

NHS Greater Glasgow and Clyde	Paper No. 26/143
Meeting:	NHSGGC Board Meeting
Meeting Date:	29 October 2026
Title:	Population Health Organisation (PHO) Maturity Matrix
Sponsoring Director/Manager	Dr John O'Dowd, Interim Director of Public Health
Report Author:	Marion O'Neill, General Manager Public Health

1. Purpose

The purpose of the attached paper is to:

To present the NHS Greater Glasgow and Clyde (NHSGGC) Population Health Organisation Maturity Matrix self-assessment and improvement priorities ahead of submission to the Scottish Government in December 2026 and to seek NHS Greater Glasgow and Clyde Board (NHSGGC) validation of the assessment and agree the next steps required to develop a credible organisation-wide improvement plan.

2. Executive Summary

The paper can be summarised as follows:

- Engagement to date supports the broad direction of the draft self-assessment and places NHSGGC at Level 1 (Emerging).
- NHSGGC has important foundations but maturity remains variable.
- Developed aspects include established governance, partnership working, public health intelligence, inequalities expertise, and examples of prevention and early intervention.
- Key development needs include embedding prevention and inequalities in mainstream decisions, strengthening shared accountability, improving use of intelligence and evaluation, understanding investment in prevention, translating strategy into delivery, and sustaining community involvement.
- Three cross-cutting themes have emerged: stronger organisational ownership; shared intelligence and measurement; and prevention at scale.
- Continued operational pressure, unclear ownership and competing priorities create a risk that prevention will be deprioritised or delivery fragmented. Visible

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sponsorship, named ownership, routine oversight and tighter prioritisation are proposed mitigations.

3. Recommendations

NHSGGC Board is asked to consider the following recommendations:

- Approve the assessment and emerging priorities.
- Affirm NHSGGC's commitment to becoming a Population Health Organisation.

4. Response Required

This paper is presented for **Approval**.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- | | |
|------------------------------------|-------------------------------|
| • Improve Outcomes for People | <u>Positive</u> impact |
| • Health Quality Care & Experience | <u>Positive</u> impact |
| • Digital First Approach | <u>Neutral</u> impact |
| • Sustainability and Value | <u>Positive</u> impact |
| • Supported Workforce | <u>Positive</u> impact |

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity:

- Initial assessment undertaken by the Public Health Directorate.
- Engagement with non-Executive Board members of the Population Health and Wellbeing Committee.
- System wide survey developed and shared to canvass further feedback.
- Director-level PHO Maturity Assessment and Action Planning session.
Further engagement with primary care colleagues during the week commencing 5 October 2026.
- Public Short Life Reference Group established to help prepare the response and monitor progress during the first year of implementation.

7. Governance Route

This paper has been previously considered by the following groups as part of its development:

- Public Health SMT
- Corporate Management Team
- Population Health and Wellbeing Committee

8. Date Prepared & Issued

Paper prepared on: 2 October 2026

Paper issued on: 21 October 2026

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Situation

NHS Greater Glasgow and Clyde is developing its Population Health Organisation (PHO) Maturity Matrix self-assessment and associated improvement plan for submission to the Scottish Government (due December 2026).

A programme of engagement has been undertaken to test the initial assessment undertaken by the Public Health Directorate, strengthen the evidence base and identify practical improvement priorities. This has included engagement with non-Executive Board members of the Population Health and Wellbeing Committee, the development and sharing of a survey to further canvass feedback, and a wider, Director-level, PHO Maturity Assessment and Action Planning session.

As progressing towards a mature Population Health Organisation requires visible ownership and collective action across the whole organisation (rather than being led primarily through the Public Health Directorate), ongoing engagement with senior leaders will continue beyond the initial development phase.

This will support a more detailed action plan to be developed and monitored through appropriate existing governance arrangements.

Background

The initial self-assessment indicates that NHSGGC has important foundations on which to build, including established governance arrangements, partnership working, public health intelligence, inequalities expertise and examples of prevention and early intervention.

However, maturity remains variable across the matrix, with recurring development needs in relation to:

- embedding prevention and inequalities within mainstream planning and

- decision-making;
- shared accountability across organisational and partnership boundaries;
- routine use of population intelligence and evaluation;
- understanding and governing investment in prevention;
- translating strategic ambition into service, team and individual delivery; and
- ensuring meaningful and sustained community involvement.

The discussion with non-Executive Board members of the Population Health and Wellbeing Committee reinforced several of these themes.

These included the need to:

- maintain flexibility when defining populations across service and geographical boundaries;
- strengthen professional public health leadership across localities;
- understand why prevention is marginalised in financial decisions;
- articulate both the short-term and wider return on investment from prevention;
- enhance reporting to include future strategic intent alongside assurance of delivery; and
- increase the visibility of population health considerations at Board level.

The PHO Maturity Assessment and Action Planning session provided a further qualitative evidence base. Across the three breakout groups, there was broad thematic alignment around the continuing dominance of treatment, crisis response and immediate operational pressures. The discussions indicated that prevention is not yet consistently embedded in governance, planning, redesign, funding or resource allocation. Participants also identified opportunities to improve access to intelligence, strengthen shared accountability, evaluate and spread good practice, and develop more sustainable approaches to prevention investment.

Further targeted engagement sessions have taken place separately with the realistic medicine team and primary care colleagues (recognising the contribution of their work to Principles 4 and 5 respectively). In addition, and although not a requirement, a Public Short Life Reference Group has been established to help prepare the response and monitor progress within its first year of implementation.

Assessment

The engagement undertaken to date supports the broad direction of the draft PHO self-assessment, placing the organisation at Level 1 (Emerging). It suggests that the key challenge is not a lack of understanding of the case for prevention. Rather, the challenge is establishing the organisational conditions, leadership behaviours, governance arrangements and resource mechanisms needed to embed prevention consistently across the system.

Three cross-cutting themes have emerged:

1. Strong foundations and organisational ownership

There is a need to increase the visibility of the PHO ambition, establish clear leadership sponsorship and make prevention and inequalities an integral consideration within governance, planning, investment and service redesign.

Emerging proposals include Director-level sponsorship, more consistent organisational communications, careful use of language around demand prevention

and demand management, and the introduction of a prevention and inequalities section within relevant papers, plans and business cases.

2. Shared intelligence and measurement

Population health data and analytical capability exist, but access and use are inconsistent. Data is not routinely transformed into intelligence, and intelligence is not consistently connected to planning, prioritisation, performance management or investment decisions.

Emerging proposals include improving access to data, upskilling workforce capacity in intelligence, clarifying the analytical offer, developing a consistent population health and prevention dashboard, and testing measures relating to outcomes, inequalities, preventative reach, demand avoided and wider value. Any dashboard would require agreed definitions, baselines, attribution methods and data-quality standards before avoided activity or financial impact could be reported confidently.

3. Prevention at scale

There are existing examples of prevention and early-intervention activity, but good practice is not consistently evaluated, sustained or spread across NHSGGC. Emerging proposals include mapping established work, selecting a small number of priority programmes with the potential for wider impact, assessing their evidence and transferability, and developing a more deliberate mechanism for scaling effective approaches.

Leadership engagement

Continued operational pressure, unclear ownership and too many competing priorities were identified in the synthesis as risks that could lead to prevention being deprioritised or delivery becoming fragmented. Suggested mitigations include visible sponsorship, named ownership, routine oversight and tighter prioritisation.

Recommendation

NHSGGC is asked to:

1. Validate the assessment and emerging priorities.
2. Affirm NHSGGC's commitment to becoming a Population Health Organisation.

Population Health Organisation Maturity Matrix Assessment

1. Understand the Needs of the Population

Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
A: System	1 - Emerging	Population health data exists and is being used in parts of the system, particularly for reporting. Digital enablement for population analytics is beginning, and there is recognition that shared standards and joint strategic needs assessment work are important next steps.	Data remains largely held within individual teams and is not yet routinely linked, shared or used to drive planning, performance, budgets or resource decisions. Community assets may be mapped but are not routinely used in planning.
B: Collaboration	2. Developing	There is evidence of work with local authorities, IJBs, CPPs and communities to gather intelligence on population needs, assets and priorities. Co-design occurs in selected programmes and community / voluntary sector evidence is included in some examples.	Shared population intelligence is not yet consistently shaping joint planning across partners. Co-production is not yet the norm and shared dashboards are not routinely used by community planning partners.
C: Accountability	1 - Emerging	Core population health and inequalities indicators are beginning to be reviewed and there is an emerging direction of travel towards early mutual assurance with partners.	Assurance remains largely acute-focused and prevention is weakly embedded. A recurring gap is the absence of joint dashboards and agreed reporting cycles for population health indicators across partners.

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Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
D: Learning	1 - Emerging	Population health intelligence is recognised as important for understanding needs and inequalities. Some inequality segmentation is underway.	Use of data to identify improvement opportunities and inform planning is inconsistent and often exists in “pockets” rather than as a core approach. ROI and modelling are at a very early stage.
E: Equity	2 - Developing	Inequality analysis is used in some areas to identify priority populations and targeted action, and there are examples that could support a developing judgement. System Commitment to mainstreaming equalities (actively address inequalities in access) reflected in Equality Scheme.	Equity analysis is not yet consistently informing planning, monitoring or resource allocation. Proportionate universalism is discussed, but is not yet embedded consistently across strategies, commissioning, risk, assurance and performance.
F: Resource	1 - Emerging	There is initial investment in population health data, analytics, tools and workforce capability. Time for improvement and partnership working is developing.	Budgets remain acute-focused and prevention still relies mainly on short-term funding. Prevention spend, workforce needs and protected analytical / improvement capacity are not yet sufficiently quantified.
TOTAL	8/24		

2. System Focused and Collaborative

Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
A: System	1 - Emerging	The organisation is beginning to work with partners across the local population health system, including IJBs, CPPs, local government and the community and voluntary sector. Population health, prevention and inequalities are referenced.	Population health is only starting to influence governance and workforce planning. Workforce plans remain mainly focused on maintaining services and community planning involvement is still described as largely transactional.
B: Collaboration	1 - Emerging	The organisation is beginning to work with partners across the local population health system, including IJBs, CPPs, local government and the community and voluntary sector. Population health, prevention and inequalities are referenced.	Community engagement is not routinely embedded in planning, delivery and evaluation of services and/or interventions. Partnership skills not recognised as a key workforce skill.
C: Accountability	1- Emerging	There is early evidence of joint working and collective responsibility across NHS, local government and CPPs is emerging. Some performance frameworks are beginning to reflect prevention and upstream issues.	Accountability remains organisational and activity-focused. Shared prevention responsibilities, joint performance review, cost avoidance and shifts in the balance of care are not yet consistently embedded.
D: Learning	2 - Developing	Teams are beginning to share performance data and learning, with analysis supporting some planning and improvement activity. There was a more optimistic judgement here than for several other areas.	Continuous learning not routinely embedded across partners, limited shared data and evaluation practices. Intelligence not used routinely to drive major service change.

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Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
E: Equity	2 - Developing	Inequalities awareness is improving and data segmentation is used in some planning. Teams use inequalities and access data in some areas to tailor action and reduce barriers	Proportionate universalism is not yet consistently embedded in commissioning or resource decisions. Workforce planning and service redesign do not yet systematically target areas of highest need.
F: Resource	1 - Emerging	A small but growing group of staff are developing public health skills and relationships, and work is beginning to quantify prevention spend, cost avoidance and workforce transformation needs.	Prevention remains underfunded and workforce development is limited. Protected time, specialist roles, community engagement capacity and measurable prevention spend are not yet consistently in place.
TOTAL	8/24		

3. Prevention and Tackling Inequalities

Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
A: System	2 - Developing	Delivery plans increasingly include prevention, Anchor and Community Wealth Building actions. There are examples of cross-sector action supporting priorities such as Best Start, and teams are beginning to identify missed opportunities for prevention.	Prevention and inequalities are not yet consistently shaping strategy across the whole system. The action identified was to consolidate and strengthen this work rather than treat it as fully embedded.
B: Collaboration	1 - Emerging	Early prevention initiatives are co-designed with communities, the voluntary sector and business, and these are expanding in some areas.	Engagement remains compliance-led and programme-based. Community and voluntary sector data is not consistently used in planning, and seldom-heard groups have limited influence.
C: Accountability	1 - Emerging	Prevention governance is being established and responsibilities are being clarified. Early reporting includes upstream prevention, inequalities, child poverty and Anchor / CWB indicators.	Accountability for prevention, inequalities, child poverty and Anchor activity remains siloed. Shared dashboards and routine partner review are not yet sufficiently developed.
D: Learning	1 - Emerging	Prevention activity draws on evidence and there is some early work beginning to assess ROI and inequalities impact.	Evidence on prevention, Anchor impact and inequalities remains fragmented. Evaluation and learning are uneven, and structured improvement cycles / ROI work are not yet consistently in place
E: Equity	1 - Emerging	There is awareness that prevention can widen inequalities and early work to identify barriers to access and uptake. Procurement and employment	Inequalities are not yet consistently operationalised. Equality impact assessments do not reliably influence

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Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
		activity may provide some examples linked to fair work and inclusive access.	resource or workforce decisions, and proportionate universalism is not yet consistently applied.
F: Resource	1 - Emerging	Plans are in place to shift resource from treatment to prevention and there are some positive examples, including income maximisation pathways and early prevention spend tagging. Explicit investment and programmes being delivered via the Public Health Directorate include: Vaccination Screening Smoking Cessation Weight loss services Addiction services Financial inclusion services Social Prescribing interventions	Prevention investment remains unclear, acute spend still dominates, and staff time for partnership / Anchor work is not protected. The group noted this as an area requiring further work with finance colleagues. Funding for existing PJ services are perceived to have lower priority than acute services, with funding for some precarious/ dependent on external grant funding (eg financial inclusion services), and others subject to higher savings targets than acute services
TOTAL	7/24		

4. Focus on Primary and Community Care

Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
A: System	1 - Emerging	Clinical Strategy / Transformation agenda reflects commitment to shift to primary and community care. Service redesign is beginning to consider population health needs in specific teams and functions, and clinical / corporate systems are starting to adopt SRF and PHF priorities.	Redesign remains limited to a small number of pathways. Systems remain acute-centred and partnerships are still largely transactional rather than consistently strategic.
B: Collaboration	1 - Emerging	Engagement with communities and statutory partners increasingly informs some service design, with early focus on co-production and use of community assets.	Place-based co-design is not yet routine across the scale of the system. There are positive local examples, but variation across HSCPs means this does not yet represent system-wide practice.
C: Accountability	1 - Emerging	Some SRF-aligned shifts from acute to community care are evident and responsibilities for shifting the balance of care are being clarified.	Assurance remains organisation-specific, and accountability for resource shifts is not yet systematically managed through agreed programme boards, dashboards or mutual partner accountability.
D: Learning	1 - Emerging	Small pilots test early impacts within specific teams or pathways, and population health considerations	Learning is localised, and data is still mainly used to manage acute performance. Shared dashboards,

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Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
		are beginning to inform redesign alongside acute-focused approaches.	learning networks and systematic segmentation are not yet sufficiently established.
E: Equity	1 - Emerging	Equity impacts are considered in some redesign activity, with early mitigation actions.	Equity is recognised but not yet operationalised. Assessments and monitoring are inconsistent, and proportionate universalism is not yet visible enough in pathway redesign.
F: Resource	1 - Emerging	Resources to support public-health-led redesign are being identified and are beginning to flow in some areas. There are some positive examples, including Hospital at Home, although these were described as inconsistent.	Budgets remain acute-centric and investment in community models is limited. Transformation capacity and funding shifts are not yet consistently established or sufficiently underpinned by community planning. Sustainability and Value/cost savings programmes at locality level are heavily focused on prevention, recognising difficulty to present immediate impact
TOTAL	6/24		

5. Value-Based Health and Care

Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
A: System	1 - Emerging	Value-based health and care and Realistic Medicine are understood in parts of the system. There are selected examples of pathway mapping and outcomes work, but these are not yet consistent.	Value-based health and care is not yet driving planning or investment decisions. Reducing low-value activity with reinvestment into higher-value care is not yet sufficiently established.
B: Collaboration	1 - Emerging	There are some examples of PROMs and shared decision-making activity in selected pathways.	Shared decision-making and “what matters” outcomes remain inconsistent. PROMs, PREMs and WREMs are not routinely collected or used to drive co-design and redesign across services.
C: Accountability	1 - Emerging	Boards may consider outcomes, experience, equity and resources in some contexts, and some value indicators appear in reports.	Accountability is siloed and acute activity still dominates performance reporting. Value-based principles are not yet consistently driving governance, resource allocation or service accountability.
D: Learning	1 - Emerging	Teams test value-based ideas in some areas. There is some developing understanding of resource use along patient pathways and service areas.	Measurement is inconsistent and data is mainly used for operational pressure. Learning systems do not yet routinely triangulate outcomes, experience and resource use to support redesign.

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Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
E: Equity	1 - Emerging	Fairness and inequalities are referenced, and some PROMs / PREMs activity may support future segmentation.	Equity is not yet operationalised in value-based work. Stratification of data and action is limited, and value improvement activity is not yet consistently targeting inequities
F: Resource	1 - Emerging	Initial investment supports measurement and value-based health and care roles. Some costing and prioritisation work is developing in selected areas. Ongoing work around Procedures of Low Clinical Value is a positive example of this	Costing tools, granular pathway cost information and routine value cases are not yet mature enough to support systematic disinvestment and reinvestment.
TOTAL	6/24		

6. Governance and Accountability

Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
A: System	3 - Established	Population health priorities from national frameworks are increasingly reflected within Board strategies, assurance arrangements and governance discussions. The Board works routinely with Integration Authorities, local government and community planning partners on prevention, inequalities and wider determinants of health. Governance structures such as the Population Health and Wellbeing Committee provide an established mechanism for considering population health priorities and improvement activity.	Population health is not yet consistently the primary driver of all strategic, financial and commissioning decisions. Cross-system governance, resource allocation and accountability arrangements remain variable. More systematic integration of prevention, equity and population health considerations into decision-making and resource allocation is required to progress towards Level 4 maturity.
B: Collaboration	2 - Developing	Senior leaders take part in key local partnerships, including CPPs, and arrangements support community and voluntary sector involvement in governance and co-design.	Systematic partner and community input is not yet consistently shaping key decisions. Co-production is not yet routine and community engagement is not embedded across governance cycles

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Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what's working well)	Areas for Development
C: Accountability	2- Developing	The Board reviews progress with delivery teams and community planning partners in some areas, and some joint reporting exists.	Joint reporting is mainly descriptive. Shared outcome frameworks, joint assurance, risk management and public reporting are not yet fully embedded across NHS, Integration Authorities and local government.
D: Learning	2 - Developing	The Board receives population health reports and uses some data / benchmarking to inform discussion. There is clearer presentation of data in some areas.	Linked data and evaluation are not yet embedded in governance and routinely acted upon. Analytical capability needs to be developed and shared across partners to strengthen system-wide understanding of inequalities and performance
E: Equity	2 - Developing	Equity impact assessment processes are in place and some targeted actions complement universal provision. The discussion reflected that the organisation talks about proportionate universalism and applies it in some areas.	Quality and impact of equity assessment varies. Proportionate universalism is not yet embedded across strategy, commissioning, risk, assurance and performance.
F: Resource	1 - Emerging	There is recognition of the need to establish a baseline of prevention and population health spend and capacity, and to agree an initial aim to rebalance resource.	This was identified as one of the weakest areas. Prevention investment is limited and acute-focused, and the group noted the need for further work with finance colleagues to understand what other

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Development Area	Maturity Level 1 – Emerging 2 – Developing 3 – Established 4 – Leading	Evidence	
		Strengths (what’s working well)	Areas for Development
			Boards are doing and how prevention spend could be defined and tracked.
TOTAL	12/24		

2c) Improvement Plan

Use the table below to capture your identified improvement priorities and action plan against each of the [PHO principles](#). We suggest one improvement priority as a minimum for each principle, however, it is more important that you agree a prioritised and realistic set of impactful actions rather than covering off every area. Think about how you will know if the actions taken have moved you towards becoming a PHO and achieving the aims of the PHF and the SRF.

PHO Principle and Development Area	Improvement Priority	Improvement Action to be Taken	By Whom?	By When?	Indicators of Success
Understand the Needs of the Population (System / Learning)	Strengthen population health intelligence and data capability	Promote the existing intelligence resources and address barriers to the use of available systems and dashboards.			Increased usage of existing data on Discovery Dashboard and other existing resources
		Develop a population health intelligence framework that establishes routine surveillance, agreed core indicators, shared reporting arrangements and a population health dashboard to support planning, assurance and decision-making across the system. This should include clarification of data standards, analytical responsibilities and partner contributions.			Agreed core indicator set in place; routine surveillance established; population health dashboard developed; evidence of intelligence being used in planning and assurance discussions.
		Prototype a prevention dashboard including: preventative reach and uptake;			

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		• inequalities in access and outcomes; • population outcomes; • demand avoided or capacity released, where attribution is sufficiently robust; and • financial and wider value (including proxy primary and secondary prevention measures for existing acute delivery targets)			
Governance and Accountability (System and Accountability) Prevention and Tackling Inequalities (Accountability/Equity) Value Based Health Care (System) Understand the Needs of the Population (System / Learning)	Introduce a more robust prevention and inequalities lens across governance arrangements	Develop a proportionate mechanism through which relevant strategies, plans, Board papers, business cases and redesign proposals address: • prevention; • population need; • inequalities and equity; • short-term and longer-term impact			Proportion of Board papers referencing population need and prevention; proportion of redesign proposals including an equity impact assessment; number of committees receiving routine population health intelligence; number of projects demonstrating preventative return on investment
		Director-level commitment to becoming a Population Health Organisation via: <i>To be agreed by CMT</i>			

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System Focused and Collaborative (Collaboration)		Refresh the Public Health Inequalities Group Terms of Reference to clarify its leadership and delivery role in advancing PHO maturity, with active HSCP representation, shared ownership of priorities and routine monitoring of cross-system actions.			Revised Terms of Reference agreed; Appropriate representation secured from each HSCP; PHO actions incorporated into the group's workplan; Progress, barriers and impact reviewed routinely; Clear reporting and escalation route established through relevant governance arrangements.
Prevention and Tackling Inequalities (Learning and Resource)	Implement prevention at scale	Map established work, selecting a small number of priority programmes with the potential for wider impact, assessing their evidence and transferability, and developing a more deliberate mechanism for scaling effective approaches.			Shift from a series of local initiatives into a learning system that routinely identifies, evaluates and scales effective practice
Governance and Accountability (Resource and Accountability)	Improve understanding of prevention investment	Work with Finance, workforce colleagues and system partners to establish an initial baseline of: identifiable prevention expenditure;			Baseline prevention investment identified; prevention expenditure reported consistently; resource discussions include

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		• workforce capacity supporting population health (initially focused on specialists); • analytical and improvement capacity; and • current funding mechanisms and constraints.			prevention and population health considerations; improved understanding of investment aligned to PHO priorities.
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