating with housing colleagues to unlock valuable NHS data. This enables us to identify communities where targeted interventions - such as vaccinations and income maximization - can be supported through housing initiatives. The work is being integrated into public health strategies, including efforts to reduce child poverty and enhance the frailty pathway. Understanding population trends allows us to refine approaches, ensuring housing and health remain central to our initiatives. Ms Grugeon confirmed that sustainability requires a whole-system approach beyond just health. Our PPF Oversight Group includes representatives from community planning, health and social care, and we have an open community of practice for shared learning. We are developing a CAD guide to help communities bring these principles to life while understanding their real needs. In Torry, Aberdeen, we are designing solutions with vulnerable community members and partners to address issues like drug-related deaths and mental health. Housing outreach plays a key role, as our colleagues regularly engage with those at risk and we are learning that vulnerable populations may not attend health-focused sessions, but they respond better to informal gatherings with food and a supportive environment. By testing and adapting this approach in different	

areas, we can refine and share insights across the system to drive meaningful change. Early collaboration with colleagues in Moray reflects the whole-system focus needed for lasting impact.

Mr Robertson and Dr Tomlinson agreed that we all have responsibility here and in other committees, to promote this approach. Dr Tomlinson sought social care partnership perspectives from Ms Morrison and Mr Reid.

Ms Morrison indicated that effective engagement with communities requires going to where people live their real lives rather than simply organising events and expecting participation. Many self-organised community activities occur organically, often unnoticed by formal health and social care structures, yet they significantly contribute to community well-being. Health and social care professionals and the broader system should support and connect with existing community efforts without disruption or over-formalisation.

Mr Reid indicated that during his attendance at two recent CADs, stall holders fed back to him that they valued creating connections with other stakeholders and that community engagement is vital. He suggested that community connections, engagement and leadership are crucial in solving both present and future challenges.

Ms Webb echoed Ms Morrison's caution about preserving community activism as a grassroots movement rather than turning it into a service. The human learning system approach helps capture insights on what supports or hinders community action, it is important to ensure committees remain open to this learning. Traditionally, new ways of working tend to be forced into existing structures, making it essential to bring these lessons to the Population Health Committee / Population Health Portfolio Board structures.

Currently, similar initiatives use different terminology, which can slow progress. Ms Grugeon is working to align language across the system, ensuring clarity and consistency. With frameworks like 'Getting It Right for Everyone' and 'Realistic Medicine' sharing the same intent, the challenge is simplifying language to reinforce our shared commitment and objectives.

The Committee:

- **Noted the progress report and the priority areas for 2025/2026**
- **Considered the risks to pace of delivery, mitigating actions to address the risk and opportunities for Portfolio Leads to provide visible leadership support to enable progress**
- **Noted there is no change to the strategic risk status but at our deep dive session in November, we will review the progress on the route map, particularly in relation to advancing the mainstreaming of the approach.**

	Assurance: This paper provides assurance that the policies and processes are working effectively, any gaps have been identified and assessed, and risks are being mitigated effectively.	
8.	**Public Health** There were no committee items.	
9.	**Strategy, Governance & Performance** **9.1 Population Health Committee Annual Assurance Report** Dr Tomlinson thanked Ms Penman for pulling the annual assurance report together. **The statement was approved by the Committee** **9.2 Population Health Committee Development 2025-2026** Mr Humphreys extended his thanks to Ms Penman for authoring the paper and indicated the proposal is to maintain the current approach. This provides a good format for development and engagement. He asked if the proposed topics were relevant and pointed out that there remains flexibility to amend these. <u>Questions and Comments</u> Mr Riddell reiterated that, having mentioned before, we tend to have extensive narratives and reports that describe background, policy and ambitions. Whilst these are valuable, we need to shift our focus towards defining what success looks like and evaluating our progress towards achieving it. Are we doing our best to deliver what we've agreed upon, or do we need to reconsider what success should look like in the short to medium term? Reports should be more focused in this direction to guide discussions effectively. In addition to utilising the template for strategic risk, the goal should not be just to provide more space for reviewing reports as they currently exist, but rather to refine the way we assess progress. Dr Tomlinson confirmed to Ms Robertson that the deep dives and learning and development events are conducted online. Ms Webb added that they are recorded, which is particularly useful for the executive team and other board members to access at their convenience. The session recordings will be stored in a centralised location for easy accessibility. **The Committee:** • **Considered and endorsed the proposed 'deep dives' and learning and development programme, including flexibility where needed.**	**H Haylett-Andrews**

9.3 Population Health Portfolio Board Assurance Report

The committee noted the paper and Ms Webb highlighted a few areas of discussion from the meeting:

The Child Health strategy was discussed at the Portfolio Board but was deemed not ready for the Population Health Committee, so will return to the Children's Board, Ms Webb and chief officers can support colleagues to finalise it. While this may cause a slight delay, it is important to get it right. It was thought this would give reassurance that the Population Health Portfolio Board carefully reviews proposals rather than approve them outright.

The board reviewed the Health Equity and Anchors annual reports, which chief officers found highly valuable. This prompted a discussion on streamlining and consolidating reports into a single system-wide version to reduce bureaucracy. The intention will be to do this next year, aiming to enhance planning and collaboration across public health programmes.

Ms Penman made a final point relating to the preventative healthcare paper, which sparked robust discussions at the meeting. Key cross-system opportunities were identified, to strengthen connections between the brain health service and the dementia strategy. Additionally, there was a focus on improving support for people with substance use whilst in ARI and making links with the unscheduled care programme. These connections are now being actively pursued.

<u>Questions and Comments</u>

Ms Webb clarified to Dr Tomlinson that confirmation of the Unscheduled Care bid is still pending, as requests far exceeded the available funds, meaning full funding is unlikely. The bid reflects reinstating the Drug and Alcohol Care team (DACT). If funding is approved for this component there needs to be realignment with last year’s review undertaken by the Public Health Directorate. Despite the tight turnaround for the application, Ms Fraser and her team ensured substance use was included, and has confirmed following the PHPB that the review findings will inform any service development if funding successful.

Dr Tomlinson asked about the maternity pathways focus on embedding prevention, he was considering how the Population Health Portfolio Board tracked and evaluated progress. While optimising pathways to prevent harm now, redesigning them effectively requires a system-wide approach. He asked if there was a structured method for monitoring these developments, as a crucial factor in gaining traction.

Ms Webb confirmed that yes, focus is on embedding existing programmes, like smoking cessation in maternity pathways, to improve outcomes and performance is monitored. The integrated families’ portfolio was one of the first to undergo baselining using the three horizons approach, helping track progress in prevention and tackling inequalities. While direct correlation may not always be possible, we aim to see improvements. Additionally, discussions are underway to strengthen ties between the integrated families’

portfolio and the Population Health Committee, with a proposal forthcoming for review.

Ms Robertson highlighted the excellent Moray IJB session held last week, which brought together a diverse group of stakeholders. She suggested that similar sessions could serve as a valuable opportunity to unite IJBs with their council partners in advancing the child health strategy.

Mr Robertson emphasised Ms Webb's point above about the Portfolio Board's diligent scrutiny of proposals rather than approval outright and suggested the Committee take great assurance from this.

The Committee:

- **Were assured that the Portfolio Board has robustly scrutinised the reports and considered cross-system implications and actions.**

Assurance:

This paper provides assurance that the policies and processes are working effectively, any gaps have been identified and assessed, and risks are being mitigated effectively.

9.4 Integrated Impact Assessment Update

Mr Humphreys introduced his update paper highlighting that progress made over the year on integrated impact assessment (IIA) has been shared periodically.

The IIA documents are now professionally formatted and launched for staff assessing financial savings to use. Our first Q&A session was held, with another scheduled next week. Of 77 savings identified, 12 require deeper assessment, and these sessions are designed to help teams navigate the process effectively.

Expectedly, some resistance arose, as those handling the assessments may not have proposed the savings. Teams are being guided to trust the process, surface concerns, and explore mitigations. Despite this, there were no issues with the form or concept - just challenges around determining what to assess and concerns about specific savings.

Ms Penman reflected on the Q&A and suggested more work is required. She added that over the next year, our priority will be to embed this process as business as usual, ensuring high-quality decision-making. We must ensure organisation-wide awareness of the importance of IIAs and available tools.

<u>Questions and Comments</u>

Mr Robertson requested assurance that a timeline is in place for manager training, ensuring everyone knows how to use it effectively.

	Mr Humphreys advised that the rollout of the new impact assessment process is progressing, but there is still work to be done. Trained impact assessors familiar with the equality impact assessment should adapt easily to the new process, as it builds on existing principles. Currently, around 17 assessors across the organisation have been trained to this level. Efforts are underway with the People and Change team to develop a structured TURAS training module, though capacity challenges have delayed its implementation. The goal is to launch this over the summer. In the meantime, Q&A sessions are being held with smaller groups to provide one-on-one support, ensuring assessors are guided through the transition effectively. While the process is moving forward, further steps are needed before it can be considered fully embedded and widely understood. Ms Penman indicated all committee members have a role in supporting the success of the IIAs. Ms Evison agreed that collective effort is essential for the process and proposed that committee papers be drafted in a way that facilitates progress rather than adding unnecessary complexity. Ms Webb indicates we have to accept that it is a culture change, we have a good foundation with our tools and cognisance of IIAs at our CET meetings upon which to build. Ms Robertson shared her concern that the process could become routine without real impact and turn into a mere tick-box exercise. When making decisions, we must look beyond individual papers and recognise the cumulative impacts across the system. She hoped this concern is properly addressed, based on her experience with IIAs, especially from a Council perspective. Dr Tomlinson highlighted the challenge of navigating large IIA documents, particularly to appropriately use the information in leadership roles and decision-making, where key information can be difficult to find. He suggested that those using these documents should engage in an exercise to improve how they access and utilise the content effectively. To support this change, he emphasised the need to reflect on what information should be included and how IIA documents should highlight information. He suggested to Ms Penman that further discussion is needed to refine this approach. Mr Riddell said that as committee chairs and members, it is our responsibility to highlight important issues, such as significant reports and other matters receiving little discussion, despite containing issues with potential implications. The concern about avoiding a siloed approach is crucial to avoid unintended consequences. A structured IIA tool could help identify risks and ensure they are properly addressed. Mr Russell asked if there was clear guidance for when the tool should be applied. Ms Penman indicated that the guidance document describes when an IIA is needed and when it is not required. The results will show whether users have interpreted it easily.	**CHAIR/ K Penman**

	Mr Humphreys indicated that completion of a reasonable volume of IIAs in a short space of time for the financial savings will allow us to assess usability and spot any unintended consequences. Through business as usual/incremental receipt of IIAs, he wondered if we would stay alert to that. Mr Humphreys stated that adjustments to the IIA forms could be made over time as the clarity of the guidance is assessed. He also confirmed that he would provide an update to a future committee following a six-month review. **The Committee:** • **Noted the progress made to date** • **Endorsed the phased launch of the IIA process starting in April, with urgent and/or large strategic projects being prioritised and supported to carry out the process** • **Acknowledged the intended timeframe for roll-out to the wider organisation, followed by a period of review** • **Acknowledged the change in mind-set required among staff to embed the IIA process and that members take a proactive approach to ensuring IIAs are completed when they are considering strategic decisions within the relevant forums they attend** • **Acknowledged that updates will come to future meetings on how we get traction going forward** **Assurance:** This paper provides assurance that the policies and processes are working effectively, any gaps have been identified and assessed and risks are being mitigated effectively. **Escalation:** Dr Tomlinson requested that a discussion on focusing efforts, where relevant, on impact assessments should be escalated to the next Committee Chairs meeting.	**S Humphreys** **A Evison**
10.	**Creating Equity** **10.1 Health Equity Plan Annual Assurance 24-25** Prof Paranjothy outlined the purpose of the report to provide assurance that work is progressing on the five-year Health Equity plan for Grampian that was approved last year, and to seek endorsement of priority areas for Year 2. She reported that the longer-term ambition is to reduce health inequalities, focusing on six priority areas and four enabling actions. Progress in Year 1 has been strong, with 78% of actions on track, including key initiatives in screening equity. Funding has been secured to continue and expand efforts. While some areas face challenges due to capacity and competing priorities, engagement remains high, particularly with allied health professionals and	

	primary care. As we move into Year 2, we are refining engagement strategies and applying insights gained. The Institute of Health Equity has reviewed our plan, providing valuable feedback to shape our next steps. Ms Martin added that in the first year of the anchor work plan, a strategic group was established, a framework was developed and key activities were implemented; including baselining, communications, and engagement. Partnerships were strengthened, a regional procurement group was formed and efforts initiated to support recruitment and retention in domestic services. Regionally, work took place within the North East Anchors Group to embed best practices, laying strong foundations for upcoming community wealth-building legislation. Next year, the aim is to integrate anchor principles into decision-making, enhance engagement, and refine procurement and premises strategies to improve local impact. While challenges remain, our committed team is well-positioned to expand engagement and drive progress. <u>Comments and Questions</u> Dr Tomlinson asked Ms Martin to clarify the links with partners who are also anchor organisations. Ms Martin highlighted several partnership approaches, including the North East Anchor Group, which connects local authorities and third-sector interfaces. We are strengthening existing relationships to prepare for the Community Wealth Building legislation, aiming for greater collaboration and improved population health. Our Regional Procurement Group facilitates knowledge-sharing, leveraging local authority expertise, data, and business links. Additionally, our strong ties with local employability groups align NHS job opportunities with available funding to support workforce integration. Ms Lawrie, our lead for work and jobs, collaborates with Aberdeen City's 25 by 26 programme, ensuring a coordinated approach between employability support and NHS placements. Mr Robertson asked whether text messaging was being utilised for screening improvements, noting that men, in particular, tend to respond well to this approach in primary care. Prof Paranjothy reported that there is a need to advance text messing, which had proven effective for diabetic retinopathy screening, however progress was hindered by information governance challenges. AAA screening engagement was improved through a data-driven approach, identifying areas with lower uptake and implementing targeted community outreach. Also proactively contacting individuals who missed appointments, fostering personal conversations have significantly enhanced participation. Dr Tomlinson asked for clarification of the information governance challenge and Prof Paranjothy reported challenges in advancing progress (in implementing the text messaging service) was due to difficulties in obtaining approval at a local level due to capacity constraints in the local team. In addition limited data prevents highlighting certain inequalities, such as	

ethnicity and other protected characteristics. National efforts to improve data collection on these protected characteristics are delayed, impacting local implementation.

Ms Webb stated that efforts are underway to improve local information governance processes, including allocating resources to streamline paperwork and reduce delays. However, capacity issues remain. Several national programmes are being prioritised, supported by a memorandum of understanding with Public Health Scotland through the North-East Population Health Alliance. This partnership serves as a test bed for addressing national information governance barriers, assuring the committee that steps are being taken to overcome these challenges.

Dr Tomlinson stated that it is a well-structured read, summarising the six priorities and four enablers effectively while highlighting key cross-references, particularly in engagement and partnerships. The foundations seem strong, and moving into the next phase with tangible examples is promising. The impact of the new posts on demand, though initially small, aligns with the broader aim of understanding how initiatives influence access and service demand. Overall, it connects well with the ongoing work on putting people first and transitioning towards measurable outcomes.

The Committee:

- **Noted the progress made to meet the priorities set out in the Health Equity Plan and acknowledged some of the challenges around capacity and competing priorities in the system**
- **Endorsed the priority areas of focus for year 2**
- **Noted that future reports should have a focus on the impact of the actions taken**

Assurance:

This paper provides assurance that the policies and processes are working effectively, any gaps have been identified and assessed and risks are being mitigated effectively.

10.2 Equality Outcomes/Mainstreaming Report

Mr Humphreys indicated that both reports were published in draft ahead of the April deadline, pending approval through our governance processes – the Population Health Committee and the Staff Governance Committee. Both reports are essential for our compliance with the Equality Act: the Mainstreaming Report outlines the work undertaken to embed equality into our core operations while the Equality Outcomes Report details key commitments aimed at strengthening our approach.

Ms Bird reported that both reports comply with the Equality Act 2010, with equality outcomes set for four-year reporting periods, this update being 2021-2025. A progress report is published every two years and the format of the report is based on equality outcomes for consistency and year-on-year

	comparisons of initiatives from departments and services. Future reports aim to capture more projects as we progress our equalities agenda. She highlighted Equality & Diversity business as usual endeavours: • Mandatory equality and diversity training has doubled from 1,300 to 2,400 in 2024-2025, attributed to a shift to online Teams delivery, allowing 250-300 staff per session. 30% of our workforce compliance rate. • An Integrated Impact Assessment Tool developed to meet specific duties under the Equality Act 2010. • Services include face-to-face interpreters and telephone interpreting via Language Line. In 2024, 23,753 language line calls and 4,917 face-to-face interpreter appointments (including British Sign Language) covering 72 languages across Grampian. • An Anti-Racism Plan was launched in October 2023 with additional guidance from Scottish Government for further development, ensuring integration into both workforce and service provision. <u>Questions and Comments</u> ***Mainstreaming Report & EO Update*** Mr Robertson thanked Ms Bird for the reports and pointed out that, from an IJB perspective, the term "service user" is no longer in use. He suggested updating the terminology to better reflect current practice. Ms Webb acknowledged the reference to the changing population profile but noted the lack of detail on its evolution, emphasising the need to ensure no groups are overlooked. In response, Ms Bird stated that future reports will incorporate national census data and insights from Aberdeenshire and Moray primary care colleagues regarding asylum seekers and refugees to provide a more comprehensive picture. Ms Webb enquired about the baseline target for training eligible staff. Ms Bird indicated that while the ultimate goal is to have 100% of staff complete mandatory training, a more realistic expectation for us is achieving 80% compliance within the next three to four years. We are also exploring the development of an e-learning module designed for the entirety of NHS Scotland, with the potential for blended learning to create a more flexible and engaging training experience. Mr Humphreys shared that a recent audit was conducted on the use of translation services, examining factors such as frequency, location, and overall value. The findings provided valuable insights into the types of translations being carried out, revealing growth in overall usage, with segmentation by language. This data will be shared following the meeting. Dr Coldwells noted that, among the eight mandatory training modules for staff, the Equality and Diversity module is the only one that requires in-person attendance at a fixed time, while the others can be completed on a	**S Humphreys**

	flexible, ad-hoc basis. Transitioning to a blended e-learning approach will undoubtedly enhance compliance. Dr Coldwells noted the reference to blood-borne viruses and HIV viral suppression, and questioned why 100% suppression was not achieved among those who came forward. He speculated whether this applied only to identified, treated individuals or the broader population. He acknowledged the efficacy of current treatments and suggested discussing the matter offline. ***Equality Outcomes Report 2025-2029*** Ms Bird reported that last year, the NHS Scotland Equality and Diversity leads met with the Equality and Human Rights Commission to shape the outcomes for the report, to focus on key areas rather than all nine protected characteristics, while still ensuring broader inclusion. The approach prioritised practical improvements, addressing gaps in evidence, business priorities, national and local needs, and feedback from patients, staff, and stakeholders. Reports will be produced every two and four years, reflecting lived experiences to assess impact. The development process involved collaboration across services and departments, emphasising a shared responsibility. Currently, there are five equality outcomes, but additional ones may be introduced throughout 2025–2029. The Equality and Diversity team will support services in formulating new outcomes as needed. Ms Webb suggested that this plan could be cross-checked with the Health Equity Plan looking at the commonality in a different lens, e.g., gender inequalities; reports have demonstrated that women's access and outcomes are much poorer than men's in certain services that we deliver. This could be an opportunity to support each other. Dr Tomlinson emphasised the importance of mainstreaming equalities and recommended that the Population Health Portfolio Board review any additional proposed outcomes, with an update provided in six months to Committee. **The Committee:** • **Noted the April publication deadline of these statutory reports has been met and the data they now contain relates to the calendar year previously approved by members** • **Endorsed the content of both reports** • **Noted if new equality outcomes are being considered in future, they be brought back via the population health portfolio board for approval**	**S Humphreys**

	Assurance Improvement to policies and processes are being made and appropriate evidence of these has been provided to the Board's satisfaction. Dr Tomlinson expressed his gratitude to everyone for their attendance and contributions. He reiterated his well-wishes to Ms Webb, offering her his best for the future at the conclusion of her final Committee meeting. Ms Webb thanked Dr Tomlinson for his kind words, reflecting on her rewarding 30 years at NHS Grampian and time with the Population Health Committee. She praised his curiosity and advocacy for embedding population health into the agenda. On behalf of the team, she expressed gratitude, noting the hope and recognition it has given public health staff. She wished the committee continued success and thanked them for their support.	
11.	**Date of Next Committee:** Friday 18 July 2025 at 10:00am virtually by Teams	