

**NHS GREATER GLASGOW AND CLYDE**

**Minutes of the Meeting of the  
Population Health and Wellbeing Committee  
held on 23 April 2026 at 2.00 pm  
via MS Teams**

**PRESENT**

Mr Charles Vincent (in the Chair)

Ms Libby Cairns	Mr Jamie Kinloch BEM
Cllr Jacqueline Cameron	Cllr Colette McDiarmid
Dr John O'Dowd	Ms Ketki Miles
Ms Dianne Foy	Dr Lesley Thomson KC
Mr David Gould	Ms Karen Turner

**IN ATTENDANCE**

Ms Anna Baxendale	Head of Health Improvement
Mr Bryan Forbes	Operations Manager Clinical Public Health
Ms Katrina Heenan	Chief Risk Officer
Mr Julian Heng	Planning and Development Manager
Mr Neil Irwin	Service Lead, Public Health
Ms Heather Jarvie	Public Health Programme Manager
Dr Iain Kennedy	Acting Lead Clinician for Health Protection (from 2.40pm)
Ms Fiona Moss	Head of Health Improvement & Inequality, Glasgow City HSCP
Ms Jillian Neilson	Corporate Services Manager/Board Secretary
Ms Marion O'Neill	General Manager, Public Health
Mr Derrick Pearce	Chief Officer, East Dunbartonshire HSCP
Dr Alison Potts	Consultant in Public Health/Screening Coordinator

			<b>Action By</b>
<b>17.</b>	<b>Introductory Remarks, Welcome and Apologies</b>		
	The Committee Chair, Mr Charles Vincent, welcomed those present to the April 2026 meeting of the Population Health and Wellbeing Committee. Apologies for absence were noted on behalf of Professor Jann Gardner and Councillor Robert Moran.		

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	<p>The Chair welcomed Dr John O'Dowd to his first meeting as Interim Director of Public Health.</p> <p>The Committee noted that Dr Iain Kennedy was joining the meeting slightly later, therefore items 6-8 would be taken later in the agenda.</p> <p><b><u>NOTED</u></b></p>		
<b>18.</b>	<b>Declarations(s) of Interest(s)</b>		
	<p>The Chair invited members to declare any interests in any of the matters being discussed. There were no declarations made.</p> <p><b><u>NOTED</u></b></p>		
<b>19.</b>	<b>Minute of Previous Meeting held on 22 January 2026</b>		
	<p>The Board considered the minute of Population Health and Wellbeing Committee held on 22 January 2026 [Paper PHWBC(M)26/01] presented for approval.</p> <p>On the motion of Mr David Gould and seconded by Ms Dianne Foy, the Committee were content to accept the minutes of the meeting as a complete and accurate record.</p> <p><b><u>APPROVED</u></b></p>		
<b>20.</b>	<b>Matters Arising</b>		
	<p><b>a) Rolling Action List</b></p> <p>The Committee considered the Rolling Action List [Paper 26/10] presented for approval.</p> <p>There were 3 items proposed for closure and one item would remain ongoing in relation to the inventory of statutory requirements.</p> <p>The Committee were content to approve the Rolling Action List.</p> <p><b><u>APPROVED</u></b></p>		

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<b>21.</b>	<b>Urgent Items of Business</b>		
	<p>The Chair invited members to raise any urgent items of business. There were no issues raised.</p> <p><b>NOTED</b></p>		
<b>22.</b>	<b>Epidemiology Update</b>		
	<p>Dr Iain Kennedy, Consultant in Public Health, provided a short presentation on meningococcal disease.</p> <p>It was noted that meningitis referred to inflammation of the lining of the brain and could arise from a range of causes. It most commonly presented as meningitis or septicaemia and Public Health Scotland data showed that incidence remained highest among children under five years of age, although the reasons why infection became invasive were not fully understood. It was also noted that whole genome sequencing had significantly changed understanding of the disease. Recent data indicated higher rates in 2020, 2021 and 2022. No significant difference in incidence by gender was identified.</p> <p>The presentation also considered the impact of vaccination policy and how the introduction of vaccination has altered disease patterns.</p> <p>It was noted that the vaccine may provide 30 to 40 per cent cross-protection, although evidence from other countries suggests that effectiveness may be variable. It was emphasised that vaccination policy in this area was complex. It was also noted that local and national uptake rates were changing in slightly different ways, with local performance shifting more quickly than the national picture. Further work was therefore required to understand and address the variation in uptake.</p> <p>Members discussed school attendance, noting that while this became more apparent during the COVID-19 period, it reflects a broader issue, however the pandemic may have accelerated existing trends. The Committee heard that alternative vaccination arrangements were available for children who were home-schooled or excluded from school, although these were not a complete solution. Discussion highlighted the wider significance of school attendance as a public health issue, given the role of schools in education and in delivering health improvement and prevention</p>		

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	<p>activity. Members acknowledged the need to consider the implications of reduced school attendance in future planning.</p> <p>The Committee were content to note the update.</p> <p><b>NOTED</b></p>		
<b>23.</b>	<b>Vaccination and Immunisation Performance Report</b>		
	<p>The Committee considered the Vaccination and Immunisation Performance Report introduced by Dr John O'Dowd, Interim Director of Public Health, and presented by Dr Iain Kennedy, Consultant in Public Health, for assurance.</p> <p>Dr Kennedy provided an overview of the paper, which covered the period 1 September 2025 to 28 February 2026.</p> <p>He advised that flu vaccination update had improved across six of the seven groups, with particular improvement noted among staff. It was noted that reporting was currently based on Board area residence rather than Board area work location. Members were advised that this would be the last report presented in the current format, with a new national vaccine reporting framework to serve as the template for future reports.</p> <p>It was further noted that the annual report would be presented at a later stage.</p> <p>In response to a question regarding the delivery model of vaccinations and the impact in terms of vaccine uptake, it was noted that this had been considered and could form the basis of a further piece of work. It was noted that the quarterly vaccination uptake by practice treatment centre was still received, however analysing this to work out GP practices required work and there were a range of other factors.</p> <p>In response to a question regarding data of some of the vaccinations delivered on the NHSGGC estate that were not included in the report, for example monkeypox, Hepatitis B and HPV vaccination for men who have sex with men, it was clarified that the report primarily covered routine programmes, while HPV was reported separately through the annual report that comes to this Committee. The Committee noted that this was largely because existing databases were not yet sufficiently robust to report more than once a year. A programme of improvement work is also underway nationally, and improved data recording was expected. It was agreed that a deep dive of excluded or unavailable vaccination datasets would be included in the annual report.</p>		Dr Kennedy

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	<p>It was noted that although local flu vaccination uptake had improved, national uptake had also risen and local performance remained below the national average across all categories. A question was raised on what learning could be taken. Dr Kennedy reported that the position was multifactorial and uptake was influenced by a range of factors. Work had been carried out looking at partial targeted options and routine review of the winter programme.</p> <p>In response to a question regarding the decline of uptake in care home residents, feedback suggested that withdrawal of consent or objections from next of kin were becoming more common. Discussions had therefore been taking place with primary care, general practitioners and care homes to identify ways to improve uptake, including the introduction of vaccine champion roles within each care home. A national winter programme lessons-learned report had been received and would be reviewed to identify relevant best practice that could be applied locally. The Committee noted that misinformation about immunisations and differing levels of capacity across the system were also barriers. These pressures were not consistent across all areas and may warrant further consideration, including the potential impact of care homes operated by English providers. Differences in approval arrangements were also noted, as these may affect staff and the way vaccination was considered in care home settings.</p> <p>Many of the issues identified were multifactorial and depended on ensuring that the right information reached the right people. Support from Corporate Communications should therefore be used where appropriate to strengthen this approach.</p> <p>In relation to a question regarding the HPV vaccination uptake and participation among younger people, it was noted that the data was collected on an annual basis and that data for the 2024/25 school year would be available in due course. The vaccination was offered from S1 onwards to support earlier uptake. It was also noted that the Board was no longer the best-performing Board in relation to HPV vaccination, therefore the need to improve HPV vaccination performance was acknowledged and a delivery group would take ownership of the recommended actions. Further discussion would take place when the annual report was available.</p> <p>The Committee were assured by the update.</p> <p><b>ASSURED</b></p>	

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<b>24.</b>	<b>Measles Elimination Plan</b>		
	<p>The Committee considered the Measles Elimination Plan [Paper 26/12] introduced by Dr John O'Dowd, Interim Director of Public Health. Dr O'Dowd invited Dr Iain Kennedy, to provide an update.</p> <p>Dr Kennedy presented the refreshed NHS Greater Glasgow and Clyde (NHSGGC) measles elimination plan which set out the Board's approach to reducing the risk of measles outbreaks across NHSGGC and provided assurance on governance, monitoring and ongoing improvement activity.</p> <p>The Committee were assured by the update.</p> <p><b><u>ASSURED</u></b></p>		
<b>25.</b>	<b>Scottish Vaccination and Immunisation Programme (SVIP) – Implementation and Prioritisation</b>		
	<p>The Committee considered the Scottish Vaccination and Immunisation Programme (SVIP) – Implementation and Prioritisation [Paper 26/13] introduced by Dr John O'Dowd, Interim Director of Public Health, and presented by Dr Iain Kennedy, Consultant in Public Health, for assurance.</p> <p>Dr Kennedy provided an overview of the paper, which detailed the approach to prioritising activity under the Scottish Vaccination and Immunisation Programme 5 year framework implementation plan.</p> <p>A range of structural and communication challenges associated with improving vaccination uptake were noted, noting that some wider policy and national campaign measures were outwith local control. Members heard about ongoing work in relation to public transport audit, communications activity, and the promotion of positive outcomes through targeted engagement. An update was also provided on the measles outbreak in Govanhill, where no further linked cases had been identified, alongside community engagement work in Govanhill intended to support longer-term improvement in uptake.</p> <p>Progress was reported across a number of immunisation initiatives, including staff flu vaccination and work within prison settings. The staff flu campaign has been supported by Staffside and HR colleagues, particularly through enabling staff to attend for vaccination during working time, and a staff flu fortnight was planned for this year. In prisons, a pilot immunisation programme</p>		

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	<p>achieved 70% flu vaccine uptake, with positive outcomes despite the challenging environment, and this model was now being considered in other settings, including with social care staff. Additional engagement measures included co-produced materials with people living in prison, drop-in chat sessions, work at Clydebank Health Centre, and continued support through the Vaccine Contact Centre. It was also noted that data was being used increasingly to better understand patterns of attendance and uptake.</p> <p>Members welcomed the emphasis on open conversations and highlighted the ongoing challenge of misinformation, including ongoing concerns linking vaccination and autism. It was noted that the term 'vaccine confidence' better reflected the nature of this work than 'vaccine hesitancy', and that transparent discussions with trusted healthcare professionals were key to addressing wider health misinformation. Members also explored the longer-term impact of the Govanhill outbreak on vaccine uptake, particularly within the Roma community, with reference made to evidence from previous outbreaks and the positive effect of whole-system interventions on uptake. Finally, discussion considered the risks associated with lower staff flu vaccination uptake, noting that while the direct risk to patients may be difficult to quantify, experience from COVID-19 outbreaks demonstrated the significant impact that staff absence can have on service stability.</p> <p>The Committee were assured by the update.</p> <p><b><u>ASSURED</u></b></p>		
<b>26.</b>	<b>Adult Screening Programme: Annual Report and Screening Inequalities Action Plan</b>		
	<p>The Committee considered the Adult Screening Programme: Annual Report and Screening Inequalities Action Plan [Paper 26/14] introduced by Dr John O'Dowd, Interim Director of Public Health, and presented by Dr Alison Potts, Consultant in Public Health, for assurance.</p> <p>Dr Potts provided an overview of the paper which outlined screening uptake and annual activity levels across the programmes. This included bowel screening, breast screening, cervical screening and diabetic eye screening activity. A traffic light system was used to indicate performance against the national HIS target for screening uptake. Dr Potts advised that the</p>		

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	<p>cervical screening uptake was 50.7%, which was significantly below the 80% target (with other Boards also below this target).</p> <p>There were five distinct screening programmes, each with its own activity profile and pressures. The programmes were described as well established, evidence based, government funded and embedded within healthcare delivery. Public information was available through standard channels, including NHS inform, and the programmes benefit from established quality assurance arrangements and performance monitoring against key performance indicators.</p> <p>There was a strong support network for programme delivery, and the programmes continued to make an important contribution to prevention and early detection. A commitment from government to screening was noted, including investment in breast screening modernisation. Implementation of lung cancer screening was highlighted as a further area of development. Work to improve cervical screening uptake was ongoing. Screening was also referenced within the Board's Annual Delivery Plan and a programme of work with Corporate Communications was also noted as a positive development.</p> <p>In terms of weaknesses, Dr Potts reported that the absence of current breast screening data was identified as a key limitation. Data quality issues within national databases were creating gaps in understanding of current performance. Further limitations were noted in relation to cervical screening. For diabetic eye screening, a new national patient management system had been in place for four years, however reliable data extraction remained unresolved.</p> <p>Benchmarking against other Boards and countries remained limited. National data and patient management systems were described as outdated and no longer aligned with current service requirements. The current systems do not support text or email communication and rely primarily on letters, particularly for cervical screening, with limited multilingual capability. Low uptake and persistent inequalities remained significant concerns. There was limited flexibility to change delivery models because of the way programmes were commissioned. For bowel screening, the gap in uptake between the most and least deprived groups remained above 20% and had not narrowed over time.</p> <p>There were opportunities to improve uptake and early detection through established partnership working, including closer collaboration with local partners and health improvement leads to</p>	



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	<p>raise awareness of screening in local communities. A range of evidence-based approaches to reducing inequalities was underway, including work led by a learning disability nurse, trauma-informed approaches, and use of GP-level data to target improvement activity. Forthcoming national developments include new IT systems with improved communication functionality and cervical self-sampling pilots supported by the Scottish Government and Cancer Research UK. Changes to Board processes, including virtual assessment, were also noted.</p> <p>A key threat related to the diversion of government funding previously intended to address inequalities. While some funding continued to support screening nationally, the reduction in Board-level resource limits local capacity to address inequalities and secure specialist expertise. Securing suitable local accommodation for service delivery also remained challenging. Breast screening had relied on locations such as hospital and supermarket car parks, however, some of these sites were no longer available and alternative arrangements were being explored to maintain accessibility.</p> <p>In summary, Dr Potts advised that the screening programmes were well established, however were operating within significant service and funding pressures. These pressures were affecting the ability to implement the inequalities action plan in full. Although the programmes remained strong, they were increasingly under strain and at risk from reduced funding. Progress continued to be made despite these constraints. It was recognised that, while many pilots were introduced, sustaining improvement over the longer term remained challenging.</p> <p>In response to a question regarding cervical screening pilots, the Committee noted that three cervical screening self-sampling pilots were outlined. The first was a small, targeted pilot delivered through Sandyford outreach clinics for vulnerable groups, including women experiencing homelessness and those involved in sex work. The second was a Scottish Government pilot involving four Boards and four GP practices, aimed at women who had never attended screening or had defaulted. This was expected to commence shortly and the pilot running until year end, alongside ongoing evaluation and consideration of implementation challenges, including IT systems. The third was a Cancer Research UK randomised controlled trial involving practices serving deprived urban and rural populations, including a significant number in NHSGGC, with plans to recruit 40 practices. International evidence, including experience from Australia where self-sampling had been</p>	

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	<p>incorporated into routine screening, indicated positive uptake, particularly among younger and older women, previous non-attenders, and those in rural areas.</p> <p>The Committee noted that a charity-led pilot for prostate screening had been referenced in recent media coverage. The initiative appeared to be privately funded through a charity and was not working in partnership with NHS GGC or Scottish Government cancer policy colleagues. Prostate cancer screening was considered by the National Screening Committee on an evidence-based basis and that the evidence was kept under regular review. At present, testing was not regarded as sufficiently sensitive or specific to support a population-based screening programme, nor was it considered robust enough to distinguish effectively between higher-risk and lower-risk cases.</p> <p>A point was raised regarding Non-Executive Members supporting future engagement with Public Health Scotland and strengthening the strategic case for action. Discussion focused on the need to better understand the factors contributing to lower screening uptake, including the balance between structural barriers and behavioural factors, particularly in relation to cervical screening.</p> <p>It was noted that national data systems limited opportunities for benchmarking and hindered the ability to assess comparative performance. Members welcomed the emphasis on disability and mental health and considered whether wider engagement through Public Health Scotland, including health equity work, could provide further support. The fragility of the national screening infrastructure was highlighted, alongside the potential value of a sub-national approach and the need for pragmatic decisions regarding service delivery, replacement of infrastructure, and the use of technology to support more effective and preventative models of care. Members also reflected on the importance of trust-building within communities, including anti-racism work, and acknowledged that some structural issues, such as accommodation and capital planning, continue to present local challenges. It was suggested that any significant request for support should be made at Board level. Concern was expressed regarding reduced funding at a time when cervical screening performance was declining, and it was noted that any future proposal should clearly articulate both the immediate and longer-term benefits, particularly in relation to prevention and a spend-to-save approach.</p> <p>The Committee were assured by the update provided.</p> <p><b>ASSURED</b></p>		

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<b>27.</b>	<b>A Fairer NHS GGC – Monitoring Report 2025-26</b>	
	<p>The Committee considered A Fairer NHS GGC – Monitoring Report 2025-26 [Paper 26/15] presented by Mr Julian Heng, Planning and Development Manager, for awareness.</p> <p>The Chair advised that, following changes to the Terms of Reference, the report now fell within the remit of the People and Staff Governance Committee, although certain elements would remain within the remit of this Committee. The Committee was therefore asked to note the report, with full endorsement to be provided by the People and Staff Governance Committee.</p> <p>Mr Heng provided an update on the first year of the Strategy. He advised that equality had been embedded within the quality Strategy to ensure coherence. Actions taken included strengthening inclusive communication and progressing this work at scale. New complaints pathways had also been developed to make it easier for BSL users to raise concerns. The team had progressed frontline equality assessment to support more practical application at service and Board level and to ensure staff feel supported.</p> <p>The team participated in targeted vaccination and community-based work, including responding to measles cases in the Govanhill area through appropriate community engagement. Equality-led engagement had also informed service design, particularly for disabled people and other groups who may be underserved or less likely to access services. The Fairer Scotland Duty was embedded within this work. Equality requirements had been maintained across procurement and contracting practice.</p> <p>More than 20 assessments were completed during the reporting cycle across a wide range of acute Board areas, with a focus on ensuring services were equipped to respond appropriately to autistic and neurodivergent people, including through identification of reasonable adjustments.</p> <p>In relation to EQIAs, 11 were completed during the reporting cycle across a wide range of areas, including the primary care workforce review and the GGC workforce strategy. Three specific outcomes were identified as reasonable and proportionate.</p> <p>Mr Heng provided an update on Specific Equality Outcomes including delivery of the NHS GGC Anti-Racism Plan across patient pathways and the workforce.</p>	

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	<p>Year 1 activity had focused on neurodivergence, with further co-production planned. This would support a more informed approach to the design of acute services. Practical tools had been developed to support ward staff and improve equality intelligence through the process. Work was underway to support appropriate access to the full range of urgent care services. EQIAs have been undertaken in partnership with the Person-Centred Care Team and the PEPI Team to strengthen patient engagement and apply an equality lens to this work.</p> <p>Work had been undertaken to publish the minority health and wellbeing survey, which captured feedback from 2,600 participants to help ensure meaningful benefit.</p> <p>Mr Heng reported that systems were required to support continued engagement. Engagement with the PEPI Team and Corporate Communications was intended to ensure that no community groups were overlooked. This included work undertaken in partnership with Roma Traveller communities. This would help ensure system readiness to respond to evolving legal and regulatory requirements. There was an evolving piece of work in relation to the BSL Act to comply with the UNRC, however the organisation was in a good position.</p> <p>Mr Heng clarified the distinction between neurodiversity and neurodivergence as referenced in the paper. He noted that neurodiversity related to the full breadth of human cognitive experience, whereas neurodivergence refers more specifically to individuals with a diagnosis who may experience particular challenges and identifiable barriers in accessing services. He further advised that, where such barriers were recognised, mitigating actions should be considered to address them. This would inform the equality assessment work being undertaken with the Acute Adult Steering Group to better understand the barriers that neurodivergent individuals may encounter throughout their journey through services.</p> <p>It was noted that the format of the report would be considered for the next update.</p> <p>Dr O'Dowd advised that a meeting involving the Scottish Government and Public Health Scotland was expected to take place next week in advance of the publication of the UK national drug death statistics. A sustained rise in drug deaths was acknowledged. It was noted that this did not appear to be a short-term spike, and that further information and advice from Public Health Scotland was expected shortly. There was no indication that</p>	

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	<p>prevention activity had suddenly worsened, however, emerging evidence suggested increased use of synthetic agents in Scotland. It was noted that this may require a more intensive approach to harm reduction and prevention, including outreach activity and broader engagement across relevant sectors, including safer drug consumption and addiction services. Particular concern was noted in relation to people liberated from prison and those on remand, given the challenges in tracking and registering individuals in order to reduce risk. It was agreed that the Committee would receive an out-of-sequence update should further information emerge and consideration would be given on whether this would be escalated to the full Board, given the priority attached to drug deaths. Consideration would also be given to whether a more detailed discussion should be scheduled for the next meeting.</p> <p>The Committee were content to note the update.</p> <p><b>NOTED</b></p>		
<b>28.</b>	<b>Public Health Strategy 2018-2028: Turning the Tide through Prevention Annual Update</b>		
	<p>The Committee considered the Public Health Strategy 2018-2028: Turning the Tide through Prevention Annual Update [Paper 26/16] presented by Dr John O'Dowd, Interim Director of Public Health, for assurance.</p> <p>In year 8 of the 10-year strategy, the report reflected a period of transition and ongoing strategic development. It highlighted the importance of understanding population needs, including updated population references and ethnic wellbeing survey work, alongside continued engagement with communities and key partners. Dr O'Dowd highlighted two specific areas of work: hospital-based health improvement services, which provided visible and valued support on hospital sites, and patient information services, which remained a priority in supporting informed choice through accessible language and dedicated support. Across this work, there was a continued emphasis on addressing inequalities, although demonstrating measurable impact remained challenging.</p> <p>In response to a question regarding Public Health information services and how information was distributed, the Committee noted that there were Public Health dissemination points, for example Health Visitors, District Nurses and GP's.</p>		

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	The Committee were assured by the update.		
	<b><u>ASSURED</u></b>		
<b>29.</b>	<b>Population Health Framework</b>		
	<p>The Committee considered the Population Health Framework update by Dr John O'Dowd, Interim Director of Public Health, for assurance.</p> <p>Dr O'Dowd and Ms O'Neill provided an overview of work that was underway. It was noted that, while there remained limited clarity regarding the public health framework, there was increasing understanding of how the various elements aligned. The presentation outlined a matrix structure based on a set of principles, six developmental areas, and four maturity levels. These were described in terms of emerging and developing practice, with particular reference to governance and accountability, systematic engagement, and the proposed maturity assessment.</p> <p>Discussion highlighted the need for prioritisation in implementing the approach, including consideration of how the framework would be used for self-assessment and the implications for planning colleagues, where related discussions were already under way. Members also considered how progress would be measured, how the work would be funded, and the wider complexity associated with balancing immediate pressures against longer-term priorities. The challenge of funding and prioritisation was noted, particularly the need to balance investment in future priorities with present demands. The difficulty of addressing current and future bias was acknowledged and the importance of ensuring that decisions were informed by clear values and appropriate safeguards was noted.</p> <p>The audit team would undertake the scoring process in a number of areas. A further update would be provided in due course, noting that further discussion would be required to agree scoring and reach a final conclusion.</p> <p>The Committee were assured by the update provided.</p> <p><b><u>ASSURED</u></b></p>		

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<b>30.</b>	<b>Quarter 3 Public Health Assurance Information Progress Report</b>		
	<p>The Committee considered the Quarter 3 Public Health Assurance Information Progress Report [Paper 26/17] presented by Ms Marion O'Neill, General Manager, Public Health, for assurance.</p> <p>Ms O'Neill provided an update on quarterly progress against the key priorities as outlined in the Public Health Assurance Information Framework. She highlighted that the Adult Weight Management Services continued to show improvement and reported that child development programmes, which had previously experienced difficulties, were now in a more positive position. She noted areas that required further improvement was Blood-Borne Virus (BBV) testing and smoking, however a robust improvement plan was in place for the smoking target and the launch of emergency opt-out testing had demonstrated positive uptake for BBV testing.</p> <p>The Committee were assured by the update provided.</p> <p><b><u>ASSURED</u></b></p>		
<b>31.</b>	<b>Local Child Poverty Action Report – East Dunbartonshire</b>		
	<p>The Committee considered the Local Child Poverty Action Report – East Dunbartonshire [Paper 26/18] presented by Ms Anna Baxendale, Head of Health Improvement, for approval.</p> <p>Ms Baxendale presented the 2025/26 Local Child Poverty Action Report (LCPAR) from East Dunbartonshire. This report supplemented the previous Child Poverty Action Plan reports presented in October 2025 and January 2026.</p> <p>The report highlighted persistent rates of child poverty, with significant variation across GGC local authorities and summarised thematic actions to address child poverty including; income maximisation, support for priority groups, and partnership working.</p> <p>It was asked whether there was a clear understanding of the number of children living in poverty who were not being reached and how this intelligence might be used to inform action. The Committee noted that the Public Health Scotland dashboard was a source of data. It was noted that, although data was available</p>		

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	<p>across the three national agencies, there was scope to make better and more targeted use of this intelligence to identify and support the most vulnerable families.</p> <p>The Committee were content to approve the report.</p> <p><b><u>APPROVED</u></b></p>		
<b>32.</b>	<b>Committee Governance</b>		
	<p>The Committee considered the Committee Governance [Paper 26/19] presented by Ms Jillian Neilson, for approval.</p> <p>The Committee were asked to approve the report as part of the annual governance review. A proposed amendment to the Terms of Reference was noted, specifically the removal of a reference to the People Committee. It was agreed that the document would be updated and re-circulated, including the transfer of the Equalities Reporting Duty to another Committee.</p> <p>Subject to circulation and minor amendments, the Committee were content to approve the Terms of Reference, Draft Annual Report and the Annual Cycle of Business.</p> <p><b><u>APPROVED</u></b></p>		Ms Neilson
<b>33.</b>	<b>Corporate Risk Register Extract</b>		
	<p>The Committee considered the Corporate Risk Register Extract [Paper 26/20] presented by Ms Katrina Heenan, Chief Risk Officer, for approval.</p> <p>Ms Heenan presented the Corporate Risk Register for March 2026. A new template had been used, and the risk section now included scoring against the revised matrix. Ms Heenan welcomed feedback on the new format.</p> <p>Ms Heenan said that 100% of risks had been updated by the relevant risk owners. The paper also noted that a new corporate protocol was in development. Risk owners had provided assurance that actions could be completed; however, the actions table identified some items as pending, subject to approval of the protocol.</p> <p>Across the two risks, there are six actions in total, comprising two completed actions, one with a revised completion date, one</p>		



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	<p>overdue action, one newly opened action, and two new actions. Full details were included in the paper.</p> <p>The Committee were content to approve the Corporate Risk Register.</p> <p><b><u>APPROVED</u></b></p>		
<b>34.</b>	<b>Closing Remarks and Key Messages for the Board</b>		
	<p>Mr Vincent thanked members for attending and closed the meeting.</p> <p><b><u>NOTED</u></b></p>		
<b>35.</b>	<b>Date of Next Meeting</b>		
	<p>The next meeting would be held on Thursday 18 June 2026 at 2.00 pm hybrid via MS Teams and in the Board Room, JB Russell House</p>		