Approved

NHS GRAMPIAN

Minute of Meeting of the Population Health Committee
9.30am to 1pm on Friday 21 November 2025
Via Microsoft Teams

Board Meeting
19.03.26
Open Session
Item 12.2

Present
Dr John Tomlinson, Non-Executive Board Member (CHAIR)
Mr Hussein Patwa, Non-Executive Board Member (VICE CHAIR)
Cllr Ann Bell, Non-Executive Board Member
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 Colette Backwell, Non-Executive Board Member
Ms Shona Campbell, Location Manager, Aberdeenshire H&SCP (obo Ms Leigh Jolly)
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 Dennis Robertson, Non-Executive Board Member
Mr Dave Russell, Public Lay Representative
Ms Laura Skaife-Knight, Chief Executive
Mr David Watkin, ST5 in Public Health Medicine

Paper Authors
Ms Louise Ballantyne, Head of Engagement (for item 8.1)
Mrs Roda Bird, Interim Equality & Diversity Manager (for item 9.1)
Mr Mike Brown, Director of Dentistry (for item 10.3)
Mr Declan Cairns, Specialist Registrar, Public Health (for item 10.3)
Ms Luan Grugeon, Strategic Development Manager (for items 7.2 & 8.1)
Ms Jillian Evans, Head of Health Intelligence (for item 10.4)
Dr Jonathan Illoya, Consultant in Dental Public Health (for item 10.3)
Mr Phil Mackie, Consultant in Public Health (for item 10.1)
Ms Elizabeth Robinson, Consultant in Public Health (for item 10.1)

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

No.		Action
1	**Apologies** Apologies were received from: Mr Hugh Bishop, Executive Medical Director; Leigh Jolly, Chief Officer Aberdeenshire H&SCP; Fiona Mitchelhill, Chief Officer, City H&SCP; Judith Proctor, Chief Officer Moray H&SCP; Mr Philip Shipman, Interim Director of People and Culture; and Mr Alan Wilson, Director of Infrastructure and Sustainability	

Approved

2. Declarations of Interest and Transparency Statements

Item	Member	Rationale for Declaration of Interest
9.1	Dr Tomlinson	As Chair of Grampian Regional Equality Council, he noted that the paper referenced their support to NHSG through face-to-face interpretation and translation services, and highlighted that future meetings could consider budget reductions. He therefore indicated he would withdraw from the meeting for this agenda item only, and Vice Chair Mr Patwa would step in.

Item	Member	Rationale for Transparency Statement
9.1	Mr Patwa	Collaborates closely with a contact from NE Sensory Services, who was listed in the paper as a BSL provider. He had considered the objective test and saw no issue to remain in the meeting, but wanted to declare it for transparency.
10.1	Cllr Robertson	Is Chair of the Moray Community Planning Board
	Ms Evison	Is a member of the Kincardine and Mearns Community Planning Group for Aberdeenshire Council
	Mr Mackie	Is Vice Chair of the Community Planning Management Group in Aberdeen City
	Cllr Yuill	Is a member of Aberdeen City Council, a partner in Aberdeen City Community Planning Board
	Dr Tomlinson	Represents NHS Grampian and the Integration Joint Board on the Aberdeenshire Community Planning Partnership.
	Prof Paranjothy	Sits on all three Community Planning Boards

Dr Tomlinson noted he would consult Sarah Duncan for guidance on the extent of disclosure required for declarations concerning community councils and community planning partnerships going forward, as they are integral to our work.

CHAIR

3. Chairs Welcome and Introduction

Dr Tomlinson welcomed attendees and expressed his anticipation for today's important discussions. He reminded everyone to keep the Committee's statement on equalities and health inequalities in mind while reviewing the agenda items.

4. Minutes of Meeting held on 26 September 2025

The minutes were approved as a true and accurate record of the meeting.

5. Matters Arising

There were none.

6.	**Committee Planning** **6.1 Action Log** Ms Skaife-Knight asked whether actions marked *in progress* and *due today* were on track, stressing the need for clear end dates. A short discussion ensued and it was agreed to include that detail in future action logs. It was explained that actions marked as complete are removed subject to any queries from committee members. There were no further queries and Dr Tomlinson confirmed that all items marked as 'complete' on the log would now be removed from the action log. Mr Riddell suggested that the Lunch and Learn session on young people should focus less on explaining why the topic matters (already understood) and more on presenting detailed evidence of what has been delivered, to provide assurance that responsibilities are being met. Dr Tomlinson added that the Executive team has been asked to remain mindful of the collective impact. Dr Backwell highlighted the need for greater transparency in papers by clearly identifying who is accountable for delivery, beyond listing authors or lead officers; stressing the importance of naming the NHS Grampian lead responsible for reporting progress or delays. Prof Paranjothy agreed with the points above and noted that accountability currently sits with her and Mr Humphreys through their direct reports but accepted that clear communication could be helpful going forward. Mr Humphreys suggested it might be prudent for *all* committees to adopt papers indicating where there is shared delivery responsibility. Dr Tomlinson acknowledged this and indicated that the Executive team and colleagues can consider including additional clarity in reports as suggested. **The committee noted the position of the action log at this point.** **6.2 Forward Planner** Ms Evison advised that committee forward planners will be reviewed at the January Board Seminar, noting that PHC will require additional time due to changes in the national Population Health Framework – the revised forward planner will be considered at its next meeting in February. Dr Tomlinson will discuss with Prof Paranjothy and Mr Humphreys if it is possible to provide an early indication for the committee and board. **The Committee noted the position of the forward planner at this point.**	**HH-Andrews** **S Paranjothy/ S Humphreys** **CHAIR/ S Paranjothy/ S Humphreys**
7.	**Putting People First** **7.1 Route Map Communication & Engagement Framework** Mr Humphreys explained that the route map has evolved from an action plan into a system-wide model for delivering transformation, focusing on	

	embedding a common approach into planning, assurance, and improvement processes. It no longer requires a separate communications plan, as communications will align with organisational priorities. Ms Skaife-Knight agreed this action could be closed for this committee but noted the need for a broader organisational communications and engagement approach. She advised that the Strategic Change Board will pause in December to allow alignment of key work streams going into quarter four of 2026, including sub-national changes, population health and service renewal frameworks, a refresh of the Plan for the Future, and responding organisationally with our own improvement plan that will come to the board in December. A revised organisational communications response will follow. **The Committee noted the position and that this item is closed.** **7.2 Putting People First (PPF) Deep Dive** The committee received a comprehensive update from Ms Grugeon on the progress of the PPF approach, which is central to NHS Grampian's commitment to building trust and fostering ongoing dialogue with communities. This update outlined key achievements from year one, highlighted the cultural shift required to embed relationship-based engagement, and set out priorities for the next phase. It emphasised that implementing PPF requires an adaptive, trust-based approach within a complex system, where progress is non-linear and driven by continuous learning and collaboration. <u>Questions and Comments</u> • Cllr Yuill asked if specific examples could be shared where real-time feedback loops have led to a positive impact. • Ms Grugeon indicated real-time feedback loops are still in early testing, but they had already highlighted small actions that make a big difference, such as staff taking time to reassure patients during emergency admissions. Positive feedback has also been shared with teams, including clinical and domestic staff, helping boost morale and improve care. • Mr Patwa enquired about what success looks like for the lived experience panels, and how will their impact be measured? • Ms Grugeon replied that success for lived experience panels and similar relational approaches will be measured by their impact on service changes, the ability to close the feedback loop with participants, and increased engagement through the public involvement network. Evaluation will include metrics on participation, evidence of influence on decisions, and feedback from participants on whether they felt valued and listened to, supported by benchmarking through a dedicated public health research post.	

	• Mr Patwa asked if lived experience panels were intended to be short-term, and how will we ensure a diverse flow of participants - including seldom-heard communities, over time? • Ms Grugeon answered that the panels will follow a flexible model, adapting to the needs of each project rather than being fixed in duration or membership. A deliberate equity lens will guide recruitment to ensure diverse voices, including seldom-heard communities, are represented. Engagement will also be supported through digital platforms and existing community networks, offering multiple ways for people to participate. • Ms Ballantyne highlighted an example of how lived experience panels can evolve into mutual partnerships, where participants not only inform service design but also receive support themselves (e.g., peer support groups). It also stresses that these approaches are bespoke and adaptable, with learning continuing as the model expands into other pathways. • Mr Riddell stresses that approaches like PPF must be embedded across the entire health and care system - not treated as an add-on or limited to one committee. He called for stronger integration of public engagement insights into service redesign, savings plans, and IJB discussions, with clear evidence of impact (e.g., improved outcomes, reduced complaints) to influence decision-making. He expressed confidence in the progress and affirmed that PPF is the right approach, but remains uncertain whether it will achieve the level of impact required across the whole organisation. • Ms Robertson emphasised the need to better empower communities by using existing structures, such as elected members and community councils; as ambassadors for health engagement. She also called for a more joined-up approach to digital engagement and consultation across partners to avoid duplication, reduce public fatigue, and make better use of limited resources. Finally, she sought assurance that partnership working and shared services are fully embedded rather than operating in isolation. • Cllr Bell supports PPF and believes the feedback being gathered will provide the evidence needed to show its impact. She also reinforced the importance of elected members and community councils in sharing information and feeding back to strengthen community engagement. She suggested there is a need to improve the visibility in the staff/public arena.	

	• Ms Ballantyne indicated the focus is promoting self-help through tool kits and a voice tool that enhances planning and oversight. The aim is to ensure engagement activities meet best practice standards while raising awareness of the PPF approach, which is currently limited among staff. Plans include benchmarking understanding through polls and revisiting progress over time. New roles will be crucial for building relationships, championing the initiative, and showcasing its charity-supported nature. Continuous outreach through meetings and collaborations will help increase visibility and drive meaningful change. • Ms Morrison highlighted the importance of aligning PPF with Getting It Right for Everyone (GIRFE) and Realistic Medicine to improve visibility and simplify a complex landscape for both the public and staff. Integrating these initiatives, such as through the Hope Conference, will help present shared priorities and make navigation easier across what currently feels like separate programmes. • Dr Backwell praised the presentation and highlighted the positive momentum of the approach. She emphasised the value of integrating PPF with GIRFE and Realistic Medicine, and the importance of engaging Community Councils to embed these practices locally, despite communication challenges. She supported the *fold-in* approach and focus on people, noting the need to demonstrate impact with data to secure wider engagement and scalability. While concerned about limited resources, she commended the team's achievements so far and stressed the potential for significant progress. • Ms Evison praised the presentation and its clear visuals, stressing the need for assurance that PPF is embedded across all plans. She advocated for a strategic approach through community planning, involving councils, patient participation groups, and sharing toolkits like the Community Appointment Days model widely. She highlighted the importance of real-time feedback loops and suggested linking with existing initiatives, such as Grampian Hospital Arts Trust style storytelling, to strengthen impact. Overall, she emphasised system-wide embedding and collaboration to ensure consistency. • Prof Paranjothy advised that PPF is starting to be embedded through community planning structures and gave examples: A paper will go to the next Shire Community Planning Board on taking a strategic approach to Community Appointment Days; in Aberdeen City, this approach is already becoming *business as usual*, for example in delivering the chronic pain service; and similar work is planned for Moray, though it may be called different things in different areas. She added that while progress is being	

	made, there is a need to be clearer about how this is managed and to demonstrate its impact over time. • Cllr Robertson noted that Community Planning Board membership needs review. In Moray, most statutory area forums are ineffective, while 13 Community Councils and a Joint Community Council have been re-established. She proposed giving the Joint Council a seat on the Board to share information with all councils, reducing duplication. Members should take this back to their respective meetings. • Dr Backwell made the point that current community planning does not effectively reach local people. While many public sector and charity partners are involved, patients and community groups remain under-heard and under-reached. She agreed with Cllr Robertson's idea about involving Joint Community Councils could help, but believes a fundamental change in how local communities are engaged is needed. • Cllr Bell exclaimed her agreement with the points above. • Dr Tomlinson thanked the group, noting that having three councillor members on the NHS Board, as part of this committee had demonstrated its importance for fostering system-wide traction and support (acknowledging the Board Chair's decision on such membership for the committee). He also noted the *liberated model*, defining sustainability as aligning capacity with demand. Using substance use work as an example, he noted awareness of a PPF initiative to analyse Emergency Department presentations to identify interventions that reduce attendances, impacting targets like four-hour waits and ambulance pressures. He concluded this approach could shift prevention from what can seem a vague intent to delivering measurable results. • Ms Grugeon confirmed Dr Tomlinson's understanding and explained the plan to engage 20 high-intensity ED users with substance use issues, gathering their experiences alongside feedback from frontline staff. These insights will be shared in a joint session with partners across ED, community, police, and ambulance services to explore new approaches. One idea is to create a *creative solutions forum* where professionals collaborate more flexibly to better support vulnerable individuals, prevent crises, and reduce unplanned care demand. • Dr Tomlinson welcomed applying this approach more broadly to population health initiatives and praised the strategy of integrating rather than adding on. He noted this aligns with the board's three priorities and supports evolving them with a population health lens.	

	• Ms Skaife-Knight reassured the group that this discussion mirrored one held with the Chief Executive team earlier in the week. She confirmed that the approach is being embedded into the system improvement plan, using the three priorities, particularly unscheduled care; as examples. Practical actions, such as the high-intensity user work, have been agreed for immediate implementation alongside medium-term plans to better join up efforts. Dr Tomlinson acknowledged his contentment that the minutes would reflect that members are assured about the positive direction and progress, but also highlight concern about ensuring traction and achieving scale of impact**.** He asked executives to take away the feedback gathered and considered that the committee members had derived learning and influence from the discussion. He emphasised the need for future reports to explicitly address progress on impact and traction**,** and thanked Ms Grugeon and Ms Ballantyne for their 'deep dive' into this subject.	**Committee Members**
8.	**Strategy, Governance and Performance** **8.1 Strategic Risk Updater Citizen Engagement (Risk 3650)** Ms Grugeon summarised the progress made on mitigating actions related to strategic risk 3650, noting significant achievements over the past year and the added capacity expected from charity funding. While progress was strong, the risk remains high due to insufficient scale at this stage. The committee was asked to review the assessment, confirm assurance levels, and consider any need for escalation. <u>Questions and Comments</u> Mr Patwa asked whether, within GDPR rules, demographic data can be collected for Community Appointment Days to identify if certain communities are being missed. He also asks if any analysis has been done on who is attending these initiatives. Ms Grugeon confirmed that some demographic data is being collected (postcode, gender, age), but there is not yet a universal dataset, and more work is planned in the year ahead. She acknowledged that Community Appointment Days are large, busy events and not suitable for everyone, so alternative approaches like the liberated method are being explored for vulnerable people. She also noted efforts to improve accessibility, such as offering weekend sessions for chronic pain and targeting priority neighbourhoods; so equity and inclusion are central to future development. Mr Patwa noted the lack of a complete data set and, considering earlier comments about the risk rating potentially changing within 12 months, asked whether this was about developing a more dynamic data set that would continue to be collated over the coming year.	

	Ms Grugeon explained that plans were in place to develop a consistent data set for Community Appointment Days. These events were launched and delivered quickly - ten in the first year - and varied in format. The aim for the coming year is to standardise data collection and strengthen evaluation. Prof Paranjothy added that Mr Patwa's point related to what is often called *missingness* in the healthcare system - people who rarely make contact. She said work was underway nationally and locally to identify who these individuals were and what that meant for engagement and improving access. Locally, this would start through cardiovascular disease work with general practices, where early risk factors were being identified. Part of this effort involved reaching people who rarely engage, which would provide learning to inform approaches like Community Appointment Days. She noted that this required working through primary care data sets to better understand and address the issue. Mr Patwa appreciated the explanation and said that one of the main challenges will be linking data sets from different parts of the system so that all areas can access and use this intelligence. Mr Russell pointed out that the report clearly states a risk due to insufficient mechanisms and priority for ongoing engagement. He noted that the Integrated Impact Assessment (IIA) process ensures NHS Grampian meets legal obligations, but the report also says the IIA tool will not be fully embedded until March 2028. Given this, and the request to endorse improving the control rating from *limited* to *reasonable*, he questioned the basis for that change. He suggested it would be helpful to understand: clarity on the number of current change initiatives, how many are classified as change programmes, how many of those are major, and how engagement is assessed across each. Ms Grugeon explained that the reason for recommending a change in assurance was the establishment of a Putting People First Oversight Group, which met regularly to review the delivery plan for all elements of the programme. Ms Grugeon added that a core group also met frequently to monitor progress in specific areas where individuals held direct responsibility. She noted that this addressed part of the question, while acknowledging that Prof Paranjothy could answer the latter. Prof Paranjothy clarified that while the report stated March 2028 for full rollout of the Integrated Impact Assessment, this referred to complete implementation. She explained that interim steps were already planned, including ensuring by March 2026 that toolkits, resources, and manager support for implementing assessments would be embedded within the fundamentals of the management programme. This step-by-step approach aimed to achieve full rollout over time. She then sought confirmation that the question related to how these varied controls and timelines aligned with the 12-month framework for assurance. Mr Russell questioned our confidence about the level of engagement that currently exists within the various change programmes or initiatives.	

	Prof Paranjothy acknowledged that the main challenge was embedding the approach at the necessary scale and pace to make a real impact. She said commitment was increasing, as reflected in the discussion and Ms Skaife-Knight's comments about integrating this work into the three priority programmes. She expressed reasonable confidence that progress would be achieved, noting that the risk would continue to be reviewed every three to six months, with a formal review in six months to assess controls and impact. Dr Tomlinson emphasised that the risk relates to reducing demand through citizen engagement, so it is important to understand what level of demand reduction is expected, in which parts of the system, and when. He acknowledged this is challenging but said linking expected impact to specific activities would clarify which actions contribute to reducing demand and over what timeframe. This would also address Mr Russell's point about joining things up and provide a clearer sense of the intended outcomes. Prof Paranjothy acknowledged the comment as fair and explained that while the team could model and articulate expected outcomes, some of which would be captured in a logic model, it was more challenging to quantify impacts without completing the necessary steps and learning from implementation. She noted that the logic model would outline anticipated results and, if scaled up, the timeframe and impacts expected. Work had already begun toward developing this approach. Ms Evans wondered about the nature of that strategic risk in the context of rising healthcare demand driven by demographic change. Can citizen engagement alone realistically reduce this demand? It seems unlikely given the scale of ageing-related pressures. The real risk may be that citizens lack knowledge, confidence, and tools to make informed health choices. Without this, they will not use healthcare resources appropriately or effectively. While engagement can reduce inappropriate demand, expecting a quantifiable overall reduction through this approach feels unrealistic. Dr Tomlinson indicated that this risk originated from the Chief Executive Team, so whilst a relevant challenge, in the first instance it was for that Team to be asked to consider if any change is required, while today we focus on the current risk discussion. Mr Humphreys indicated this was the second time the corporate risk has come to committee, as required; twice a year. Ms Grugeon and Ms Ballantyne have presented their reports previously, so this should be familiar to members. Also, from the recent PPF meeting, it was discussed being more intentional going forward – targeting specific geographic areas and services based on learnings from this year, rather than just following appetite. Finally, on embedding: a toolkit will be launched to help staff organise activities like community appointment days, but there is an inherent risk around staff time and capacity to use these tools. Embedding won't happen overnight; it requires effort, data to show benefits, and creating space for staff to apply these tools effectively. The same applies to impact assessment - tools exist, now it is about education and integration.	

	Dr Backwell indicated that Ms Evans had captured her concern, which she had struggled to articulate earlier: was this the right risk, and was it too soon to downgrade its level? It was still early days for the programme, and achieving what had been set out might be challenging. Secondly, on lived experience, drawing on her own experience of caring for two 88-year-olds, she indicated they were an overlooked group, unable to access community engagement and reliant on GPs, which often failed. She suggested prioritising engagement with this group to gather meaningful feedback. Mr Riddell made a point, noting earlier discussions about mainstreaming and business as usual. Referring to governance and assurance on the risk, he highlighted point 3.5, mentioning core group meetings with lead roles and the quarterly oversight group of system leaders. He observed that the term *system* could mean different things to different people and questioned whether the leaders involved had sufficient authority and influence to ensure the risk was managed across the system. Ms Grugeon explained that the oversight group included representatives from the three Community Planning Partnerships, leaders from health and social care, and TSIs. She also reported directly to the Chief Executive Team every six weeks. She added that there was a strong focus on PPF within NHS Grampian, which should provide assurance. She then asked Mr Riddell if he had specific individuals in mind who should be involved. Mr Riddell responded that the comments were helpful and reassuring. However, he suggested that those involved might need to actively take work away from the meetings and ensure the message was implemented elsewhere. Ms Robertson noted the paper was interesting, building on the earlier presentation. She highlighted the challenge of reducing demand through system engagement and stressed the importance of a whole-system approach, as previously mentioned by others. Referring to issues raised about reaching hard-to-engage groups, she suggested involving wider services such as housing, money advice, social work, and education to ensure the right people were reached. She added that effective engagement should help share information and capture the views of those most in need of support, who are often the hardest to reach. Cllr Yuill confirmed he was in agreement with Dr Backwell that it is too early to be making changes to risk levels. Dr Backwell put forward a suggestion that future reports should include information on the impact of these activities, allowing the Committee to discuss how the actions had led to measurable changes for patients and communities. Mr Russell confirmed to be clear, that his question was not around the actual risk rating, it was the change in the controls improvement status from *limited* to *reasonable*.	

The committee noted that while a table existed to explain the shift, this was not part of the recommendations. However, the discussion reflected doubt and a lack of assurance about the rationale for the change. Mr Tomlinson stated he was not assured by the explanation provided and suggested hearing from the executives before deciding next steps. He proposed recording a concern about the shift and referring the matter back to the Chief Executive's Team for review.

Prof Paranjothy explained that the change was made because measures were now in place that had not existed previously, although these would take time to embed and show effect. She clarified that the risk score remained unchanged, as it was calculated based on likelihood and impact using a set formula. She acknowledged that the conversation indicated a need to consider reframing the risk.

Ms Evison highlighted the importance of recording that there was strong confidence in the progress being made. However, she noted that insufficient time had passed to draw firm conclusions. From a staff perspective, including team morale, she stressed the need to emphasise support for the steps taken and the overall direction of travel, while recognising that it was too early to make any changes on that basis.

Recommendations:

The Committee:

- **Acknowledged evidence of improvement activities but noted gaps in controls and mitigations.**
- **Agreed there is not yet sufficient scale or spread of these activities to justify reducing the risk rating.**
- **Are only <u>partially</u> assured that current actions will achieve the desired impact, particularly regarding demand reduction.**
- **Agreed an escalation is not required but this matter will be referred to the CET to confirm whether this is the correct risk or if a variation is needed.**

8.2 Population Health Portfolio Board Assurance Report/Review

Prof Paranjothy indicated that following the recent development session, the committee agreed to use the Population Health Portfolio Board as the primary mechanism for oversight of progress toward becoming a Population Health Organisation. This approach builds on the Board Seminar held on 13 September and the recent Population Health Committee development day, which explored the concept and its domains in greater detail. The discussion emphasised the need to embed population health principles within the three priority programmes - particularly acute care - and strengthen connections with the wider system.

To achieve this, the Portfolio Board will serve as the space for ensuring population-based data informs future service planning. Key actions include

	revising the Board's terms of reference and developing a monitoring framework with clear indicators and milestones. These steps are scheduled for completion by the end of March and will align with the review of the Population Health Committee's forward plan. This will ensure that work undertaken within the Portfolio Board provides the appropriate assurance re Dr Tomlinson sought assurance that this approach would succeed where previous efforts had struggled due to limited engagement, and asked for further comment from Ms Skaife-Knight. Ms Skaife-Knight provided context on a wider review of operational governance within the organisation. This includes resetting expectations for the Chief Executive's Team, revising its terms of reference and membership to ensure a stronger system-wide focus, and clarifying reporting lines to both the executive team and board committees. She noted that this work is being approached holistically, alongside governance changes for the acute triumvirate and the wider senior leadership team. Internal engagement on these changes will begin shortly, with implementation planned for quarter four, aligning with the timeline for related work on the Population Health Portfolio Board and its role within the broader governance structure. Mr Patwa asked that while the board had been stood down, the paper refers to significant material being circulated to members by email. Could the executives confirm whether there is sufficient staff capacity to manage this effectively? Email communication can lack the opportunity for discussion that meetings provide, and given the likely volume of information, assurance on this process would be helpful. Prof Paranjothy explained that the approach had been necessary, as the alternative would have resulted in insufficient attention to the matter. By adopting this method, the team was able to secure valuable feedback. She noted that multiple channels were used to gather input, including management groups and the acute governance system, which is currently operating in shadow form. These mechanisms ensured appropriate engagement and oversight. She emphasised that the governance structure is still evolving, with a transition underway toward a more robust and effective model for the future. **Recommendations** **The Committee:** • **Reviewed and scrutinised the information provided in this paper and confirmed that it provided assurance that robust mechanisms have been adopted to review the governance arrangements for population health in NHS Grampian, and despite the Portfolio Board not convening, cross-system input has been sought on key population health matters.** **8.3 Population Health Committee Development Session Output/Agreed Actions inc. development of Population Health Good Governance Indicators**	

	Agreement was reached to go straight into questions and comments as the paper was self-explanatory. <u>Questions and Comments</u> Ms Skaife-Knight welcomed the actions outlined but stressed the need for clarity on accountability and timelines. She asked for assurance that progress would remain on track between now and March 2026, requesting detail on what needs to happen, by whom, and how the committee can monitor delivery beyond the current bullet points. Prof Paranjothy stated that by the next Population Health Committee meeting, members should expect to see a revised forward planner, updated terms of reference for the Population Health Portfolio Board, and a monitoring framework with milestones and indicators to track progress toward becoming a population health organisation. A position paper outlining the future approach will also be prepared. These actions are scheduled for completion by the end of March, with progress reported to the Committee in February 2026. Ms Skaife-Knight confirmed the response addressed her question but requested early notification if any actions become undeliverable before the deadline. She emphasised the need for assurance that progress will continue as planned over the next four months. Dr Tomlinson assured Ms Skaife-Knight that he and Mr Patwa would receive a draft of the progress report in advance of release of the final committee papers. Cllr Bell noted that the recent development day had been a very good session. She highlighted a suggestion raised during the discussion about sharing the work of committees with other partners. While Ms Evison's board report is already shared with councils, she proposed that committee work - at a high level rather than in detail - could also be shared more widely. This would support a whole-system approach and provide partners with deeper insight into the work of the health board. She noted that this suggestion had not appeared in the bullet points from the session. Ms Penman stated that the session notes have been shared with those who normally receive the committee papers as well as those who were participating, and it also should have reached IJBs etc. Dr Tomlinson emphasised the importance of linking the work on developing a Population Health Organisation (or system) to the three priority programmes. He wants to ensure that as this work progresses, its impact on areas such as cardiovascular disease (CVD), obesity, and other priorities is made explicit and integrated into those programmes, rather than remaining separate. This connection should be clear and visible in future planning and reporting.	

	Dr Tomlinson thanked all concerned with the planning of the development session, as well as those who contributed. It gave us a platform for review of the terms of reference and focus for the committee going forward. **The committee noted the current position, endorsed the progress made and confirmed that further detail (taking into account the discussion at this committee) will be brought to the next committee meeting.**	
9.	**Creating Equity** **9.1 Compliance with Equity Related Duties** Mr Humphreys gave a brief introduction to say that Ms Bird will highlight key points from the annual return on meeting equality related duties. He indicated that the papers have been circulated for review, and while we will not cover them in detail, it is important to note that NHS Grampian continues to demonstrate strong compliance with statutory equality requirements, reflecting a positive and inclusive approach across services and the workforce. This includes meeting obligations under the Equality Act, publishing reports such as the gender pay gap and workforce diversity monitoring, and progressing initiatives like integrated impact assessments (IAAs), equality training, and participation in community events such as Grampian Pride. These efforts underscore our commitment to fairness, transparency, and equitable access to care. Ms Bird continued with a brief overview of key points from her report and pointed out that there is also a BSL Action Plan for NHS Grampian, which was separate to this report. She noted that she will provide an update on progress next year, along with the new IIA, which is being used to support our value and sustainability projects. <u>Questions and Comments</u> Cllr Bell asked whether NHS Grampian has observed or received reports of an increase in incidents of prejudice within the hospital recently, given the unfortunate direction that parts of society have moved in recently. Ms Bird commented that we cannot always control staff or patient behaviour, but people now feel more confident to speak up, which supports our anti-racism commitment. Some issues remain in certain departments, and we are working with them to address these. As an anti-racist organisation, we will not cover up incidents. Our goal is to tackle these problems and ultimately eliminate them. Cllr Yuill asked whether the organisation had seen an increase in discriminatory incidents in recent years, given the concerning trends in society - or whether things are staying the same or improving. Are staff experiencing comments from patients, and what actions, if any, can we take as an organisation to address this? Mr Humphreys noted that while he could not confirm the trend, increased promotion of reporting mechanisms is likely leading to an increase in reportable incidents, reflecting greater awareness rather than societal	

	changes. He added that normalising the message that discriminatory behaviour is unacceptable is key, and encouraged reporting as part of this approach. Stuart queried whether there is any intelligence on the nature or severity of incidents - such as micro-aggressions - rather than just overall numbers, and invited Ms Bird to provide further insight if available. Ms Bird noted that while incidents vary case by case, staff and patients are increasingly confident that issues raised will be addressed proactively. Online reporting mechanisms have helped, including cases where patients reported overhearing inappropriate comments. This rise in confidence and proactive management is a positive development. Mr Patwa stated that we are spending almost half a million on translation services, are we making the best use of that investment; and are we leveraging AI or the latest tools to ensure we are getting the best value for money? Ms Bird noted that while machine translation has its place, clinical content requires both a high degree of accuracy and human verification. She advised that tools like Google Translate are acceptable for basic phrases but not for medical instructions, where qualified interpreters or Language Line should be used to ensure patient safety. She added that AI translation for written information may be viable in the future, but a process for human assurance is essential at present to avoid errors that may impact on care/outcomes. Mr Humphreys noted that while AI is not yet fully utilised, national work is underway to explore its benefits and manage risks. He highlighted the lack of consistent information governance for sharing patient-identifiable data and said progress is cautious but positive, with wider slow, but-steady adoption expected over time. Mr Patwa asked if we had any data showing whether missed appointments occur because patients cannot access the information they need, or are unaware of their appointments due to accessibility issues. Mr Humphreys explained that there is no data comparing missed appointments (DNAs) specifically linked to patients being unable to read appointment letters. He noted that individual services follow up with calls to minimise DNAs and introduced an example of success where Ms Bird had sourced a rare-language interpreter to resolve repeated missed appointments for a particular service. Ms Bird agreed that departments are proactive in arranging interpreters and work hard to support patient attendance and encourage confirmation of accessibility needs. She noted that Deaf BSL users often contact her or the ARI General Office to check interpreter availability and shared that she had also arranged a braille appointment letter for a patient with visual impairment. **Recommendations** **The committee:**	

	• **Noted the activity taken to ensure NHS Grampian's compliance with statutory duties of the Equalities Act** • **Acknowledged the equality work and work undertaken on the anti-racism agenda as part of NHS Grampian's Anti-Racism Plan** • **Acknowledged the growth in interpretation and translation requests and the work being undertaken by third-party assessors to review delivery contracts** • **Noted that ongoing compliance with legislation is dependent on capacity and resource availability, with any future decisions around these being made in keeping with our Finding Balance principles**	
10.	**Public Health** **10.1 NHSGs contributions to Community Planning Partnerships (CPPs) Annual Report (inc. child poverty)** Ms Robinson gave a brief introduction on the updated paper which responded to the request for a broader view of NHS Grampian and Board contributions to CPPs. CPPs aim to reduce inequalities through collaboration, joint resourcing, and evidence-based approaches, though progress and commitment varies across Grampian. The paper reflected current work and highlighted opportunities for greater impact through improved coordination and clearer objectives. <u>Questions and Comments</u> Ms Robertson, speaking specifically about the recent management restructure of Moray CPP, stated that the Moray Council post responsible for community planning remains vacant, leaving significant gaps. This burden falls on the council so additional shared resources would help. There are also challenges faced in translating broad ambitions into practical action – breaking down big priorities into smaller initiatives that connect to achieve larger goals may help us make more tangible progress. Ms Evison indicated that the report did not clearly show how these actions link to community planning, and read more like a list of organisational priorities rather than contributing to agreed community planning priorities. It would be helpful to see how our work aligns with partnership aims, what gaps remain, and what others are doing. While she admitted the projects - especially around anchors - the paper lacked clarity on the difference community planning makes. There is a need to focus more strongly on the aims of each partnership and clearly show our contribution. She added there are also questions about resourcing and how we embed this work across NHS Grampian. Should it sit with a small group or involve the wider system, particularly if we aim to be a population health organisation? We should relate our actions more closely to agreed outcomes, involve the right people to make the biggest impact, and ensure we are working at a local level to support health and wellbeing interventions.	

	Dr Tomlinson commented that as a regional organisation, we need to align with the different approaches taken by the three community planning partnerships, but a common theme for us should be health determinants. While each partnership works differently, we can apply a single health-focused lens to influence priorities and outcomes. This means ensuring health determinants are considered in planning and impact, even as we respect the varied local approaches. Ms Skaife-Knight indicated the paper had raised similar thoughts for her as it did for Ms Evison, but also broader questions about the Board and the organisation's overall contribution to Community Planning Partnerships. She stressed that attendance at meetings is only the starting point and asked what collective action happens between meetings to drive progress. She highlighted the need to embed this work into business-as-usual as part of future planning (2026–27), warning against it being seen solely as the responsibility of Public Health or specific individuals. She saw this as an opportunity to integrate community planning and anchor strategies across the organisation and challenged the Board to make this a routine part of NHS Grampian's approach. Prof Paranjothy replied that she supported making community planning "everyone's business" across NHS Grampian. The paper set out the baseline of what NHS Grampian is currently doing and how it engages with community planning. She acknowledged Ms Evison's point about evaluating impact, noting that this will need to develop as partnerships mature. Public Health Scotland and the Improvement Service already assess community planning boards annually, and results vary across the three areas. While NHS Grampian can support improvement, she stressed the need to respect the role of the partnerships themselves. She concluded that the organisation should focus on clearly articulating the journey to impact and defining what that impact looks like. Ms Evison pointed out that the way child poverty reporting and action planning has evolved is a strong example of good practice - clear actions, defined responsibilities, and focus on outcomes. She suggested using this model across other areas of work and emphasising health within it. Recognising and sharing successful approaches is important for development. Ms Robinson acknowledged resourcing challenges and the need for better system-wide support. She views Aberdeen City as a strong example, benefiting from resources like the Health Determinants Research Unit, Marmot funding, and Public Health Scotland support. Ms Robinson suggested Moray and Shire could learn from and leverage this expertise within the region to improve effectiveness, emphasising collaboration and sharing best practice across the system. Dr Tomlinson queried if there was a forum or process for ongoing discussions among those involved in community planning, beyond the formal meetings, as Ms Skaife-Knight suggested? Prof Paranjothy indicated there are two main forums for ongoing discussions: the Public Health System Leadership Group, which brings partners from	

	health, social care, and community planning together to discuss priority areas like child poverty and anchors; and the North East Population Health Alliance, where chief executives meet to deep dive into issues and agree actions. These groups connect and share updates across the system. **Recommendations** **The Committee:** • **Reviewed and scrutinised the information provided in this paper, noted the position and acknowledged progress from a public health focus to a whole-organisation approach, with areas identified for improvement.** • **Noted that a detailed paper on anchor work is being brought to the Board in June, following a review through the Population Health Committee. Future reports, including the annual update, will provide more detail.** Due to time constraints, the following agenda items were taken as read, and the meeting proceeded directly onto questions and comments. **10.2 Screening Annual Report** <u>Questions and Comments</u> Mr Patwa asked if we had considered what more can be done to increase cervical screening uptake among 25–29-year-olds, such as working with key employers, employability services, or government agencies to reach this group after they leave education. Prof Paranjothy indicated that there is work being done to ensure the correct denominator, as some people remain registered with a local GP after leaving university but are no longer resident. Alongside this, we have targeted initiatives for younger women. For example, Torry Medical Practice will begin phoning non-responders from 1 December to offer one-to-one support and confirm who is genuinely eligible. Also being introduced is staff cervical screening clinics to make access easier for those working in hospitals or nearby. These actions form part of our equity plan, which is being implemented this year to address lower uptake in this age group. **Recommendations** **The Committee:** • **Noted the content of the annual reports from the five screening programmes** • **Noted the progress on work across the system to address screening inequalities and asked to see trend information included in the next report.**	

	10.3 Dental Plan 2016-2022 Update Questions and Comments Mr Patwa wanted to better understand the factors contributing to the potential underutilisation in Moray and pointed out that from the figures, it appeared there were more practices accepting new patients compared to Aberdeenshire, yet Moray is highlighted as an area of concern. His initial thoughts pointed to rurality and transport challenges, but would appreciate some narrative or context around this. Mr Brown explained that, unlike general medical practices, dental capacity was constrained by the number of practices willing to take on patients. Moray and parts of Aberdeenshire had been challenging in this regard, though the situation in Moray was improving. A new practice with three surgeries was opening, expected to register 4,500 patients over two years, and another practice was planning to relocate to larger premises, which would further increase capacity. Mr Patwa thanked Dr Illoya for the clarification that the figures were misread: Moray currently has six practices accepting patients, compared to 16 in Aberdeenshire. This represents a significant improvement for Moray, given that immediately post-pandemic, no practices were accepting patients. Dr Tomlinson asked if the main work on prevention and self-management limited to the website, or does it involve a broader range of activities? Mr Brown replied that there are broader efforts beyond the website, including public health prevention campaigns and initiatives like Mouth Cancer Awareness Week. Practices also provide patients with information to support self-management. The website remains our central resource, and they are working to make it accessible year-round rather than only during specific campaigns. Dr Tomlinson highlighted that in some disadvantaged areas, patients are registered but not attending appointments. This gap limits opportunities for self-management and preventive care. He emphasised the need to measure impact in this area as part of the broader prevention agenda. Mr Brown agreed and noted the importance of understanding why registered patients do not attend. Reasons could include personal choice or capacity issues within practices. He highlighted the need to improve participation, noting that registration without attendance achieves little. Bridging this gap is a top priority. Dr Illoya added that inequalities in participation remain a significant challenge post-pandemic. A national Citizens Panel survey found many people only seek dental care when in pain, rather than attending regular check-ups. This trend is widespread across the country, not just in Grampian. He also highlighted that concerns about the potential cost of dental treatment are a barrier for some patients. To address this, NHS Grampian is using its website to direct people to information about entitlements and free dental care for those on benefits.	

	Ms Campbell pointed out that the plan covers 2016–2022 and it is now 2025, and asked if the plan had been reviewed to confirm that the actions identified in 2016 are still appropriate, or did it need to be updated. Mr Brown replied to say the plan was reviewed, and some actions - particularly around child registration - are still ongoing. Also awaited is a nationally agreed needs assessment methodology to inform a new plan. Rather than simply updating dates, work continued on remaining actions while preparing for a full refresh. This will also align with national data and the incoming Chief Dental Officer, who may set a new strategic direction. Dr Illoya added that in the interim, there is also a child oral health improvement plan, which is currently extant and there is a link in the report to that. **Recommendations** **The Committee:** • **Reviewed and scrutinised the information provided in this paper and confirmed that it provided sufficient assurance that the policies and processes are working effectively, any gaps have been identified and assessed, and risks are being mitigated effectively.** • **Were satisfied that an updated plan would be provided once the national work is completed, including comments on trend data and linking to impact, as aforementioned.** **10.4 Sustainability and Climate Change Annual Report/Adoption Plan Update** The committee agreed that this item was to be deferred to the next meeting. Dr Tomlinson acknowledged the time constraints, noting that the papers for agenda items 10.2 and 10.3 were not given full consideration during the meeting. He agreed to follow up with Prof Paranjothy after the session to determine whether additional work or discussion should be brought back to the committee sooner, rather than waiting another year.	**CHAIR/ S Paranjothy**
11.	**Date of Next Committee:** Friday 27 February 2026 at 10.00am virtually by Teams	