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NHS GRAMPIAN

**Minute of Meeting of the Population Health Committee
10am to 12.30pm on Friday 27 February 2026
Via Microsoft Teams**

Board Meeting
11.06.26
Open Session
Item 15.1.5

Present

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

In Attendance

Mr Paul Bachoo, Acute Medical Director
Dr Hugh Farrow-Bishop, Executive Medical Director
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
Mr Sandy Reid, Lead People & Organisation, Aberdeen City H&SCP (obo Ms Fiona Mitchelhill)
Mr Dave Russell, Public Lay Representative
Ms Laura Skaife-Knight, Chief Executive
Mr David Watkin, ST5 in Public Health Medicine

Paper Authors

Mr Chris Littlejohn, Consultant in Public Health (items 7.1 and 7.2)
Lorraine Scott, Head of Planning, Improvement and Performance (item 8.2)
Clare-Louise Walker, Consultant in Public Health (item 7.3)

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

No.		Action
1	Apologies Apologies were received from: Leigh Jolly, Chief Officer Aberdeenshire H&SCP; Fiona Mitchelhill, Chief Officer, City H&SCP; Judith Proctor, Chief Officer Moray H&SCP; Mr Dennis Robertson, Non-Executive Board Member; and Mr Philip Shipman, Director of People & Culture	
2.	Declarations of Interest and Transparency Statements Cllr Yuill made a transparency statement in relation to item 7.2 and stated that he is a member of Aberdeen City Council, which is a partner in drafting the Grampian Joint Health Protection Plan. He considered the objective test and did not believe it was necessary to withdraw.	
3.	Chairs Welcome and Introduction Dr Tomlinson welcomed attendees and shared the following updates:	

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	<ul style="list-style-type: none">• He noted that this was Mr Patwa’s final meeting as a member of the Committee, thanked him for his contribution as Vice-Chair, and wished him well in his new role as Vice-Chair of the Staff Governance Committee ahead of assuming the Chair’s position. He also welcomed Mr Patwa to attend future Committee meetings.• He welcomed the appointment of Dr Colette Backwell as Chair of PHC at the end of his tenure at the end of January 2027 and noted that she will attend the next Committee meeting as Vice-Chair.• He extended his congratulations to Mr Chris Littlejohn on his appointment to the post of Deputy Director of Public Health with effect from 1 April 2026, wished him well and thanked him for his support of the work of the Committee thus far.• He acknowledged Mr Littlejohn’s video and asked the committee for feedback on the benefit of prior sight.• Noted that there were no items under the equity remit, but had been covered at the previous meeting, and that the IIA report will be considered at our next meeting; members were reminded that the equality statement remains relevant across all work areas.• Noting recent time pressures, which partly led to the use of video to support more time for discussion, he highlighted that today’s agenda was more evenly balanced and sought members support in managing both time and effective scrutiny.	
4.	Minutes of Meeting held on 21 November 2025 The minutes were approved as a true and accurate record of the meeting, subject to the following amendment: Ms Skaife-Knight will be added to the attendance, as she was present.	H H-Andrews
5.	Matters Arising Strategic Risk – Citizen Engagement Update (page 14): Dr Tomlinson confirmed that the action to refer the matter to the Chief Executive Team has now been completed and updated on the action log. NHS Grampian’s Contribution to the CPP Annual Report (page 21): Dr Tomlinson advised that the date had changed since the last Committee meeting, with the detailed paper on anchor work now scheduled to be presented to the Board in October 2026 rather than June 2026.	
6.	Committee Planning 6.1 Action Log Dr Tomlinson highlighted the last closed action on Strategic Risk – Citizen Engagement Update and Prof Paranjothy indicated the matter was taken to the CET for further consideration. Agreement was reached to reframe the	

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	<p>risk: The inability to effectively engage citizens to shape service improvement and transformation, as this better reflects the intended impact of citizen engagement, rather than the previous focus on reducing demand.</p> <p>The committee noted the position of the action log at this point.</p> <p>6.2 Forward Planner</p> <p>Dr Tomlinson gave his thanks to Mr Patwa for his suggestions on the formatting and explained that the introductory content was intended to clarify the rationale and its alignment with strategic frameworks and the Committee's terms of reference.</p> <p>Ms Penman added that the forward plan had been reframed to align with the population health framework and population health organisation. A key has been included to show this alignment across all items, with each meeting structured to focus on different aspects of the population health organisation.</p> <p>Ms Skaife-Knight thanked colleagues for the update and noted that, while organisational priorities for the year ahead were still being finalised, it was proposed that prevention would be one of five key priority areas. Subject to approval, she anticipated that prevention-related KPIs would be overseen by this Board-level Committee and highlighted the need for some flexibility as this was confirmed.</p> <p>Dr Tomlinson welcomed this and noted that a further update would be provided once formalised. He also highlighted improved alignment between the Board and Committee forward planners, ensuring reports are considered by the Committee in advance rather than retrospectively.</p> <p>Dr Tomlinson noted that the forward planner reflects Ms Evison's work with committee chairs to better align member visits with forthcoming areas of work. Members are invited to suggest visits to support future decision-making or scrutiny by contacting lead executives. He highlighted (albeit short-notice) an opportunity to visit the Peterhead Vaccination Centre on 12 March, where staff are keen to showcase their work, with scope for a wider system-focused visit. Cllrs Bell and Yuill, along with Dr Tomlinson, confirmed their interest. Mrs Haylett-Andrews will notify the organiser and copy in those attending.</p> <p>The Committee noted the position of the forward planner at this point.</p>	<p>HH-Andrews</p>
<p>7.</p>	<p>Public Health</p> <p>7.1 Protecting Health Deep Dive</p> <p>The committee had received a Mr Littlejohn's pre-recorded presentation on renewal of the Grampian Joint Health Protection Plan for 2026/28, for review ahead of the meeting to help maximise time for discussion. The committee felt the presentation added valuable context and clarity to the accompanying report.</p>	

7.2 Protecting Health Assurance Report

Questions and Comments

Cllr Yuill indicated there are growing health protection risks and reduced capacity, which raises concern about complacency as budgets tighten, but it is positive that time and resources are still being invested in testing and preparedness, which is seen as essential and worth protecting.

Mr Littlejohn indicated that he and NHS Grampian shares those concerns but has increased local health protection capacity, helping offset wider environmental health pressures through joint working. Local arrangements sit within wider national systems to address ongoing and emerging public health threats.

Mr Robertson enquired how much of the enteric infection data is linked to rural factors such as animal or zoonotic transmission, and how do our figures compare nationally - do rural areas like Aberdeenshire and Moray see higher rates? Also, given the ageing environmental health workforce and lack of training provision in Scotland, what more can be done nationally to support training and succession planning to prevent future workforce shortages?

Mr Littlejohn stated that some enteric infections are linked to rural and agricultural exposure, including animal contact and private water supplies. Targeted joint work with local authorities has reduced previous spikes, particularly around farm attractions and water safety, though private water supplies remain an ongoing risk.

There is a well-recognised national workforce challenge, with many environmental health officers nearing retirement and difficulties recruiting and training replacements. Accreditation issues and limited training routes add pressure, with teams responding by developing staff internally and exploring links with local universities.

Mr Patwa enquired if there is a capacity shortfall during a contingency, do the sub-national arrangements allow for quicker and more effective cross-board working providing additional resource?

Mr Littlejohn reassured him that existing contingency arrangements already allow NHS Grampian to draw on additional capacity from neighbouring boards and Public Health Scotland, predating subnational working. There are formal crosscover agreements (MOUs) with Tayside and Highland, plus access to national field epidemiology teams for major incidents. Local contingency plans enable rapid reprioritisation of staff and resources in serious events. While nationwide incidents (e.g. COVID) limit mutual aid, national support and funding mechanisms provide additional resilience and gave overall assurance that sufficient capacity could be mobilised if local resources were overwhelmed.

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Cllr Yuill asked if shifting environmental health capacity from local authorities to NHS Grampian create a better balance overall, or does it simply move costs between public bodies without delivering real savings or benefit?

Mr Littlejohn explained that NHS Grampian has taken over enteric infection case interviews from environmental health teams, which reflects arrangements elsewhere in Scotland and is seen as the right approach. This allows the NHS to focus on managing cases and identifying transmission risks, while freeing up reduced environmental health teams to concentrate on vital but often invisible preventive work, such as food safety and private water supplies. The change has been enabled by additional health protection funding following the pandemic and has helped mitigate local authority workforce reductions, with a sound rationale that this division of responsibilities makes sense and may have been appropriate regardless of budget pressures.

Mr Russell had interest in further exploring the two areas flagged as red, particularly around pandemic recovery and the mitigations in place. Given recent leadership changes, he sought clarification on how lessons from COVID have been captured. In addition, under pandemic preparedness, he requested clarification on logistics and supply chain arrangements, which were critical previously.

Mr Littlejohn commented that a national pandemic centre within Public Health Scotland is expected to provide guidance, and developing an updated pandemic plan should become a priority as soon as this is available. Prof Paranjothy reassured Mr Russell that NHS Grampian has already collated timelines and learning from COVID as part of inquiry preparations and has implemented improvements locally where possible. While national guidance is still awaited, current plans are being tested through real incidents and outbreaks (e.g. measles), demonstrating that local outbreak and resilience arrangements are being actively used and reviewed.

Prof Paranjothy explained that incident management processes include a formal report, and lessons-learned review through existing clinical governance arrangements. Dr Tomlinson noted that, for assurance purposes, the Committee does not require full detail but would welcome a summary of the evidence underpinning this work to support assurance.

Ms Evison agreed there is a strong need for assurance and prioritisation around pandemic planning, both locally and nationally, particularly given leadership changes and the need to capture learning and noted the accompanying report highlights pressure on health services, where good work is being done but rising demand is impacting staff and capacity, and this should be noted as a key issue.

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Mr Reid declared an interest as a manager of the Grampian Sexual Health Service but credited the team and not himself. He added that as an example of preventative work, the service is trialling walking evening clinics over the next four Wednesdays to provide long-acting reversible contraception for women. This responds to reduced provision in primary care and aims to help prevent rising termination rates. The pilot, funded within existing resources, will assess demand across Grampian and could increase access to preventative appointments if successful.

Cllr Yuill asked how is NHS Grampian; working with partners, ensuring pandemic preparedness is forward-looking and adaptable, so plans prepare for future and different threats rather than repeating preparation for the last pandemic?

Mr Littlejohn answered that pandemic planning had been based on influenza-specific assumptions, which did not account for different types of pathogens behaving in different ways. COVID exposed the limitations of this approach, particularly the early decision to stop contact tracing, which was later reversed once the scale of risk became clear. The key lesson is that preparedness must be flexible and adaptable, recognising that future pandemics may require different responses rather than a one-size-fits-all model based on experience.

Prof Paranjothy added to Mr Littlejohn's point to give assurance that work is underway nationally to exercise and plan for less traditional threats. Recent exercises across Scotland have focused on more complex, nontraditional scenarios involving multiple unknowns. For example, during Exercise Pegasus, NHS Grampian participated through workbook completion rather than active participation, but this has highlighted several areas for further exploration, with debriefing still ongoing. Therefore, while full national plans are not yet in place, there is active work underway to strengthen resilience and planning in this area.

It was agreed that the learning outputs from Exercise Pegasus would be shared at a future committee.

Dr Tomlinson indicated that having read page 44, it appears the issue is largely technical, particularly around having sufficient cases to evidence the target. Given that, although it is rated red, asked if it was fair to say this was not a major concern for us; or was that an oversimplification?

Mr Littlejohn summarised that NHS Grampian has high levels of bloodborne virus testing, including hepatitis C, and is actively working to increase access through measures such as dry blood spot testing, which removes the need for a health professional. The main challenge is reaching and treating those at highest risk, particularly people who inject drugs, who often face multiple competing priorities. While effective treatments are available, engagement and adherence remain difficult. There are also technical issues with how

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national targets have been set, which are now under review. Additionally, the suspension of community pharmacy delivery has significantly affected treatment uptake, although work is underway nationally to reinstate this model. As a result, performance is rated red, reflecting a genuine concern about meeting treatment targets, not just a technical reporting issue.

Recommendations:

The Committee:

- **Reviewed and scrutinised the information provided in the paper and confirmed it provided assurance that the policies and processes necessary are in place and are robust**
- **Endorsed the proposals contained in the plan**
- **Noted that a renewed JHPP is required for 2028/30**

7.3 Vaccination and Immunisation Annual Report

Dr Walker gave a comprehensive overview of the third annual immunisation report and highlighted three key areas:

- (i) the continued expansion of vaccination programmes such as RSV and shingles;
- (ii) the development of new delivery models, including an increasingly digital travel health service, community-based vaccination in Moray; and
- (iii) an expanded school's vaccination pilot in Aberdeen City and the challenges faced this year, particularly around IT system delays and workforce limitations. While much of this work happens behind the scenes, the report demonstrated how services continue to evolve and grow in response to national guidance, local need, and service pressures.

Questions and Comments

Mr Reid acknowledged the substantial amount of work delivered by Dr Walker and the immunisation service, recognising the detailed account of challenges faced, including static national funding and the need to rapidly implement new service models. He particularly commended how effectively the team has adapted to significant premises challenges in Moray, noting that this has been managed extremely well. Drawing on his own positive experience as a service user, he described the report as very positive overall and concluded that the service has performed exceptionally well. Dr Walker extended her thanks and indicated she would share this with the team.

Cllr Bell thanked Dr Walker for the report and praised the Aberdeen City schools' pilot, noting that a week-long presence in schools can encourage uptake and may be worth expanding, particularly in academies. She also welcomed the move to delivering vaccinations closer to home, noting that this improves attendance and reduces travel for families and older people.

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Dr Tomlinson noted national evidence showing the RSV vaccination reducing hospital admissions by 62% in older adults and by around 80% in infants under 1 year old, highlighting these figures are important prevention data, demonstrating the impact of vaccination on demand and patient flow across the system. He would take a note of any others that followed.

Mr Patwa welcomed the move to delivering closer to home vaccinations but asked what more can be done to ensure affordability and access, particularly around transport, does not remain a barrier, potentially through better use of community services or volunteers.

He also raised concerns about equity and workforce uptake, and asked why ethnic minority communities continue to be harder to reach and what more can be done to engage trusted community influencers, as well as how staff vaccination uptake can be further encouraged so staff are protected and lead by example.

Dr Walker indicated that accurate staff vaccination uptake is difficult to assess due to poor-quality data, but available figures suggest uptake has increased slightly this year, though it remains low; particularly among care home staff. The issue appears less about access and more about fatigue, complacency, and misinformation, and progress depends on stronger organisational leadership, management engagement, and consistent messaging to encourage staff buy-in.

Uptake among some ethnic minority communities remains lower, and while more needs to be done, work is underway to address this through targeted communications, focus groups, engagement with trusted community voices, and improved accessibility. This is recognised as a gradual, long-term effort rather than a quick fix.

Ms Evison made the point that while the travel health work has value, it should not be a priority compared to other vaccination work with greater public health impact. She suggested that limited resources should focus on core vaccination programmes, as travel vaccinations can be partly accessed elsewhere, and therefore should not take precedence in overall service prioritisation.

Dr Walker supported the view that travel health should not be a priority based on vaccination impact alone and agreed that, while a wholesaler licence would enable a more comprehensive travel service, pursuing it should only be justified if there were additional strategic reasons, not as a vaccination priority. This aligned directly with the earlier suggestion that limited capacity should be focused on higher-impact vaccination work rather than expanding travel clinics.

Dr Tomlinson confirmed that the report had clearly and thoroughly addressed a previous request from the committee.

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	<p>Recommendations</p> <p>The Committee:</p> <ul style="list-style-type: none">• Reviewed and scrutinised the information provided in the paper and confirmed that it provided assurance and evidence in relation to the effective delivery of the vaccination programme in NHS Grampian.• Noted that the next Grampian Vaccination and Immunisation Annual Report will be brought back to the Committee in 2027, to include a model of potential impact by doing more targeted action to address inequalities. <p>Due to time constraints, the following agenda items were taken as read, and the meeting proceeded directly onto questions and comments.</p>	
8.	<p>Strategy, Governance and Performance</p> <p>8.1 NHS Grampian as a Population Health Organisation (PHO)</p> <p><u>Questions and Comments</u></p> <p>Ms Skaife-Knight thanked Prof Paranjothy for the paper and emphasised the need to align operational governance, noting that the Population Health Programme Board should also report to the CET and be incorporated into the new Executive Team from April 2026.</p> <p>Dr Tomlinson sought clarity on governance on the new North-East Transformation Group (NETG), how it will formally report into the board or committee structure. Ms Skaife-Knight explained that the group's terms of reference and reporting arrangements will be agreed at its first meeting on 20th March. Once agreed, the governance and reporting lines will be brought back to the board, allowing members to see how the groups connect and where the touchpoints are.</p> <p>Ms Evison endorsed the approach and encouraged embedding of population health thinking across the whole system, with clear governance being essential to ensure population health work has proper focus and traction within the evolving governance framework. Finally, she noted that the committee itself may need to evolve as this work develops, and that this should be embraced as a positive and natural outcome of successful progress.</p> <p>Prof Paranjothy explained that, while the Board will complete the maturity matrix, discussions are also underway with Community Planning Partnerships, who received the population health organisation framework via COSLA. It is being proposed that the maturity matrix is applied initially to the system-focused domain, to support partnership development and identify priorities for improvement, recognising that each of the three areas is at a different stage of maturity in its community planning arrangements.</p>	

Recommendations:

The Committee:

- **Endorsed the plan for progressing towards becoming a PHO, and agreed to provide feedback to Executives to inform the next iteration of the plan**
- **Agreed that the next iteration of the plan should be presented to the Board in October to seek formal agreement for NHS Grampian to work towards becoming a PHO as a strategic objective**

8.2 Strategic Risk Update Change and Innovation (3006)

Ms Skaife-Knight reported that this paper has been reviewed by the Chief Executive Team and is presented for assurance. While the current assurance rating remains limited, reflecting that key controls are still being implemented, the paper sets out clearly what those controls are, where previous gaps existed, and the timescales for addressing them. Significant progress is already underway, with key leadership, governance, planning and transformation arrangements being put in place, demonstrating that the organisation is moving in the right direction and laying the foundations for delivery against future priorities.

Questions and Comments

Mr Riddell noted that the discussion at PAFIC was aligned with the report and welcome the progress described, particularly the clarity on the changing landscape and the actions and controls in place. PAFIC remains concerned that staff are not clear how current activity links to future ambitions and therefore welcomed proposals for a comprehensive stocktake of transformation priorities and further updates to the Board.

Support was also expressed for work to consolidate and maximise change capacity, the refocused priorities on planned care, value and sustainability, and the emphasis on leadership, culture, governance and prevention. While the foundations are in place, he stressed the importance of shifting from process to outcomes, with clear priorities, measurable impact and a strong line of sight from strategy to delivery.

Mr Russell asked the following questions:

- How does primary care and social care fit within the priorities split between unscheduled care and planned care? He also asked for clarification on a few points on the paper:
- Where the paper says each of the three priorities already have a clear plan but later refers to a delivery plan being developed by March/April. Are these separate plans?

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- In the section on communication and engagement, there is no reference to community engagement – is this being addressed elsewhere?

Ms Skaife-Knight answered as follows:

- Both planned care and unscheduled care priorities are intended as whole-system plans, explicitly including primary care, social care and mental health. Feedback has highlighted the need to make this clearer, and the wording of the priorities is being adjusted accordingly.
- There is one overarching improvement plan, which responds to the diagnostic work and brings everything together. Beneath this sit domain-specific plans (e.g. planned care, unscheduled care, prevention, leadership, culture, value and sustainability), each with clear actions, KPIs and timescales. Programme boards act as the delivery and governance mechanism for these plans.
- Community engagement is already underway and embedded within the 2026–27 priorities, with recent sessions held with community groups. This is intended to be an ongoing programme of engagement, not a one-off exercise, and will continue to be developed based on feedback from communities.

Dr Tomlinson stated that while he is more assured that progress is being made, he wanted to check that this is because the transformation reset is still at an early stage and that, as the transformation board and system-wide approach mature, the work will become more detailed, tangible and impactful. He reflected that for several years there had been talk of “putting the conditions in place” without enough clarity or delivery, but was now starting to see clearer structures, partner engagement and governance emerging — and he asked for confirmation that this assessment is correct.

Ms Skaife-Knight agreed with Dr Tomlinson’s assessment and confirmed that the work is still at an early stage, but this time it is being set up deliberately to succeed. There is now clear alignment of transformation and improvement resources within NHS Grampian, rather than fragmented effort. System partners have agreed, through the NETG, to pool resources collectively, with eight priority areas already identified for redesign and transformation. Its first meeting on 20th March will focus on prioritisation, resourcing, and learning from why a previous version of this group did not work, to avoid repeating past mistakes. The work is being formally embedded into assurance and governance, with partner and Scottish Government involvement, making commitments explicit and accountable.

Recommendations

The Committee:

- **Reviewed and scrutinised the information provided in this paper and was assured that:**

- i. **The updated position on the current landscape and the opportunities and challenges this brings in relation to redesign and transformation of sustainable health and care in NHS Grampian is accurate.**
 - ii. **Improvements are being made regarding the management of Strategic Risk 3006, and appropriate evidence has been provided of these improvement activities.**
 - iii. **Any gaps in controls or mitigations have been identified and are being addressed as part of the agreed next steps endorsed by the Chief Executive Team on 13 January 2026.**
 - iv. **The assurance level assigned to the management of Risk 3006 is appropriate: Limited.**
- **Endorsed the proposals contained in the paper**
 - **Noted that the next report will be brought back to the committee in six months' time.**

8.3 Strategic Risk Register – Worsening Health (Risk 3131)

Prof Paranjothy introduced the paper and outlined the current risk position, recent national and local developments, and the actions and controls in place to mitigate the risk, including progress towards becoming a population health organisation, strengthened governance, and improved performance oversight. The risk currently provides reasonable assurance, while recognising that some controls are still being embedded.

Questions and Comments

Prof Paranjothy confirmed to Dr Tomlinson that the annual performance report would be brought to the committee in May 2026, based on 2025–26 data, with the new performance framework aligned to the 2026–27 delivery plan and reported annually thereafter.

Ms Penman added that work is underway to develop a dashboard providing a single reference point for key indicators, which will accompany the annual report, noting that this will continue to evolve as national performance frameworks are developed.

Mr Patwa welcomed the paper and, by way of transparency, noted their role as CoChair of the Scottish National Action Plan on Human Rights Leadership Panel. They particularly welcomed the explicit reference to human rights, especially the rights of children and young people, noting that while support for human rights is widely understood, it is not always made sufficiently visible in public-facing papers. He described this as a positive and important step towards greater transparency and visibility of human rights within public bodies.

Ms Penman added that a quality assurance review of integrated impact assessments is currently underway, with a particular focus on children and

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	<p>young people’s rights. This work involves the Child Commissioner and aims to strengthen how children’s rights are consistently considered in strategic planning and key decision-making, providing further assurance.</p> <p>Dr Tomlinson noted that the paper now provides a more tangible and joined up picture, with clearer links between priorities, transformation and assurance. As new priorities are approved, the committee will be better placed to scrutinise prevention work in a meaningful way, both within NHS Grampian and across the wider system.</p> <p>Recommendations:</p> <p>The committee:</p> <ul style="list-style-type: none">• Reviewed and scrutinised the information provided in this paper and was assured that:<ul style="list-style-type: none">i. The updated position on the current landscape and the opportunities and challenges this brings in relation to the Worsening Health Strategic Risk is accurate.ii. Improvements are being made regarding the management of Strategic Risk 3131, and appropriate evidence has been provided of these improvement activities.iii. Any gaps in controls or mitigations have been identified and are being addressed as part of the agreed next steps endorsed by the Chief Executive Team on 10th February.iv. The assurance level assigned to the management of Risk 3131 is appropriate: Reasonable• Endorsed the proposals contained in this paper• Noted that the next report will be brought back to the committee in six months’ time. <p>8.4 Population Health Board Assurance Report</p> <p>Dr Tomlinson shared his positivity that the Board is now being re-established and aligned with other programme boards.</p> <p>The committee agreed to note the position for assurance, with no further action required.</p>	
<p>9.</p>	<p>Any Other Competent Business</p> <p>Cllr Bell’s suggestion from a previous meeting was agreed - at the end of each meeting, the committee could agree a small number of key themes or messages to be shared back with partner organisations, particularly given the councillor representation on the committee.</p>	<p>S Humphreys S Paranjothy</p>

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	<p>Executives were asked to consider this approach and propose a short set of headline points that members could take back to IJBs and councils to support whole system working.</p> <p>Mr Patwa noted that this was his final meeting and wished to place on record his thanks to Mrs Haylett-Andrews for her excellent support of the committee and for enabling their full participation. He also thanked the executive team for their support over the past two years, acknowledging the committee's journey and expressing confidence that this strong support would continue.</p>	<p>K Penman</p>
<p>10.</p>	<p>Date of Next Committee:</p> <p>Wednesday 20 May 2026 at 10.00am virtually by Teams</p>	