Plan for the Future
Healthier Together
2022 - 2028

Health Equity Plan 2024-29

NHS Grampian

Foreword

Our 'Plan for the future 2022-2028' sets out our vision to re-imagine the organisational purpose to reach beyond responding to poor health to one which equally invests in preventing harm, improving health and supporting communities across Grampian to thrive. This commitment to taking a population health based approach has a focus on prevention and explicitly requires actions that will address the social and environmental factors that lead to, as well as mitigate the consequences of existing health inequalities.

Following a period of improving mortality rates and reducing inequalities in the first decade of the 21st century, improvements have stalled, and some inequalities have widened across Scotland. The situation in Grampian is consistent with the national Scottish context of large and persistent inequalities in health between the most and least deprived neighbourhoods.

This is NHS Grampian's health equity plan, which sets out our longer term ambition to reduce the gap in healthy life expectancy between the most and least vulnerable groups in society and our priorities over the next five years to progress towards this. It builds on the progress achieved over the last three years and is informed by our data as well as what we have learned through engaging with our colleagues, partners and communities. It is aligned with the policy objective of using shared-decision making and trauma-informed practice to deliver person-centred care, ensuring that everyone gets the right care at the right place at the right time. The plan also sets out a framework for how as a health service we can do more to address the impacts of the wider determinants of health. Given the challenging financial landscape we face, the plan responds to the need to ensure the health and care needs of the most disadvantaged groups in our population continue to be met to avoid exacerbating health inequalities. We look forward to continuing to work with our partners to take a whole system approach and ensure our collective activities are connected and impactful in supporting our communities in Grampian to live healthy fulfilled lives.

Susan Webb
Director of Public Health

Adam Coldwells
Interim Chief Executive

Glossary

Anchor organisation

Large, typically non-profit organisations e.g. NHS boards, local councils, whose long-term sustainability is tied to the wellbeing of the populations they serve
https://www.health.org.uk/newsletter-feature/the-nhs-as-an-anchor

Community appointment days

Provide a comprehensive range of services under one roof taking place within communities, they offer resources tailored to the specific needs of the local population, providing same-day access to services including assessments, advice, health promotion, rehabilitation and community and voluntary sector support, all in a non-medicalised environment
Joint venture: how an NHS physio waiting list was shrunk in just two days - New Local

Community assets

All communities have local health assets as well as health needs. Assets that can support health and wellbeing include:

- Skills, knowledge, social competence and commitment of individual community members;
- Friendships, intergenerational solidarity, community cohesion and neighbourliness within a community;
- Local groups and community and voluntary associations, ranging from formal organisations to informal, mutual aid networks such as babysitting circles;
- Physical, environmental and economic resources within a community;
- Assets brought by external agencies – public, private and third sector.

Quality statement 3: Identifying community assets | Community engagement: improving health and wellbeing | Quality standards | NICE

Community empowerment

Refers to the process of enabling communities to increase control over their lives
https://www.who.int/teams/health-promotion/enhanced-wellbeing/seventh-global-conference/community-empowerment

Community engagement

Is a way of developing a working relationship between public bodies and community organisations, good community engagement will mean both groups can understand and act on the needs or issues of community experiences
https://www.scdc.org.uk/community-engagement/what-it-is

Community led health

Is a way of improving health and wellbeing that starts with what people say is important to them and to take the lead in developing solutions
Community-led health | SCDC - We believe communities matter

Community paradigm
Is an approach that argues more power and resources should be given to communities rather than being held by central government or public services
https://www.newlocal.org.uk/publications/the-community-paradigm/

Community Planning Partnerships (CPPs)
Is the name given to all services that come together to take part in community planning. There are 32 CPPs across Scotland, one for each council area. Each CPP focuses on where partners' collective efforts and resources can add the most value to their local communities, with particular emphasis on reducing inequality
https://www.gov.scot/policies/improving-public-services/community-planning/

Fairer Scotland Duty
Places a legal responsibility on public bodies in Scotland to actively consider ('pay due regard' to) how they can reduce inequalities of outcome caused by socio-economic disadvantage, when making strategic decisions
https://www.gov.scot/publications/fairer-scotland-duty-guidance-public-bodies/pages/2/

Health behaviours
The combination of knowledge, practices, and attitudes that together contribute to motivate the actions we take regarding health. Health behaviour is influenced by various factors including social, environmental and psychological factors.

Health equity
Health equity is the state in which everyone has a fair and just opportunity to attain the highest level of health.

Health inequities
Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age.

Healthy life expectancy
The average number of years a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury
https://www.who.int/data/gho/indicator-metadata-registry/imr-details/66

Human learning systems
Is an approach that embraces complexity, human relationships and continuous learning. It enables a group of people to come together to share and learn about a particular topic, to build knowledge and speed up improved outcomes.

Liberated method

Where public services support people by helping them create the conditions to effect the changes they feel compelled to make and liberating people's own power for internal change. It's this phenomenon, the combination of extrinsic and intrinsic support and resource, that lies at the heart of the liberated method.

Placed based approaches

Is about understanding the issues, interconnections and relationships in a place and coordinating action and investment to improve the quality of life for that community https://www.ourplace.scot/about-place/place-based-approaches

Prevention

Is about keeping people healthy and avoiding the risk of poor health, illness, injury, and early death https://publichealthscotland.scot/our-areas-of-work/public-health-approach-to-prevention/what-is-prevention/

Proportionate universalism

To reduce the steep social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage Proportionate universalism and health inequalities (healthscotland.com)

Social gradient

Evidence shows in general, the lower an individual's socioeconomic position, the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. https://www.who.int/news-room/questions-and-answers/item/social-determinants-of-health-key-concepts

Vulnerable communities

Refer to communities more susceptible to experiencing harm, discrimination, or disadvantage due to various factors such as their social, economic, geographic location, or physical circumstances Vulnerable groups | INEE

Whole system approach

Involves applying systems thinking, methods and practice to better understand public health challenges and identify collective actions https://www.publichealthscotland.scot/our-organisation/about-public-health-scotland/supporting-whole-system-approaches/applying-a-whole-system-approach/

Wider determinants of health

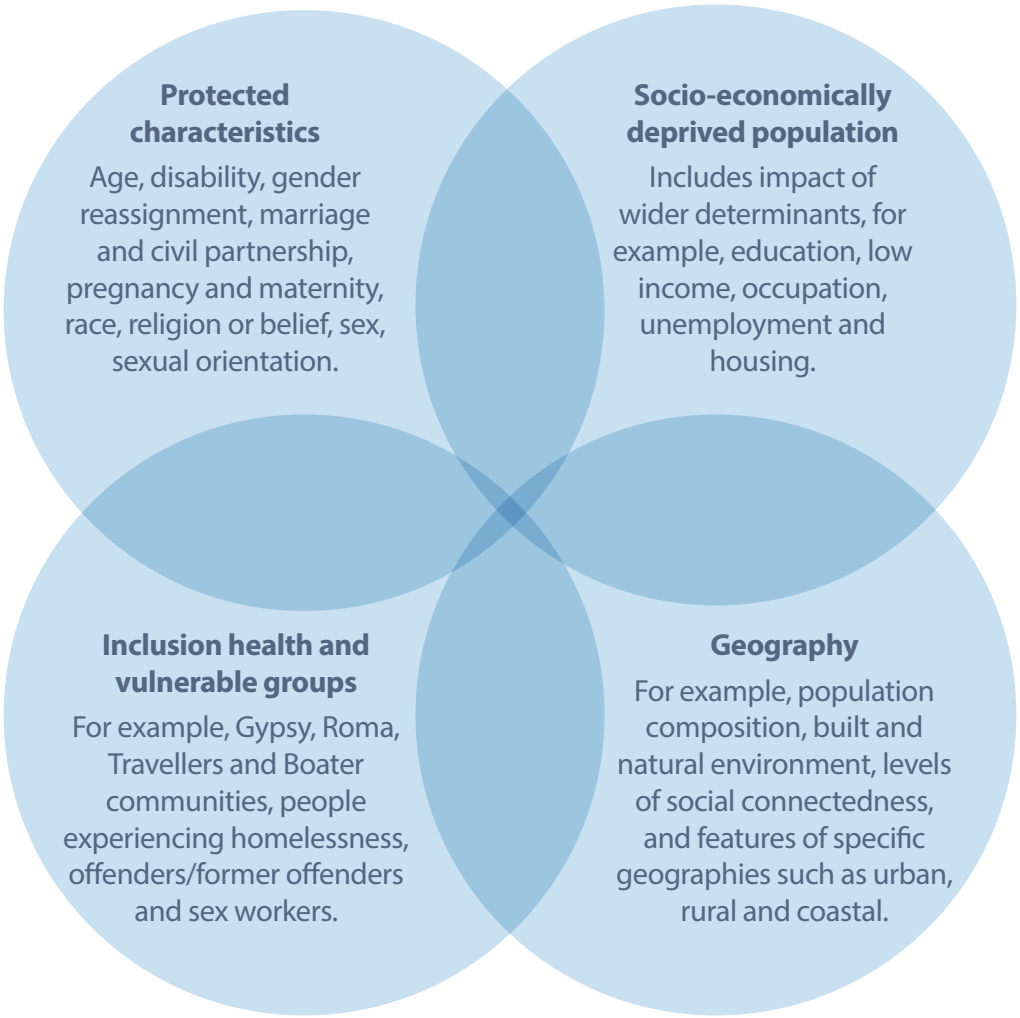
Are a diverse range of social, economic and environmental factors which influence people's mental and physical health Chapter 6: wider determinants of health - GOV.UK (www.gov.uk)

Case for change

Health inequities are the observable differences in people's health across the population and between specific population groups. It is common for the term "health inequalities" to be used inter-changeably with "health inequities". In this plan we use the term inequities.

Health inequities can be experienced by people grouped by a range of different factors (see Figure 1). These factors often overlap, meaning people can fall into more than one category compounding the severity of health inequities experienced.

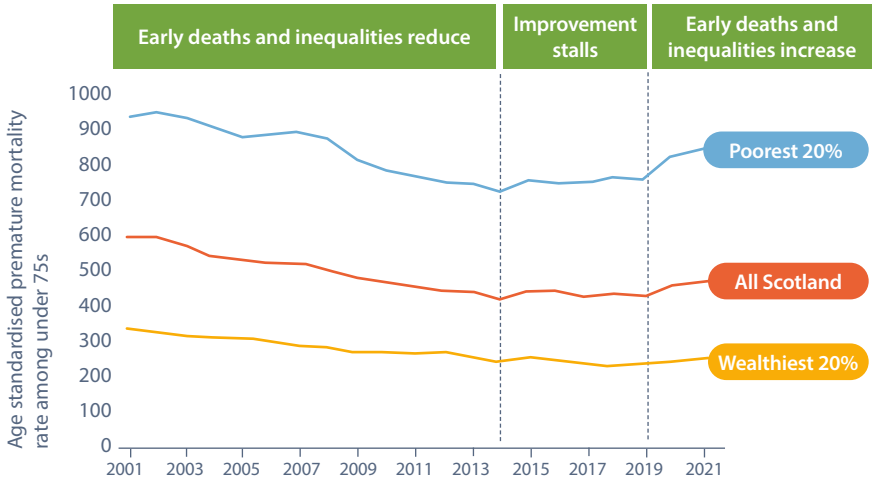
Figure 1: Groups at risk of health inequities (Source: Public Health England)[1]



Health inequities can be seen and measured through the prevalence of health conditions and mortality, behavioural risks to health such as smoking, the wider determinants of health such as housing and employment, access to care and the quality and experience of using healthcare services.

NHS Grampian's Director of Public Health Report for 2022 (Director of Public Health's Annual Report (nhsgrampian.org) set out the worsening picture of health in the North East, which is occurring at a faster pace in our most vulnerable communities. This worsening trend reflects the pattern in Scotland (Figure 2).

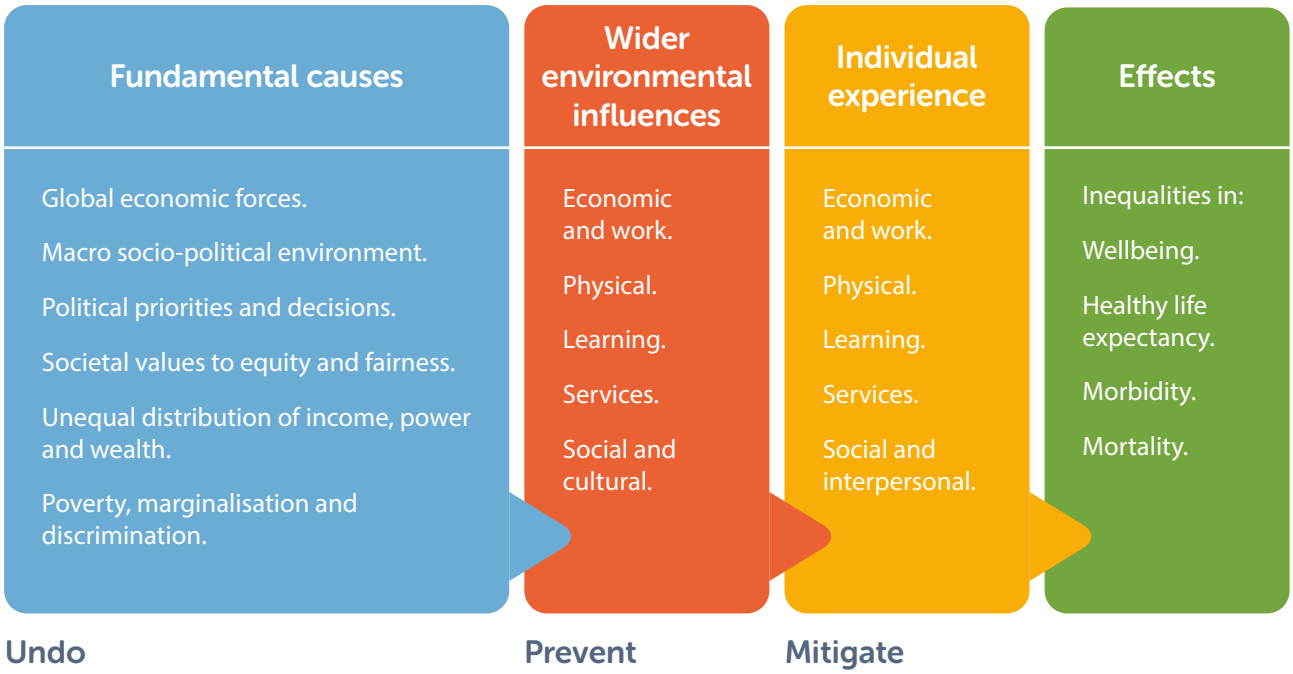
Figure 2: Trend in premature mortality rate for Scotland [2]



Source: National Records Scotland

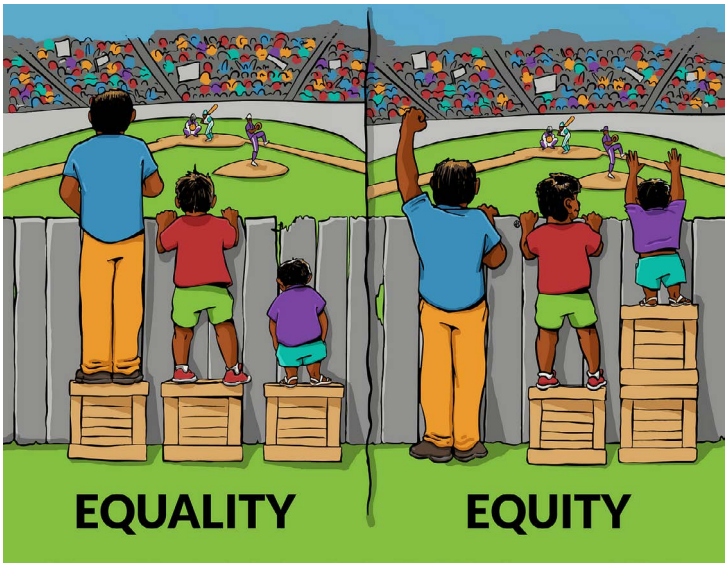
Health inequities are unjust and go against the principles of social justice because they are avoidable. They do not occur randomly or by chance. Health inequities are fundamentally caused by an unequal distribution of power, income and wealth due to wider global, political and societal influences. They are socially determined by circumstances largely beyond an individual's control. These circumstances impact on the wider environment in which people live, work, grow and play, which shapes their experiences and consequently their health. Differences in employment, income and housing (social inequities) mean that large groups of people are disadvantaged and this limits their chance to live longer, healthier and fulfilled lives. The existence of health inequities in Grampian, and in Scotland, means that the right of everyone to the highest attainable standard of physical and mental health is not being enjoyed equally across the population. Action needs to focus on undoing the fundamental causes, preventing harmful environmental influences and mitigating negative individual experiences (Figure 3).[3]

Figure 3: Action to address the factors that drive health inequities



Individuals have unique needs based on their circumstances. Treating everyone equally may therefore not lead to equitable outcomes because different people require different levels of support (Figure 4). We can address this by resourcing and delivering universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need. This approach (known as proportionate universalism), combines a focus on improving the health of the most disadvantaged groups, whilst also reducing the entire social gradient.[4]

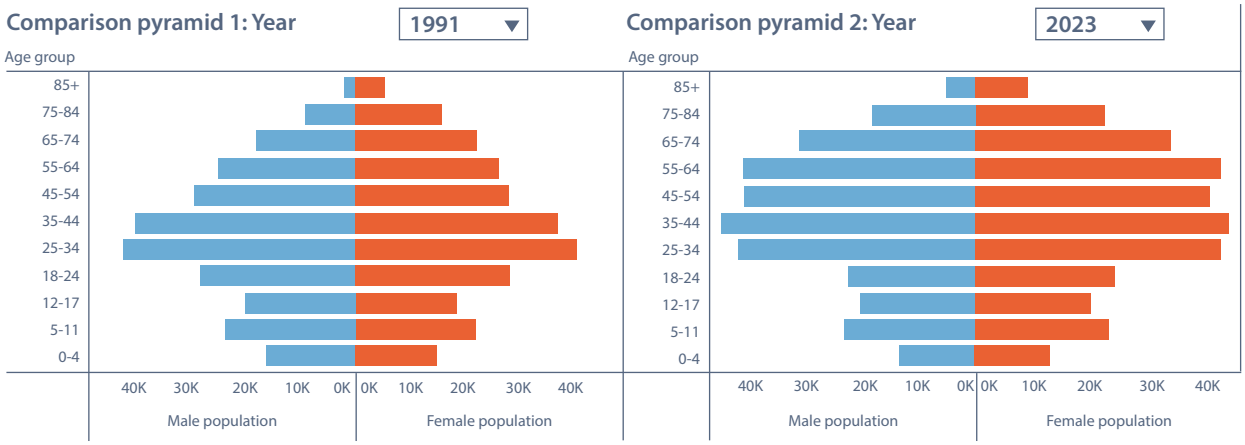
Figure 4: Equality versus equity



Health inequities in Grampian

The population in Grampian is ageing (Figure 5). There is some variation in the age structure of the population across the three Local Authority areas, with a relatively younger population in Aberdeen City, compared to Aberdeenshire and Moray.[5]

Figure 5: Age distribution in Grampian, 1991 and 2023



Life expectancy had stalled across Grampian since before the pandemic (Figure 6), and currently varies across our Local Authority areas, ranging from 77 to 79 years for men and 81 to 82 years for women. The difference in life expectancy between the most and least vulnerable groups across our Local Authority areas ranges from 2.8 to 8.1 years for women and 6.4 to 10.0 years for men (Figure 7).

Figure 6: Trends in life expectancy in Grampian by local SIMD

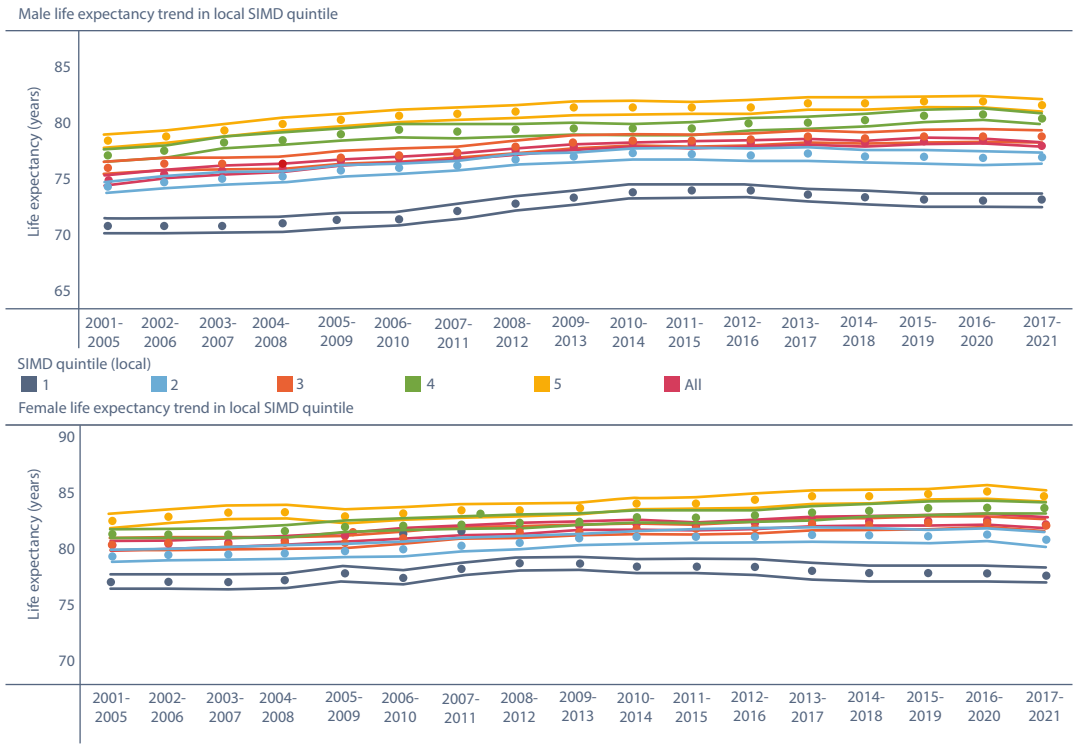
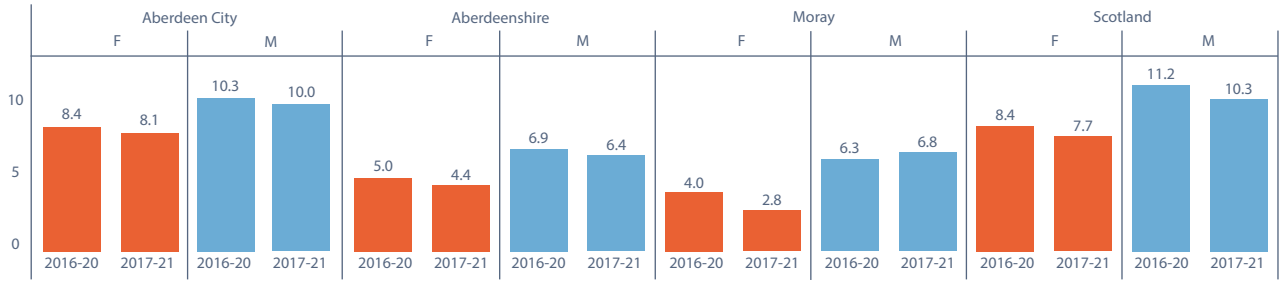
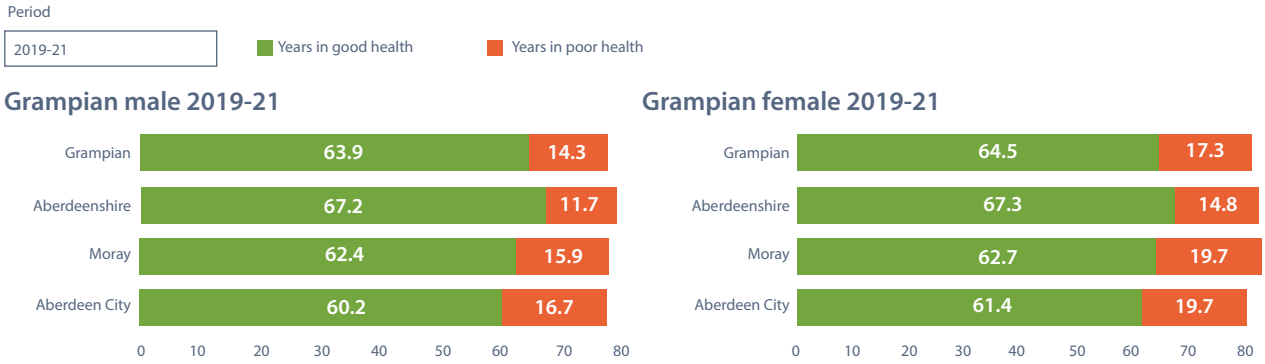


Figure 7: Differences in life expectancy between highest-lowest deprivation quintile by local authority and nationally, 2017-21



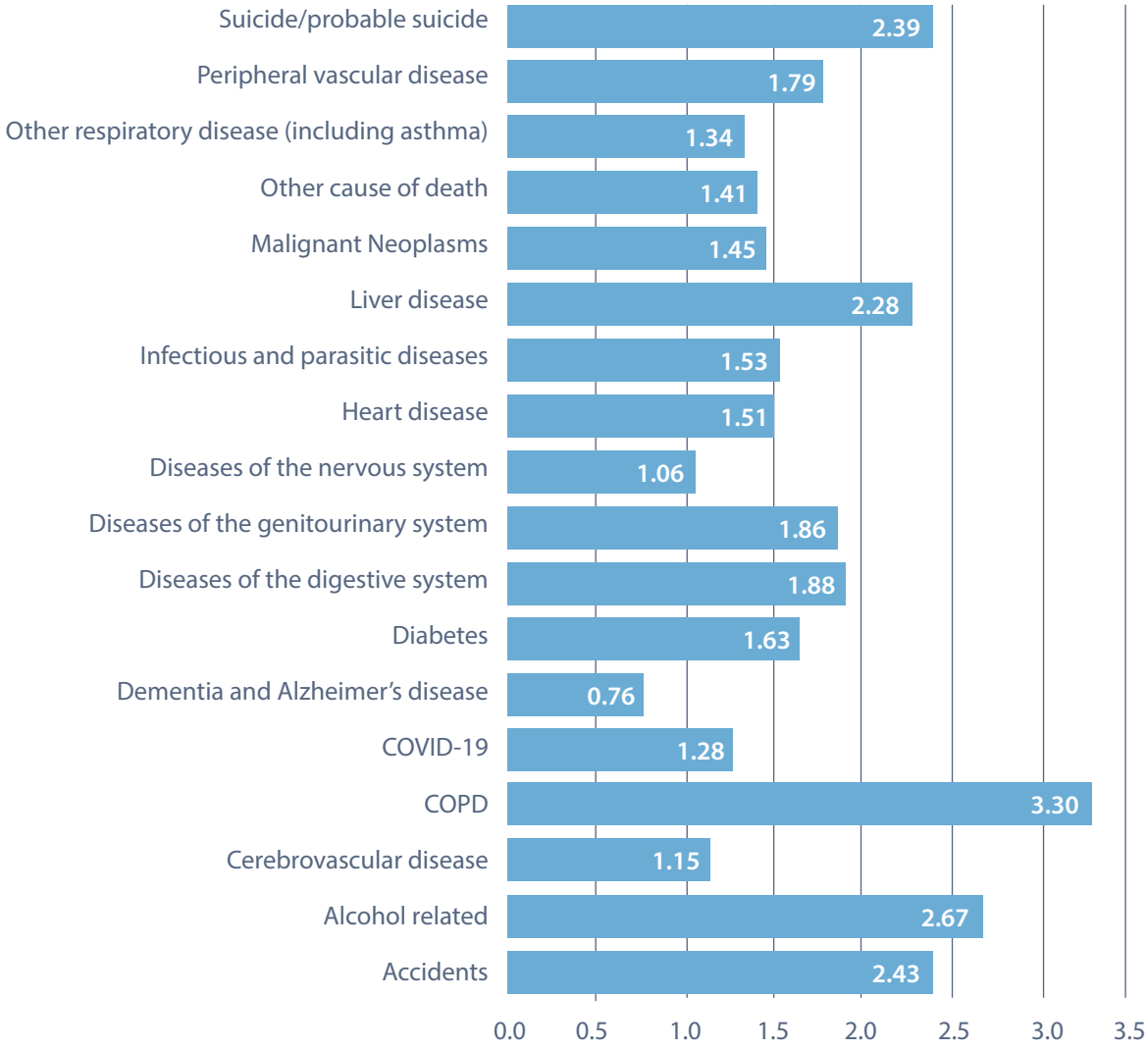
Men spend fewer years in good health compared to women (Figure 8), however this is also socially patterned, with people who live in more deprived areas experiencing a shorter period in good health compared to people who live in less deprived areas. Although men spend fewer years in good health, women experience a longer period in poor health. This difference will influence the type of women's health services that will be required to meet their needs.

Figure 8: Years spent in good/poor health by sex, 2019-21



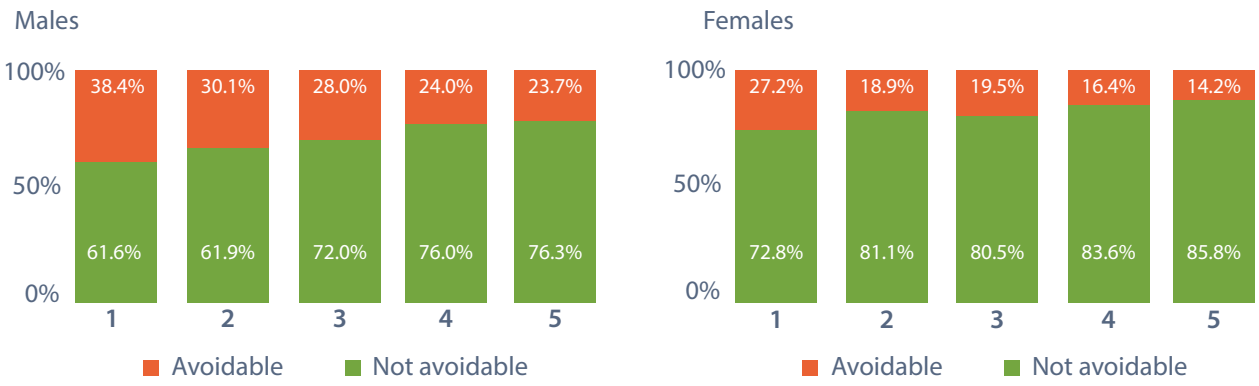
In Grampian, heart disease and cancer are the leading causes of death. The mortality rates for these causes are about 1.5 times higher in the most deprived than in the least deprived areas. The biggest differences in mortality rates are observed for Chronic Obstructive Pulmonary Disease (most deprived areas have a rate 3.3 times higher than least deprived), alcohol-related (2.7 times), accidents (2.4), suicide (2.4) and liver disease (2.3) (Figure 9).

Figure 9: Ratio of mortality rate in most deprived quintile to mortality rate in least deprived quintile by cause, 2013-22



Avoidable mortality is higher among men than women and is nearly three times higher in the most deprived areas (Figure 10). This gap has increased over the last ten years.

Figure 10: Percentage of all-age deaths deemed avoidable by deprivation quintile and sex



Similar inequities were observed in behavioural risk factors such as cigarette smoking and alcohol consumption, and in uptake of prevention programmes such as vaccinations, and screening programmes (data presented in later sections of this plan). More detail about health inequities is Grampian is available from NHS Grampian's Health Inequalities Report, 2023.[5]

Progress towards health equity in Grampian 2021-24

NHS Grampian established a Health Inequalities Action Group (HIAG) in 2021 to provide leadership and cohesion in our efforts to address health inequities. Following a review of the strategic landscape and a self-assessment of key deliverables, an action plan was developed for 2023/24 that recognised the need to take a whole system approach. This plan included our actions as an anchor organisation and to tackle child poverty that, with our local authority partners, addresses the statutory duty within the Child Poverty (Scotland) Act (2017).

Our work to date has laid the foundations for our mission to achieve equitable health in Grampian and clarified our priorities for the next five years. Key achievements during 2023/24 include.[6]

- Progressing the development of an integrated impact assessment tool to support our compliance with the Fairer Scotland Duty.
- Strengthening our partnerships with public and third sector organisations through our work with Community Planning Partnerships and the North East Population Health Alliance.
- Strengthening our data and evidence led approach for reducing health inequities.
- Developing our approach to community led health, engagement and empowerment.
- Progressing our ambitions as an Anchor organisation.

We learned there is significant activity underway across the organisation to address health inequities, but ongoing systemic complex challenges will require sustained and deliberate long-term commitment to action. Capacity and resource remain an issue and there is more we can do to make our approach to reducing health inequities business as usual. For example, access to timely data, evidence of what works and good practice to reduce health inequities are needed.

Recognising the complexity and multi-faceted drivers of health inequity, we have started to explore how paradigms such as human learning systems can help us to drive forward our ambitions with our partners. We now need to test out these approaches in our work with our partners to drive forward our ambition to reduce health inequities in Grampian.

Achieving health equity in Grampian: Priorities for the health and care system over the next five years (2024-2029)

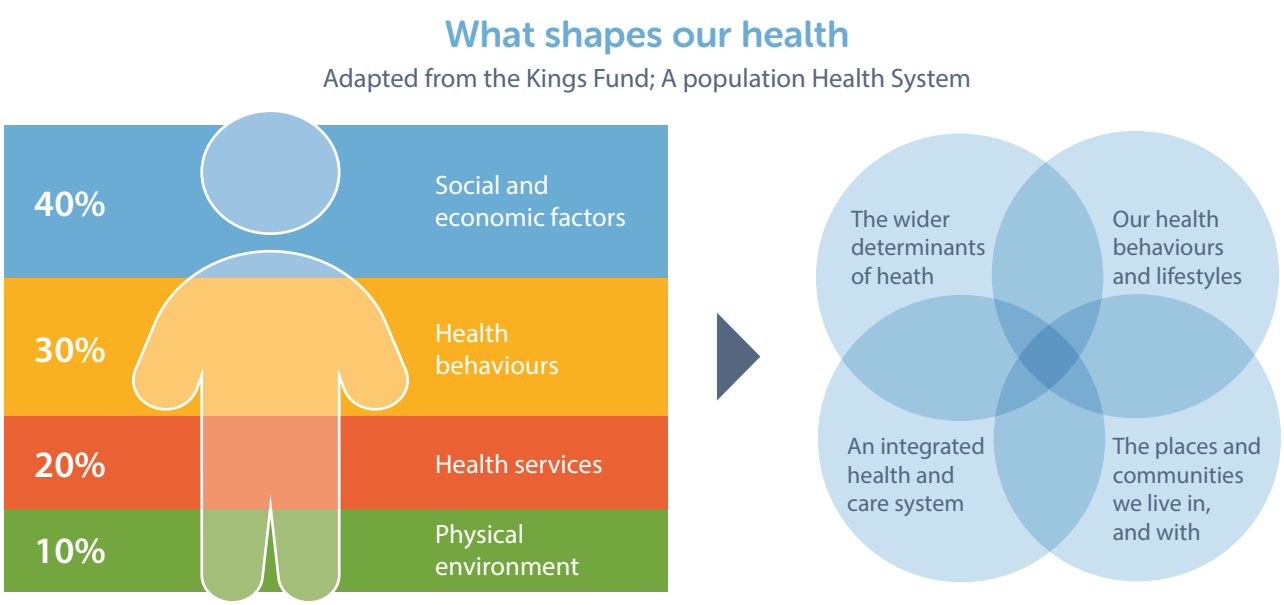
Our long-term ambition is to reduce the gap in healthy life expectancy between the most and least vulnerable groups in society. We will do this through our efforts to improve the health of the whole population across the social gradient, while simultaneously improving the health of the most disadvantaged fastest.

We know that where and how we live, and what we do accounts for at least 80% of the observed health inequities in our population.[7] The King's Fund Four Pillars of Population Health is a framework for action to reduce health inequities (Figure 11).[8] This framework recognises that there is overlap between the four pillars - social and economic factors (wider determinants of health), health behaviours, health services and the environment in which we live. This means that we can use the framework to identify how as a health and care system we can:[9]

- Improve the social and economic factors that create health through our work as an anchor organisation.
- Create healthy and sustainable places and communities through our work with Community Planning Partnerships.
- Promote health and wellbeing by supporting action on prevention, early detection, and early intervention and treatment.
- Ensure equity across the whole pathway of care, recognising that disadvantaged groups experience disproportionately poorer access and outcomes.
- Take a value based approach to delivering health and care, ensuring equitable care is delivered in the right way, by the right person at the right time.
- Deliver person-centred care through shared decision making and trauma-informed practice.
- Identify and tackle unwarranted variation in health, treatment and outcomes.

The framework also helps us to work with our partners to ensure our collective activities are connected and balanced across the four pillars that influence health.

Figure 11: Kings Fund; A population Health System



The Marmot work sets out the evidence base and makes the case for reducing health inequities through action in eight areas (Figure 12). We have used this and the framework set out above as a guide to identify six priorities over the next five years, building on the work that has been done over the last three years. Action to address Marmot in area seven is specifically addressed in NHS Grampian's Anti-racism plan. NHSGrampian-Antiracism-Plan-2023.pdf

In addition we have identified four enabling actions to help us develop our capacity and capability as a health and care system to progress our ambition for health equity in Grampian. We have set out the high level actions that we will take over the next two to three years in relation to each of these priorities and enabling actions. This will allow us to review and refresh our plans for the latter two to three years, building on progress during the preceding years.

Figure 12: Marmot eight areas for action to reduce health inequity [10]

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control of their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.
- Tackle racism, discrimination and their outcomes.
- Pursue environmental sustainability and health equity together.

To progress our ambition, our priorities over the next five years will be to:

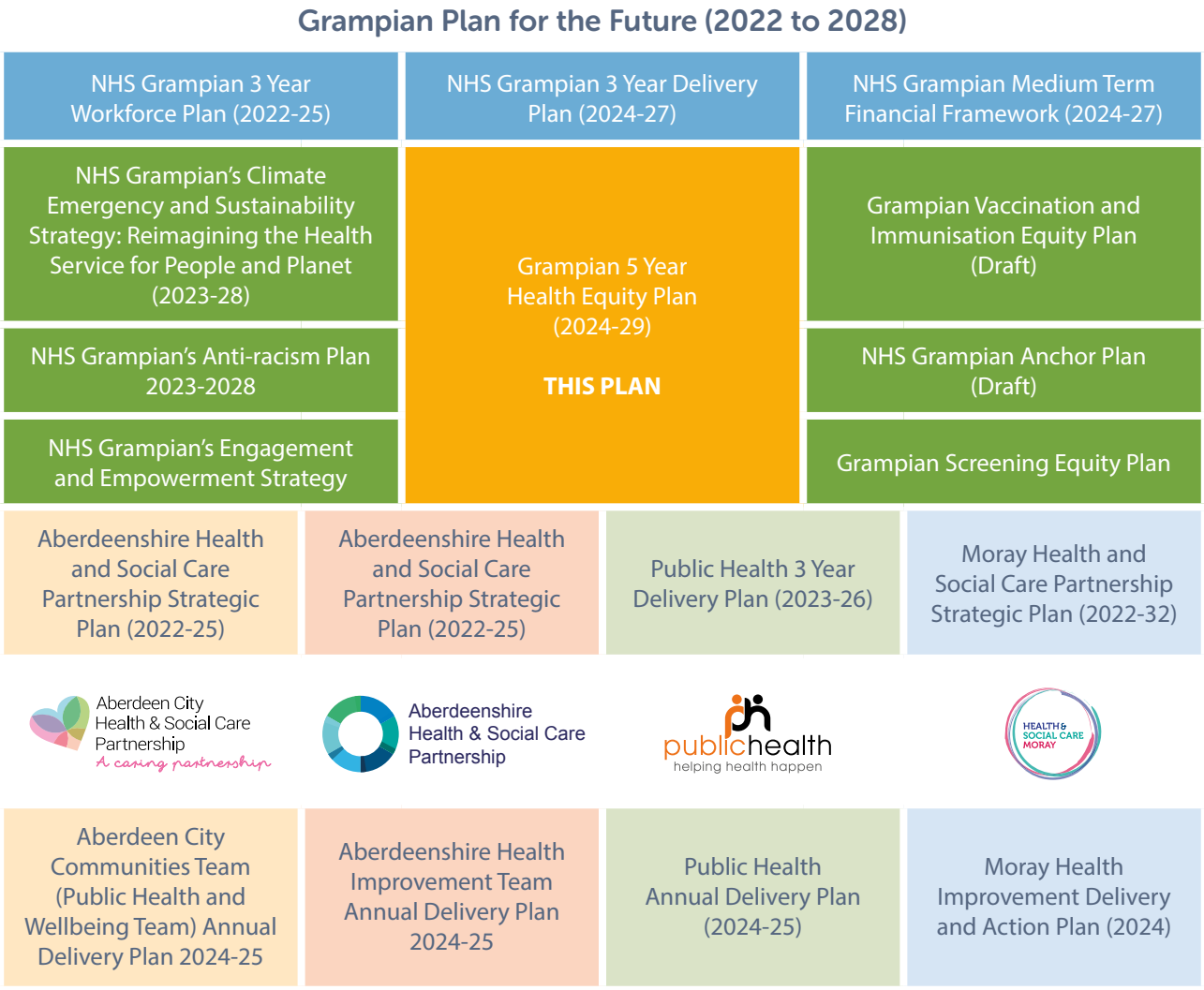
1. Use our power as an anchor organisation through employment, purchasing and assets to contribute towards addressing the economic drivers of health inequities. [Marmot areas 3,4]
2. Further develop community led health approaches and strengthen place based working. [Marmot area 5]
3. Strengthen our child poverty action plans and work effectively with our partners to ensure these are delivered with maximum impact. [Marmot areas 1,4]
4. Ensure our pathways of care include opportunities to maximise prevention, and are responsive and adaptable to meet individuals' needs, taking account of where and how they live. [Marmot area 6]
5. Understand variation and inequities in access to healthcare and health outcomes, and take action to address these. [Marmot areas 6,8]
6. Take a health inequity lens to any new pathway development/service improvement completing equity impact assessments as standard practice. [Marmot areas 1,8]

These will be supported by the following enabling actions:

- **Engagement** - Work collectively to engage with colleagues and citizens ensuring the lived experience voice is heard.
- **Staff development** - Support teams across the organisation to better understand and take action to address inequities in their areas by investing in training and staff development, improving access to data and evidence reviews of what works, support for evaluation of tests of change and develop our capabilities as a human learning system.
- **Leadership** - Provide leadership for increasing health equity, ensuring we resource and deliver services at a scale and intensity that is proportionate to the degree of need and advocating for equitable health in Board committees and wider networks.
- **Partnerships** - Strengthen our work with partners across Grampian, including the third sector to maximise our collective impact.

We recognise that effective engagement with our colleagues and the public, empowering communities and supporting the creation of sustainable environments are key to achieving health equity, and this five year health equity plan compliments NHS Grampian's strategic plans for these areas (Figure 13).

Figure 13: Relationship with Plan for the Future and other NHS Grampian strategies



Priority 1

Use our power as an anchor organisation through employment, purchasing and assets to contribute towards addressing the economic drivers of health inequities.

Anchor institutions are large organisations rooted in their community that have sizeable assets and a mission to advance the welfare of the populations they serve. As such, NHS Grampian is an anchor institution and, as a steward of public resources, has a responsibility to ensure best use of resources to maximise population wellbeing. NHS Grampian has a central role in the delivery of health and care services but it is the wider determinants of health, such as income, employment and housing, which are the foundations of good health. These wider determinants are the drivers of health inequities and NHS Grampian has an opportunity to influence these through our economic power as a purchaser (with a trade spend of approximately £299 million per annum), an employer (of 17,000 people) and an owner of land and buildings.

NHS Grampian has committed to their role as an anchor institution by identifying this as a priority in the Plan for the Future. This commitment focuses our thinking on how we use our power as a large employer to employ more local people, how we spend more of our money locally, boosting the local economy and how we use our buildings and land to maximise benefits for communities. By acting with intentionality and applying a health inequities lens to this work to address the social determinants of health, we can prevent ill-health and mitigate health inequities.

Work has already taken place to progress NHS Grampian's anchor ambition.

During 2023/24 we:

Set up a task and finish group to progress and co-ordinate our anchor activity. We submitted our actions in relation to anchor to Scottish Government in October 2023, and have established our baseline position for the anchor metrics defined by Scottish Government. Highlights of this work include:

- Community benefits delivered through 50 work placement days.
- 23 new jobs as part of the Baird and Anchor construction projects.
- Engagement with Aberdeen City and Aberdeenshire Council Procurement to initiate a North East procurement community wealth building group to explore collaborative opportunities for increasing local spend.
- Continuing to maintain living wage accreditation.
- Creating a multi-use space with the vaccination centre in Aberdeen, bringing people into the city centre.
- Working collaboratively with The Russell Anderson Foundation providing classroom sessions with eight Aberdeen city primary schools promoting NHS Grampian as a prospective employer.

- Working collaboratively with The Wood Foundation and St Machar Academy to transform a classroom into a simulated healthcare area where young people can learn more about the range of careers available in healthcare and get hands-on experience and health related teaching via NHS, health and social care staff and school teaching staff.
- Approval of Leanchoil Trust Community Asset Transfer for Leanchoil hospital, with the two organisations progressing cooperatively through the legal conditions required to complete the sale.
- A suite of documents have been prepared to support ease of third sector use of our facilities.
- A register of our property assets is annually updated and posted on our NHS Grampian website.

Over the next three years, we will:

- Develop a vision and strategic framework outlining our ambitions as an anchor organisation. This will include our contribution to creating a fair local wellbeing economy which enhances local wealth, reduces poverty and inequality through spending locally, creating fair and meaningful employment, utilising our buildings, land and assets to maximise community benefits and reduce our environmental impact.
- Outline our current anchor activity and identify where we can do more, using tools available from Public Health Scotland.
- Produce a workplan underpinned by data and evidence using learning from across the UK. This will outline our activity aligned to each of the anchor pillars of workforce, procurement and land and assets.
- Develop a communication strategy to support embedding an anchor approach within the organisation.
- Develop our relationships with other anchor institutions in Grampian, identify opportunities and work in partnership to maximise our impact on population health and health inequities.

Priority 2

Further develop community led health approaches and strengthen place based working.

Community life, the places where people live have social connections and a voice in local decisions, are all factors that make a vital contribution to health and wellbeing. Evidence supports the case for a shift to more person and community-centred approaches to health and wellbeing. Actively involving citizens in prevention programmes and strengthening community assets is a key strategy in helping to improve population health.

Building healthy, resilient, connected and empowered communities is an essential step in improving the health of the population at a greater pace than we are currently able to achieve. Effective place-based working across sectors and in partnership with communities has been demonstrated to improve health outcomes.

During 2023/24 we:

- Set out our plans to develop community led health approaches.
- Further developed our place and wellbeing network and hosted a second symposium with over 100 partner representatives from across the North East attending.
- Worked in partnership with the Scottish Community Development Council (SCDC) to strengthen confidence and skills in staff to deliver community led health approaches.
- Worked in partnership with the Kings Fund and Aberdeenshire Health and Social Care Partnership to support and test the practice and culture of engagement as described in the community paradigm model by New Local.

Over the next three years we will:

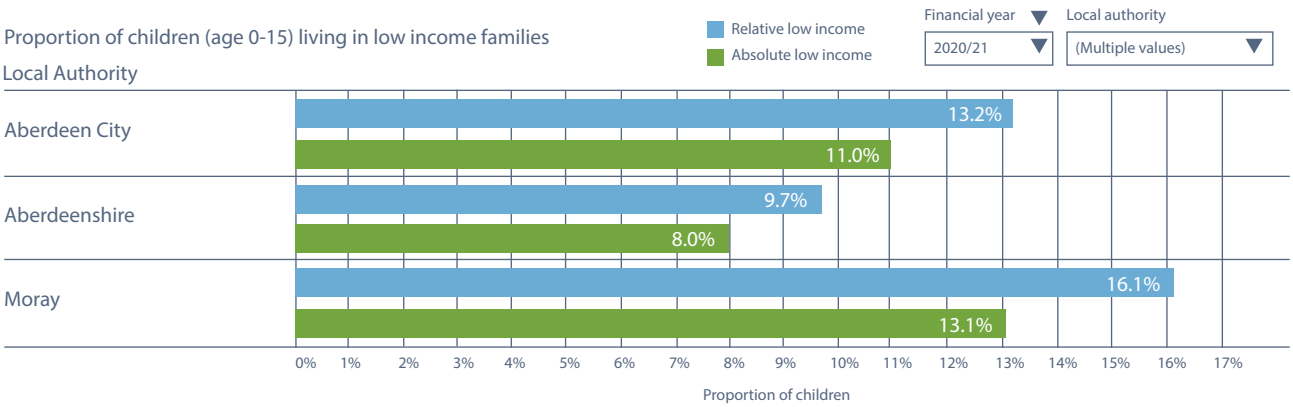
- Test community led health approaches including liberated methods, community paradigm approach and community appointment days.
- Work with our Health and Social Care Partnerships to strengthen leadership, knowledge and skills and confidence in community approaches within the constraints of the current financial context.
- Embed place and wellbeing network and approaches to place based working e.g. green social prescribing.

Priority 3

Strengthen our child poverty action plans and work effectively with our partners to ensure these are delivered with maximum impact.

In Grampian, 1 in 8 children are living in poverty. Department of Works and Pensions (DWP) data shows that in 2020/2021 the risk of the pandemic to escalate child poverty had been mitigated (Figure 14). Since then, the cost-of-living crisis has brought further financial strain for families. Figures 15 and 16 set out the characteristics of families considered to be most at risk of experiencing poverty and sets out the drivers to reducing child poverty.[11]

Figure 14: Proportion of children living in low-income families 2020/21 and 2019/20 by local authority area



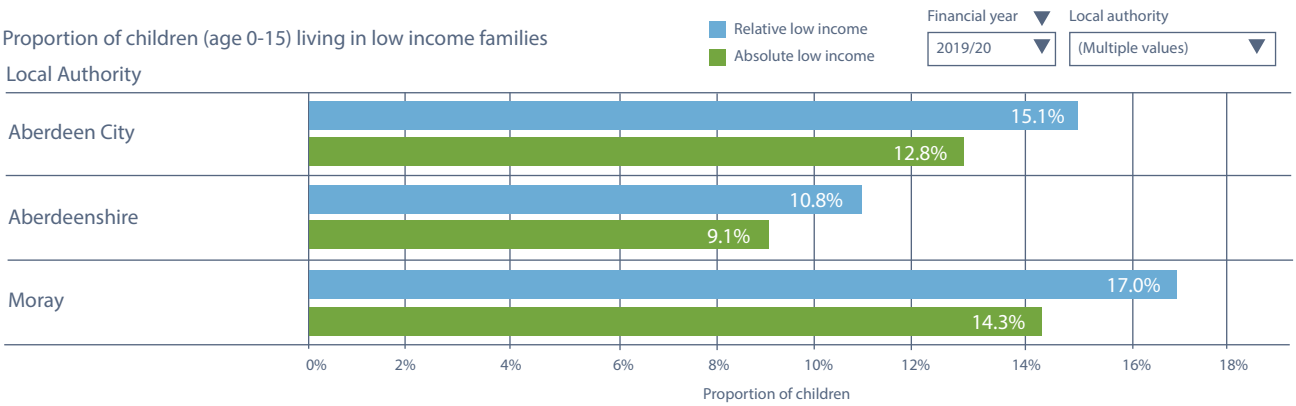
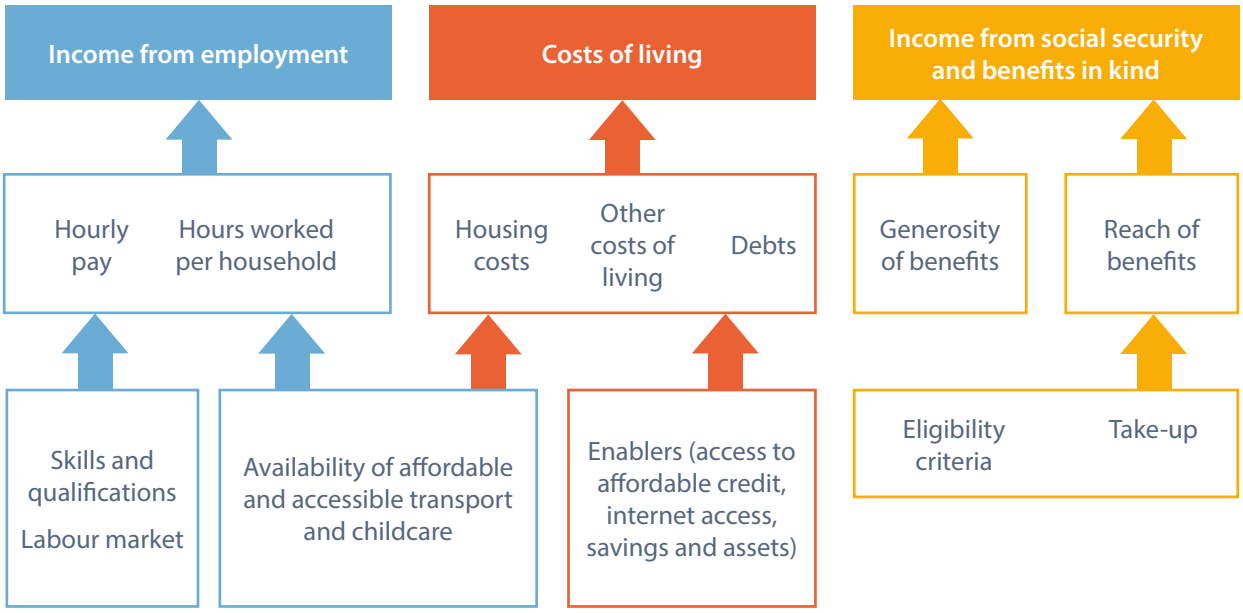


Figure 15: Priority families at high risk of experiencing poverty

Lone parents	Disabled	3+ Children	Ethnic minority	Youngest child aged <1	Mothers aged <25
36% of children in relative poverty.	30% of children in relative poverty.	30% of children in relative poverty.	37% of children in relative poverty.	32% of children in relative poverty.	44% of children in relative poverty.

Figure 16: Drivers for reducing child poverty



The Child Poverty (Scotland) Act (2017) requires NHS Boards and Local Authorities to prepare and publish a joint annual report and action plan (LCPAR) that describes the measures taken during the reporting year to contribute to meeting the child poverty targets. In Grampian, these are developed collaboratively with local partners with the intention of enabling a 'step change' in action to tackle child poverty.

During 2023/24 we:

- Developed and rolled out a Pan-Grampian Early Years Financial Inclusion Pathway. Midwives, health visitors and family nurses make routine financial enquiry in order to refer families that require support to maximise their income. The pathway has been expanded to include allied health professionals that work with families, and Childsmile in Aberdeen City.
- Developed an infant feeding in a crisis pathway to help ensure that mothers and families with children aged under five years who are at risk of food insecurity have access to breastfeeding support, first stage formula, nutritious food, and income maximisation support.

Over the next three years we will:

- Ensure all current and new staff are aware of how to use the financial inclusion pathways through regular promotion and updates.
- Extend the infant feeding in a crisis pathway across Grampian to include maternity services.
- Strengthen our data capture and reporting systems to support evaluation of these pathways.
- Support our colleagues to make routine enquiry and onward referral through a child poverty learning and training framework.
- Use our status as an anchor organisation to ensure that we maximise opportunities to support colleagues with children, who may be experiencing poverty.

Priority 4

Maximise prevention in our pathways of care and ensuring they are responsive and adaptable to meet individuals' needs.

The top six causes of ill-health (disease burden) in Scotland are cancer, cardiovascular disease, neurological disorders, mental health disorders, musculoskeletal diseases and substance use disorders.[12] The annual disease burden is forecast to increase by 21% between 2019 and 2043, with the same top five leading causes, but chronic respiratory diseases replace substance use disorders in sixth place.[12]

Absolute increases in disease burden are forecast to be largest for cardiovascular diseases, cancers, and neurological disorders, and relative increases for common infectious diseases, unintentional injuries; diabetes and kidney diseases; and chronic respiratory diseases. These relative increases are due to the disproportionately high impact of these causes in elderly age groups. A significant proportion of years of life lost due to ill health and premature mortality is attributable to multiple deprivation (Figure 17), and also avoidable through prevention and/or early diagnosis and treatment. There are three types of prevention, described as primary, secondary and tertiary, and these are explained in Figure 18.

Figure 17: Leading 15 causes of population health loss and extent of health loss inequalities [13]

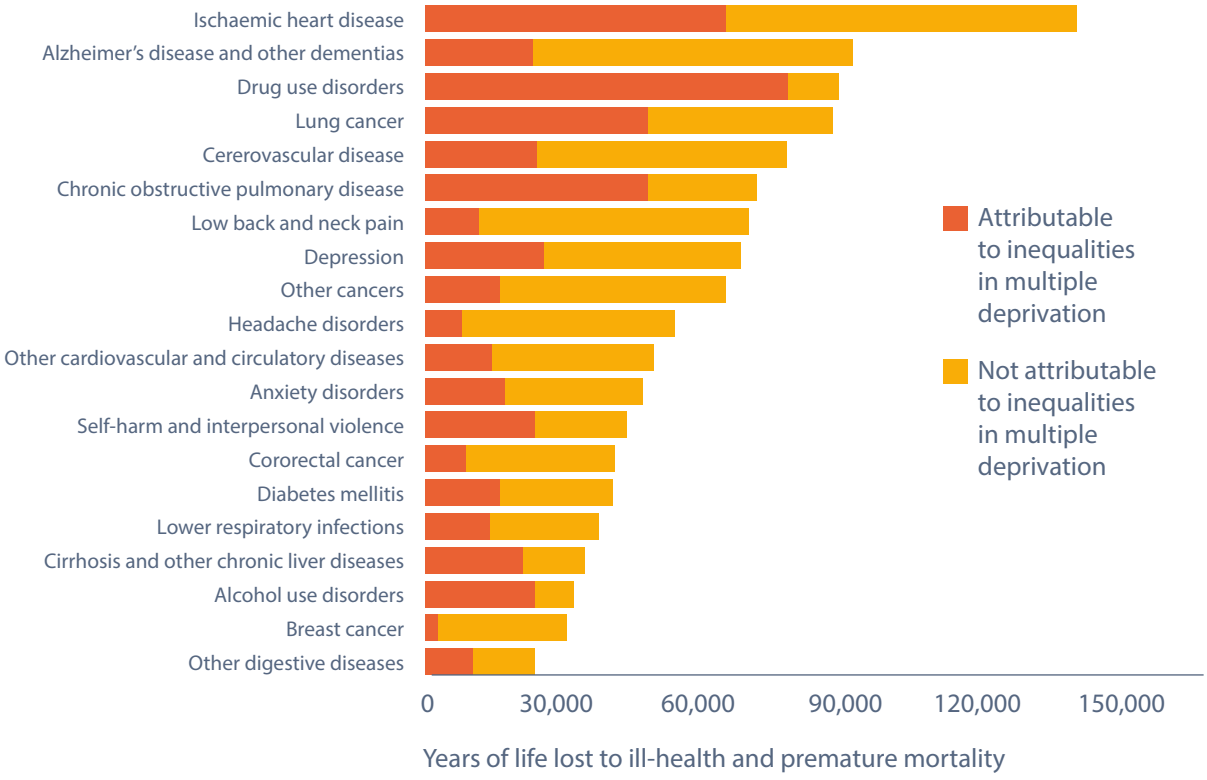


Figure 18: Three types of prevention [14]

Primary prevention: these actions try to stop problems happening in the first place, through actions at a population level that reduce risks. There are three pillars of primary preventions:

- Ensuring everyone has access to the building blocks of health by addressing the upstream drivers (e.g. addressing the inequalities in income, wealth and power that certain communities experience).
- National government fiscal and legislative policies that minimise exposure to cheap unhealthy food, alcohol and tobacco.
- Prevention of infectious diseases (e.g. vaccination and needle exchange programmes) and environmental risks through the work of health protection and environmental health teams).

Secondary prevention: these actions focus on early detection of a problem to support early intervention and treatment or to reduce the level of harm (e.g. population based cancer screening programmes, prescribing statins to reduce cholesterol, early years health visitor checks and human immunodeficiency virus (HIV) testing services).

Tertiary prevention: these actions attempt to minimise the negative consequences (harm) of a problem through careful management (e.g. dietician input and foot care for those living with diabetes, rehabilitation support for those who experienced a stroke, addressing the emotional, social and economic needs of those with a long-term condition or cancer diagnosis through wrap-around support for income maximisation, counselling and peer support).

In the following sections we consider inequities in health behaviours followed by inequities in population based prevention programmes such as vaccination and screening.

Enabling good health:

Unhealthy behaviours such as smoking, alcohol consumption, diet and physical activity can impact on the risk of developing different preventable illnesses, including some cancers and lung, liver and heart disease. In Grampian, rates of cigarette smoking, alcohol related hospital admissions and deaths due to substance misuse continue to be much higher in areas with the highest compared to the lowest levels of social deprivation as shown in the following graphs (Figures 19, 20 ,21).[5]

Figure 19: Smoking during pregnancy in Grampian

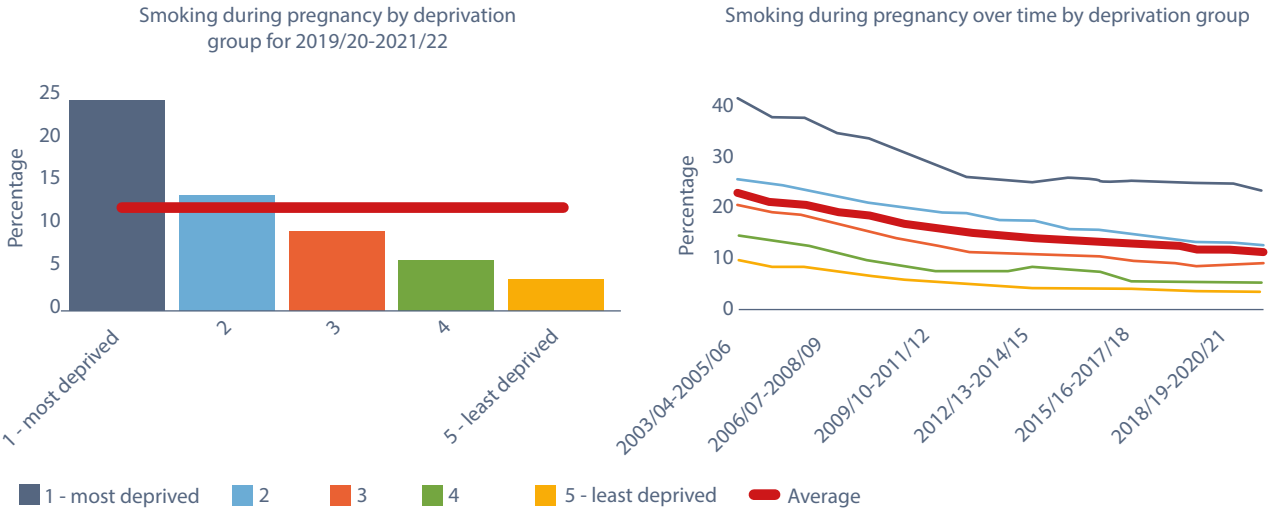


Figure 20: Drug related deaths per 100,000 per annum 2013-2022

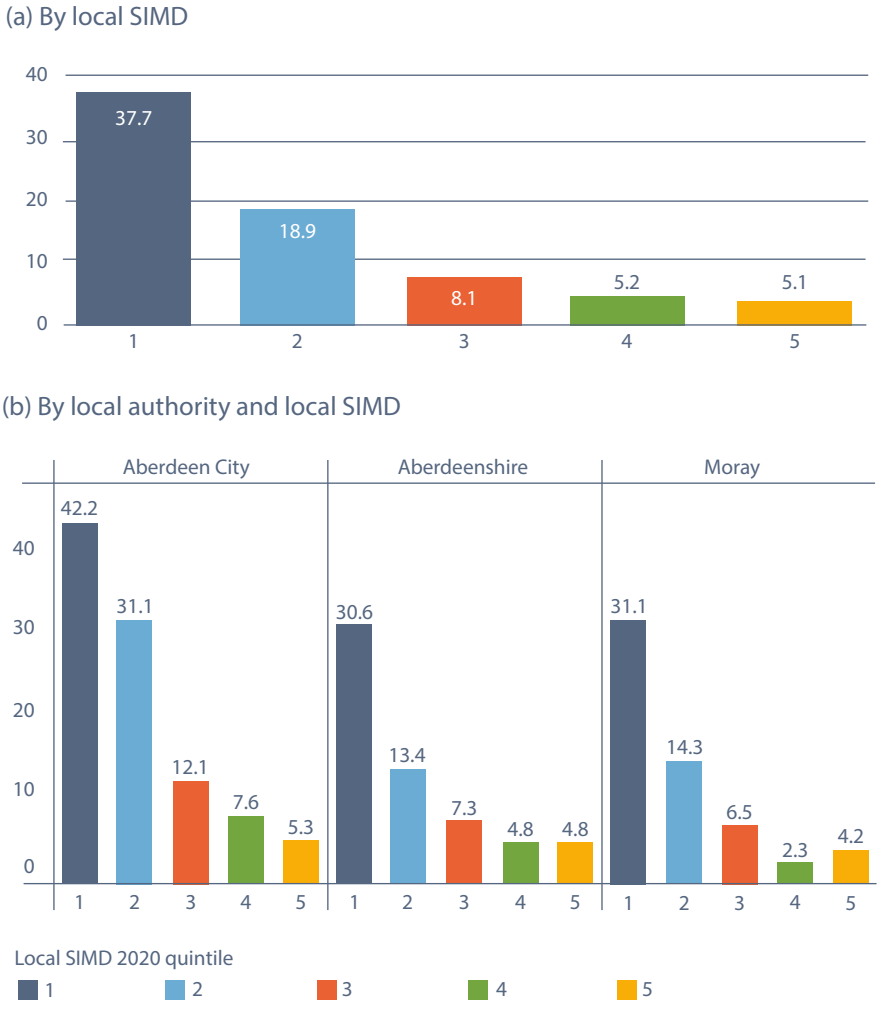
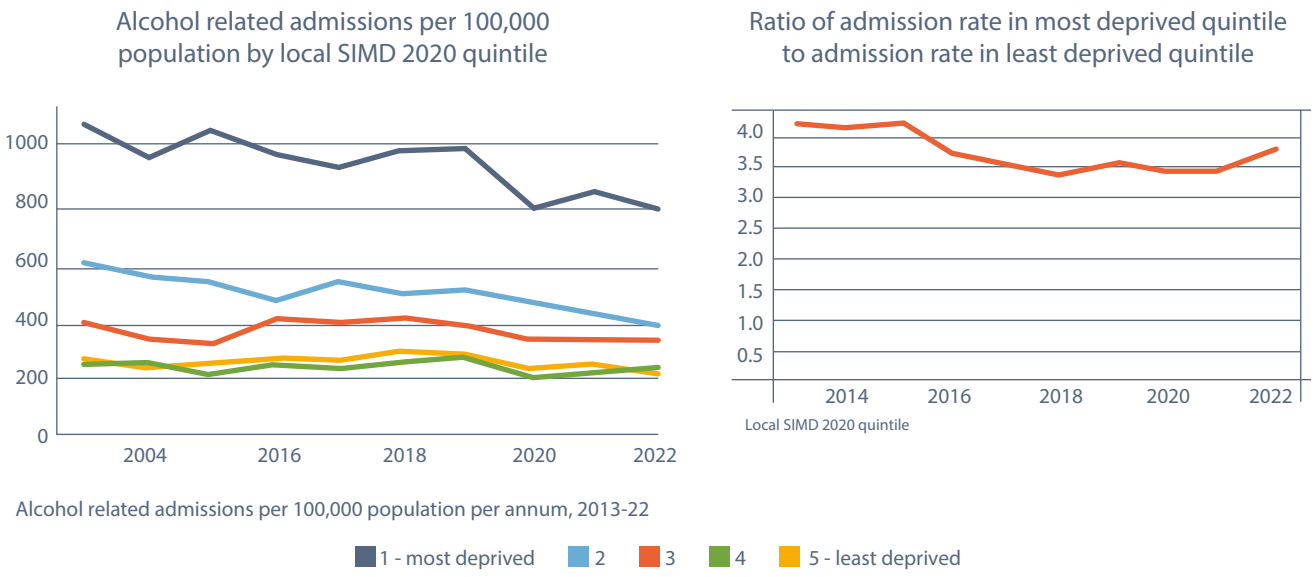


Figure 21: Alcohol related hospital admissions in Grampian



During 2023/24 we:

- Refreshed our Grampian Tobacco Strategy.
- Developed a whole system approach for tackling obesity in Grampian.
- Implemented a waiting well service to support patients on waiting lists for planned care to improve their health and provide wrap-around support e.g. income maximisation and mental wellbeing.
- Completed an oral health needs assessment for children and young people.

Over the next three years we will:

- Implement our action plan for reducing the prevalence of smoking in Grampian, with a focus on reducing inequities in smoking prevalence.
- Progress our plans to implement a whole system approach to tackling obesity.
- Embed primary, secondary and tertiary prevention into our clinical pathways (e.g. using approaches such as Making Every Opportunity Count, and alcohol brief interventions), starting with the Integrated Families and Unscheduled Care Portfolios.
- Implement the recommendations from the child oral health needs assessment.

Reducing inequity in vaccination and screening programmes

Screening is the process of identifying apparently healthy people who may have an increased chance of a disease or condition. [15] The aim is to detect the early signs of a condition, to enable earlier treatment and improve health outcomes. There are significant inequities in participation across the national population screening programmes. These have persisted despite effort to address them and occur across the whole screening pathway.

Vaccination programmes are one of the most effective public health interventions as they prevent the spread of infectious diseases which can have life-threatening consequences. The primary aim of vaccination is to protect the individual who receives the vaccine. Vaccinated individuals are also less likely to be a source of infection to others. This reduces the risk of unvaccinated individuals being exposed to infection. This means that individuals who cannot be vaccinated will still benefit from the routine vaccination programme ('herd' immunity). High uptake rates are important to minimise the risk of outbreaks in the population and it is important to ensure there is equity across all population groups.

Participation in both vaccination and screening programmes has been observed to be lower in certain groups including; among minority ethnic groups and those from lower socio-economic backgrounds. Lower uptake in certain population groups increases the risk of exacerbating health inequities further through a rise in incidence in preventable infectious diseases and more advanced presentations of disease at both an individual and population level. Our data shows that uptake in Grampian is lowest among Polish communities, followed by African, African Scottish and African British communities.

Several factors influence people's decision to get vaccinated or participate in screening programmes. These range from cultural norms, beliefs, trust in the healthcare system, misinformation, and confidence in vaccines through to practical barriers to access. Often these barriers are the result of much larger systemic issues relating to broader issues of poverty and inequity. All of these factors can make access to vaccination and screening challenging, especially for vulnerable and hard-to-reach communities.

Figure 22: Cervical and Breast screening uptake rates in NHS Grampian [5]

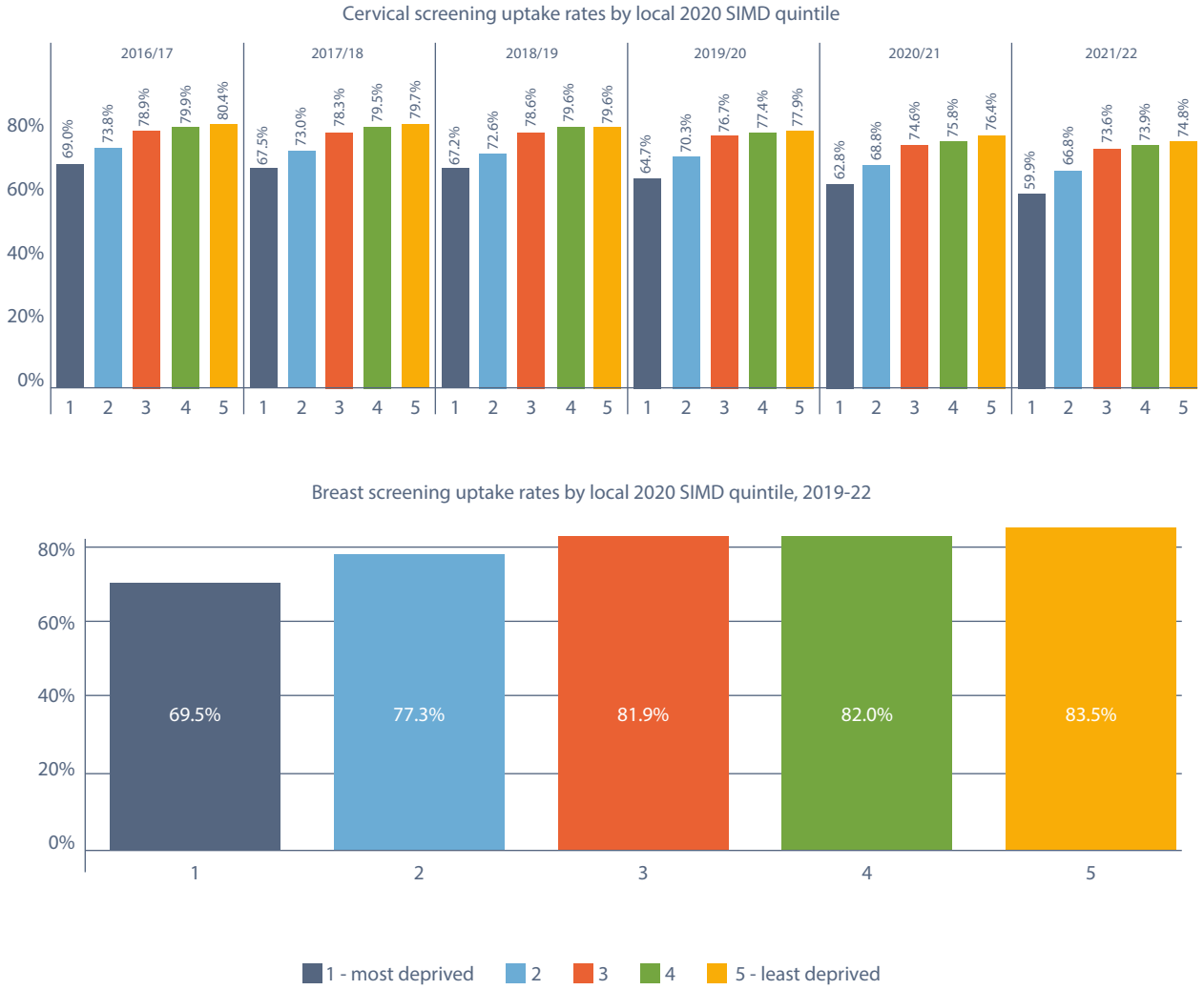


Figure 23: COVID vaccination uptake rates [5]

During 2023/24 we:

- Established the NHS Grampian Screening Equity group, with membership including academics from the Health Services Research Unit at the University of Aberdeen, Grampian Regional Equality Council (GREC) and the National Screening Programme Lead for Health Inequalities.
- Set up a vaccination and screening data programme to support our actions to reduce inequities.
- Commissioned an overview of systematic reviews to understand factors influencing uptake of cancer screening populations (cervical, bowel and breast).
- Developed a five-year screening equity plan for NHS Grampian.[16]
- Completed a needs assessment to inform our approach to reduce inequities in the uptake of childhood vaccinations.

Over the next three years, we will:

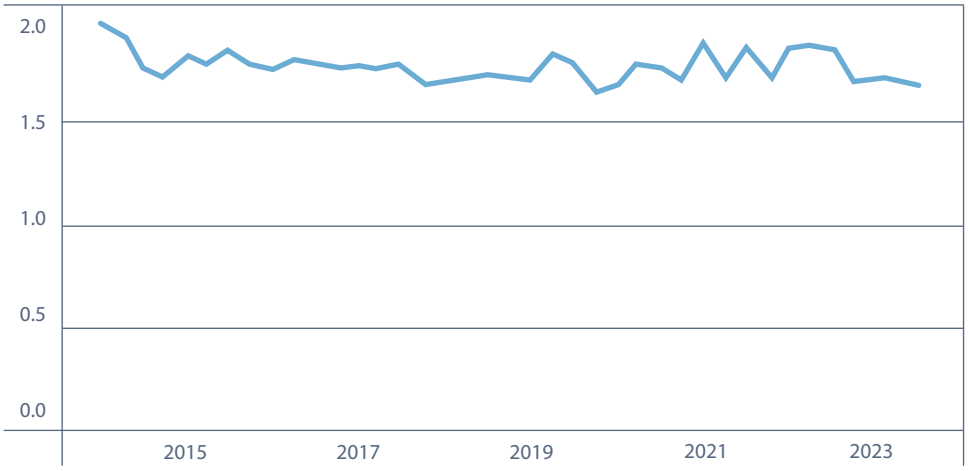
- Monitor uptake rates of vaccination and screening programmes and identify priority population cohorts that require support.
- Identify and provide training to health and care staff and people who work with communities so that they can have conversations about screening and vaccinations. Engage with Polish and Black African ethnic minority communities and those living in areas of socio-economic deprivation to understand their needs in relation to screening and vaccination programmes.
- Work with local communities, health psychologists and health behaviour scientists to produce a suite of culturally appropriate resources to support these communities to engage with and participate in screening and vaccination programmes.
- Develop a network of community champions who can continue to work with communities to increase knowledge and informed choice about participation in screening and vaccination programmes.
- Better understand the data on variation in uptake of diagnostic tests following a positive screening test by different population groups and develop plans to address this, working with the integrated and planned specialist care portfolio.

Priority 5

Understand variation and inequities in access to healthcare and health outcomes, and take action to address these.

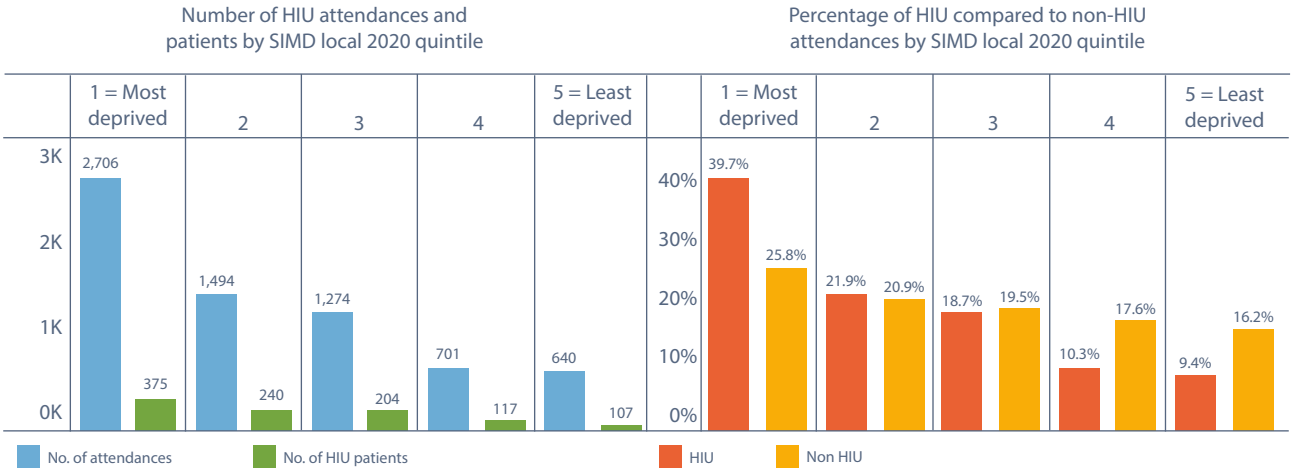
Attendance levels at Grampian's emergency departments (ED) have not yet returned to pre-COVID levels and are clearly socially patterned, with people from the most deprived areas having substantially higher usage than those from the least deprived areas (Figure 24).[5]

Figure 24 Ratio of ED attendance rate in most to least deprived local SIMD quintile



These rates vary by local authority area. For example, although emergency department attendance rates among people living in Aberdeenshire are lower compared to Aberdeen City and Moray, there has been an increase in the rate of usage by people living the most deprived areas. Our data also shows that people who live in the most deprived areas are more likely to have at least five attendances at the emergency department compared to those living in the least deprived areas (Figure 25).

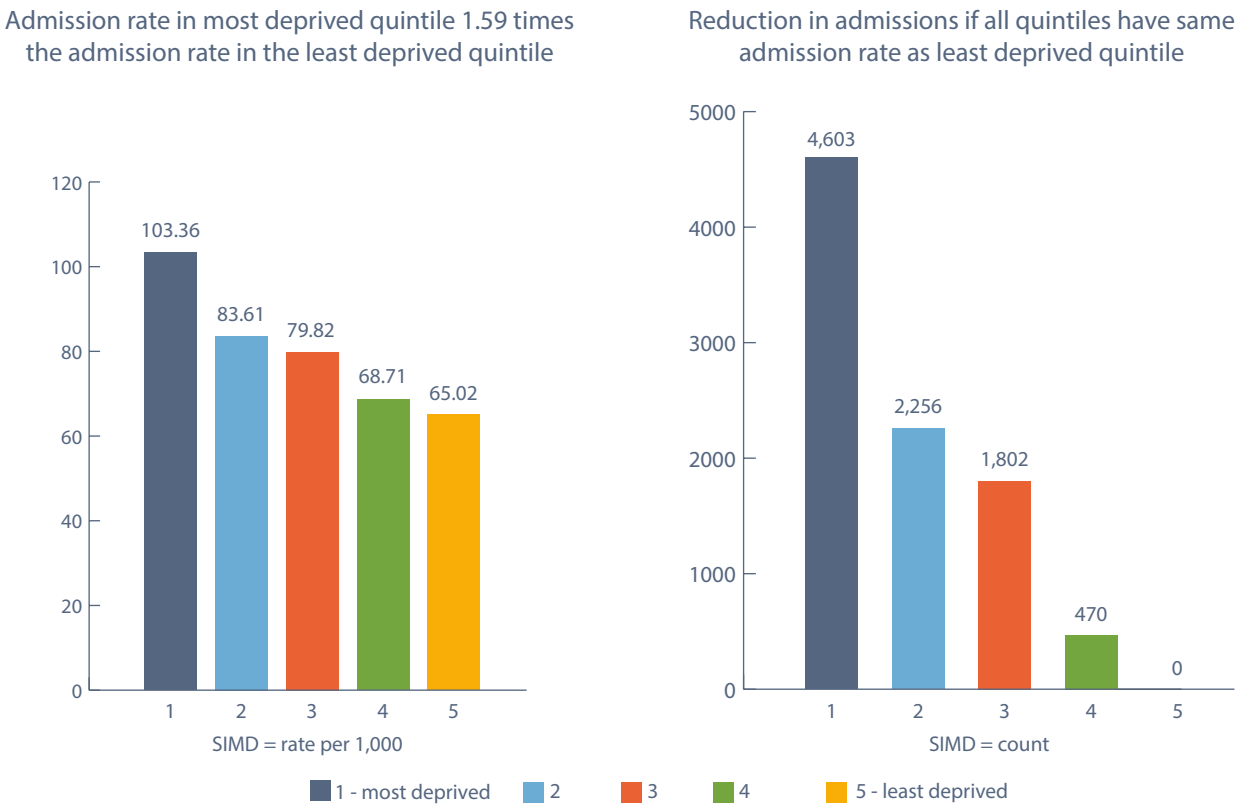
Figure 25: High intensity emergency department users year ending 31st Oct 2023 [5]



HIU = person with at least five attendances during the year

Similar patterns of variation are observed for emergency hospital admissions (Figure 26). This data highlights our need to understand how we can reduce the variation in the avoidable use of urgent support such as emergency services through better access to preventative care.

Figure 26: Emergency admission rate (per 1000 population per annum) for 2020 local SIMD quintiles and modelled reduction in admissions if admissions per SIMD could be reduced to least deprived [5]



During 2023/24 we:

Set up the data flows and systems to enable a better understanding of our data and laid the foundations for a data and evidence led approach to understanding and addressing inequities in access to our care pathways. There are a number of factors that may explain these observed differences which will require further exploration.

Over the next three years we will:

Work to better understand the underlying factors that are driving this variation and develop solutions. This will include;

- Review of the causes of admission and characteristics of our high intensity users to identify opportunities for early intervention across the health and care system.
- Explore our data to understand inequities in healthcare access and outcomes for women to support implementation of the women's health plan.
- Engaging and listening to our communities with lived experience and working with them to develop solutions that we can test.

Priority 6

Take a health inequity lens to any new pathway development/service improvement completing equity impact assessments as standard practice.

Decisions made by NHS Grampian affect people using its services, their wider family and the community. It is important that when these decisions are made, their impact on local people who experience health inequities are fully understood and considered. The Fairer Scotland Duty legally requires NHS Grampian to explicitly consider how strategic decisions can reduce inequities of outcome caused by socio-economic disadvantage. This includes decisions about budgets and investment, service redesign/transformation, commissioning and procurement.

Robust and routine use of impact assessments makes sure that appropriate attention is given to how the decisions we make about how we deliver health and care may impact on disadvantaged groups in our population. In 2023/24 work started to improve how impact assessments are used across our health system acknowledging that this is not currently understood or embedded as standard practice.

During 2023/24 we:

- Developed an integrated impact assessment process to complement existing equalities impact assessment tools.
- Completed three enhanced inequities impact assessments for NHS Grampian Delivery Plan 2023-26, NHS Grampian Tobacco Strategy 2023, NHS Grampian Non-Patient Retail Catering Review.
- Gathered insights from this process which led to an agreement by NHS Grampian's Health Inequalities Oversight Group and Population Health Committee that an integrated impact assessment should be put in place to provide a single streamlined process for NHS Grampian, integrating all the requirements of the Public Sector Equalities Duty and Fairer Scotland Duty as well as human rights, child and young people's rights and sustainability considerations.
- Completed desk research to review a range of integrated impact assessment tools being used across Scotland to inform the development of NHS Grampian's Integrated Impact Assessment (IIA).
- Produced a draft IIA.

Over the next three years we will:

- Test the Integrated Impact Assessment, modifying as required and adopting across NHS Grampian to support strategic decision-making across the organisation.
- Develop resources to support the use of the IIA, including guidance for managers, planners and policy officers and a compendium of in/equalities data for Grampian that can be generically accessed to support impact assessment.
- Refresh of training and awareness provided to more fully reflect an integrated approach.
- Develop and adopt quality assurance measures to assess the extent to which the IIA process is used as standard practice.

Enabling actions:

Engagement - Work collectively to engage with colleagues and citizens and ensure the voice of the lived experience is heard.

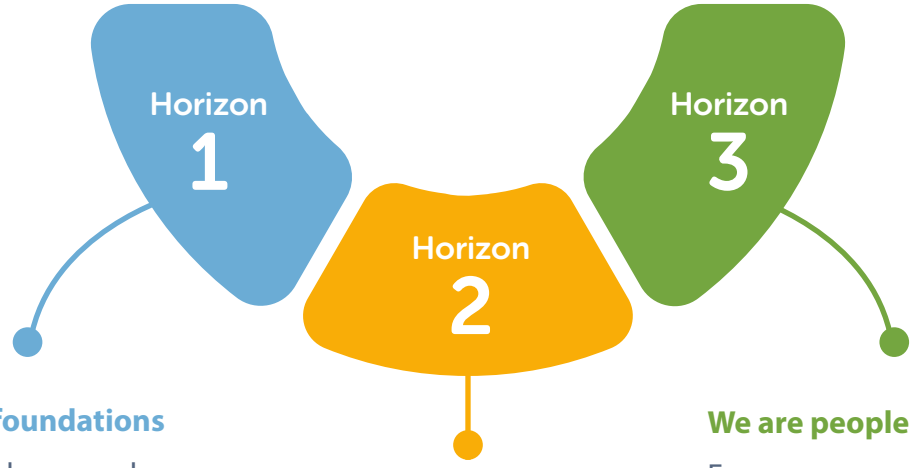
Engagement and empowerment are key strands of NHS Grampian's Plan for the Future and work is underway to create a strategic vision for citizen and colleague engagement. This has been informed by tests of change including work in New Pitsligo, Aberdeenshire, supported by the Kings Fund, to test the community paradigm model. Learning from this highlighted a different relationship with communities more on an equal foot and this approach highlighted how it can be the catalyst to re-define local issues and enable existing assets and individuals to be part of solutions for improvement.

This requires us to nurture relationships between our citizens and our colleagues and use the wealth of experience and talent within our staff and the wider community to improve services and to create a sustainable health and care system with a greater focus on wellness.

We want to create meaningful partnerships with people, in which everyone knows what is expected of them, and where everyone has the opportunity to be meaningful contributors to and not just consumers of local health care services.

A shift towards people first (Figure 27), with people contributing to and not just passively consuming health care services will over time improve the health of the population, increase self-management and help achieve our ambition for health equity in Grampian.

Figure 27: NHS Grampian Strategic Plan for Citizen and Colleague Engagement



Setting the foundations

Build a shared approach which has senior leadership support.

Increase tools and support for staff to engage with the public locally.

Develop a movement of people to share good practice and spread the approach.

Use existing expertise to develop Community Appointment Day approaches.

Use existing expertise to test Rapid Cycle Feedback loops.

Develop the infrastructure so we can more easily identify gaps/collaboration opportunities for engaging across the system.

Putting people first

Create a movement - building culture, competency and capacity.

More services doing regular engagement with the public.

More third sector involved in development and delivery of care pathways.

More care delivered in community settings, wrapped around people.

Frontline staff more involved in improving care and innovating.

Clear infrastructure which connects the work across Grampian.

Improved staff and public satisfaction.

We are people first

Everyone can contribute to shaping services and to the health of the population.

All care pathways have third sector and community involvement.

More people are able to self-manage and take an active role in their health and wellbeing.

Highly motivated workforce who have autonomy to innovate to improve outcomes.

We have reduced health inequities and improved health outcomes in our communities.

Years 1-2 | Years 2-6 | By 2032

During 2023/24 we:

- Established an Engagement and Empowerment Oversight Group bringing together engagement leads across Grampian to share practice, address barriers collectively and identify opportunities for collaboration.
- Developed and delivered a 1-year plan on engagement overseen by the Engagement and Empowerment Oversight Group. This included the launch of NHS Grampian's anti-racism plan and roadshow and the development of a volunteer policy.
- Developed our relationship with academic partners through learning and sharing good practice with participatory research into Tobacco use in Aberdeenshire with the University of Aberdeen, ASH Scotland and Turning Point Scotland.
- Mapped the skill profile of staff in community-led health approaches and developed a plan to identify gaps and delivered training on Community-led Health approaches with Scottish Community Development Centre (SCDC), as well as a Policy Briefing session.
- Began creating a depository of good engagement practice examples from across Grampian using improved VOiCE digital software and delivered training for VOiCE to GEN partners to encourage its use.
- Began developing a 'Community of Practice'/'Engagement Champions' by formalising the Grampian Engagement Network (GEN) and holding quarterly information and learning sessions.

Over the next three years we will:

- Develop our strategic intent for citizen and colleague engagement, building on the evidence base and what is already happening, to set out our longer-term approach to achieving a cultural shift.[17]
- Implement recommendations from our strategic approach to colleague and citizen engagement identifying opportunities within existing work programmes to test proof of concept areas in year 1.

Staff Development - Support teams across the organisation to better understand and take action to address inequities in their areas by investing in training and staff development, improving access to data and evidence reviews of what works, support for evaluation of tests of change and develop our capabilities as a human learning system.

Health inequities are visible across our population and our health and care system. A common pattern is that people living in the most deprived areas have the poorest health and lowest health service uptake and people living in the least deprived areas have the best health and highest service uptake. Geographical differences are also evident, although these are likely to be linked to deprivation and other factors besides just physical location.

It is important that we consider health inequities, the wider determinants of health and take a value-based health and care approach when we redesign our care pathways to improve health and ensure we have an equitable and sustainable health and care system.

Our health inequities data programme is helping us to learn lessons from good practice and move towards a sustainable, integrated approach on how data (quantitative and qualitative) are used to drive progress towards our ambition for health equity in Grampian.

During 2023/24 we:

- Worked to make health inequities more visible through the analysis of our data, ensuring that our health intelligence reports now routinely include at least three or four domains of drivers of inequalities as part of the suite of information presented.
- Produced a 'gateway' to understanding the importance of health inequities in the Grampian context along with a collation of key data resources.
- Set up the Aberdeen Health Determinants Research Collaborative (AHDRC), led by Aberdeen City Council and in partnership with the University of Aberdeen and Robert Gordon University.
- Completed evidence reviews on infant food security and fuel poverty, and a policy and practice briefing on interventions to mitigate the rising cost of living.
- Built dashboards to pull together information on inequities from the health system.

Over the next three years we will:

- Continue to build the suite of reports describing health inequities in our population health and health and care system.
- Work with the AHDRC and our local authority partners to develop an atlas of health determinants describing our populations health in more detail and build a library of lived experience, capturing the voices of our population and their experience of living with inequities.
- Work with information governance to find ways to make more visible other protected characteristics where evidence supports their important role in health outcomes.
- Increase the visibility of drivers of health inequities beyond socio-economic and find ways to consider the cumulative impact of multiple inequities.
- Deliver a programme of deep dives into data to support action and use a realistic medicine and value-based health and care lens to explore and address health inequities.

Leadership - Provide leadership to ensure we resource and deliver services at a scale and intensity that is proportionate to the degree of need and advocate for equitable health in board committees and wider networks.

Our aim is to reduce inequity in healthy life expectancy. This requires strong leadership for implementation of this plan, changing the conversation and action from one that focuses on the role of the health service to one that includes the wider determinants of health – the social, economic and environmental conditions that create or restrict people's opportunities to lead healthy lives.

During 2023/24:

- Our Chief Executive Team have actively engaged in supporting the development of this five-year plan and are committed to supporting these priorities through the work that is being undertaken in their portfolios.
- Using the King's Fund Four Pillars of Population Health, Executive Directors and Portfolio Executive Leads have identified specific areas where they can provide leadership to support greater action to gain traction on reducing health inequities in Grampian, aligned to each of the priority areas in this plan.

Over the next three years we will:

- Provide leadership to ensure increasing health equity is seen as a priority by championing action to prevent and/or mitigate inequities and challenging decisions that may worsen inequities.
- Ensure that services are resourced and delivered at a scale and intensity that is proportionate to the degree of need so that the health needs of those who are most disadvantaged are met as we redesign and deliver services in the current challenging financial context.

Partnership - Strengthen our work with partners across Grampian, including the third sector to maximise our impact collectively.

We are fortunate to have strong partnerships across public agencies, private and third sectors and communities in the North East, with many examples of good practice and innovation to address the complexities of reducing health inequities. We are already working well together to tackle these challenges through our Community Planning Partnerships. However, with health gains stalling and health inequities widening across the North East, we recognise that greater action is required.

There is no single blueprint for a local population health approach. Learning and adapting from our experiences and that of others, leaders in the North East of Scotland are looking at how we can create a system of public health learning across and within our partnership arrangements to reverse current trends. We have called this the North East Population Health Alliance in recognition of our collective responsibility. The North East Population Health Alliance is a vehicle for collaboration on the population health agenda and currently comprises nine partners; NHS Grampian, Aberdeen City Council, Aberdeen City Health and Social Care Partnership, Aberdeenshire Council, Aberdeenshire Health and Social Care Partnership, Moray Council, Health and Social Care Moray, Scottish Fire and Rescue Service, Police Scotland and Public Health Scotland. Through this collaboration we have started to develop a learning system that explores our challenges and tests solutions together.

During 2022, we worked with Aberdeen City Council and our academic partners in the University of Aberdeen and Robert Gordon University to secure funding from the National Institute for Health and Care Research for the Aberdeen Health Determinants Research Collaborative (AHDRC). The AHDRC is positioned within Community Planning Aberdeen and will support our collective goal to increase the capacity for generating and using research to reduce health inequities (Figure 28).

Figure 28: Aberdeen Health Determinants Research Collaborative

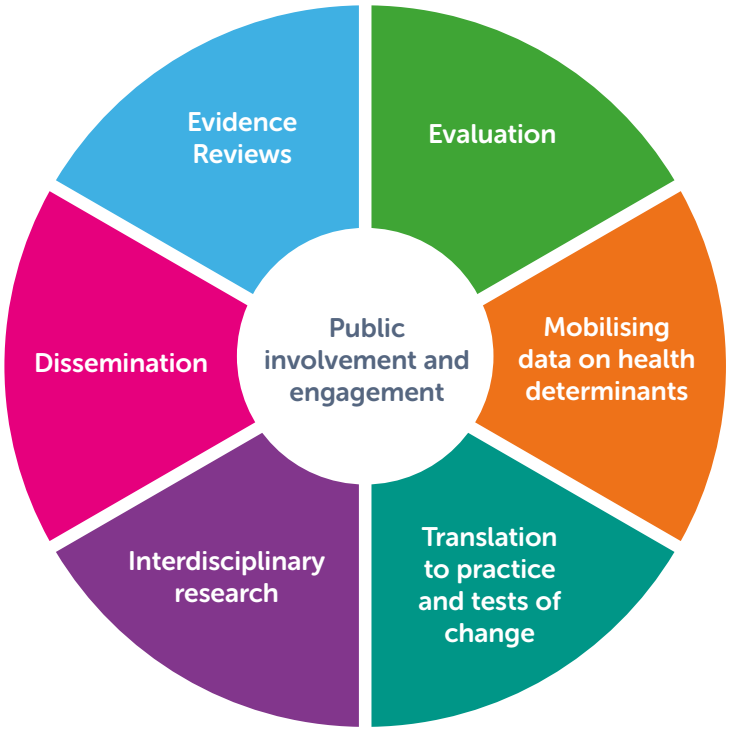
Aberdeen Health Determinants Research Collaborative

Aberdeen City Council, in partnership with NHS Grampian, University of Aberdeen and Robert Gordon University, has secured funding from the NIHR for the Aberdeen Health Determinants Research Collaborative (AHDRC).

Over the next five years, the AHDRC will facilitate a supportive and sustainable research environment, generating and translating interdisciplinary research that will support a post-pandemic recovery, a sustainable and just economic transition, reduce current and prevent future health inequalities.

Current areas of focus include

- Early years learning and childcare
- Fuel poverty
- Food insecurity
- Housing conditions
- Social prescribing
- Drug related deaths
- Place and wellbeing



ABERDEEN CITY COUNCIL · UNIVERSITY OF ABERDEEN · ROBERT GORDON UNIVERSITY ABERDEEN · NIHR | National Institute for Health Research · NHS Grampian

During 2023/24 we:

- Developed the building blocks of a Learning System – generating data together to inform and improve our practice across a number of areas including child neglect, inequalities and substance use.
- Applied the four pillars framework to substance use and identified the need and progressed work to reduce the barriers to share data, develop wrap around care and tackle stigma.
- Explored how we can use human learning systems as a paradigm to support how we learn and work together.
- Worked with our partners through the AHDRC to develop a policy and practice briefing that summarised the evidence base and highlighted areas for action to mitigate the impacts of the rising cost of living.[18]
- Worked with community planning partnerships and engaged with over 100 partners to understand what is working well, challenges and opportunities for collaboration, through the lens of our actions to address the impacts of the higher cost of living (Figures 29 and 30).

Figure 29: Positive characteristics of projects to address the higher cost of living in the North East

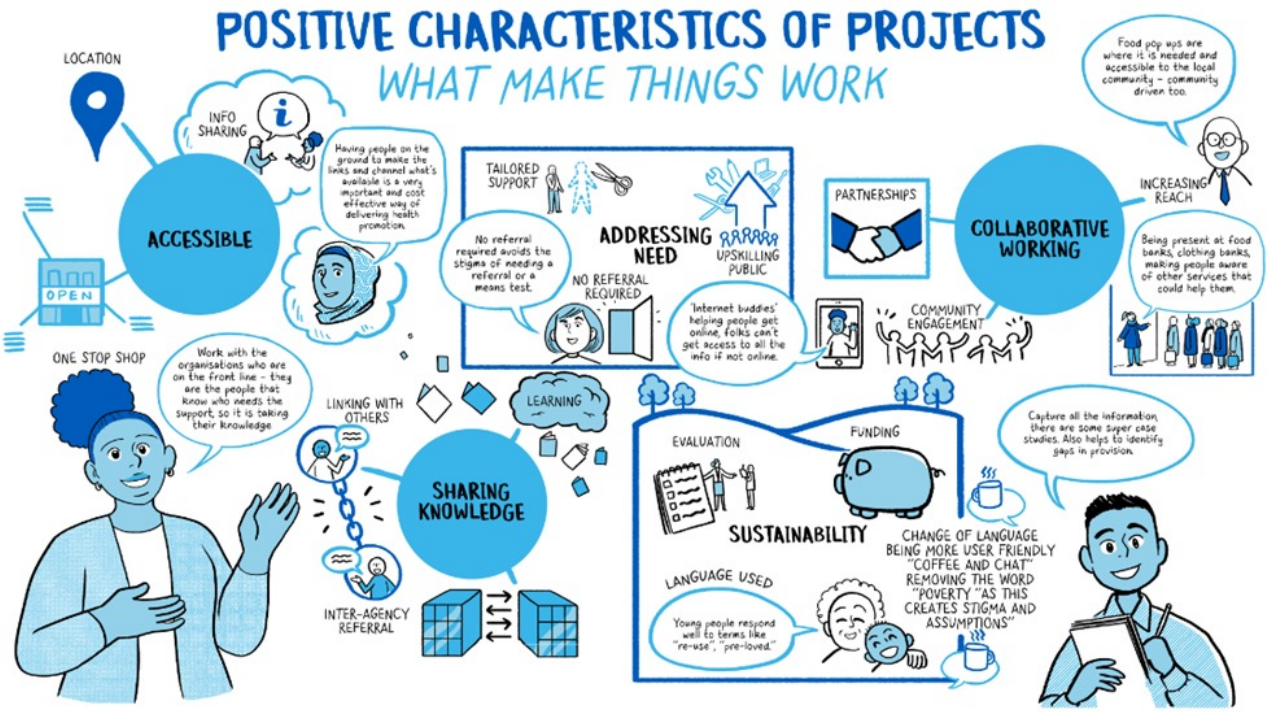


Figure 30: Barriers and challenges faced by service providers

Over the next three years we will:

Continue work with community planning partnerships and other partners, bringing our collective knowledge together with data and evidence to shape and enable more powerful collective conversations and action to achieve our vision of thriving communities living fulfilled lives. We will:

- Develop opportunities for community planning partners to come together and share good practice.
- Utilise our respective Anchor Institution collaborations to address issues such as physical space, volunteering.
- Support population health needs assessments that will enable targeted activities at local levels and support planning including the implications for access to services.
- Support evaluation of local programmes.
- Apply a human learning systems approach to substance use and child poverty.

Implementing this 5 year plan:

These priorities and enabling actions are reflected in our Three-Year Delivery Plan and further refinement and detail will be developed during the first quarter of 2024/25. We have identified a set of key performance indicators (KPIs) that will allow us to track our progress towards our ambition to achieve equity in healthy life expectancy in Grampian. Responsibility for oversight for the implementation of this plan will sit with the Population Health Portfolio Board, which will receive quarterly updates on progress. An annual report on progress will be submitted to the Population Health Committee for assurance on behalf of NHS Grampian's Board.

KPIs and indicators of success

Priority area	Action(s)	Year 1 (24/25) Key Performance Indicator(s) (KPIs)
Prevention in pathways of care.	Implement our action plan for reducing the prevalence of smoking in Grampian, with a focus on reducing inequities in smoking prevalence.	Increase smoking cessation: Number of individuals who are referred for smoking cessation therapy and % who achieve smoking quit rates at 12 weeks, presented to include gender, age, local authority area, SIMD and information on smoking cessation in pregnancy.
	Progress our plans to implement a whole system approach to tackling obesity.	Reduction of waiting management services.
	Embed primary, secondary and tertiary prevention into our clinical pathways (e.g. using approaches such as Making Every Opportunity Count (MEOC), and Alcohol Brief Interventions), starting with the Integrated Families (IFP) and Medicine and Unscheduled Care Portfolios (MUSC).	• Increase ABIs: Number of individuals who complete an ABI in Women and Children's Services. • Gap analysis and review of MEOC: Work with cohorts of staff in IFP and MUSC portfolios to ensure tools/ techniques are in place to embed MEOC into one or more clinical pathways of care.
	Monitor uptake rates of vaccination and screening programmes and identify priority population cohorts that require support.	• Uptake rates of routine vaccinations presented to include % uptake in eligible cohort(s), gender, age, local authority area and by Scottish Index of Multiple Deprivation (SIMD). • Screening programme participation rates, presented to include % uptake in eligible cohorts(s), gender, age, local authority area and SIMD.
	Identify and provide training to healthcare staff who need it so that they can have conversations about screening and vaccinations.	
	Engage with Polish and Black African ethnic minority communities and those living in areas of socio-economic deprivation to understand their needs in relation to screening and vaccination programmes.	
	Work with local communities, health psychologists and health behaviour scientists to produce a suite of culturally appropriate resources to support these communities to engage with and participate in screening and vaccination programmes.	
	Develop a network of community champions who can continue to work with communities to increase knowledge and informed choice about participation in screening and vaccination programmes.	
	Better understand the data on variation in uptake of diagnostic tests following a positive screening test by different population groups and develop plans to address this, working with the integrated and planned specialist care portfolio.	

KPIs and indicators of success

Priority area	Action(s)	Year 1 (24/25) Key Performance Indicator(s) (KPIs)
Understand variation and inequities in access to healthcare.	Review of the causes of admission and characteristics of our high intensity users to identify opportunities for early intervention across the health and care system.	Data gathered, interpreted and shared with MUSC portfolio to identify system wide actions to support individuals and reduce high usage of ED during: • Winter 24/25 (specific to winter pressures in ED). • Generally (proportionate to ongoing health and social care needs).
	Explore our data to understand inequities in healthcare access and outcomes for women to support implementation of the women's health plan.	Data gathered, interpreted and shared system wide, to be used for improving healthcare access and outcomes for women starting with: • Abortion. • Contraception (including Long Acting Methods/Pre and Postnatal)
	Engage and listen to our communities with lived experience and working with them to develop solutions that we can test.	Evidence of lived experience influencing the development of services.
Service and pathway development.	Test the use of the integrated impact assessment tool as part of NHS Grampian Financial Planning 2024/25.	Evaluation and learning captured from Integrated Impact Assessment Tool being used within the Grampian Financial process for 2024/25.
Child poverty.	Ensure all staff know about, and can use the financial inclusion pathways through regular promotion and updates to ensure that new staff are aware.	• % of staff who are aware and using the financial inclusion pathway (% of routine enquiries completed). • % of families that are referred for support.
	We will also work to extend the infant feeding in a crisis pathway across Grampian to include maternity services.	% of eligible mothers who are breastfeeding at discharge and at six months, presented to include age, local authority area and SIMD.
	We will strengthen our data capture and reporting systems to support evaluation of these pathways.	Progress the application of 'human learning systems' approach to addressing child poverty in Grampian.
Being an Anchor Organisation.	Develop a strategic framework outlining our ambitions as an anchor organisation, this will be supported through the development of a work plan underpinned by robust data, strong partnerships, and monitoring and evaluation.	See 'Anchor Plan' for KPIs.
Colleague and citizen engagement.	Clarify strategic direction for existing work programmes and identify opportunities for increasing colleague and citizen engagement and community-led approaches including; liberated methods, community paradigm approach, rapid cycle feedback loops and community appointment days.	Implementation of at least one approach recommended in strategic approach.

KPIs and indicators of success

Priority area	Action(s)	Year 1 (24/25) Key Performance Indicator(s) (KPIs)
	Map current activity in terms of: • Primary, secondary, tertiary prevention. • Inequalities and population/individual focus. • Tools available include Whole Systems Approach to Obesity.	Delivery of: • Population Health Profiles. • Joint Strategic Needs Assessments.
	Work with our Health and Social Care Partnerships to; • Strengthen leadership. • Strengthen delivery capacity. • Build confidence in community approaches.	No KPI. Work will continue through the duration of the plan.
Workforce development.	TBA	
Leadership.	TBA	
Strengthening partnership working.	Develop opportunities for community planning partners to come together and share good practice.	No KPI. Work will continue through the duration of the plan.
	Utilise respective Anchor Institution collaborations to address issues such as physical space, volunteering.	See 'Anchor Plan' for KPIs
	Provide a broader context to data sharing.	
	Public Health Directorate and Public Health Scotland to consider how to support population health needs assessments that will enable targeted activities at local levels, this would include, for example, looking at issues such as transport in rural areas and the implications for access to services.	No KPI. Work will continue through the duration of the plan.
	Public Health Directorate and Public Health Scotland to consider how to support evaluation of local programmes.	No KPI. Work will continue through the duration of the plan.

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