APPROVED

NHS GRAMPIAN

Minute of Meeting of the Population Health Committee
10:00 on Friday 7 July 2023
Via Microsoft Teams

Board Meeting
Open Session
07.12.2023
Item 15.6

Present
Dr John Tomlinson, Non-Executive Board Member (CHAIR)
Ms Amy Anderson, Non-Executive Board Member
Mr Hussein Patwa, Non-Executive Board Member
Mr Sandy Riddell, Non-Executive Director of the Board
Mr Ian Yuill, Non-Executive Board Member

In Attendance
Mr Simon Bokor-Ingram, Chief Officer, Health and Social Care Moray
Mr Alan Cooper, Head of Strategy, Governance and Performance, Public Health
Ms Alison Evison, Non-Executive Board Member
Ms Luan Grugeon, Non-Executive Board Member
Prof Caroline Hiscox, Chief Executive
Mr Stuart Humphreys, Director of Marketing and Communications
Prof Shantini Paranjothy, Deputy Director of Public Health
Mr Dennis Robertson, Non-Executive Board Member
Mr Dave Russell, Public Lay Representative
Ms Susan Webb, Director of Public Health

Paper Authors
Ms Jillian Evans, Head of Health Intelligence **(Item 8.1)**
Mr Eddie Graham, Head of Resilience **(Item 9.1)**
Ms Susan Harrold, Planning Manager, Planning Innovation and Programmes Directorate **(Item 6.3)**
Dr Jonathan Iloya, Director of Dentistry/Consultant in Dental Public Health **(Item 9.2)**
Mr Simon Rayner, SMS Operational & Planning Manager/ADP T/L, Adult Mental Health **(Item 7.1)**

No.		Action
1 & 2	**Welcome and apologies** Dr Tomlinson welcomed everyone to today's committee meeting and formally introduced Mr Patwa, who was recently appointed to NHS Grampian Board as a non-Executive Board member and is replacing Mr Robertson as a Population Health Committee member. Dr Tomlinson looks forward to Mr Patwa's contributions and extended his thanks to Mr Robertson for his contribution to the Population Health Committee to date. Mr Patwa introduced himself and indicated that his biography would soon be included on the NHS Grampian website for information. Dr Tomlinson asked that committee members introduce themselves as they contribute during the meeting, for Mr Patwa's benefit.	

	Apologies were received from: Ann Bell, Non-Executive Board Member and Professor Nick Fluck, Medical Director	
3.	**Minute from Previous Meeting on 19 April 2023** The minute was accepted as an accurate record of the meeting.	
4.	**Matters Arising** **4.1 North-East Population Health Alliance** Ms Webb gave a verbal update on the North East Alliance and indicated that following a recent joint meeting with the North East Partnership Steering Group, it was agreed that it was helpful to have 'Population Health' contained within the title. The Alliance has therefore been renamed as the North East Population Health Alliance (NEPHA) to explicitly state its purpose. The agenda items/activities considered at the joint meeting were noted as follows: • The PHS/NEPHA Draft Strategic Partnership Agreement – currently with respective organisations for feedback, and endorsement (agenda item 4.2 for endorsement from committee members). • The Director of Public Health Annual Report – agreed to focus on the higher cost of living, including an engagement process which has been set up over Summer to identify the good practice that is happening across North East and the areas that will add value if we work on them together. • Update on work on tackling the stigma around substance use. • A North East Place and Wellbeing network event on 15th August to consider green or nature based social prescribing. **4.2 NEPHA and PHS Draft Strategic Agreement** Key points gathered as follows: Ms Webb replied to Mr Patwa's question on whether there had been any co-design or co-production of the engagement process by indicating that the NEPHA work with community planning partnerships as key partners, alongside a Steering Group led by Mr Cooper which is co-designing the engagement process. Ms Anderson enquired if the membership of the NEPHA is strategic or operational. Ms Webb indicated that membership comprises North East Public Sector Chief Executives, Chief Officers and commanders from Police Scotland and Scottish Fire and Rescue. The networks that have arisen are practitioner-based from across public, third and academic sector and communities. Mr Riddell indicated that partnership has been spoken about for a long time and wondered what will we be able to do differently through the NEPHA this time? Prof Hiscox agreed it is important to maximise the opportunity and the intent, as a leadership group, is to make a difference using the framework and conditions we have now, in a way that has not been done before.	

	Mr Bokor-Ingram reported Moray IJB have had sight of the PHS/NEPHA Draft Strategic Partnership Agreement and feedback will be provided through its Chair. He specified NEPHA as an enabler to community planning is a positive direction to take. Ms Grugeon commented that this type of engagement has potential to be really innovative and suggested we think about a role for the third sector interface (TSI) in the NEPHA to get the right people at the right layers. Ms Evison indicated as there is a lot of diversity across our local areas so need to be conscious to note that our collective learning will not have relevance everywhere. She suggested the name change from North-East Alliance to North-East Population Health Alliance be communicated around the system. Mr Robertson said we need to ensure we have the appropriate membership on the Community Planning Partnerships so we are able to represent the NEPHA in the same way, with the same message. He enquired who can be invited to the Place and Wellbeing network event on 15th August and can others come along as observers? Ms Anderson suggested some CPPs are more active than others and stated that not all of their websites are as up to date as they could be. Dr Tomlinson fed back that he agrees with the NEPHA name change and that it needs to be communicated widely to avoid confusion. Furthermore, there is a possibility for the NEPHA and the way it is linked to the various bodies to help promote partnership working and keep a future focus. Prof Hiscox noted all of the points made by the Committee would be considered at the next NEPHA meeting and indicated that there is a commitment from each NEPHA member to take the NEPHA/PHS Draft Strategic Partnership Agreement into their respective governance systems. Ms Webb reported that going forward a short briefing note will be circulated to Committee members after each meeting of the NEPHA. **Ms Webb extended an open invitation to participate in future place network meetings but would encourage members to go as participants rather than observers.** **The NEPHA will be included on the Committee agenda as a standing item to receive verbal / written updates.** **The Committee noted and approved the NEPHA/PHS Draft Strategic Partnership Agreement and Appendix 1 key and acknowledged that updates will be provided going forward.** **Ms Webb indicated that a final updated draft will be taken to and endorsed by the NEPHA before going to the constituent bodies for sign**	**Committee Members** **Heather Haylett-Andrews** **S Webb** **S Webb**

	off. It was noted that Public Health Scotland are holding their Board meeting in Aberdeen on 16th August and an email update on the programme for the two days will be provided to Committee Members. **Dr Tomlinson asked that the final version of the PHS Draft Strategic Document be reviewed by himself, Ms Webb and Ms Anderson on behalf of the Committee before circulation to Committee Members.**	**S Webb/J Tomlinson/ A Anderson**
5.	**Committee Forward Planner** Mr Cooper indicated that following an action at our last committee meeting to review the Committee's forward planner against its Terms of Reference, work has taken place over the last few weeks in this regard. Appendix 2 of the paper highlights the potential gaps and how these gaps are being addressed through the population health portfolio governance structure. Mr Humphreys added that the Engagement and Empowerment Oversight Group (EEOG) is overseeing the areas of work which will be brought to the Population Health Committee for assurance and will be detailed in the forward planner going forward. Mr Russell remarked that it is good to see the linkage in the forward planner but wondered if it was clear how the reporting lines will work? Mr Humphreys explained that the EEOG is a sub-group of the Population Health Portfolio Board and indicated that it may be a good idea to recirculate the diagram showing reporting structures following the meeting. **The Population Health Portfolio Board governance structure to be re-circulated to Committee members.** **5.1 Action Log** Dr Tomlinson indicated that some Committee members may not have received the Action Log and asked that it be re-circulated after the meeting for information.	**H Haylett-Andrews** **H Haylett-Andrews**
6.	**Strategy, Governance and Performance** **6.1 Fairer Scotland Duty Principles** The committee noted the paper provided. Ms Webb reported that a conversation took place between herself, Ms Grugeon, Ms Anderson and Dr Tomlinson in relation to developing Committee principles. She indicated that the questions set out in appendix 3 of the paper underpin how we wish to work as an organisation and would serve the Committee well. Furthermore, these questions may serve all NHS Grampian Committees in service of NHS Grampian in fulfilling the Fairer Scotland Duty. Ms Evison commented that the whole Board can benefit from the Fairer Scotland Duty and we should not lose sight of this. Mr Yuill agreed that this is very sensible approach and something we should embrace.	

Ms Grugeon agreed this is great and suggested the Committee cascade these principles to the Committee Chairs Group.

Ms Anderson indicated her keenness for this to be taken forward and specified that this should also be shared with the Compliance Committee, and acute and medical colleagues, to raise awareness.

Dr Tomlinson noted that from a practical point of view, we will see these principles reflected in reports going forward to this Committee. He indicated that we would want to invite other Committees and the Chief Executive Team to consider where these principles may play a part in taking forward the population health agenda more broadly.

Ms Grugeon stated that the Fairer Scotland Duty is a statutory requirement that we are required to deliver on as a Board.

Ms Webb indicated to the Committee that an integrated impact assessment tool is in the process of being developed to accompany the principle questions contained in this report. She agreed as a starting point, it would be helpful to reinforce today's conversation with the Committee Chairs Group.

The Committee noted and is supportive of the potential benefits and challenges of utilising the Fairer Scotland Duty as part of the development of the Committee's assurance framework.

6.2 Meeting of the Population Portfolio Board 12 June 2023

The Committee noted the assurance overview provided within the paper and accompanying papers found in the appendix.

6.3 Grampian Delivery Plan 2023/26 as a Population Health Enabler

Ms Webb gave an overview of the paper which highlights NHS Grampian's objectives and areas of work sitting within those objectives. A number of these areas of work were set by Scottish Government's one-year annual delivery planning guidance. Furthermore, NHS Grampian has signalled its strategic intent through our three-year delivery plan.

Ms Webb, in answering Ms Anderson's question of seeing more granularity on the objectives identified to see the relevance for population health, indicated that that level of detail is contained in the work plan and is cross-referenced in the papers. Ms Webb indicated she would be happy to send that level of detail to the Committee. Dr Tomlinson suggested at the next Committee, we focus on the next level of detail.

Ms Webb confirmed with Mr Russell that the areas greyed out in the delivery plan sit with other Committees and Portfolios of the Board.

Ms Webb advised that the Delivery Plan has been submitted to the Scottish Government and we anticipate Policy Leads will provide feedback to us on

	areas requiring further work. The Committee will receive updates in this regard. Ms Harrold advised that the Scottish Government has returned their feedback on our initial submission which was fairly positive, asking for clarity on a few areas. Work is ongoing with Portfolio leads now. Quarterly update reports will go back to the Scottish Government and to our PAFIC Committee, from a performance assurance perspective. Dr Tomlinson invited Ms Anderson to assist as Vice Chair to consider what might be helpful in terms of Committee assurance in this area. Ms Webb extended an invite to Committee members to attend a 'show and tell' to describe our work within the Delivery Plan in more detail. **The Committee acknowledged:** • **That the draft delivery plan is an enabler to improving population health. It references the need to respond to illness balanced with improving wellness, and that this supports the strategic direction of the Grampian Plan for the Future.** • **The plan is ambitious in that it cannot be delivered by one single organisation but will require all partners, including citizens as partners in their care, working in close collaboration, to make the changes required which will ensure our health and care system is sustainable for future generations.** • **We are on an engagement and learning health system journey. New models of engagement will need to be designed and embedded; different ways of evidencing success and improvement need to be embraced, including hearing from those with lived and living experience.** • **By focusing on test bed areas, we can work strategically together across organisations to improve outcomes in population health and reduce inequalities**	
7.	**Creating Equity** **7.1 MAT Standards** Mr Rayner shared a presentation prepared by Mr John Mooney for awareness on medication assisted treatment (MAT) standards across the three North East alcohol and drug partnerships (ADPs). He indicated that the MAT standards are an initiative by the Scottish Government and Public Health Scotland to ensure consistency and equity of service provision across Scotland in terms of substance use and medications that are provided to help people to stabilise that drug use. Ms Grugeon stated for Mr Patwa's benefit that there had been 1,092 preventable drug related deaths in Scotland in 2022 and is the reason there is such focus from the Scottish Government and enquired on NHS Grampian's responsibility. Ms Grugeon also enquired as to whether any progress has been made around NHS Grampian becoming a corporate Naloxone sponsor.	

	Mr Rayner indicated there is a working group progressing with this work, to include a video with Ms Webb and Prof Hiscox. Dr Tomlinson supports the approach but indicated it would be useful for our wider work to understand the rationale on how this is working without targets being put in place. Mr Rayner indicated this approach was initiated by Public Health Scotland and as there are four large cities involved, it is not a one size fits all in terms of targets. Mr Rayner suspecting targets may come in terms of the proportion of people who start treatment on the same day as presentation but not if people have a reason for delaying treatment. There is a lot of learning taking place through the process. The benchmarking will happen in January to March so gives us a very narrow window to be making improvements. Mr Russell asked if, on the Pan Grampian aspect, we have the appropriate clinical support in our custody suites and prison services. Mr Rayner indicated yes custody suites is a pan-Grampian service, but it is hosted by Aberdeenshire Health and Social Care Partnership. HMP Grampian in Aberdeenshire has a large number of city population but Public Health Scotland are taking forward a new Justice work stream in relation to the MAT standards to ensure that pan-Grampian has equity of support for justice settings. Ms Anderson wondered what the service users are feeding back on their thoughts and if there was a bit more information on any outcomes and experiential metrics. Mr Rayner indicated that feedback received has been generally quite positive about services in Grampian. Some feedback received has been from people who have become quite well established and stable in their recovery. There is room to gather more experiential feedback from people who are actively using substances and are more recently present in services, and from families. The process put in place by Public Health Scotland could be slicker and our aspiration is to be more adept at getting service user feedback and experience and putting that into operational practice. Mr Patwa wondered whether we are also clearly articulating the benefits of Naloxone being used given the connotations around justice and criminal drugs too. Mr Rayner stated absolutely, our aspiration is that Naloxone is available to individuals at risk and their family members in all forms, associated with any sort of opioid prescription supplied across NHS Grampian. There is also work being undertaken around de-stigmatisation for people seeking out Naloxone. Ms Evison enquired if CPPs et al have been involved in helping with finding premises in particular areas. Mr Rayner indicated that we have been quite innovative in terms of using existing premises and believes Aberdeenshire would have explored every opportunity/engaged all partners.	

	Ms Evison wondered how we feedback on 'help with experiential learning data analysis and processing' given to ADPs. Mr Rayner reiterated that Public Health Scotland will need to refine their feedback retrieval and NHS Grampian has done work around closing the loop on these sorts of improvements in a more rapid way. **The Committee noted the report and accompanying appendix and sought to receive an update from Mr Rayner and colleagues on the specific requirements of NHS Grampian in this domain by the end of 2023.**	**S Rayner**
8.	**People Powered Health** **8.1 Learning Health Systems** Ms Evans shared a presentation which introduced Learning Health Systems (LHS), describing what they are and why they are needed. The discussion today will be the start of many as we work through LHS, looking at systems, what it means for the way we work in the future, nurturing our assets and how affects our data and intelligence infrastructure. Dr Tomlinson invited Committee Members to give some initial feedback to Ms Evans. Mr Patwa was pleased with Ms Evans point about not being fixated on targets. If this is to become systemic at all levels, a culture strategy should be drawn up too, to embed on the ground level which in turn will empower staff to disseminate widely through their teams. Ms Grugeon sees this as a fundamental enabler on how we engage with the public differently and linking it in with our plan for the future. She acknowledged 'human learning systems' has also been heard before, so we ought to be mindful of using one term and one term only. She indicated this was great to see and encourages its use. Ms Anderson indicates she is bought into the concept and wonders if there are any short, medium and long term objectives set out for establishing this culture and way of working. She said she was unaware if we have had the conversation with the public about what we can and cannot do. Dr Tomlinson sought Mr Russell's input. He indicated that a diagram in the presentation brought out this idea of having a repository for data relating to each patient held in the one place, with access for all who need to know, as a starting point. Dr Tomlinson suggested it becomes part of the way we do things as NHS Grampian but also how we collaborate in a wider sense. It's important to reflect on where we go on this journey, the pace we move and how we bring people along as we go. Ms Evans reflected on member's comments and thanked everyone for their contribution. She indicated that NHS Grampian and some councils too have been on this journey for a long time.	

	Ms Evans suggested there be a collective effort in defining, naming and designing the approach, and writing about it as it evolves to help the next health system learn from our experience. She advised there will be a much more focussed event in September with wider participation including this Committee. **The Committee agreed to this approach in principle, with a desire to be part of the journey. Lead Executives will look at the forward planner with a view to bringing this subject back to the Committee at a future date.**	**S Webb/S Humphreys**
	8.2 Engagement and Empowerment Action Plan Mr Humphreys sent his apologies due to a lost connection. Dr Tomlinson indicated that as we have seen this document at previous meetings, it would be prudent to collect comments now. Mr Riddell indicated that we are going in the right direction, but it seems slightly one way. The section at the start of the document needs to be more explicit about what we feed back to the public. It's seems too much like 'you said, we did'. The loop does not feel all that strong, we need something that gives clear feedback and evidence in relation to feeding back to the public to build the trust and momentum. Ms Evison is pleased to see a section in the document about ensuring young people have a voice. She would ask that we explicitly talk about care experienced young people and mention the Promise within that section too. We need to keep highlighting our work on that. Ms Grugeon agreed with Mr Riddell and had underlined a section on page 82 where it says 'we want people to feel valued', but thought it should be 'we want people to be of value to us', about how they contribute to and get involved with helping people to have good health. We need to be bold and clear about our ambition. She asked if we see our engagement being done by a team of people (the Engagement Team) or are we seeing this more as how we change the culture of the organisation so that all people have the skills whether they are in leadership or frontline roles to engage with the public in their day to day life? She indicated there is a lot of activity outlined in year 1, she would like to see milestones for year 1, 2 and 3, highlighting progression from the previous year. Will we be taking the learning and targeting specific groups or are we going to engage with everybody? Will we have an engagement and involvement framework to outline that clearly? She wondered how this connects with the thinking around volunteering and our health inequalities plan, as it does not feel like it is connected at the moment?	

	Ms Anderson indicated that it was good to see this plan. To answer Ms Grugeon's point, she referenced page 78, 'developing and sharing a toolkit for staff to utilise, supporting them when engaging with communities'. Ms Anderson would like to see an overarching aim of the EEOG to cascade their knowledge so engagement is done as business as usual. She would also like to see some key themes captured at 6 months, 12 months to gather the learning from the process. Mr Patwa said we have to be very careful about engagement, one size does not fit all. Sometimes we get lost in the overall ambition of wanting to engage with anybody and everybody, and lose focus. He enquired as to what 'good' looks like, we should have milestones for 2-3 years' time to measure our success. Mr Russell, building on Ms Grugeon and Mr Patwa's earlier comments, indicated that there are two distinct processes here. There is engagement to *generate* the message and engagement to *cascade* the message. It is really important to get the right people involved to generate the message, not necessarily a large group, realising that one size does not fit all. Ms Webb thanked committee members for their comments and indicated that this is a plan for this year. We have committed to refreshing our approach to engagement, over the course of this year and based on learning from New Pitsligo and other activities through community planning. The feedback has been really helpful to build into that process. Ms Webb indicated that this is absolutely about trying to embed a different way of working. Engagement is ongoing and we need all staff to play their role in engagement. We need to go beyond our major service change standards to engage to empower our communities. This requires a cultural shift. She thanked the Committee members again for their helpful comments and indicated that this feedback can be incorporated into the plan as it stands for this year and will be fed back to the team working on it. Dr Tomlinson summarised that we are learning as a Committee and invited anyone in the meeting or in future meetings to comment on how effectively they believe the Committee is discharging its remit.	**S Webb/S Humphreys** **Committee Members**
9.	**Public Health** **9.1 Resilience and Emergency Planning** Mr Graham provided a brief overview of the paper indicating its purpose to provide the Committee with assurance against the Civil Contingencies and Emergency Planning work plan, response to emerging risk, and to highlight key risks relating to development of plans. The Committee noted the report including areas of significance which Civil Contingencies colleagues are heavily involved in, to comply with the 41 Standards for Organisational Resilience 2018 (Second Edition). Mr Riddell indicated that he was very reassured by the report and if anything requires a systemic and collaborative approach, this is it, all parts of the	

	system need to work together. In mind of H&SC Moray policy predating the inception of the partnership whereby affecting changes to governance and staffing, his plea is for Civil Contingency colleagues to be mindful when working with partners in terms of training and updating policies that every part of the system is developing at the same pace. Mr Graham indicated that Health and Social Care Partnerships are now all Category 1 responders in terms of the Civil Contingencies Act and are all involved in planning arrangements, including resilience and business continuity lead representation in a dedicated MS Teams channel. They are all sighted on all new information that is available through the channel. Mr Russell spoke of an offshore major incident 35 years ago and enquired if there were policies in place to handle that type of incident today. Mr Graham confirmed that having been involved in multiple offshore incidents over the years, we tend to share the Resilience Partnerships plans that are available on a multi-agency basis along with the participation of all sectors which includes the oil and gas sector. We are always involved in processes for offshore pipeline plans etc. Dr Tomlinson thanked Mr Graham for his contribution today. **The Committee noted the overview provided including the recommendations and updates provided on the current status.** **The Executive Leads are asked to cross-reference the risks and highlighted areas against the Committee's terms of reference, particularly the key strategic risk of pandemic preparation. This item should be considered within the forward planner for the purposes of receive assurance updates.** **9.2 Dental Public Health** Dr Iloya indicated he had shared a link in the chat function to the Covid-19 Inquiry Report on recovery of dental services, which will give a wider perspective on the issues around dentistry. He provided an overview of his paper specifically around two main issues; the challenges in terms of recruitment and retention of dentists in Moray and part of North Aberdeenshire areas, and the knock-on effect of dental registration and the inequalities indicators. Dr Tomlinson thanked Dr Iloya for the assurance paper and indicated that he will be invited to a future Committee meeting for further progress updates, ensuring this important issue features earlier on the agenda. **The Committee noted the current position regarding access to general dental services in Grampian, the associated risks and the mitigating actions to facilitate improvements in access to general dental services.**	**S Webb/S Humphreys**
9.	**Date of Next Committee**	

	Dr Tomlinson indicated that Mr Riddell entered a note into chat saying that the date of the next Committee, 28 September, clashed with the Moray IJB Meeting. **Ms Haylett-Andrews will source an alternative date.** Suggested date – Friday, 6th October at **0900-1130** hours via Microsoft Teams	**H Haylett-Andrews**