

Board Meeting
08.10.26
Open Session
Item 11.5

NHS GRAMPIAN

Minute of Meeting of the Population Health Committee 10am to 12.30pm on Wednesday 20 May 2026 Via Microsoft Teams

Present

Dr John Tomlinson, Non-Executive Board Member (CHAIR)
Dr Colette Backwell, Non-Executive Board Member
Cllr Ann Bell, Non-Executive Board Member
Mr Dennis Robertson, Non-Executive Board Member
Cllr Kathleen Robertson, Non-Executive Board Member
Mr Dave Russell, Public Lay Representative

In Attendance

Ms Kay Dunn, Interim Programme Manager (for Melanie Saunders, Interim Director of People & Culture)
Ms Alison Evison, NHS Grampian Chair
Mr Stuart Humphreys, Director of Marketing & Corporate Communications
Ms Lynn Morrison, Director of Allied Health Professionals
Professor Shantini Paranjothy, Director of Public Health
Ms Kim Penman, Public Health Planning Manager

Paper Authors

Ms Lisa Allerton, Public Health Manager (item 8.1)
Ms Jessica Butler, Lead Health Data Specialist (item 8.1)
Ms Tracy Davis, Child Health Lead (item 8.2)
Ms Sonia Emes, Project Manager PPF (item 9.2)
Luan Grugeon, Strategic Development Manager, Colleagues & Citizens Engagement (item 9.2)
Michelle Hankin, Clinical Governance and Risk Team Lead, NHS Shetland (item 9.3)
Mr Chris Littlejohn, Deputy Director of Public Health (item 7.1)

Clerk/minute taker to the Committee – Mrs Heather Haylett-Andrews

No.		Action
1	Apologies Apologies were received from: Sandy Riddell, Non-Executive Board Member; Laura Skaife-Knight, Chief Executive; and Cllr Ian Yuill, Non-Executive Board Member.	
2.	Declarations of Interest and Transparency Statements There were none noted.	

3.	Chairs Welcome and Introduction Dr Tomlinson welcomed all attendees to the committee including Dr Colette Backwell who joined today as Vice-Chair. He confirmed that, following positive feedback from the Committee, the presentations viewed ahead of the committee will continue to be used, as a complementary way of sharing information, with recordings retained for future access. This approach helps maximise time for discussion, meaning only brief introductions to papers are required. As usual, particular attention is drawn to the equality statement, which applies to all reports, including the IIA report presented today.	
4.	Minutes of Meeting held on 27 February 2026 The minutes were approved as a true and accurate record of the meeting.	
5.	Matters Arising Dr Tomlinson announced that progress had been made following the suggestion to share committee headline messages with partner organisations and indicated that Ms Evison is meeting with three council members in early June to start that initial discussion. Ms Evison confirmed that there are opportunities to better align the population health organisation work with partnership activity, including how Non-Executive Directors on councils can support this. Following the initial discussion, there is scope to strengthen links further as the work develops. Dr Tomlinson welcomed the point, noting it aligned with the intended Committee membership structure and ongoing work to strengthen system connections. He agreed it was timely and should be explored further. He then invited additional comments and he looked forward to hearing the feedback. Prof Paranjothy confirmed to Mr Robertson that there is ongoing engagement with Community Planning Partnerships (CPPs), for example, there are upcoming presentations during June to Shire and Moray CPPs to introduce the Population Health Organisation work and maturity matrix assessment, with the offer of using this as a framework to support how we strengthen NHS Grampian's contributions to the partnerships. This discussion has already taken place in the City at their previous CPP meeting in March 2026.	
6.	Committee Planning 6.1 Action Log	

Mr Russell sought clarification on the governance of the Director of Public Health's submission to the COVID inquiry, including input and whether it was formally endorsed.

Prof Paranjothy advised that the submission was made via the central legal process using evidence from health protection records, and did not routinely go through Clinical Governance, though she would confirm this.

Mr Russell noted the importance of understanding any lessons learned across NHS Grampian, Prof Paranjothy confirmed that while some areas undertook learning, this was not done system-wide, but feedback is now being gathered from former executives to inform this and will be shared with the committee in due course.

The committee noted the position of the action log at this point.

6.2 Forward Planner

Dr Tomlinson gave his thanks to Ms Penman for her work on the forward planner and noted the committee's remit having multiple frameworks and priorities to consider, and highlighted the need for dedicated time to review and streamline focus going forward. Prof Shantini and Mr Humphreys were asked to explore options for a development half day to support this.

Members noted that while a substantial amount of sub-national planning work is highly relevant to the committee, it is already being reported through existing Board updates. Members agreed it is important to avoid duplication, but recognised clear links with key priorities such as unscheduled care, orthopaedics, and opportunities for digital and service transformation.

It was agreed that sub-national planning should be viewed as interconnected strands across existing work rather than a separate theme. Population health is already being incorporated, with relevant updates brought to the committee as needed. However, members felt further consideration is required - particularly around issues such as health inequalities in rural and island communities - to determine how best to reflect and oversee this work while maintaining alignment with Board-level reporting.

Feedback on the nationally submitted reports is expected in July, expected to be fed back via the Chief Executive's Office, after which it could be cascaded through relevant committees. This would allow the Population Health Committee to review it from its own perspective and consider implications at an early stage.

Members agreed that once feedback is received, it should be discussed by the committee to inform both response and contribution to wider planning. Given that sub-national planning will shape future priorities, including

**S Paranjothy/
S Humphreys**

S Humphreys

	business systems and data use, it is important the committee has an opportunity to input where relevant at the next committee meeting in July. The Committee noted the position of the forward planner at this point.	
7.	Public Health 7.1 Understanding Needs as a Population Health Organisation Deep Dive The committee had received two pre-recorded presentations for review ahead of the meeting (1) Scotland's Population Health Framework: Planning for Our data needs and (2) Grampian consensus approach for Joint Strategic Needs Assessment. The committee felt the presentation added valuable context and clarity to the accompanying report. Prof Paranjothy gave an overview of the report, focusing on how data is used across the system to inform planning and provide assurance on progress. She outlined four key areas: improving consistency in joint strategic needs assessments, strengthening data maturity and sharing, using system data to inform priorities (e.g. unscheduled care), and the population health organisation maturity matrix, which is in its final stages of development at national level. In Grampian, this work is being progressed with the Northeast Population Health Alliance (NEPHA), with further assessment of maturity levels to follow in collaboration with partners. <u>Questions and Comments</u> Dr Backwell asked the following questions: • How can we improve partner engagement to strengthen interaction and collaboration across the system? • How do we respond to current demographic pressures and plan ahead for future changes and turn this into practical action? • How do we move from data to action, shift the system from treatment-focused care to prevention-focused approaches across partners? Prof Paranjothy explained that the key challenge in translating data into action is the current lack of effective data sharing across organisations. Work has been underway for over a year to address this, and while progress is being made, further improvement is needed. Planned workshops, focusing on areas such as substance use and healthy weight, will help identify what data needs to be shared, what is currently hindering progress, and the practical steps required to enable more proactive, preventative action across the system. Ms Butler indicated that we already use data to understand problems and predict future needs - but data-sharing barriers are stopping us from turning	

that insight into day to day, proactive action. Our goal over the next few years is to fix those systems so this becomes normal practice.

Mr Russell asked whether there was clarity on the scale of the work required, specifically whether the number of Joint Strategic Needs Assessments to be undertaken was known.

Prof Paranjothy reported that each Health and Social Care Partnership undertakes a Joint Strategic Needs Assessment (JSNA) on a two-year cycle to inform its strategic delivery plan and support broader planning, including for demographic change. In addition, where system-wide planning is required for specific population groups - such as children - targeted health needs assessments may be carried out. The current work on child health reflects this approach, building on the previous Director of Public Health annual report and supporting improved use of cross-system data to inform planning.

Professor Paranjothy clarified to Mr Russell that this year's Director of Public Health annual report focussed on women's health but it would not necessarily be the case that a JSNA would be done next year. The children's needs assessment was undertaken to address a gap, whereas needs assessment work on women's health was already in progress and had been used to inform the current report. She added that a range of needs assessments (e.g. substance use) are being brought together into a central repository on the Grampian website, providing a shared evidence base and single access point for partners, with this work continuing to evolve.

Dr Backwell asked whether there should be a national conversation on information governance, given that the issue has persisted year after year.

Prof Paranjothy confirmed work is underway to move towards this, including through the NEPHA in partnership with Public Health Scotland. She noted that efforts are ongoing to address data maturity and information governance challenges, although progress is gradual. She also highlighted that JSNA work is progressing at a national level, with engagement across health boards and local authorities, and that this is likely to help generate wider discussion and momentum around information governance.

Ms Evison welcomed the organisation's involvement at a national level and found the supporting materials helpful. She confirmed that the information governance issue will be raised at upcoming national Board Chairs meetings and committed to taking this forward as an action. She emphasised the importance of improving data accessibility and sharing, noting that making data more widely available can drive local action and have a tangible impact on population health outcomes.

Dr Tomlinson highlighted the role of non-executives in promoting greater alignment across committees, Health and Social Care Partnerships and CPPs, noting the opportunity to support more joined-up working on data and

	needs assessments and to set clear expectations for collaborative approaches. He suggested reinforcing the importance of this work through existing forums, including upcoming engagement with council representatives, and exploring whether it could be reflected within the North East Transformation Group agenda. He further emphasised that, while a significant amount of data is available, the key challenge will be prioritisation, and queried whether modelling could support partners to identify high-impact areas and focus on actions most likely to deliver tangible improvements in outcomes. Ms Butler indicated that an example from housing and health work showed how data can help target action. By identifying Aberdeen-owned homes that do not meet energy efficiency standards, particularly those with three or more children where there is a high rate of respiratory issues, the team narrowed a large problem down to around 300 priority families. This supports more focused, practical action rather than trying to address all 22,000 properties at once. Recommendations The Committee: • Reviewed and scrutinised the information provided and confirmed their assurance that work is progressing with partners to improve the approach for ensuring comprehensive and comparable data across areas, to enable a good understanding of population need and variation in outcomes. • Endorsed the approach being taken to improve how data and intelligence is used to understand and respond to the population's needs in Grampian	
8.	Creating Equity 8.1 DPH Annual report - Women's Health The committee had received a pre-recorded presentation from Dr McGhee for review ahead of the meeting. Prof Paranjothy introduced the Director of Public Health annual report and stipulated it follows a standard approach of focusing on a specific population group or theme each year, with this year's report centred on women's health, informed by a recent needs assessment. The report has been developed through stakeholder engagement and whole-system input, and will be used to support development of a Grampian Women's Health Action Plan aligned to national priorities. She thanked Ms McConnachie and Ms Allerton for their tremendous work in collating, getting people together and producing the report. She indicated that the easy read version was included in the appendices, and that MVC	

team will produce this, planning for this to be in time for the June Board meeting.

Questions and Comments

Mr Russell asked for further explanation of the statements in the report that women experience inequalities in access to healthcare - specifically relating to longer waiting times for treatment and longer stays in emergency departments.

Prof Paranjothy noted that available data already points to some inequalities, particularly longer waiting times seen in areas such as gynaecology. However, she highlighted that data is not always routinely analysed by sex, meaning these differences are not always visible. She advised that further analysis, including a planned deep dive into planned and unscheduled care metrics through an inequalities lens, will help build a clearer understanding.

Ms Allerton added that some data suggests women may attend emergency departments later, particularly for conditions such as gynaecological pain. As a result, cases may be more advanced or complex by the time they present, which can contribute to longer stays. She noted that further work is needed to better understand the reasons behind delayed presentation.

Both Mr Russell and Dr Backwell saw merit in seeking further clarification on the stark reading and looked forward to receiving same.

Dr Backwell asked the following questions:

- When will the local Women's Health Action Plan be published, and will it be a joint plan with NEPHA?
- How can the learning from the report be translated into forward-looking, preventative strategies, rather than primarily responding to issues after they occur?

Prof Paranjothy advised that the Women's Health Action Plan will be developed following publication of the report. Initial discussions are scheduled to begin shortly, with an anticipated timeline of approximately 6 to 12 months for completion, although this will be confirmed as work progresses.

In response to the wider question on moving from data to action, she explained that the report sets out high-level recommendations for a whole-system response. The next stage will be to co-produce a detailed action plan with partners across the system, building on engagement already undertaken. This will translate the findings into practical, deliverable actions, with a strong degree of stakeholder buy-in, to support a more coordinated and forward-looking approach.

Ms Butler explained that inequalities can arise even if each specialty manages its own waiting list well, because some specialties disproportionately serve women. A population-level approach is needed to address this, using targeted interventions (e.g. community appointment days) to prevent worsening outcomes while people wait. She added that true prevention requires linking data across the whole patient journey, rather than looking at specialties in isolation - so patterns like increased prescribing or longer hospital stays can be understood and acted on at a population level.

Ms Evison welcomed the engagement around the report and emphasised that, while the report highlights existing inequalities, the key focus must now be on developing and delivering the action plan. She noted the 6–12 month timeline is appropriate, but stressed that in the meantime the report should be widely shared to encourage teams and departments to start making immediate improvements, rather than waiting for the formal plan to be completed.

Dr Tomlinson noted that the committee is now in a stronger position to tell a clearer, more joined-up story about the impact of current decisions. He suggested that there is an opportunity to increase accountability by highlighting the consequences of existing choices and the alternatives available, rather than continuing with “business as usual.”

He also raised the importance of tracking progress over time, questioning how data from multiple reports and sources can be brought together - such as through the dashboard - to provide a clear, ongoing picture of impact without becoming overwhelming.

Prof Paranjothy explained that the Director of Public Health report provides a high-level “state of the population” overview by highlighting specific themes or population groups, but the issues it identifies are not separate from ongoing work. Instead, they feed directly back into the Public Health Directorate’s core work programme, where the recommendations are taken forward and implemented. She added that progress and actions are then tracked through existing mechanisms, such as the Directorate work plan and the Population Health Programme Board, ensuring the report’s priorities are built into routine delivery.

Dr Tomlinson acknowledged the response and suggested this should be taken forward into the committee’s development half-day session and terms of reference. He emphasised the need to strengthen the focus on prevention, ensuring it has more traction alongside urgent pressures, and proposed this as a potential theme for further development, to help drive a step change in impact from the work underway.

Recommendations:

The Committee:

**S Paranjothy/
S Humphreys**

- **Noted and endorsed the content of the Director of Public Health Report for 2025.**

8.2 Annual Assurance Report for Children/NHSG Child Health Strategy

Ms Davis gave a succinct overview of the report, indicating that Together for Children is NHS Grampian's child health strategy for 2026–2032, developed collaboratively with partners, staff, and families.

It responds to ongoing challenges including child poverty, widening inequalities, and rising mental health and neurodevelopmental need. Building on the Director of Public Health's report, it sets a clear, evidence-based plan aligned with national frameworks and supported by statutory duties.

The vision is that every child grows up healthy, safe and supported. The strategy focuses on five priorities: best start, mental health, reducing inequalities, complex needs, and healthy environments - shifting from crisis response to prevention and early intervention.

Delivery will be overseen by the Children's Health Board, with progress already underway. Overall, it aims to reduce demand, improve outcomes, and create a more joined-up, equitable system.

Questions and Comments

Dr Tomlinson sought clarity on the frequency and audience for future progress reports. Ms Davis indicated that yes, because the strategy is aligned with the partnership children's services plans, there is already a requirement to produce an annual report against those plans. The health elements linked to the strategy will be pulled together and brought back to the committee annually as a progress report.

Dr Backwell welcomed sight of the Impact Assessment and raised four linked questions/points:

- She asked whether issues like harm from vaping and social media will be considered and potentially built into the strategy
- Are there detailed indicators behind the headline measures and why timescales vary?
- How will the Children's Health Board hold partners to account beyond simply receiving reports?
- Asked whether the long-term priorities are realistic or more aspiration.

Ms Davis responded:

- Issues like vaping and social media are being addressed elsewhere (e.g., in statutory reports and national work) but the strategy was deliberately

kept high-level so it cannot include everything. She acknowledged a gap in how information is gathered, meaning some activity is not fully captured, and this needs improvement.

- Timelines were shaped through consultation and experience, particularly for complex needs. Longer timescales reflect the complexity of system and pathway redesign, and the need to move at a realistic pace the workforce can sustain, not just resource constraints.
- The Children's Health Board has been strengthened with senior leadership and clearer structure, improving its authority. However, accountability also relies on wider governance, including committees like this one to provide oversight.

Mr Russell referenced the whole-system approach and noted that the children's dental health strategy was not explicitly included. He asked how many other underpinning strategies contribute to children's health within this framework. He also sought clarification on whether the reference to Childsmile reflects the reinstated programme, or if this remains work in progress.

Ms Davis explained that there are many related strategies and while we have tried to align them, not all are explicitly referenced in this one. She clarified that Childsmile was being restarted in practice, supported by wider collaborative work, but this strategy was not solely written to lead that effort.

Ms Evison asked, how will we actually deliver this in practice, especially where it goes beyond our direct control - and how can we be confident it will happen?"

Ms Davis accepted the challenge, suggested clearer wording and alignment are needed, and points to ongoing work and senior-level discussions are key to strengthening system-wide delivery.

Ms Robertson emphasised that this is not only about child health, but overall life outcomes, which all link together. She reinforced that accountability is mutual across partners, as everyone shares responsibility for improving outcomes.

Recommendations

The Committee:

- **Reviewed and scrutinised the information provided in the paper and confirmed that they were not sufficiently assured at this stage around two points: holding to account and the expectations on delivery. They noted that further consideration of those will be given ahead of a report to the NHS Grampian Board in June.**

- **Endorsed ‘Together for Children’ - NHS Grampian’s Whole System Child Health Strategy 2026-2032 subject to any further wording on the above points**
- **Supported ongoing reporting via the Children’s Health Board to provide assurance on delivery of priorities, impact on inequalities and measured outcomes being brought back to the committee at a future date**

8.3 IIA Quality Assurance

Mr Humphreys summarised the report and advised that the quality assurance audit confirms IIAs are in use across the organisation, with a generally good understanding of their purpose and value, supported by the equality and diversity team. However, quality and consistency vary, with some lacking sufficient evidence, data, or lived experience.

Key issues to be addressed include; complex guidance, inconsistent understanding of when IIAs are required, and weaker consideration of areas such as sustainability and environmental impact.

A number of improvements have been identified, including simplifying the IIA tool and supporting guidance, improving access to data, and sharing examples of good practice. Overall, while the right processes are in place, further work is needed to strengthen consistency and embed IIAs more effectively.

Questions and Comments

Mr Russell questioned whether the sample used in the QA review demonstrates how well the process is embedded, noting that only 10 IIAs were reviewed. He asked if there is data on how many IIAs were completed compared to how many should have been.

Ms Penman indicated that there is no way of knowing for sure whether all decisions that should have an IIA actually have one – this is a known gap. There is not yet a robust, organisation-wide process or audit mechanism to track this consistently. The overall responsibility sits with senior leaders to sense check whether an IIA should be done and ensure that it has been. We are working to improve this so it becomes clear and more consistent.

Dr Tomlinson and Ms Evison agreed to take Ms Penman’s point to the Committee Chairs for further discussion.

Ms Robertson highlighted that the council use a mandatory tick box method to ensure authors consider IIAs early. Papers are delayed or rejected if an IIA has not been completed, because decisions should not be taken without understanding impacts. This shows how important IIAs are for decision

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making, not just as a formality. How confident is NHS Grampian that IIAs are being done early enough to genuinely shape decisions?

Ms Penman and Mr Humphreys acknowledged two governance gaps around IIAs that NHS Grampian needs to improve:

- Not all committees consistently check whether an IIA has been completed and is of sufficient quality when decisions are brought forward.
- IIAs are often completed too late in the decision-making process, and there is no mechanism to check afterwards whether the proposed mitigations were effective.

Ms Morrison reflected that IIAs are still seen as a relatively new and developing process in her area. She felt there is more to do to build understanding across the workforce, so IIAs are used proactively in planning and genuinely shape decisions.

Ms Evison was concerned that IIAs are still described as 'new' despite two years of work, indicating slow progress. She agreed there was a governance gap, noting that decisions happen operationally, and questioned whether IIAs are being applied appropriately at that level - there is a need for stronger assurance that IIAs are consistently understood, applied, and information decisions across the system.

Prof Paranjothy agreed that IIAs need to be embedded at different levels as part of the wider prevention agenda and highlighted that IIA content is being introduced within a new Fundamentals of Management course, to build understanding at the operational level. She agreed that this needs a broader, system-wide approach beyond committees.

Mr Humphreys highlighted that the Committee has taken a robust approach to reviewing IIAs, expecting clear evidence rather than accepting assurances at face value. He also raised a concern about a lack of clarity around what constitutes a 'strategic decision' suggesting IIAs may be underused, i.e., there may be important decisions being made slipping through without IIAs being carried out first.

Ms Dunn supported linking IIAs to the Fundamentals of Management Programme and Corporate Priorities, and will feed back to the Culture Programme Board, including the earlier points raised on data. She suggested priority programmes and different boards should lead by example, actively championing and embedding IIAs in everything they review. She promoted a shift in organisational culture to 'always consider impact', and only justify when an IIA is *not needed* – making impact assessment a routine expectation.

Dr Backwell noted that while IIAs may feel new, this reflects the challenge of embedding them across a large organisation. She highlighted opportunities

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	to learn from other organisations, but emphasised that delivery is hindered by the potential scale and administrative burden on already stretched staff. She therefore called for clarity on the level of assurance required by committees and the Board, alongside better resourcing and support for teams to implement IIAs effectively. Recommendations: The committee: • Reviewed and scrutinised the information provided in the paper and confirmed that it provided assurance and a clear account of our position but noted that further improvement is required. • Endorsed the proposals contained in this paper and agreed to highlight key steps by developing a position statement from the paper and discussion, including escalation to committee chairs, the Executive Team and potentially the Board. • Emphasised the need for a collective decision on next steps after two years, involving the wider system.	
9	Strategy, Governance and Performance 9.1 Annual Population Health Dashboard and Public Health Annual Report 25-26 Ms Penman introduced the report and the committee noted the draft population health dashboard, designed to provide a comprehensive overview of key indicators and direction of travel at three levels (high-level, RAG status, and detailed data). Currently, 20 of 45 indicators are rated green. The annual report highlighted progress against four strategic priorities, with evidence of delivery and impact; however, overall population health outcomes remain largely unchanged and health inequalities persist. <u>Questions and Comments</u> Dr Backwell emphasised the need for a strong partnership approach across the system and queried the extent of NHS Grampian's ability to influence certain metrics, noting not all are within its control. Dr Tomlinson reflected general support for the direction of travel, despite persistent population health challenges and inequalities and asked how progress can be demonstrated meaningfully over time, beyond delivery activity, where outcomes have yet to improve. Prof Paranjothy noted that current actions are evidence-based and expected to improve healthy life expectancy over time, though impacts are expected to manifest in the longer-term. She advised progress can be assessed by	

increased traction in more deprived groups, indicating movement towards reducing inequalities and improving outcomes.

Ms Grugeon emphasised the use of a clear logic model to set out assumptions, actions, and expected outcomes. She noted this approach is applied in practice but needs to be more explicitly reflected in high-level reporting narratives.

Dr Backwell highlighted that improvements in population health outcomes are long-term, and papers should set realistic expectations of what can be achieved within current timescales and NHS Grampian's control. Dr Tomlinson noted the need to balance this with a clear narrative that avoid diminishing the importance and accountability of prevention work.

Mr Littlejohn explained that population health improvements usually take years or decades, though large societal changes can shift outcomes more quickly. He emphasised that impact depends on system-wide action beyond the NHS, raising the key question on whether efforts are being delivered at sufficient scale to drive change. He also highlighted that wider external factors also influence outcomes, often beyond NHS control.

Dr Tomlinson reflected that Mr Littlejohn's points highlighted the need for realism about expected outcomes. He suggested future reporting should explicitly interpret data through this lens (scale, influence and external factors). He emphasised maturing the overall approach, recognising the roles of NHS, the wider system, and external influences.

Recommendations

The committee:

- **Reviewed and scrutinised the information provided in the paper and confirmed that is provided assurance that the evolving Population Health Dashboard provides a holistic overview of population health outcomes in Grampian to support our understanding of changes required to improve population health and reduce health inequalities.**
- **Agreed that progress against the four public health strategic objectives has been achieved in the past 12 months, with evidence of positive impact on people's lives.**
- **Noted that further work is required to clarify the underlying logic models - setting out expected impacts, assumptions, and dependencies, including those out with NHS Grampian's direct control.**

9.2 Strategic Risk Review Citizen Engagement (Risk 3650)

Ms Grugeon provided an update including progress since November, planned actions for 2026/27 and ongoing system challenges. She noted the risk has been reframed to focus on NHS Grampian's ability to effectively engage citizens in service improvement. She highlighted progress in governance, capacity and evaluation, though approaches are not yet embedded at scale to reduce the risk rating. She confirmed the risk remained high, with further embedding of approaches planned and review scheduled in six months.

Questions and Comments

Mr Robertson asked Ms Grugeon to identify the obstacles that are preventing the approach embedding into the system.

Ms Grugeon reported the obstacles as (1) limited staff and system capacity due to day to day pressures, (2) the need to implement change at a manageable pace while bringing staff and communities along with it and (3) difficulty evidencing long-term preventative impact using short-term metrics.

Mr Robertson supported a measured, sustainable approach that takes time to embed change and bring staff with it. He emphasised the need for broader staff engagement and recognition that they can contribute to positive change.

Ms Dunn confirmed to Dr Tomlinson that she would highlight this strategic risk in core skills, management skills and capabilities and risk development work in the management fundamentals programme.

Dr Backwell highlighted the need for realism about what Community Appointment Days (CADs) can achieve in the short term and suggested further evaluation is required to evidence their impact (e.g. reducing referrals) before scaling up.

Ms Grugeon explained a twin approach: developing and testing robust data/evidence alongside spreading core CAD principles to local teams. She noted teams are being supported to apply key elements (e.g., co-design, third sector involvement) while evaluation continues in parallel.

Ms Evison shared a positive example of a CAD being developed locally and adopted by GP practices, demonstrating the model in action. She highlighted strong partnership working (including third sector involvement) and noted this as an encouraging step, though not yet evaluated.

Recommendations

The Committee:

	Reviewed and scrutinised the information provided in the paper and confirmed that it provided assurance that processes regarding the management of strategic risks are in place and are working effectively. Any gaps in controls are identified and are being addressed. 9.3 Strategic Risk Report – Board Risk Appetite & Strategic Risk Process The committee considered the information presented in the report and endorsed the revised NHS Grampian Risk Appetite Statement. 9.4 Population Health Portfolio Board Assurance Report The committee noted the information presented and welcomed the revised format. 9.5 Population Health Committee Governance Assurance Statement 2025/26 The committee noted the paper. <u>Comments and Questions</u> Dr Backwell observed the report as strong on process but lacked emphasis on the impact and outcomes of the committee's work. Dr Tomlinson highlighted the need to balance process and outcomes, suggesting more should be included on the outcomes achieved. Ms Penman was asked to draft a paragraph to add to the report to better articulate the outcomes. Prof Paranjothy suggested that outcomes could be better evidenced by referencing the developing dashboard and the use of integrated impact assessments. She highlighted these as examples of progress and as mechanisms to demonstrate impact more clearly in reporting. Mr Humphreys suggested capturing examples where the Committee has driven action elsewhere in the organisation and tracking what outcomes resulted from those escalations. Dr Tomlinson agreed and proposed strengthening the narrative on outcomes, including system-wide working and use of data (e.g., dashboards, IIAs, reports).	K Penman
10.	Date of Next Committee: Thursday 30 July 2026 at 10.00am virtually by Teams	