The Elective Care Project

NHS Grampian

Initial Agreement

APPENDICES

October 2018

Appendix A
Benefits Register

<table>
<tr><th colspan="6">Identification</th><th>RAG</th><th>Comments</th></tr>
<tr><th>Ref. No.</th><th>Benefit</th><th>Assessment</th><th>As measured by</th><th>Baseline Value</th><th>Target Value</th><th>Relative Import</th><th></th></tr>
<tr><td>1.</td><td>Supports reduced lengths of stay for specialties directly involved</td><td>Quantitative</td><td>Analysis of in-patient stays.</td><td>Average Elective LOS: Only Acute Episodes with a length of stay greater than zero included

<table>
<tr><th colspan="4">Average Elective LOS (days) : April 2016 - March 2017</th></tr>
<tr><th>Specialty</th><th>Grampian</th><th>Scotland Rate</th><th>Scotland UQ</th></tr>
<tr><td>Cardiology</td><td>2.2</td><td>2.5</td><td>1.7</td></tr>
<tr><td>Dermatology</td><td>6.6</td><td>10.2</td><td>8.2</td></tr>
<tr><td>Ear, Nose & Throat (Ent)</td><td>1.8</td><td>1.7</td><td>1.1</td></tr>
<tr><td>Gastroenterology</td><td>3.1</td><td>3.1</td><td>2.6</td></tr>
<tr><td>General Surgery</td><td>3.5</td><td>3.4</td><td>2.0</td></tr>
<tr><td>Neurology</td><td>2.3</td><td>3.1</td><td>2.6</td></tr>
<tr><td>Neurosurgery</td><td>4.5</td><td>4.7</td><td>3.7</td></tr>
<tr><td>Ophthalmology</td><td>1.6</td><td>1.7</td><td>1.3</td></tr>
<tr><td>Oral Surgery</td><td>1.5</td><td>1.4</td><td>1.0</td></tr>
<tr><td>Plastic Surgery</td><td>3.6</td><td>3.1</td><td>1.9</td></tr>
<tr><td>Renal Medicine</td><td>2.6</td><td>5.1</td><td>2.4</td></tr>
<tr><td>Respiratory Medicine</td><td>2.4</td><td>2.9</td><td>2.2</td></tr>
<tr><td>Trauma And Orthopaedic Surgery</td><td>4.1</td><td>3.9</td><td>3.5</td></tr>
<tr><td>Urology</td><td>2.5</td><td>2.6</td><td>2.0</td></tr>
<tr><td colspan="4">Data Source: NSS Discovery</td></tr>
</table></td><td>‘Upper quartile’ in Scottish context.</td><td>5</td><td></td></tr>
<tr><td>2.</td><td>Supports more patients having treatment as day cases</td><td>Quantitative</td><td>Health Intelligence analysis</td><td>British Association of Day Surgery(BADS) including outpatient procedures:-
% BADS achieved</td><td></td><td>5</td><td></td></tr>
</table>

				BADS Daycase Rates: April 2016 - March 2017 **Specialty** / **Grampian** / **Scotland** / **Target** ENT: 88.1% / 94.0% / 94.1% General Surgery: 53.2% / 63.1% / 85.6% Head and neck surgery: 70.2% / 82.1% / 83.3% Medical: 52.2% / 64.7% / 72.4% Ophthalmology: 86.9% / 95.4% / 99.5% Orthopaedic surgery: 84.1% / 86.1% / 94.0% Urology: 81.9% / 83.7% / 85.0% Vascular Surgery: 74.8% / 68.6% / 88.8% **Data Source: NSS Discovery** **BADS Daycase Rates: April 2016 - March 2017** **Treatment Location** / **Actual** / **Peer Achieved** / **Target** Aberdeen Royal Infirmary: 71.5% / 78.6% / 88.4% Dr Gray's Hospital: 85.3% / 88.7% / 93.2% Woodend General Hospital: 83.2% / 89.0% / 94.1% **Data Source: NSS Discovery**			
3.	Increased theatre productive time for specialties directly involved in proposal	Quantitative	Reduction in unproductive time	Reduction in unproductive time: The session unproductive time is the sum of any hours lost due to the session starting late plus any gaps between cases plus any hours lost due to finishing early. This is then compared to the total available time (i.e. any early start + actual session length + any late finish) and aggregated over the reporting period. **Unproductive Theatre Time: Jan - Dec 2016** **Specialty** / **ARI/ Woodend** / **Dr Gray's** / **Grampian** / **Highland** / **Tayside** Cardiac Surgery: 24% / - / 24% / - / - Cardiology: 67% / 51% / 60% / - / 52% Ear, Nose & Throat (Ent): 28% / 37% / 29% / 36% / 28% Gastroenterology: - / 51% / 48% / - / - General Surgery: 23% / 36% / 26% / 52% / 27% Neurosurgery: 25% / - / 25% / - / 18% Ophthalmology: 37% / 25% / 36% / 33% / 33% Oral Surgery: 23% / - / 25% / 37% / 45% Plastic Surgery: 25% / - / 27% / 46% / 33% Trauma And Orthopaedic Surgery: 25% / 33% / 26% / 25% / 23% Urology: 34% / 52% / 36% / 35% / 35% Vascular Surgery: 30% / - / 30% / - / 29% **Data Source: NSS Discovery**	Upper quartile (lowest %) unproductive time	5	
4.	Supports improved	Quantitative	Improved utilisation,	Utilisation: The difference between allocated used hours and total actual hours expressed as a percentage of allocated	95% utilisation of		

<table>
<tr>
<td></td>
<td>theatre utilisation for specialties involved</td>
<td></td>
<td>planned vs actual hours used</td>
<td>used hours.
<table>
<tr><th colspan="6">Theatre Utilisation: Jan - Dec 2016</th></tr>
<tr><th>Specialty</th><th>ARI/ Woodend</th><th>Dr Gray's</th><th>Grampian</th><th>Highland</th><th>Tayside</th></tr>
<tr><td>Cardiac Surgery</td><td>85.4%</td><td>-</td><td>85.4%</td><td>-</td><td>-</td></tr>
<tr><td>Cardiology</td><td>55.2%</td><td>80.2%</td><td>67.5%</td><td>-</td><td>52.3%</td></tr>
<tr><td>Ear, Nose & Throat (Ent)</td><td>90.1%</td><td>82.2%</td><td>88.7%</td><td>169.4%?</td><td>82.6%</td></tr>
<tr><td>Gastroenterology</td><td>-</td><td>91.7%</td><td>90.8%</td><td>-</td><td>-</td></tr>
<tr><td>General Surgery</td><td>91.6%</td><td>81.9%</td><td>89.2%</td><td>67.3%</td><td>91.0%</td></tr>
<tr><td>Neurosurgery</td><td>85.3%</td><td>-</td><td>85.3%</td><td>-</td><td>92.5%</td></tr>
<tr><td>Ophthalmology</td><td>78.9%</td><td>87.6%</td><td>79.3%</td><td>90.2%</td><td>86.9%</td></tr>
<tr><td>Oral Surgery</td><td>99.6%</td><td>-</td><td>91.4%</td><td>80.3%</td><td>87.5%</td></tr>
<tr><td>Plastic Surgery</td><td>96.3%</td><td>-</td><td>94.9%</td><td>80.3%</td><td>87.9%</td></tr>
<tr><td>Trauma And Orthopaedic Surgery</td><td>89.7%</td><td>73.0%</td><td>87.4%</td><td>93.1%</td><td>87.5%</td></tr>
<tr><td>Urology</td><td>85.6%</td><td>83.6%</td><td>85.4%</td><td>84.5%</td><td>92.6%</td></tr>
<tr><td>Vascular Surgery</td><td>78.7%</td><td>-</td><td>78.7%</td><td>-</td><td>74.5%</td></tr>
<tr><td colspan="6">Data Source: NSS Discovery</td></tr>
</table></td>
<td>available elective lists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Moderates demand for OP appointments for specialties directly involved in proposal</td>
<td>Quantitative</td>
<td>New Outpatient Attendance rates</td>
<td>Number of new outpatient appointments per 1,000 population:
<table>
<tr><th colspan="6">New Outpatient Age Standardised Attendance Rates per 1000 pop : April 2016 - March 2017</th></tr>
<tr><th>Specialty</th><th>Grampian</th><th>Highland</th><th>Tayside</th><th>Scotland Rate</th><th>Scotland UQ</th></tr>
<tr><td>Cardiology</td><td>7.35</td><td>9.62</td><td>8.88</td><td>10.30</td><td>8.29</td></tr>
<tr><td>Dermatology</td><td>13.61</td><td>17.99</td><td>24.69</td><td>26.72</td><td>20.69</td></tr>
<tr><td>Ear, Nose & Throat (Ent)</td><td>15.76</td><td>25.68</td><td>18.56</td><td>23.79</td><td>24.21</td></tr>
<tr><td>Gastroenterology</td><td>9.31</td><td>8.52</td><td>31.72</td><td>17.21</td><td>9.39</td></tr>
<tr><td>General Practice</td><td>7.73</td><td>3.28</td><td>n/a</td><td>6.89</td><td>0.29</td></tr>
<tr><td>General Surgery</td><td>34.28</td><td>60.03</td><td>32.59</td><td>42.23</td><td>34.42</td></tr>
<tr><td>Neurology</td><td>8.03</td><td>8.12</td><td>7.92</td><td>10.23</td><td>8.71</td></tr>
<tr><td>Neurosurgery</td><td>2.58</td><td>2.22</td><td>4.07</td><td>2.68</td><td>2.64</td></tr>
<tr><td>Ophthalmology</td><td>16.69</td><td>20.59</td><td>24.09</td><td>29.63</td><td>25.96</td></tr>
<tr><td>Oral Surgery</td><td>1.15</td><td>6.43</td><td>15.75</td><td>7.03</td><td>2.51</td></tr>
<tr><td>Plastic Surgery</td><td>5.90</td><td>3.84</td><td>10.72</td><td>6.92</td><td>4.14</td></tr>
<tr><td>Renal Medicine</td><td>2.28</td><td>2.91</td><td>2.79</td><td>2.50</td><td>2.46</td></tr>
<tr><td>Respiratory Medicine</td><td>4.98</td><td>7.16</td><td>8.74</td><td>9.83</td><td>7.31</td></tr>
<tr><td>Rheumatology</td><td>4.34</td><td>7.78</td><td>5.26</td><td>6.87</td><td>5.68</td></tr>
<tr><td>Trauma And Orthopaedic Surgery</td><td>27.36</td><td>42.38</td><td>31.18</td><td>34.85</td><td>34.77</td></tr>
<tr><td>Urology</td><td>6.61</td><td>9.56</td><td>10.80</td><td>13.00</td><td>10.02</td></tr>
<tr><td colspan="6">Data Source: NSS Discovery</td></tr>
</table></td>
<td>TBC</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Supports the separation of elective and unscheduled patient pathways</td>
<td>Quantitative</td>
<td>Numbers of procedures cancelled</td>
<td>Percent of total scheduled elective cancellations in theatre systems:</td>
<td>UQ (lower) cancellations, reduced NSOPs</td>
<td>4</td>
<td></td>
</tr>
</table>

<table>
<tr><td></td><td></td><td></td><td>Reduced numbers of NSOPs</td><td>
<table>
<tr><th colspan="5">Elective Theatre Cancellations: July 2016 - June 2017</th></tr>
<tr><th>Board</th><th>Average Rate</th><th>Clinical reasons</th><th>Non-clinical</th><th>Patient</th></tr>
<tr><td>Ayrshire & Arran</td><td>9.9%</td><td>4.2%</td><td>1.4%</td><td>3.7%</td></tr>
<tr><td>Borders</td><td>9.6%</td><td>2.9%</td><td>3.8%</td><td>2.9%</td></tr>
<tr><td>Dumfries & Galloway</td><td>7.8%</td><td>3.4%</td><td>1.1%</td><td>2.7%</td></tr>
<tr><td>Fife</td><td>8.5%</td><td>3.3%</td><td>2.8%</td><td>2.1%</td></tr>
<tr><td>Forth Valley</td><td>9.5%</td><td>3.2%</td><td>2.6%</td><td>3.6%</td></tr>
<tr><td>Grampian</td><td>8.8%</td><td>2.5%</td><td>2.5%</td><td>3.5%</td></tr>
<tr><td>Greater Glasgow & Clyde</td><td>8.8%</td><td>3.9%</td><td>1.4%</td><td>3.3%</td></tr>
<tr><td>Highland</td><td>13.7%</td><td>3.7%</td><td>4.5%</td><td>5.4%</td></tr>
<tr><td>Lanarkshire</td><td>9.2%</td><td>3.1%</td><td>1.9%</td><td>4.2%</td></tr>
<tr><td>Lothian</td><td>10.3%</td><td>3.4%</td><td>1.6%</td><td>4.8%</td></tr>
<tr><td>Tayside</td><td>9.9%</td><td>3.3%</td><td>2.7%</td><td>3.3%</td></tr>
<tr><td>Scotland</td><td>9.2%</td><td>3.3%</td><td>2.0%</td><td>3.6%</td></tr>
<tr><td colspan="5">Data Source: OPERA, published on ISD Website</td></tr>
</table>
</td><td></td><td></td><td></td></tr>
<tr><td>7.</td><td>Supports the conversion of unscheduled patients to elective pathways</td><td>Quantitative</td><td>Shift of activity from IP to DC, from DC to OPLA</td><td>TBC</td><td>TBC</td><td>4</td><td></td></tr>
<tr><td>8.</td><td>Supports improved equity of access locally and regionally, for specialties directly involved</td><td>Quantitative & qualitative</td><td>Waiting times across NoS</td><td>Regional Data Modelling tool</td><td>TBC</td><td>4</td><td></td></tr>
<tr><td>9.</td><td>Reduces numbers of procedures cancelled <24hrs</td><td>Quantitative</td><td>Numbers of elective operations cancelled</td><td>Number of elective operations cancelled - diagnosis 1 code = Z53 (principal diagnosis = procedure not carried out):</td><td>UQ</td><td>4</td><td></td></tr>
</table>

				Elective Theatre Cancellations: April 2016 to March 2017			
				Specialty	**Cancellation Rate**	**Peer Rate**	**Peer UQ**
				Urology	2.33%	5.19%	3.42%
				Respiratory Medicine	2.89%	2.70%	1.56%
				Gynaecology	3.02%	2.84%	1.97%
				Ear, Nose & Throat (Ent)	3.10%	4.31%	3.25%
				Trauma And Orthopaedic Surgery	3.26%	4.07%	2.11%
				Anaesthetics	3.37%	2.27%	0.86%
				General Surgery	3.56%	4.33%	3.56%
				Plastic Surgery	3.96%	3.67%	3.04%
				Cardiology	4.21%	3.34%	1.84%
				Ophthalmology	4.45%	3.65%	1.96%
				Neurosurgery	7.05%	6.40%	6.12%
				Cardiothoracic Surgery	8.38%	5.96%	5.65%
				Data Source: NSS Discovery			
10.	Supports optimised performance against waiting times targets	Quantitative	Access performance metrics, e.g. 12wk NOP and TTG	Inpatient/Daycase Waiting Times: **Completed IPDC Waits Over 12 Weeks: April 2016 - March 2017** **Specialty** / **Percent >12 Weeks** / **Grampian** / **Scotland** Cardiology 17.8% 2.9% Cardiothoracic Surgery 8.9% 1.1% Dermatology 0.0% 0.6% Ear, Nose & Throat (Ent) 13.8% 13.1% Gastroenterology 0.6% 0.3% General Practice 0.0% 0.0% General Surgery 18.4% 13.3% Neurology 0.0% 0.8% Neurosurgery 18.7% 23.1% Ophthalmology 43.2% 11.2% Plastic Surgery 36.6% 6.6% Renal Medicine 0.8% 0.1% Respiratory Medicine 1.9% 0.0% Rheumatology 0.0% 0.1% Trauma And Orthopaedic Surgery 19.3% 27.3% Urology 14.3% 16.9% **Data Source: NSS Discovery**		5	

Completed IPDC Waits Over 12 Weeks: April 2016 - March 2017	
Board	**Percent >12 Weeks**
Western Isles	0.0%
Shetland	0.6%
Borders	2.0%
Fife	4.8%
Orkney	6.3%
Greater Glasgow & Clyde	6.5%
Dumfries & Galloway	11.7%
Ayrshire & Arran	12.3%
Lothian	12.5%
Scotland	12.6%
Tayside	17.6%
Grampian	**17.7%**
Highland	19.5%
Forth Valley	20.7%
Lanarkshire	28.3%
Data Source: NSS Discovery	

Outpatient Waiting Times:

Completed OP Waits Over 12 Weeks: April 2016 - March 2017		
Specialty	**Percent >12 Weeks**	
	Grampian	**Scotland**
Cardiology	50.6%	14.6%
Cardiothoracic Surgery	1.0%	0.3%
Dermatology	39.0%	22.2%
Ear, Nose & Throat (Ent)	17.9%	21.8%
Gastroenterology	23.2%	24.9%
General Practice	10.3%	9.8%
General Surgery	25.1%	15.5%
Neurology	38.2%	45.3%
Neurosurgery	36.4%	25.0%
Ophthalmology	34.6%	16.6%
Plastic Surgery	26.0%	7.5%
Renal Medicine	29.7%	3.4%
Respiratory Medicine	34.6%	24.2%
Rheumatology	56.9%	27.2%
Trauma And Orthopaedic Surgery	44.2%	23.6%
Urology	38.3%	17.9%
Data Source: NSS Discovery		

				Completed OP Waits Over 12 Weeks: April 2016 - March 2017 **Board** / **Percent >12 Weeks** Fife 9.8% Greater Glasgow & Clyde 9.9% Western Isles 10.9% Borders 13.8% Dumfries & Galloway 15.8% Shetland 17.5% Tayside 18.1% Scotland 18.5% Lothian 20.0% Orkney 20.5% Lanarkshire 21.4% Highland 27.6% Forth Valley 28.1% Ayrshire & Arran 29.3% **Grampian 29.9%** **Data Source: NSS Discovery**			
11.	Supports improved access to key diagnostic tests, where specialties are directly involved in proposal	Quantitative	DMMI performance	Baseline required**		5	
12.	Improved integration and communication between primary and secondary care services	Quantitative & qualitative	Referral numbers and conversion rates, Grampian Guideline Usage.			5	
13.	Patients are cared for in environs which maintain privacy and	Qualitative	Pt satisfaction surveys			5	

<table>
<tr><td></td><td>dignity</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>14.</td><td>Supports ‘One-Stop’ approach with minimised requirement to attend hospital appointments</td><td>Quantitative & Qualitative</td><td>Pt satisfaction surveys & HI data re NSOPs, clinic outcomes</td><td>Outpatient Return to New Ratios:
<table><tr><th colspan="4">Outpatient Return to New Ratio: April 2016 - March 2017</th></tr><tr><th>Specialty/Board</th><th>Ratio</th><th>Scotland Ratio</th><th>Scotland UQ</th></tr><tr><td>Cardiology</td><td>0.99</td><td>1.54</td><td>1.25</td></tr><tr><td>Cardiothoracic Surgery</td><td>1.52</td><td>1.27</td><td>0.20</td></tr><tr><td>Dermatology</td><td>2.05</td><td>1.37</td><td>1.03</td></tr><tr><td>Ear, Nose & Throat (Ent)</td><td>0.99</td><td>0.90</td><td>0.75</td></tr><tr><td>Gastroenterology</td><td>2.19</td><td>1.30</td><td>0.95</td></tr><tr><td>General Practice</td><td>0.15</td><td>0.22</td><td>0.13</td></tr><tr><td>General Surgery</td><td>1.02</td><td>1.07</td><td>0.83</td></tr><tr><td>Neurology</td><td>1.12</td><td>1.15</td><td>0.86</td></tr><tr><td>Neurosurgery</td><td>1.23</td><td>1.47</td><td>1.23</td></tr><tr><td>Ophthalmology</td><td>2.67</td><td>2.22</td><td>1.86</td></tr><tr><td>Plastic Surgery</td><td>2.69</td><td>2.25</td><td>1.65</td></tr><tr><td>Renal Medicine</td><td>14.42</td><td>10.51</td><td>6.60</td></tr><tr><td>Respiratory Medicine</td><td>2.35</td><td>2.05</td><td>1.80</td></tr><tr><td>Rheumatology</td><td>4.17</td><td>3.37</td><td>2.38</td></tr><tr><td>Trauma And Orthopaedic Surgery</td><td>2.05</td><td>1.57</td><td>1.02</td></tr><tr><td>Urology</td><td>2.12</td><td>1.44</td><td>1.00</td></tr><tr><td>Grampian</td><td>2.11</td><td>2.04</td><td>1.58</td></tr><tr><td>Highland</td><td>2.05</td><td>2.04</td><td>1.58</td></tr><tr><td>Tayside</td><td>2.83</td><td>2.04</td><td>1.58</td></tr><tr><td>Lothian</td><td>2.15</td><td>2.04</td><td>1.58</td></tr><tr><td>Greater Glasgow & Clyde</td><td>2.02</td><td>2.04</td><td>1.58</td></tr><tr><td colspan="4">Data Source: NSS Discovery</td></tr></table></td><td></td><td>5</td><td></td></tr>
<tr><td>15.</td><td>Good teaching and learning environment created to support the existing culture of learning, creating competent practitioners delivering optimal care, with positive benefits for recruitment and retention of high quality people.</td><td>Qualitative</td><td>Undergraduate and post graduate students report a good learning experience.

iMatter</td><td>TBC</td><td>GMC trainee survey – reduction in red flags.</td><td>4</td><td></td></tr>
</table>

16.	Physical estate is improved, including the functional suitability and the quality of the estate	Quantitative	Proportion of estate categorised as either A or B for physical condition appraisal facet. Functional suitability facet Quality facet	Poor	Excellent 100% A-B Excellent 100% A-B Excellent 100% A-B	5	
17.	Reduces the age of the healthcare estate	Quantitative	Proportion of estate (related to planned OP, DC and IP care) less than 50 years old	TBC	100%	3	
18.	Appropriate spaces to deliver care safely	Qualitative	Facility provides spaces which are clinically safe and appropriate for modern day healthcare	Accommodation currently not compliant with SHBN/HBN	All accommodation compliant with SHBN/HBN TBC	4	
19.	Reduced backlog maintenance and associated financial burden	Quantitative	Reduction in backlog maintenance burden in relation to accommodation associated with delivery of elective care	TBC	TBC	4	
20.	Reduced reliance on 3rd party providers and associated	Financial	Cost reduction and/or avoidance in future private	Per economic case	TBC	4	

	costs		sector expenditure, supplementary staffing, mobile scanners,				
21.	Increases level of staff engagement, supports optimisation of staffing and team working, recruitment and retention	Qualitative	Percentage of staff who say they would recommend their workplace	TBC	TBC	5	
22.	Improves design quality in support of increased quality of care and value for money	Quantitative	AEDET Score	TBC	TBC	4	

Appendix 1 - Benefits Prioritisation (from SCIM guidance)

Each identified benefit needs to be prioritised so that resources can be focussed on the delivery of those of greatest importance and/or highest impact. The following is an example of how this might be done, but the important feature is the ability to evaluate the relative importance of each benefit to the proposal:

Scale / RAG	Relative Importance
1	Fairly insignificant
2	↕
3	Moderately important
4	↕
5	Vital

Appendix B
Risk Register

Elective Care Programme Risk Register

Appendix B

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner Type	Risk Owner Individual
CLIENT / BUSINESS RISKS									
1.0	**Business risk**								
1.1	Clinical Outcome specifications will not be jointly owned by service clinical leads and operational teams, due to concerns over quality of content, or timeliness of preparation.	Financial and non-Financial	3	3	9	Ensure clear process of feedback re clinical and operational concerns, seeking prompt and flexible approach to recovery where necessary.	Feedback provided to B+A as to specific quality and timescale concerns.		JB
1.2	Clinical Output Specification will be skewed by inaccurate or incomplete data, or activity capture and will produce inaccurate planning assumptions.	Financial and non-Financial	4	2	8	Data has been provided, reviewed and debated by Health Intelligence, specialty staff and external consultants.			JE
1.3	Poor stakeholder involvement results in a lack of support for the project	Non-financial	3	2	6	Extensive and thorough engagement with stakeholders, through facilitated workshops to ensure the highest level of stakeholder involvement and a broad scope of stakeholder.	22 teams /services including support services have been included in a minimum of 3 x 3hr workshops, with multi-disciplinary teams.		LMcK

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner	
								Type	Individual
							Patient representation and Primary Care attendance at workshops and involvement in Programme has been good		
1.4	Preferred solution may require additional levels of revenue funding which are unavailable	Financial	4	2	8	Implementation plans for the delivery of elective care strategic ambitions will be developed on a basis of no additional revenue costs.	Strategic assessment and prioritisation process has considered revenue costs and affordability		JB
2.0	**Reputational risk**								
2.1	Adverse publicity occurs related to the nature of the preferred solution	Non financial	2	1	2	Ensure public and stakeholder input and engagement	Thorough engagement process with wide range of clinical stakeholders and public representation. Stakeholder event for communication and feedback on project		

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner	
								Type	Individual
2.2	Poor communication ignores stakeholder interests	Non financial	2	1	2	Ensure that the project communication plan covers issues of public perception / consultation feedback / media interest / parliamentary interest / organisational reputation, etc	Stakeholder Analysis undertaken early in planning. Communications strategy prepared by Communications Steering Group, reporting to Programme Board		CC
3.0	**Demand risk**								
3.1	Demand for the service does not match the levels planned, projected or presumed	Non financial and financial	3	1	3	Check assumptions behind reported demand levels to model projections	Thorough and deep dive health intelligence prepared for breadth of services involved, including volume and impact studies.		JE
4.0	**Operational risk**								
4.1	The planned accommodation is unable to support the proposed service model	Non financial and financial	3	1	3	Review service model & activity levels at early design planning stages and test assumptions throughout design development and implementation.	Schedules of accommodation have been utilised to test and model functionality. Independent and professional		JB

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner	
								Type	Individual
							input used to support assumptions		
PLANNING & DESIGN RISKS									
5.0	**Planning risk**								
5.1	Initial Agreement will not be complete in time for deadline for Capital Investment Group submission.	Non-Financial	3	2	6	Initial Agreement will have a dedicated author as part of a Project Team. Submission dates will be documented, with internal and preceding steps clear.	Initial Agreement has been prepared by a dedicated and full time General Manager, with adherence to national timescales and deadlines.		NS
5.2	Grampian's Initial Agreement will not be approved , due to a rejection of the preferred solution(s)	Financial and Non-Financial	3	2	6	Preferred solution(s) will be developed with thorough adherence to SCIM guidance.	Adherence to SCIM guidance with clearly demonstrated and widespread stakeholder input to strategic assessment. High level of expertise in Grampian in		GS

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner	
								Type	Individual
							producing high quality documentation for SCIM process.		
5.3	There is insufficient project team resource to meet requirements and timelines	Non - Financial	3	2	6	A dedicated project team will focus on the Programme, following good project management principles and with a clear governance structure.	Dedicated project team is in place with regular project team meetings and reporting to the Programme Board. Programme Board is in place with regular meetings and governance.		CC
6.0	**Project information risk**								
6.1	Information used as part of the strategic & project brief is unreliable	Non financial and financial	3	2	6	Planning assumptions are be clearly demonstrated in the Initial Agreement	Planning assumptions are be clearly demonstrated in the Initial Agreement, via the Output Specification Documents produced as part of the clinical engagement		NS

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner	
								Type	Individual
							process, and through thorough health intelligence gathering and modelling		
7.0	**Design risk**								
7.1	The design will not meet the solution's expectations	Financial and non financial	4	1	4	The project team will engage with the appointed contractors and stakeholders from early design planning stages onwards to avoid confusion over expectations			JB
FINANCE RISKS									
8.0	**Funding risk**								
8.1	Insufficient funding will be available for Grampian's preferred solution(s), due to limited levels of funding available nationally.	Financial	5	3	15	SG has made a commitment that there will be an Elective Care Centre in Aberdeen, but there is an expectation that currently and locally available resource is optimised. Preferred solution will demonstrate key productivity and performance metrics e.g. N2R, DOSA, LOS.	Initial Agreement clearly demonstrates the alignment and outcomes of the preferred solution with the need for change.		GS

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner	
								Type	Individual
8.2	The project estimate is poorly prepared and inaccurate	Financial	4	2	8	The level of detail required for project cost estimates should align with guidance on each planning stage	Dedicated and experienced financial planning as part of the project team		JB
8.3	The project becomes unaffordable	Financial and non financial	4	2	8	The affordability of the project should be tested at IA stage and further explored as part of the OBC and FBC stages of the project	Prioritisation process and preferred solution has accounted for capital and revenue affordability		JB

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence	Likelihood	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner	
EXTERNAL RISKS									
9.0	**Economic risk**								
9.1	Inflation costs rise above those projected	Financial	3	2	6	The likelihood of this occurring will be considered as part of the Financial Case			JB
10.0	**Legislative risk**								
10.1	Changes in legislation or tax rules increase project costs	Financial	3	2	6	The likelihood of this occurring will be considered as part of this risk register			JB
11.0	**Policy risk**								

1. Identification			2. Assessment			3. Control		4. Monitoring	
Risk No	Risk Description	Financial / Non-Financial / Unquantifiable	Consequence (1 - 5)	Likelihood (1 - 5)	Risk	Proposed Treatment / Mitigation	Action Taken	Risk Owner	
								Type	Individual
11.1	Changes to non-legislation policy affects project cost or progress	Financial and non financial	3	2	6	The likelihood of this occurring will be considered as part of this risk register			JB
11.2	There are uncertainties over future policy changes	Non financial	2	2	4	The likelihood of this occurring will be considered as part of this risk register			GS

Appendix C
Stakeholder Analysis

Appendix C

STAKEHOLDER ANALYSIS
Elective Care Programme

To achieve optimal, sustainable outcomes and from any project, it is important to work with stakeholders from an early stage. Early stakeholder analysis helps us to understand who are our stakeholders and how best to interact and communicate with them. They can aid in shaping our ideas and creating a joint vision; they are more likely to be committed to the project and its sustainability; and they can even be involved practically, often sharing resource and communication channels.

The following stakeholder analysis was undertaken for the Elective Care Programme in April 2017. It was further reviewed in December 2017.

MANAGE / PARTNER

High power, interested people:

Manage closely- these are the people who should be fully engaged and fully satisfied with information

National Programme Board
NHSG Board Members
Primary Care sector
22 Clinical Teams involved in the Programme
NoSPG
Senior Leadership Team (which includes the three Chief Officers)
Grampian Area Partnership Forum
Senior Operational Managers
Medical, Nursing, AHP and other Clinical Leaders in the Community and Acute Sectors
Advisory Committee Structure
ASLT

SATISFY / INVOLVE

High power, less interested people:

Keep satisfied - these people should be satisfied with information, but not so much that they become bored with the message.

Scottish Government and Cabinet Secretary
Local Elected Members
Scottish Central Investment Group
Asset Management Group
Elective Regional Group
Elective National Group
Local Authorities
HSCPs / IJB Boards

CONSULT / INVOLVE

Low power, interested people:

Keep informed - people should be kept adequately informed, with sufficient engagement to ensure that no major issues are arising. These people can often be very helpful with the detail of the project.

Scottish Ambulance Service
Press
Regional Partner Boards - NHS Scotland, NHS Highland, NHS Tayside, NHS Orkney
GPs
Patient Participation Groups
Patients and relatives/carers
Carer organisations
Transitions e.g. from children to adult services
Public - future and past users
People living in very remote communities
Third Sector Organisations
Equality and Diversity
Scottish Health Council

Community Planning Groups
Community Councils
Clinical and non-clinical staff indirectly affected by the programme
Care Homes – Management and staff
Hospital Pharmacy

INFORM / MONITOR

Low power, less interested people:
Monitor. These people should be monitored for further interest, but not bored with with excessive communication.

Care Home residents
Other (non-partner) Boards
RGU, University of Aberdeen
Community groups
Business Community
Private Providers
Media

Appendix D Communication and Involvement Framework

Appendix D

NHS GRAMPIAN
THE ELECTIVE CARE PROGRAMME
Communication and Involvement Framework

1. Introduction

This Framework aims to provide an agreed and transparent approach to informing patients, public and other stakeholders, and involving them in the Elective Care Programme. The Framework gives an overview of the project, and more detail is available from the Programme Team, if required. Involvement Action Plans are developed on a 6-monthly cycle; those produced to date are attached in Appendix 1. The action plans are produced, implemented and reviewed by the Programme Team.

The Framework has been informed by discussions with the Programme Board and the Scottish Health Council, by adopting written national guidance, and by views and comments gathered through patient and public involvement to date.

2. Programme Aims

There are two main aims to the project.

The first of these is to develop a transformational strategy for Elective Care in Grampian for the future and bring about significant redesign in relation to the optimised provision of elective services. The strategy will highlight implications for future elective service demand based on activity and demand trends and projections, and potential consequences of achieving degrees of optimisation in service performance and delivery. This will be underpinned by collaborative and partnership working with fellow Boards, with an agreed target operating model across the North of Scotland. This planning work is underway with colleagues from Highland, Tayside and Island Boards. It will ensure optimised and efficient use of available resource across clinical pathways and across the whole system, delivering on the following key items:

- Regional context

- National Clinical Strategy implementation
- Grampian Clinical Strategy
- Lever for comprehensive change
- Driving out “hidden” capacity

The second aim is to prioritise service options for investment within the context of an overarching strategy for elective care. This will ensure that funding is directed to where it will have maximum benefit in both service delivery and improve patient outcomes and experience.

3. Project Background

The Scottish Government is providing a £200m capital investment programme in Scotland to enhance Elective Care capacity to meet the needs of the growing and changing population over the next 10+ years. The increasingly elderly population will require more and better access to diagnostic and treatment services and facilities to meet the aims of the National Clinical Strategy and the Grampian Clinical Strategy. NHS Grampian is one of five Health Boards to benefit from a share of this funding, accessible via bidding through the Scottish Capital Investment Manual (SCIM) business planning process for the period 2017 – 2021.

NHS Grampian has embarked on a transformation programme for Elective Care to ensure that its indicative capital investment can be applied to provide maximum benefit for the population of the North East and North of Scotland. The approach to Elective Care planning was discussed at the NHS Grampian Board Seminar in May 2016. The Seminar was attended by more than 60 clinicians, managers and Board members. It was agreed that a comprehensive approach to the transformation of Elective Care was necessary. This would include a review of need associated with the changing population, and a review of service delivery in Primary Care and Acute Care. This approach would drive the maximum benefit that can be obtained from existing capacity and resources and ensure that the new capital investment can be applied effectively. The products of this approach would be a

comprehensive elective care redesign programme and a specification for new diagnostic and treatment (D&T) facilities.

To ensure that the funding is directed to where it will achieve optimum benefit, a Strategic Assessment of Elective Care in Grampian is being undertaken to shape the scope of the project over a period of 12 – 18 months. This information will be utilised to support the two key strands of the programme, namely to inform and drive the development of a Grampian Elective Care Strategy, in a regional context, and the Initial Agreement and Outline Business Case (OBC) for a share of the £200m. A requirement is that the capital is applied by May 2021 to support efficiency and additionality in future Elective Care provision.

The understanding of local priorities, opportunities and challenges which has been developed through this engagement process is being used to shape the Initial Agreement which in turn sets out the areas for capital development in Grampian, underpinning the developing Elective Care Strategy for the next 5 years and beyond.

4. Project Management Arrangements/Structure

A copy of the Programme Board Membership and Remit is enclosed as Appendix 2. The Programme Structure is enclosed as Appendix 3.

5. Past Communication and Involvement Activity

Involving staff, patients and the public is intrinsic to NHS Grampian's approach to strategic planning and service delivery. Work to involve stakeholders in the current project has been undertaken since the early stages of project planning and has been a feature of engagement adopted by the Programme Team from the start. This is also evident in the dedicated Public Involvement capacity (0.25FTE) in the Programme Team.

The four broad groups of stakeholders that the Programme Team have engaged with since December 2016 include

- NHS Grampian staff

- Patients and the public
- Third Sector organisations (charities and patient support networks)
- Regional and national planning and regulatory bodies and clinical networks

The areas of engagement have included clinical workshops; internal awareness sessions for NHS Grampian staff; discussions relating to specialist service provision with the appropriate bodies; two well-attended cross-check workshops between clinical specialties (16 and 23 August 2017); early stage project awareness sessions to Third Sector organisations; clinical workshop debriefs with patient representatives; and meetings with the Scottish Health Council.

More details on project Stakeholder Involvement to date can be found in Appendix 4.

Qualitative analysis of existing patient feedback collected by NHS Grampian over the last 5 years will also be carried out to establish, in themes, what changes in service provision would have the most potential to improve patient experience.

6. What Are We Consulting On?

It is important to be clear about the main communication messages to staff, patients and the public. These are:

- Services will not be stopping/closing
- Why service delivery is changing
- Where services are moving to and when
- What will be different and how
- What patients and the public can and cannot influence

On this last point, there are aspects of the project relating to the location and range of services which are already agreed. The focus in relation to these elements will be about *informing* staff, patients and the public. There is a

considerable service redesign and facilities development agenda that will be the focus of stakeholder involvement over the life of the project.

Other aspects of the project will be about involving and consulting with patients and the public. The issues identified so far where there is scope for people to influence the plans are:

- Helping to ensure the environment of care meets the needs of the population, for example influencing the design of the new buildings including patient access, waiting areas, internal and external environment, and signage.
- Redesign of clinical services and patient pathways of care, for example one stop clinics, functional disorder pathway, and community hubs.
- Provision of care closer to home and increased use of technology
- Redesign of patient pathways of care for example functional disorder.

7. Who Will Be Informed and Involved?

To help identify stakeholders with a concern or an interest in the project, a Stakeholder Analysis Exercise was carried out by the Programme Team on behalf of the Programme Board (Appendix 5). These involved gathering a list of stakeholders for both buildings and then prioritising them into categories in terms of their interest and influence. This exercise will allow Programme Team resources to be directed appropriately, in relation to those who need to be kept informed and others who need to be supported to be fully involved.

As people's interest and influence in the project changes over the life of the project, the original Stakeholder Analysis will be reviewed regularly.

A Benefits Realisation Plan will be an important part of planning for the project and will lead to specific pieces of clinical service redesign work which will benefit from having public and patient involvement. The details of the service redesign agenda will be worked on by the Programme Team, and this work

will benefit from establishing a current patient experience baseline and, subsequently, agreed improvement targets through consultation.

The Programme Team will also work with existing structures and networks such as the Public Involvement Network and in particular established Third Sector groups associated with the Elective Care services.

8. How and When Will People Be Informed and Involved?

As detailed in Section 5 and Appendix 4, NHS Grampian staff, public representatives and Third Sector representatives have been involved from the early stages of the project.

A common sense approach to the communication and involvement process is to dovetail activities with the stages of the business planning cycle of the project. This will allow the involvement process, including decisions about who to involve and how to involve them, to be agreed in a timely manner.

The Business Planning Cycle Stages are:

- Initial Agreement
- Outline Business Case
- Detailed Design of Facilities
- Full Business Case
- Financial Close
- Construction
- Commissioning of Facilities

These stages will progress in tandem with service redesign.

The new facilities will facilitate appropriate clinical service redesign to ensure we continue to provide high quality care in the most effective way to meet patient needs. A redesign structure has been developed by the Programme Team, including patient representation.

A number of methods will be used at these stages to *inform* patients, the public and staff about the project. Many of these suggestions were made by patients and staff. For example:

- Newspaper features
- The NHS Grampian website and intranet
- Noticeboards
- Newsletters
- Awareness sessions
- Social media presence utilising NHS Grampian 'Healthfit' Facebook and Twitter accounts managed according to agreed Social Media Guidelines and strategy

A number of methods have been and will be used to *involve* patients, the public and staff. For example:

- Representatives on Programme Board and Programme Groups
- Public representation at workshops involved with service redesign
- Patient interviews
- Patient surveys to establish a baseline for the Benefit Realisation Plans for both buildings

Although the initial stages of consultation have been quite focussed, in terms of who has been involved, the next stage of the process will include raising wider public awareness of the proposals. Subsequent action plans will detail this involvement.

9. Following National Guidance

Support from the Corporate Communications Team, including a dedicated Public Involvement Officer in the Programme Team, will help to ensure that the project adheres to national consultation guidance. There are points to note in relation to national guidance.

CEL 4 (2010) Informing, Engaging and Consulting People in Developing Health and Community Care Services is a key document, issued by the

Scottish Government to NHS Boards and setting out the relevant legislative and policy frameworks for involving the public in the delivery of services.

Extracts from this guidance include:

- *NHS Boards are required to involve people in designing, developing and delivering health care services they provide for them.*
- *Where the Board is considering consulting the public about service development and change, it is responsible for*
    - *informing potentially affected people, staff and communities for their proposal and the timetable for:*
        - *involving them in the development and appraisal of options.*
        - *involving them in a (proportionate) consultation on the agreed options.*
        - *reaching a decision.*
    - *providing evidence on the impact of this public involvement on the final agreed service development or change.*
- *The public involvement process should be applied in a realistic, manageable and proportionate way to any service development or change*
- *Boards should (...) keep the Scottish Health Council informed about proposed service changes so that it can provide Boards with advice and, if necessary, support in involving potentially affected people in the process.*

The Programme Team has met with the Scottish Health Council in relation to the Major Service Change assessment. The Scottish Health Council local office representatives have communicated their agreement in principle, with the information available at this stage, that the project does not meet the threshold for Major Service Change as set out in *Guidance on Identifying Major Health Service Change* (Scottish Health Council, 2010).

The Scottish Health Council have also attended as observes at the clinical workshops and carried out an evaluation of the engagement process (Appendix 6).

A Health Inequalities Impact Assessment will also be carried out by the project at Outline Business Case stage.

Public involvement in the project will build on NHS Grampian's commitment to follow national guidance and an established culture of communication with the people it serves, evidenced in its core organisational values of 'Caring, Listening and Improving'. The National Standards for Community Engagement will be followed to ensure good practice in day-to-day aspects of the project (see Appendix 7).

10. Progress Evaluation

Evaluation of any communication and involvement activities needs to examine both the process and the impact of involvement. For example:
Patient/public representatives on Programme Board, Programme Groups, Communication and Involvement Subgroups, and in workshops:

- Process – number of representatives, attendance of meetings, support provided
- Impact – contribution during discussions and influence on decisions

11. Post-Programme Evaluation and Benefits Realisation Plan

The programme will undertake a Post-Programme Evaluation, the purpose of which is to assess how well the project has met its objectives, including whether the project has been delivered on time, to cost and achieved quality standards.

A comprehensive Benefits Realisation Plan will be included in the Outline Business Case for the project building on the initial work outlined in the Initial Agreement. This plan identifies the potential benefits of the project, how they will be measured and how they are evaluated.

List of Appendices

Appendix 1: Involvement Action Plan

Appendix 2: Programme Board Membership and Remit

Appendix 3: Programme Structure

Appendix 4: Stakeholder Involvement to Date

Appendix 5: Stakeholder Analysis

Appendix 6: Scottish Health Council Evaluation of Engagement Report

Appendix 7: National Standards for Community Engagement

Appendix E Communication Action Plan

Appendix E

The Elective Care Project

Communication Action Plans

February – September 2017

	Actions	Timescale	Lead	Complete
	Set up first Communication and Information Group meeting to brainstorm ideas regarding staff and public engagement. The membership of the group is to include Elective Care project team (Graeme Smith, Jackie Bremner, Louise McKessock, Christina Cameron, Anna Rist), Corporate Communications (Laura Gray, Andrew Mitchell), Health Intelligence (Jillian Evans), and Aberdeenshire IJB (Adam Coldwells).	6 February 2017	JB	✓
	Meet with Kevin Toshney, Acting Head of Strategy and Transformation, Aberdeen City HSCP, to find out about early stages public involvement strategies used by the HSC.	10 February 2017	LMc	✓
	Meet with Scottish Health Council to discuss the project and get guidance on public involvement model.	28 February 2017	JB, AR	✓
	Make arrangements to have project social media accounts in place when needed.	February 2017	AR	✓
	Identify sources of existing patient feedback for elective services.	February – March 2017	AR	✓
	Attend Grampian Pain Support Committee meeting to discuss project and recruit representatives to attend clinical workshops.	3 March 2017	LMc	✓

	Attend North East Sensory Services Committee meeting to discuss project and recruit representatives to attend clinical workshops.	8 March 2017	LMc	✓
	Public representatives attending at clinical workshops 2 & 3 in Aberdeen for all specialties where possible.	March – September 2017	AR	✓
	Communication and Information Group meeting. Scottish Health Council added to the membership of the group.	11 April 2017	JB, CC	✓
	Identify project stakeholders through a stakeholder analysis exercise.	11 April 2017	JB	✓
	Communication and Information Group meeting. Renaming of the group as Communication and Engagement Group and membership of the group to formally include the Surgical Transformation Board and the Integrated Planning Board for Unscheduled Care in addition to Elective Care. Joint overarching communication and engagement strategy is to be developed. The group aims to meet 6-weekly.	4 May 2017	CC	✓
	Develop an evaluation and feedback form to be sent to all staff participating in the workshops on completion of their specialty's final workshop.	May 2017	AR	✓
	Develop an evaluation and feedback form to be sent to the public representatives by the Scottish Health Council to capture views and experiences from the second round of the workshops and to inform public participation in the third round of the workshops.	May 2017	AR	✓
	Work jointly with colleagues from STB and UC on overarching communication strategy (Healthfit) for three programme boards.	May – June 2017	AR	✓
	Work jointly with colleagues from STB and UC on first newsletter	May – June 2017	AR	✓

	under ‘Healthfit’ communication strategy			
	Prepare key messages document for public communication purposes for all Healthfit programme boards, based on Grampian Clinical Strategy.	June 2017	AR	✓
	Identify a researcher to carry out a qualitative analysis of existing patient feedback.	June 2017	CC	✓
	Liaise with Corporate Graphic Design to develop branding for the Healthfit initiative.	July-August 2017	AR	✓
	Organise a debriefing workshop with Aberdeen public representatives who have participated in the clinical workshops to capture their views and feedback. Scottish Health Council to attend for quality assurance.	14 August 2017	AR	✓
	Update Scottish Health Council on project developments and public engagement activities to date.	6 September 2017	LMc, AR	✓
	Update to Advisory Committees.	September 2017	CC	✓
	Plan for a wider public engagement strategy on finalising message and approach.	September 2017	AR	✓
	Engage with the Public Involvement Network to seek views on shortlisted Healthfit branding options.	September 2017	AR	✓
	Draft project digital strategy: social media, dedicated section in the NHSG outfacing website and dedicated intranet page.	September 2017	AR	✓

October 2017 – March 2018

	Actions	Timescale	Lead	Complete
	Write a project Communication and Involvement Framework for the Initial Agreement.	October 2017	AR	✓
	Liaise with the Scottish Health Council about major service change documents and whether these are required.	November 2017	AR	✓
	Activate Healthfit social media accounts. Starting to post once staff side has been updated and an intranet site has been set up.	November 2017	AR	✓
	Prepare a staff update flyer on the programme to be distributed in hard copy, via global email and on the intranet (including to GP practices).	December 2017	AR	✓
	Develop Healthfit intranet site with dedicated section for the Elective Care Programme.	December 2017	AR	✓
	Prepare all communication and engagement documents for the Initial Agreement submission (Framework, stakeholder analysis, report on stakeholder involvement to date).	December 2017	AR	✓
	Establish with GP leads how to communicate programme developments to GP practices –information, method, frequency.	January 2018	LMc, NS	✓
	Establish with Shire colleagues how to communicate with Community Hospitals – information, method, frequency.	January 2018	LMc, NS	
	Attend the Engagement and Participation Committee for a project update	7 February 2018	CC/AR	✓

	Contract a researcher to carry out analysis of existing patient feedback. Establish what funding is available and what internal research governance documents are needed.	March 2018	CC/AR	
	Develop a public rep participation feedback report video with Scottish Health Council support.	March 2018	AR	
	Invite public representatives to participate in the stakeholder event.	March 2018	AR	
	Develop publicity materials once programme outputs are clear.	March 2018	AR	
	Attend advisory structure meetings with a programme update.	March 2018	LMc/CC	
	Organise a number of public drop-in sessions for Q2/3 2018.	March 2018	AR	
	Organise staff awareness sessions – a mix of drop-in sessions and face-to-face panel events for affected specialties on programme developments – at ARI, Woodend and Health Village	March 2018	LMc, NS, AR	
	Support patient and public representative attendance at clinical workshops as appropriate	Ongoing	AR	
	Give a programme update to GAPF and senior partnership representatives.	TBC	LMc/CC	
	Arrange public engagement with Moray PPF and other local representatives, to coincide with Moray clinical workshops.	TBC	Moray PFPI lead	
	Set up a Comms & Engagement Group for the programme	TBC	AR	
	Meet with ACHSCP Locality Chairs and Co-Chairs to discuss opportunities for joint working on public engagement	TBC	AR, LMc	

Appendix F
Communication and Involvement Activity Report November 2016 – January 2018

Appendix F

The Elective Care Programme
Communication & Involvement Activity
November 2016 – January 2018
Summary Report

1) Introduction

This report summarises the communication and involvement activity relating to The Elective Care Programme which took place between December 2016 and January 2018. There has been significant stakeholder involvement and engagement carried out to date around the development of elective care diagnostic and treatment facilities in Grampian.

Communication and involvement activities are carried out by all members of the Programme Team, supported by the Public Involvement Officer dedicated to the programme.

A Stakeholder Analysis exercise was carried out by the Programme Team in April 2017 and reviewed in December 2017. This document, along with the first two Communication and Involvement Action Plans, has guided the project's communication and engagement activities in the early project stage. A Project Communication and Involvement Framework has been developed as part of the Initial Agreement business case. 6-monthly action plans will also be developed throughout the lifespan of the project.

2) Staff engagement and information

Programme leads met with clinical teams from the affected specialties between November 2016 and January 2017 to provide initial information about the programme and planned communication and engagement during 2017. Programme leads also provided information to the NHS Grampian Advisory Committee structure at the same time.

A series of more than 80 workshops focussing on the strategic review of existing capacity as well as system-wide opportunities for future transformation was led by Buchan Associates, external healthcare planners between March and December 2017. Over 400 staff from 22 specialties attended the workshops.

Staff evaluation of the workshops was carried out in October and November 2017.

A Communication and Engagement Group for the Programme, with participation from NHS Grampian and representation from Health and Social Care Partnerships, was established in

February 2017. This group was originally dedicated to the Elective Care Programme but the membership was extended in May 2017 to include representation from the Programme Board for Unscheduled Care & the Surgical Transformation Board to progress an overarching 'Healthfit' communication and engagement strategy.

A staff briefing flyer for was produced for January 2018 and has been distributed in hard copy and electronically to ensure equitable cascading of information to all staff groups.

A dedicated section for the programme on the NHS Grampian Intranet is being set up and will be available to staff in March 2018.

3) Public representatives

Public representatives were recruited from the existing NHS Grampian Public Involvement Network, or identified and invited by the participating services, to provide a patient voice at the strategic review workshops. 19 out of 22 specialties had patient representation in workshops between March and December 2017. On rare occasions it was not possible to assign a patient representative to a specialty, or a representative became unable to participate at short notice and could not be replaced.

Evaluation of workshops by public representatives carried out by the Scottish Health Council in July and August 2017 was very positive.

A dedicated debriefing workshop was organised for public representatives in August 2017 when the majority of workshops had finished to capture any further comments and also to thank them for their participation. The Scottish Health Council also attended for quality assurance.

A further dedicated feedback session was organised for Intensive Care Unit patients in November 2017 in view of the sensitive nature of this particular specialty.

A short video clip with public representatives talking about their participation in the workshops is currently being developed with the local Scottish Health Council team, with filming due to take place in early 2018. The video clip will be shared on social media and other NHS Grampian online platforms to raise the profile of the programme and encourage members of the public to get involved.

4) Third Sector involvement

The Programme Team attended the Grampian Pain Support Committee and the North East Sensory Services Committee meetings in March 2017 to discuss project and recruit representatives to attend strategic review workshops.

A programme of Third Sector engagement will be developed for the Outline Business Case stage.

5) Healthfit communication and engagement approach

In May 2017, the Communication and Engagement Group membership was extended beyond Elective Care Programme to include representation from the Surgical Transformation Board and the Programme Board for Unscheduled Care. It was agreed that the three programme boards would pursue an overarching high-level communication and engagement strategy under 'Healthfit' to avoid duplication or conflicting messages to staff and the public. Programme-specific communication and engagement activities also continue to be developed at programme level for each Board.

A staff-orientated Healthfit newsletter covering news from all three programme boards has been published from July 2017 onwards.

Key public messages for all three programme boards were approved for use in September 2017.

The three programme boards and members of the Public Involvement Network were consulted regarding the development of branding for the Healthfit approach in September 2017. Branding has been selected based on the consultation findings.

Dedicated Healthfit Facebook and Twitter pages were set up in November 2017. A Healthfit Intranet site with dedicated sections for each of the three programme boards is currently being set up.

6) Regional approach

A regional approach and agreed actions will be developed and confirmed linked to the progression of the Project and related Projects in Boards across the North of Scotland. It will also be linked to communication and engagement activities associated with a regional delivery plan – 'Delivering Health and Social Care tothe North of Scotland 2018-2021'.

7) Health and Social Care Partnerships (HSCP)

The programme team met with Kevin Toshney, Acting Head of Strategy and Transformation, Aberdeen City Health and Social Care Partnership, in February and May 2017 to find out more about early stage public involvement strategies used by the AHSCP and benefit from lessons learnt.

8) Scottish Health Council

The project team met with the Scottish Health Council in February 2017 to discuss the project and get early guidance on the most appropriate public involvement model.

An evaluation form for public representatives attending the strategic review workshops was developed jointly with the Scottish Health Council in June 2017. Scottish Health Council officers also attended to observe a selection of workshops in May and June 2017 for quality assurance purposes.

A project update was given to the Scottish Health Council in September 2017.
Feedback and ideas around future engagement were discussed.

In November 2017, confirmation in writing was received from the Scottish Health Council stating that based on the information currently available, the Elective Care Programme was unlikely to meet the criteria for Major Service Change.

9) Other

Sources of existing patient feedback have been identified for analysis and qualitative researchers from the University of Aberdeen have been identified to carry out this piece of work in 2018.

10) Conclusion

A significant amount of communication and involvement activity regarding the Elective Care Programme has been carried out between November 2016 and January 2018. Consequently, a substantial amount of valuable feedback and input has been obtained to inform the plans for enhanced diagnostic and treatment facilities, and a programme of transformational service redesign.

Anna Rist
Public Involvement Officer

Appendix G
Optimism Bias Templates

OPTION 1-9 - Elective Care

APPENDIX H

Optimism Bias - Upper Bound Calculation for Build			**After Mitigation**
Lowest % Upper Bound		**12.5%**	
Mid %		**40%**	
Upper %		**80%**	
Actual % Upper Bound for this project		**55.5%**	**26.5%**

Build complexity				
Choose 1 category		**X**		
Length of Build	< 2 years		0.50%	0
	2 to 4 years	x	2.00%	2.00%
	Over 4 years		5.00%	0
Choose 1 category				
Number of phases	1 or 2 Phases	x	0.50%	0.50%
	3 or 4 Phases		2.00%	0
	More than 4 Phases		5.00%	0
Choose 1 Category				
Number of sites involved (i.e. before and after change)	Single site*		2.00%	0
	2 Site		2.00%	0
	More than 2 site	x	5.00%	5.00%
* Single site means new build is on same site as existing facilities				
Location				
Choose 1 Category				
New site - Green field	New build		3%	0
New site - Brown Field	New Build		8%	0
Existing site	New Build		5%	0
	or			
Existing site	Less than 15% refurb		6%	0
Existing site	15% - 50% refurb	x	10%	10.00%
Existing site	Over 50% refurb		16%	0
				17.50%

Scope of scheme				
Choose 1 category		**X**		
Facilities Management	Hard FM only or no FM		0.00%	0
	Hard and soft FM	x	2.00%	2.00%
Choose 1 category				
Equipment	Group 1 & 2 only		0.50%	0
	major Medical equipment		1.50%	0
	All equipment included	x	5.00%	5.00%
Choose 1 category				
IT	No IT implications		0.00%	0
	Infrastructure		1.50%	0
	Infrastructure & systems	x	5.00%	5.00%
Choose more than 1 category if applicable				
External Stakeholders	1 or 2 local NHS organisations		1.00%	0
	3 or more NHS organisations	x	4.00%	4.00%
	Universities/Private/Voluntary sector/Local government		8.00%	0
Service changes - relates to service delivery e.g NSF's				
Choose 1 category				
Stable environment, i.e. no change to service			5%	0
Identified changes not quantified			10%	0
Longer time frame service changes		x	20%	20.00%
Gateway				
Choose 1 category				
RPA Score	Low		0%	0
	Medium	x	2%	2.00%
	High		5%	0
				38.00%

Scheme name: Option 1-9 Elective Care						
Contributory Factor to Upper Bound	**% Factor Contributes**	**Mitigation factor**	**Overall %age Mitigation**	**% Factor Contributes after mitigation**		**Explanation for rate of mitigation**
Progress with Planning Approval	4	0.40	1.60	2.40	SOC OBC FBC	Likley planning required
Other Regulatory	4	0.30	1.20	2.80	SOC OBC FBC	Local Authority, building warrant, public transport and car parking. Other issues unknown
Depth of surveying of site/ground information	3	0.20	0.60	2.40	SOC OBC FBC	Limited known site and other development
Detail of design	4	0.10	0.40	3.60	SOC OBC FBC	No design done to date. Accommodation schedule to be agreed.
Innovative project/design (i.e. has this type of project/design been undertaken before)	3	0.40	1.20	1.80	SOC OBC FBC	Standard Hospital design.
Design complexity	4	0.20	0.80	3.20	SOC OBC FBC	Backlog maintenance only limited design ops and constraints of existing site and design
Likely variations from Standard Contract	2	0.80	1.60	0.40	SOC OBC FBC	Framework 2 - laergely stardard contract
Design Team capabilities	3	0.80	2.40	0.60	SOC OBC FBC	Experienced design team. Architect well known to NHSG. M&E team will need to understand the brief well.
Contractors' capabilities (excluding design team covered above)	2	0.80	1.60	0.40	SOC OBC FBC	Appointed experienced contractors.
Contractor Involvement	2	0.20	0.40	1.60	SOC OBC FBC	Contractors appointed.
Client capability and capacity (NB do not double count with design team capabilities)	6	0.60	3.60	2.40	SOC OBC FBC	Project Team in place but required to evolve from strategy to delivery
Robustness of Output Specification	25	0.50	12.50	12.50	SOC OBC FBC	Part of existing program but detailed design work
Involvement of Stakeholders, including Public and Patient Involvement	5	0.70	3.50	1.50	SOC OBC FBC	Participation by public representatives and needs for DDA compliance
Agreement to output specification by stakeholders	5	0.40	2.00	3.00	SOC OBC FBC	Developing output spec in place.
New service or traditional	3	0.70	2.10	0.90	SOC OBC FBC	Traditional range of services with some redesign
Local community consent	3	0.30	0.90	2.10	SOC OBC FBC	Community engagement planned
Stable policy environment	20	0.70	14.00	6.00	SOC OBC FBC	Consistent with NHSG 2020 vision
Likely competition in the market for the project	2	0.90	1.80	0.20	SOC OBC FBC	Likely to be delivered as part of exisitng backlog maintenance program
TOTAL	**100**	**9**	**52.20**	**47.80**		

Note: Across all contributory factors, mitigation would be expected to be greater the greater the extent of risk quantification and risk management.

Appendix H
Optimism Bias Templates – Do Nothing

Elective Care - OPTION 10 - Do Nothing

APPENDIX H

Optimism Bias - Upper Bound Calculation for Build

		After Mitigation
Lowest % Upper Bound	**12.5%**	
Mid %	**40%**	
Upper %	**80%**	
Actual % Upper Bound for this project	**42.0%**	**16.4%**

Build complexity				
Choose 1 category		**X**		
Length of Build	< 2 years		0.50%	0
	2 to 4 years	x	2.00%	2.00%
	Over 4 years		5.00%	0
Choose 1 category				
Number of phases	1 or 2 Phases		0.50%	0
	3 or 4 Phases		2.00%	0
	More than 4 Phases	x	5.00%	5.00%
Choose 1 Category				
Number of sites involved (i.e. before and after change)	Single site*		2.00%	0
	2 Site		2.00%	0
	More than 2 site	x	5.00%	5.00%
* Single site means new build is on same site as existing facilities				

Location				
Choose 1 Category				
New site - Green field	New build		3%	0
New site - Brown Field	New Build		8%	0
Existing site	New Build		5%	0
	or			
Existing site	Less than 15% refurb		6%	0
Existing site	15% - 50% refurb	x	10%	10.00%
Existing site	Over 50% refurb		16%	0
				22.00%

Scope of scheme				
Choose 1 category		**X**		
Facilities Management	Hard FM only or no FM		0.00%	0
	Hard and soft FM	x	2.00%	2.00%
Choose 1 category				
Equipment	Group 1 & 2 only		0.50%	0
	major Medical equipment		1.50%	0
	All equipment included	x	5.00%	5.00%
Choose 1 category				
IT	No IT implications	X	0.00%	0.00%
	Infrastructure		1.50%	0
	Infrastructure & systems		5.00%	0
Choose more than 1 category if applicable				
External Stakeholders	1 or 2 local NHS organisations		1.00%	0
	3 or more NHS organisations		4.00%	0
	Universities/Private/Voluntary sector/Local government	x	8.00%	8.00%

Service changes - relates to service delivery e.g NSF's				
Choose 1 category				
Stable environment, i.e. no change to service		X	5%	5.00%
Identified changes not quantified			10%	0
Longer time frame service changes			20%	0

Gateway				
Choose 1 category				
RPA Score	Low	X	0%	0.00%
	Medium		2%	0
	High		5%	0
				20.00%

Scheme name: Option 10 Elective Care

Contributory Factor to Upper Bound	% Factor Contributes	Mitigation factor	Overall %age Mitigation	% Factor Contributes after mitigation		Explanation for rate of mitigation
Progress with Planning Approval	4	1.00	4.00	0.00	SOC OBC FBC	No planning required
Other Regulatory	4	0.50	2.00	2.00	SOC OBC FBC	Local Authority, building warrant, public transport and car parking. Other issues unknown
Depth of surveying of site/ground information	3	1.00	3.00	0.00	SOC OBC FBC	Known site and other development
Detail of design	4	0.10	0.40	3.60	SOC OBC FBC	No design done to date. Accommodation schedule agreed.
Innovative project/design (i.e. has this type of project/design been undertaken before)	3	0.80	2.40	0.60	SOC OBC FBC	Standard Hospital design.
Design complexity	4	0.80	3.20	0.80	SOC OBC FBC	Backlog maintenance only limited design ops and constraints of existing site and design
Likely variations from Standard Contract	2	1.00	2.00	0.00	SOC OBC FBC	Standard Form Contract Used
Design Team capabilities	3	0.80	2.40	0.60	SOC OBC FBC	Experienced design team. Architect well known to NHSG. M&E team will need to understand the brief well.
Contractors' capabilities (excluding design team covered above)	2	0.80	1.60	0.40	SOC OBC FBC	Experienced contractors expected to undertake appointment
Contractor Involvement	2	0.80	1.60	0.40	SOC OBC FBC	Likley existing BLM Contractors .
Client capability and capacity (NB do not double count with design team capabilities)	6	0.60	3.60	2.40	SOC OBC FBC	Capability in place, but capacity to be agreed. Current team stretched.
Robustness of Output Specification	25	0.70	17.50	7.50	SOC OBC FBC	Part of existing program but detailed design work
Involvement of Stakeholders, including Public and Patient Involvement	5	0.60	3.00	2.00	SOC OBC FBC	Participation by public representatives and needs for DDA compliance
Agreement to output specification by stakeholders	5	0.80	4.00	1.00	SOC OBC FBC	Fairly well developed output spec in place.
New service or traditional	3	1.00	3.00	0.00	SOC OBC FBC	Traditional range of services.
Local community consent	3	0.90	2.70	0.30	SOC OBC FBC	Not required refer of existing building
Stable policy environment	20	0.80	16.00	4.00	SOC OBC FBC	Inconsistent with NHSG 2020 vision
Likely competition in the market for the project	2	0.70	1.40	0.60	SOC OBC FBC	Likely to be delivered as part of exisiting backlog maintenance program
TOTAL	**100**	**13.7**	**73.80**	**26.20**		

Note: Across all contributory factors, mitigation would be expected to be greater the greater the extent of risk quantification and risk management.

Appendix I
Detailed Cost Analysis

Part 1 Capital

Appendix I - Detail Costing

Table FA1: Summary of Initial Capital Investment

	Preferred Option 5	Option 1	Option 2	Option 3	Option 4
	£000's	£000's	£000's	£000's	£000's
Enabling Projects	0	0	0	0	0
Construction Related Costs	33,705	30,472	36,957	36,838	985
Furniture and Equipment	5,392	6,505	6,988	5,633	161
Project Development and Commissioning Costs	2,006	2,006	2,006	2,006	2,006
Inflation	2,730	2,588	3,076	2,973	150
VAT	7,928	7,517	8,934	8,635	436
Total Initial Investment	**51,761**	**49,089**	**57,962**	**56,085**	**3,738**

Table FA2: Construction Related Costs

	Total
	£000's
Construction Related Costs	
Enabling Works	0
Demolitions	250
Building Costs	25,137
Site Specific Costs	0
Prelims, Fees, On-Costs	1,279
Inflation	2,271
Risk	7,040
VAT	6,816
Total Construction Costs	**42,792**

Table FA3: Project Development Costs

	Total
	£000's
Project Development Costs	
Project Team	1,626
Project Advisors	250
Other Project Costs	30
Total Project Development Costs	**1,906**

Table FA4: Project Commissioning Costs

	Total
	£000's
Commissioning Costs	
Removal (Inc Flooring Protection)	20
Security	20
Post Project Evaluation	20
Domestic and Portering	20
IT Support	20
Total Commissioning Costs	**100**

Part 2 Revenue

Table FA5: Summary of Revenue Implications - First Full Year of Operation (2022/23)

	Preferred Option	Option 1	Option 2	Option 3	Option 4
	£000's	£000's	£000's	£000's	£000's
Revenue Costs					
Additional Depreciation	1,732	1,816	2,027	1,895	105
Additional Clinical Service Costs	2,100	4,000	2,100	6,000	7,100
Additional Non-Clinical Service Costs	698	842	904	904	20
Building Related Running Costs	924	767	1,039	1,137	176
Total Costs	**5,453**	**7,425**	**6,070**	**9,542**	**7,401**

Table FA6: Depreciation - First Full Year of Operation (2022/23)

	Total
	£000's
Depreciation	
Equipment	687
Building	1,045
Total Net Depreciation	**1,732**

Table F7: Building Related Running Cost - First Full Year of Operation (2022/23)

	Total
	£000's
Building Related Running Costs	
Rates	316
Water Rates	15
Electricity	97
Heating	75
Domestics	208
Property Maintenance	213
Total Annual Costs	**924**

Table FA8: Additional Clinical Service Costs - First Full Year of Operation (2022/23)

	Total
	£000's
Clinical Service Costs	
Community Diagnostic and Treatment Hub including Biologic	500
CT Scanning Suite (1)	600
MRI Scanning Suite (2)	1,000
Total Annual Costs	**2,100**

Table FA9: Additional Non-Clinical Service Costs - First Full Year of Operation (2022/23)

	Total
	£000's
Equipment - Maintenance and Equipment	687
Secure Digital Photos	11
Total Annual Costs	**698**

Appendix J
Elective Care Re-design Programme Board

Elective Care Redesign Programme Board
Terms of Reference (including role, remit and membership)

Overall Role & Remit of the Programme Board

The overall aim of the Programme Board (PB) is to provide leadership, direction and decision making to the Elective Care Redesign Programme to ensure the delivery of the high level outcomes from the Programme:

- Appropriate whole system review through engagement with service stakeholders
- Implementation plan for realisation of the elective care strand of the Grampian Clinical Strategy
- Depiction of a target operating model for elective care
- Timely preparation and submission of paperwork in line with Scottish Capital Investment Manual (SCIM) guidance to secure appropriate capital investment that will underpin the target operating model
- Oversee the fulfilment of capital projects which will form part of an overall implementation plan

This Programme Board will guide the formation of strategies, support delivery/ commissioning plans as appropriate and monitor performance in relation to the achievement of the above outcomes. Its overall purpose is in line with the 'shared priorities' across the health and care organisations in the north east of Scotland for the provision of quality, effective, sustainable and affordable care for improved population health. This will be focussed on an outcome based approach.

This Board requires to deliver this function on a whole system basis, working in partnership with the three Health and Social Care Partnerships reporting to the Grampian Senior Leadership Team.

Objectives of the Board

The overarching objective of the Programme Board is to provide the high level strategic overview and to oversee the delivery of the ambitions for change across elective care provision in Grampian.

The Board will:

- Provide leadership, drivers for change, system-wide direction and co-ordination, guidance and decision making to support transformation of delivery of care in relation to elective care services.
- Operate as high level participants in exploring, testing and finalising proposed options for capital investment, as part of the SCIM process.
- Agree and oversee a clear programme of work for delivery of the identified ambitions for improvement and investment objectives that is consistent with local and national strategies
- Oversee links with unscheduled care models for the north east where appropriate
- Provide a focus across sectors, professions, partner organisations and partner Boards to create close links and robust communication which maximises outcomes for patients and local populations.
- Monitor performance and provide high level decision making, directing activity as appropriate.
- Act as a reporting conduit between Programme and the Grampian Senior Leadership Team to provide assurance delivery of the high level outcomes from the Programme
- Provide final review of plans, strategies and documents prior to submission for local, regional and national governance approval.

Membership of the Programme Board

The proposed membership of the Board is set out below. In addition to the Board membership, there may be times when the Board will invite colleagues and from professionals from NHS Grampian and partners to provide information, advice or reporting on specialist subjects or progress against objectives.

The Board will be chaired by Graeme Smith, Director of Modernisation and Project Sponsor.

Members of the Programme Board will have the responsibility of providing feedback and updates to their respective organisations and areas.

Member	Role
Graeme Smith	Director of Modernisation (Chair)
Duff Bruce	Programme Clinical Lead
Stephen Stott	Deputy Medical Director
Pam Gowans	Moray, HSCP, Chief Officer
Susan Carr	Director of AHPs
Paul Allen	General Manager, Estates
Paul Bachoo	Deputy Associate Medical Director
Jackie Bremner	Project Director
Steven Lindsay	Partnership Representative
Matthew Toms	Head of Performance Governance
Gary Mortimer	Director of Acute Services
Jillian Evans	Head of Health Intelligence
Shonagh Walker	Divisional Clinical Director, Clinical Support Services
Louise McKessock	Clinical Redesign Manager
Christina Cameron	Programme Manager
Neil Strachan	General Manager - Acute
Caroline Hiscox	Deputy Director of Nursing
William Moore	Public Health
Lizzie Finalyson/Stuart Reary	General Practitioner, Aberdeenshire
Caroline Howarth/Adrian Crofton	General Practitioner, Aberdeen City
Graham Taylor/Lewis Walker	General Practitioner, Moray
Jamie Hogg	Clinical Lead for Modernisation
Chris Littlejohn	Consultant in Public Health
Scott Sim	General Manager eHealth
Alan Sharp	Assistant Director of Finance
Susan Kinsey	Public Representative

Frequency of Meetings of the Programme Board

The frequency of meetings will be monthly.

Organisation and Support to the Programme Board

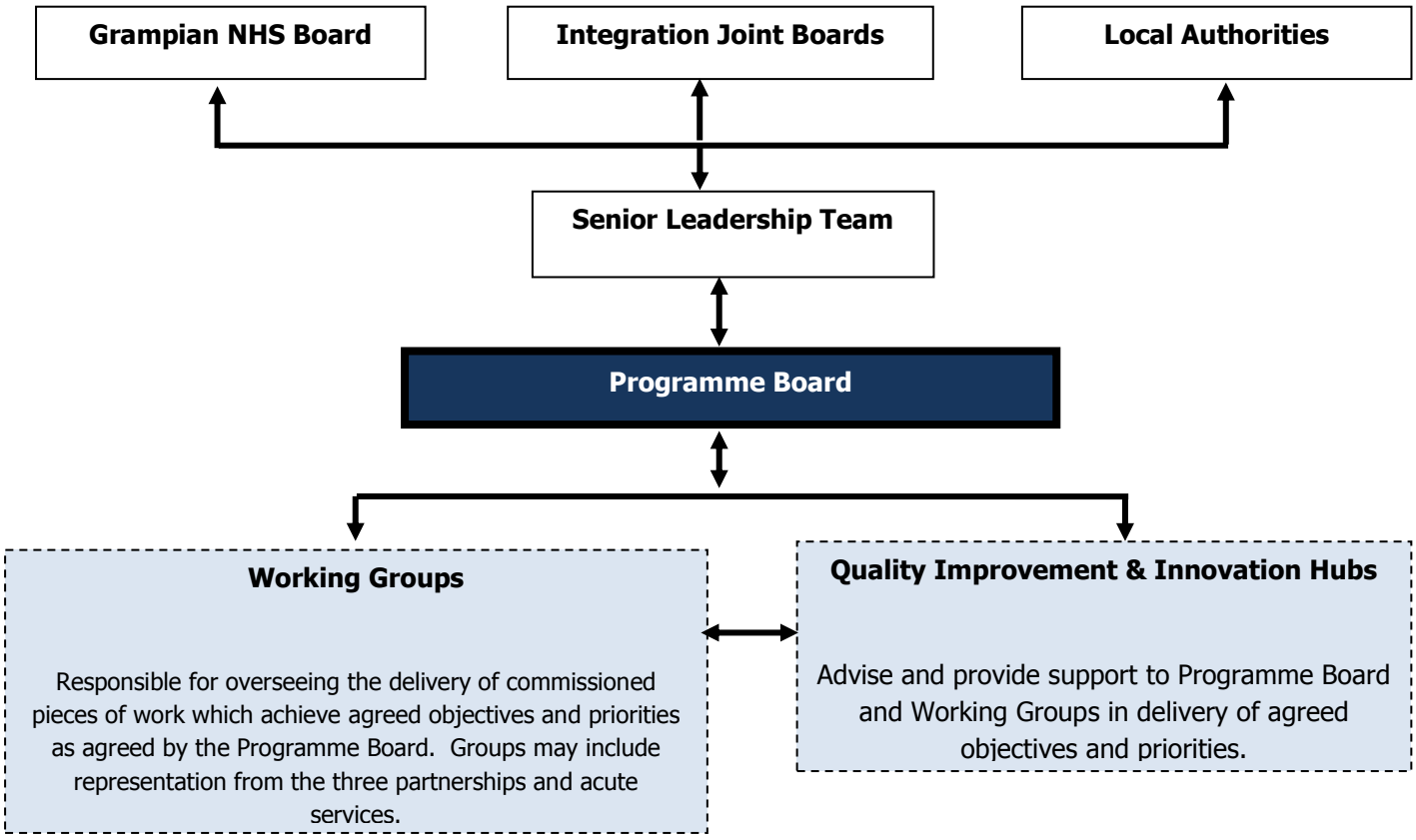
Agenda items will be discussed from a standing agenda with additional items to be included as appropriate and agreed with the Chair. Programme Management will be provided by the Modernisation Directorate, with support via the Elective Care Project Team, as below

Member	Role
Jackie Bremner	Project Director
Duff Bruce	Programme Clinical Lead
Christina Cameron	Programme Manager
Louise McKessock	Clinical Advisor
Neil Strachan	Acute General Manager
Julie Anderson	Finance Manager
Jade Williamson	Project Secretary
Anna Rist	Public Engagement Officer (Communications)
Kelly Easton	Ehealth Programme Manager
Neil Buchanan	Project Manager
Steven Lindsay	Partnership Representative
Graham Osler	Health Intelligence Analyst
Nicola Beech	Health Intelligence Analyst

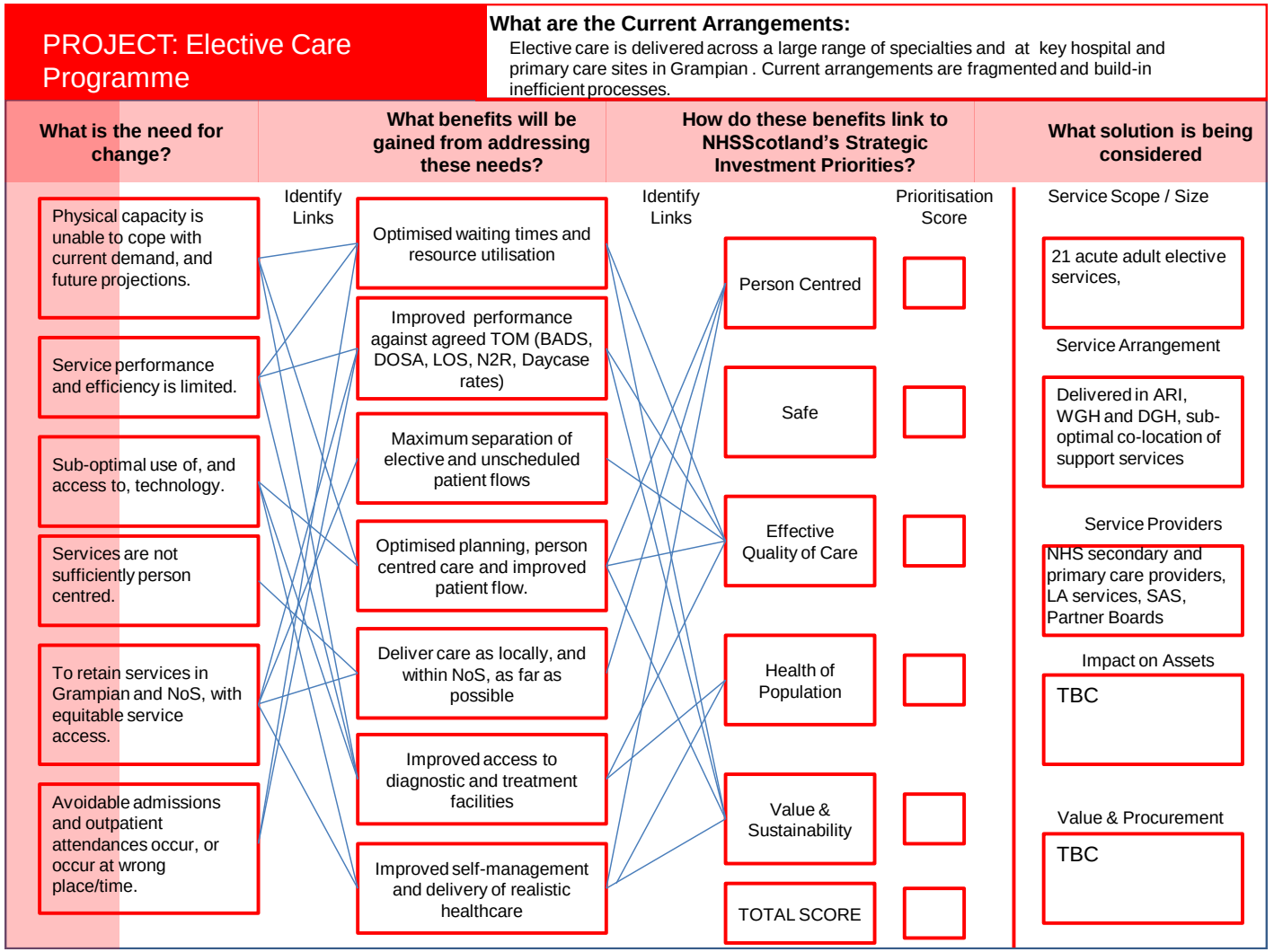
Supporting papers for Programme Board meetings will be distributed one week prior to meeting dates.

Reporting Structure of the Programme Board

The proposed reporting structure for the Board is outlined below.



Appendix K
NHS Grampian Elective Care – Strategic Assessment


PROJECT: Elective Care Programme
What are the Current Arrangements:
Elective care is delivered across a large range of specialties and at key hospital and primary care sites in Grampian . Current arrangements are fragmented and build-in inefficient processes.
What is the need for change?
What benefits will be gained from addressing these needs?
How do these benefits link to NHSScotland's Strategic Investment Priorities?
What solution is being considered
Identify Links
Identify Links
Prioritisation Score
Physical capacity is unable to cope with current demand, and future projections.
Service performance and efficiency is limited.
Sub-optimal use of, and access to, technology.
Services are not sufficiently person centred.
To retain services in Grampian and NoS, with equitable service access.
Avoidable admissions and outpatient attendances occur, or occur at wrong place/time.
Optimised waiting times and resource utilisation
Improved performance against agreed TOM (BADS, DOSA, LOS, N2R, Daycase rates)
Maximum separation of elective and unscheduled patient flows
Optimised planning, person centred care and improved patient flow.
Deliver care as locally, and within NoS, as far as possible
Improved access to diagnostic and treatment facilities
Improved self-management and delivery of realistic healthcare
Person Centred
Safe
Effective Quality of Care
Health of Population
Value & Sustainability
TOTAL SCORE
Service Scope / Size
21 acute adult elective services,
Service Arrangement
Delivered in ARI, WGH and DGH, sub-optimal co-location of support services
Service Providers
NHS secondary and primary care providers, LA services, SAS, Partner Boards
Impact on Assets
TBC
Value & Procurement
TBC

Appendix L
Potential Site and Artists Impression of Elective Care Centre (Photos)

Appendix L

Potential Site and Artists Impression of Elective Care Centre

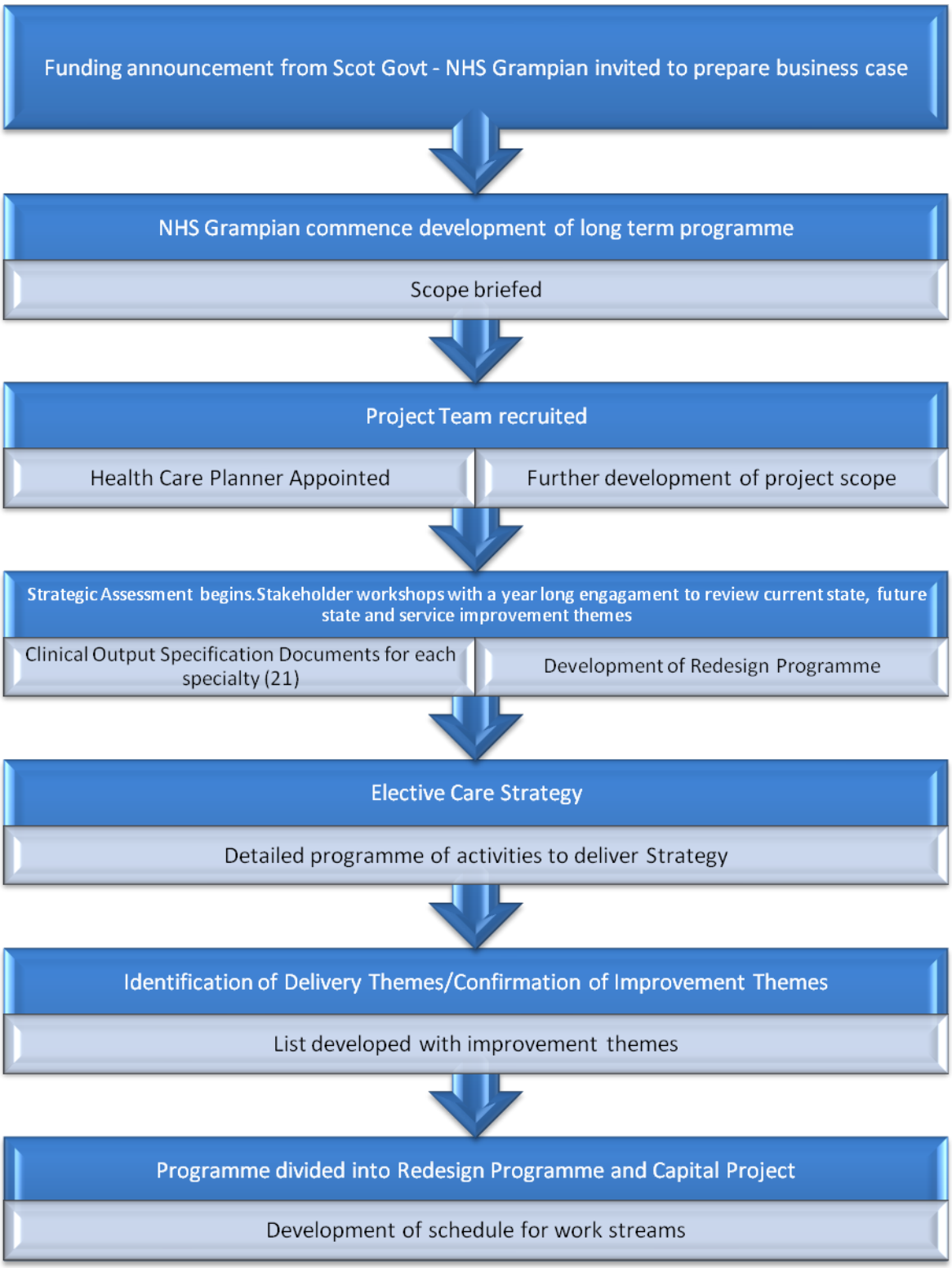
Potential Location

Artists Impression – Elective Care Centre

Appendix M
Elective Care Programme Development - Process Map

Appendix M

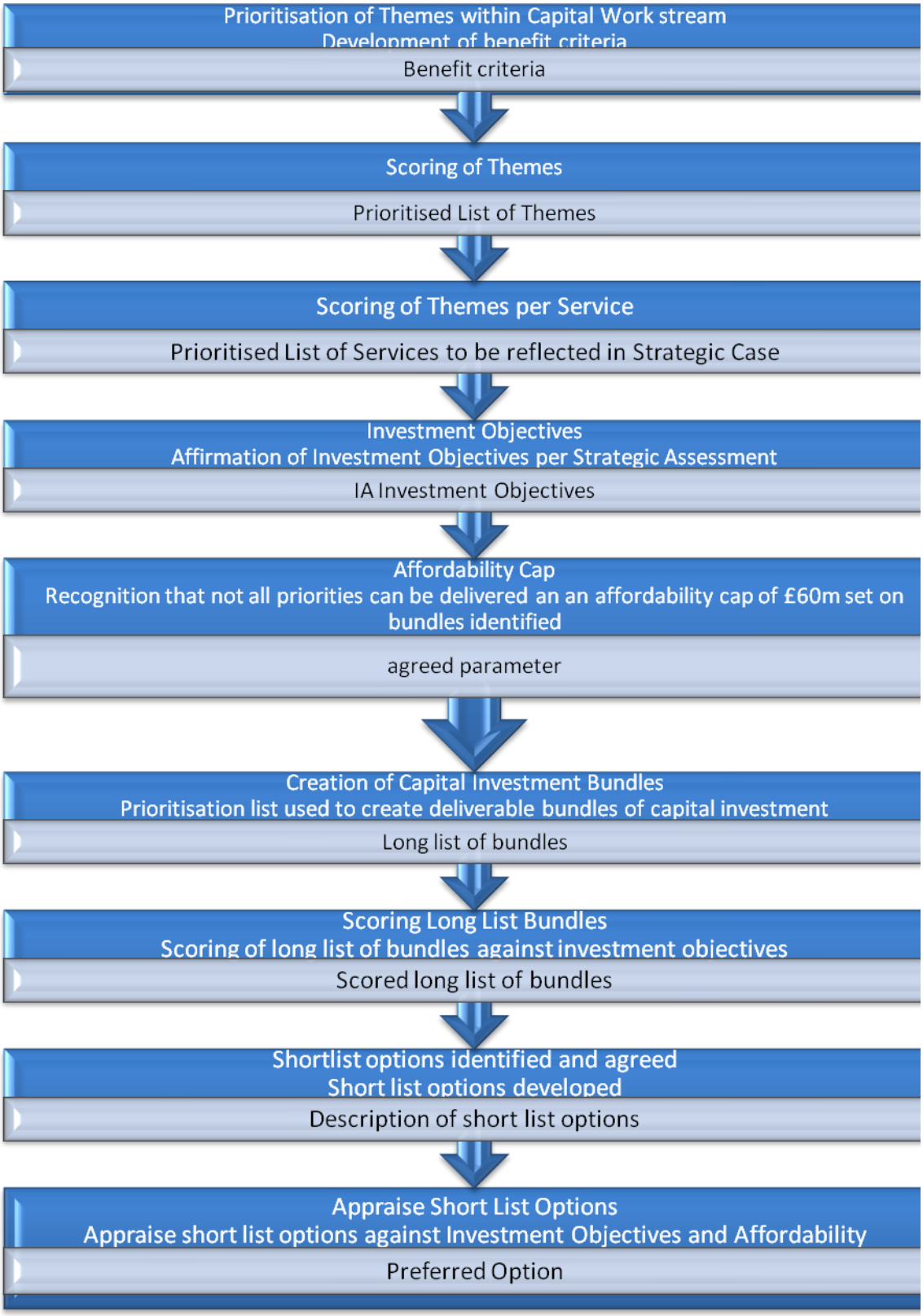
Elective Care Programme Development – Process Map



Appendix N
Elective Care – Development of Preferred Option

Appendix N

Development of Preferred Option



Appendix O
Elective Care - Prioritisation of Themes

Appendix O

Prioritisation of Themes

1. Following identification of the benefit criteria a cross section of 10 of the Elective Care Redesign Programme Team considered and weighted the Benefit Criteria identified. The table below sets out the agreed weighting

Benefit Criteria	Agreed Weight
Optimised waiting times and resource utilisation	18
Improved performance against agreed TOM (BADS, DOSA, LOS, N2R, Daycase rates)	8
Maximum separation of elective and unscheduled patient flows	5
Optimised planning, person centred care and improved patient flow	26
Sustain services and workforce to deliver care as locally, and within NoS, as far as possible	11
Improved access to diagnosis and treatment	20
Improved self-management and delivery of realistic healthcare	12
TOTALS	**100**

2. The team also considered scoring criteria and agreed those set out the table below would be used to measure the anticipated impact investment of resource (time, revenue or capital) would have.

Agreed Scoring Criteria	Score
Could hardly be better, perfection	10
Excellent, almost perfect	9
Very good	8
Good	7
Quite good	6
Status Quo	5
Less good	4
Poor	3
Very poor	2
Could hardly be worse	1

3. The team then went on to consider the themes for improvement that had been identified with a view to scoring and prioritising.

Brief Description/Name	Score * Weight	Rank
OP/Procedure system impact	830	1
Community Biologics	826	2
GP minor surgery	814	3
Pre Assessment facilities	812	4
Grampian Guidance	811	5
ERAS (Non-capital)	811	6
Community Hubs	809	7
Interventional Radiology facilities	802	8

Digital Images	802	9
CT/MRI	801	10
Biologics & medical day treatment - Hospital	799	11
DOSA facilities	795	12
Endoscopy facilities	785	13
Functional Disorder service / pathway (non-capital)	776	14
Clinical/Patient Portal	770	15
Daycase surgery facility	762	16
Critical Care redesign	731	17
Laboratory Information Management System	742	18
Cath Lab	720	19
Clinical Advice / Discussion	701	20
Laboratory facilities	687	21
Optimise use of end user IT systems	670	22
Medical Device Integration	662	23
Activity Recording	648	24
Back Office IT	581	25
DGH Outpatient facilities		26

Note - where multiple specialities have been scored within a theme the highest score is represented in the table above

4. The team also considered the Outpatient and Daycase Specialities with a view to scoring and
prioritising those specialities where investment in of resources would have the highest impact.

Specialty / subspecialty scores by theme

OPTION SCORING - Outpatient Consulting / Procedure rooms

Brief Description/Name	**Score**	**Designation**
OP/Procedure system impact	830	1
Urology	785	2
Respiratory	768	3
Dermatology	732	4
General Surgery	706	5
Plastics	690	6
Orthopaedics (NEEDS SCORED)	682	7
Vascular	679	8
Renal	652	9
Cardiology ??	646	10
Neurology	567	11
OMFS	554	12

Appendix P
Elective Care – Scoring of Bundles (Service Options)

Appendix P

Scoring of Bundles

Bundle No	Prioritisation Score IA Appraisal Rank		Option A	Option B	Option C	Option D	Option E	Option F	Option G	Option H	Option J	Option I	Option L	Option K
Total Area (m2)			**12,097**	**5,937**	**5,211**	**6,159**	**6,031**	**6,466**	**7,844**	**7,841**	**6,028**	**7,816**	**3,833**	**7,130**
CAPEX (millions)			**91.55**	**40.40**	**39.50**	**45.40**	**47.58**	**49.09**	**56.26**	**57.96**	**46.27**	**56.09**	**3.74**	**51.66**
	9,813		**3,270**	**4,743**	**4,042**	**4,789**	**4,400**	**4,805**	**5,185**	**5,202**	**7,128**	**0**	**5,606**	
			Excluded	**Excluded**	**Excluded**	**Excluded**	**Excluded**	**short list**	**Excluded**	**short list 1**	**short list 2**	**short list 3**	**short list 4**	**short list 5**
			1	**10**	**7**	**9**	**6**	**9**	**6**	**5**	**4**	**2**	**12**	**3**
Entrance to centre		y	y	y	y	y	y	y	y	y	y	y		y
18 C/E Rooms; 2 Treatment Room (top 6 - a)	830	y	y	y										
24 C/E Rooms; 2 Treatment Room (top 6 - b)	830	y	y	y	y	y	y	y	y	y	y	y		y
12 C/E Rooms; 1 Treatment Room (Community Diagnostic and Treatment Hub including Biologic)	809	y	y	y	y	y								
Community Diagnostic and Treatment Hub including Biologic	826	y					y	y	y	y	y	y		y
Interventional Radiology Suite (1 room)/cath Lab (1 room)	1,522		f									y		
Interventional Radiology Suite (1 room)	802			f	f	f	f	f	f					
Secure Digital Photos	802	y	y	y	y	n	n	n	n	n	y	y		y
CT Scanning Suite (2)	801		y											
CT Scanning Suite (1)	801				y	y	y	y	y	y	y	y		y
MRI Scanning Suite (2)	801		y		y	y	y	y	y	y	y	y		y
Biologic Area (24 Place)	801	y	y			y								
Endoscopy Suite (5 rooms)	785	y	y						y	y				
Clinical/Patient Portal	770	y	y				y							
Day Surgery Unit (2 Theatre)	1,142	y	y					y		y	y			
Day Surgery Unit (no Theatre)	762						y		y					
Lims	742		y											
Clinical Advice/Discussion	701	y	y		y									
integrated Day of Surgery and endoscopy - 1+1 - 20%	1,547	y										y		y
Project Team to Date			y	y	y	y	y	y	y	y	y	y	y	y
2nd Cataract Procedure Room			y	y	y	y	y	y	y	y	y	y	y	y
Future Project Team Costs			y	y	y	y	y	y	y	y	y	y		y

Appendix Q
List of Specialties Engaged in Elective Care Redesign Programme

Appendix Q

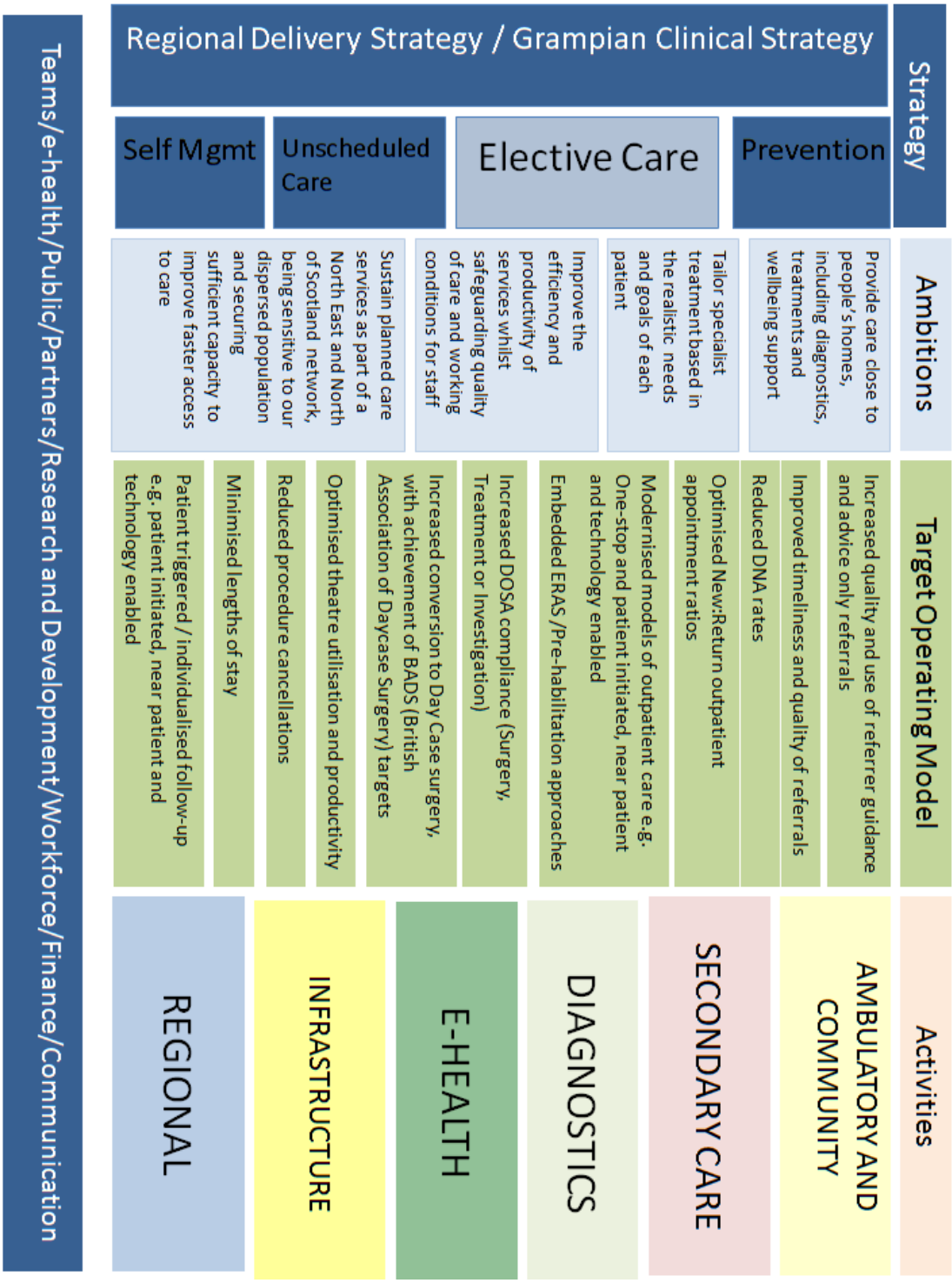
List of Specialties Engaged in Elective Care Redesign Programme

	Service		Service
1.	Cardiology	12.	Orthopaedics
2.	Critical Care	13.	Pain Management
3.	Dermatology	14.	Plastic Surgery
4.	ENT	15.	Primary Care
5.	Gastroenterology & Endoscopy	16.	Radiology
6.	General Surgery	17.	Renal Medicine
7.	Laboratories	18.	Respiratory Medicine
8.	Neurology	19.	Rheumatology
9.	Neurosurgery	20.	Theatres
10.	Ophthalmology	21.	Urology
11.	Oral Maxillofacial Surgery (OMFS)	22.	Vascular Surgery

Appendix R
Elective Care Programme – Driver Diagram

Appendix R

Elective Care Programme – Driver Diagram



Appendix S
Elective Care Programme — Patient Pathways & Current Arrangements

Patient Pathways & Current Arrangements

Figure 1: Cardiology Patient Pathway and Flow

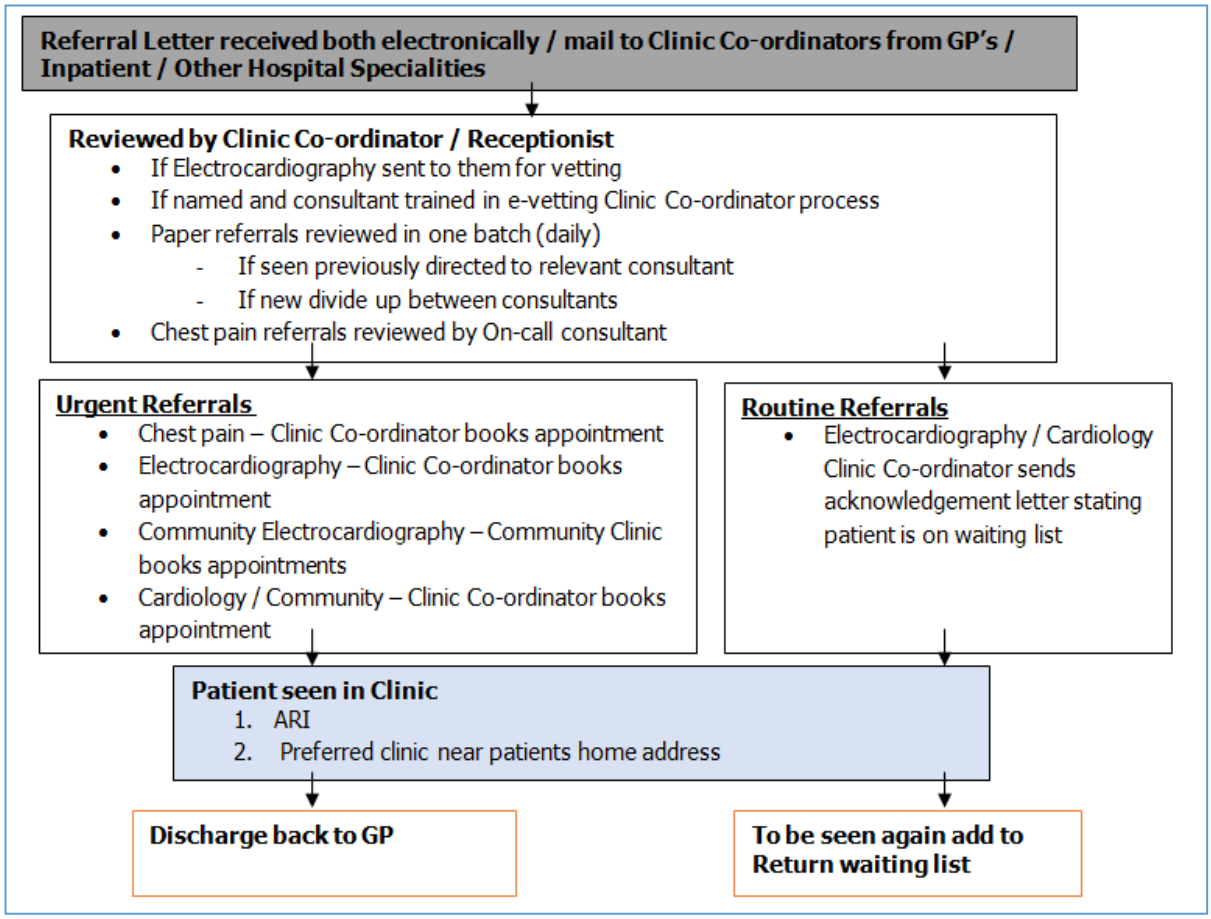


Figure 2: Dermatology Patient Pathway and Flow

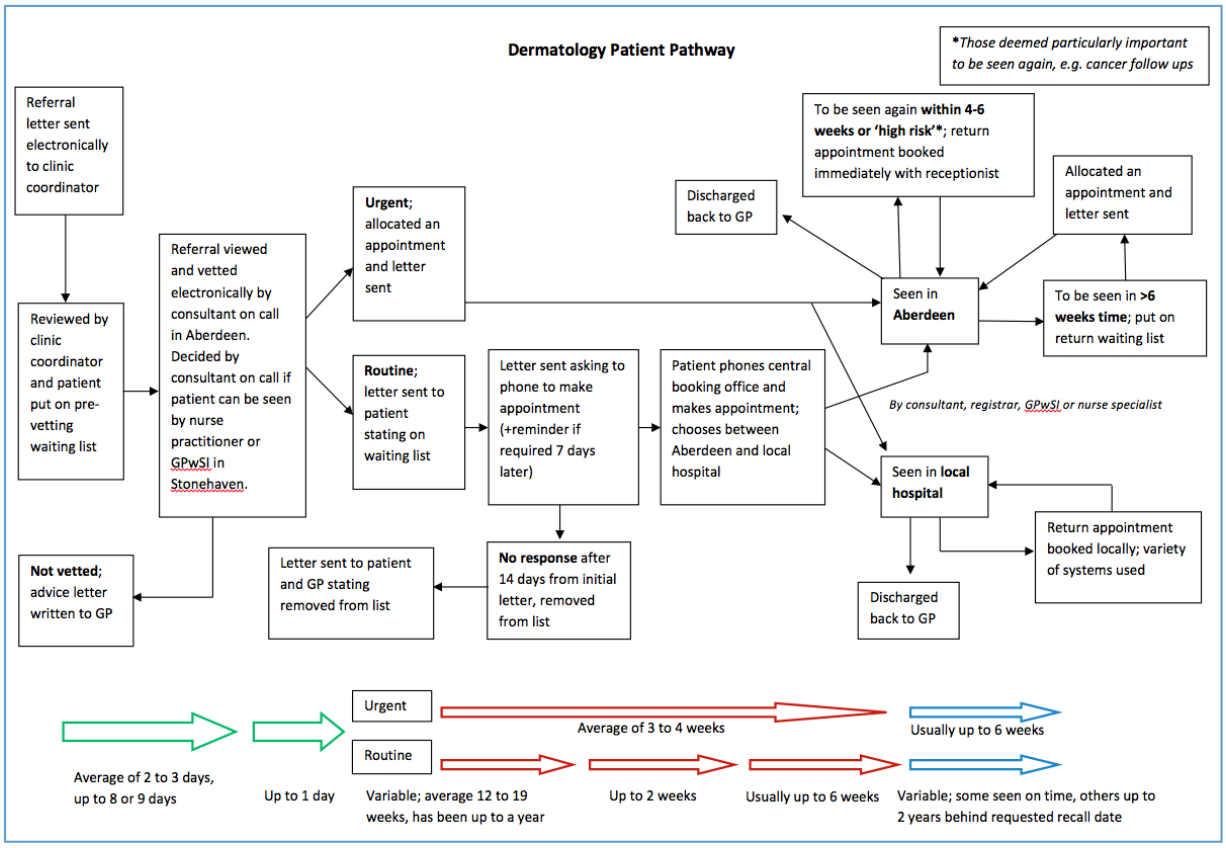


Figure 3: Endoscopy Patient Pathway and Flow

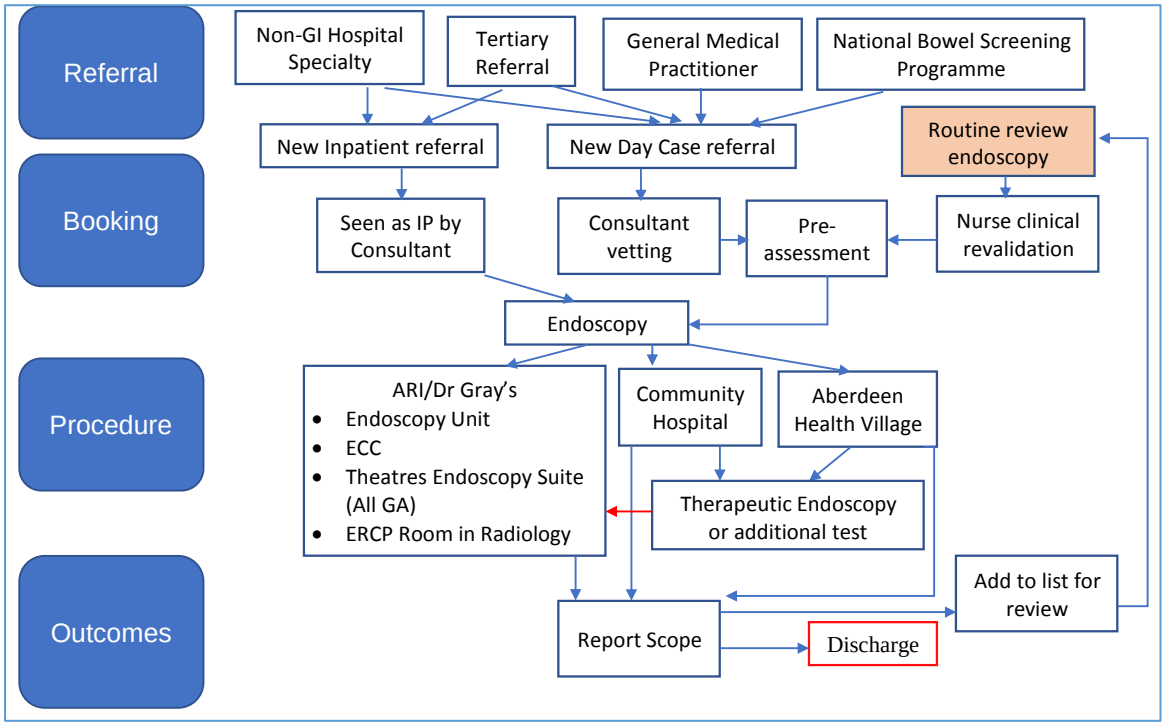


Figure 4: Respiratory Patient Pathway and Flow

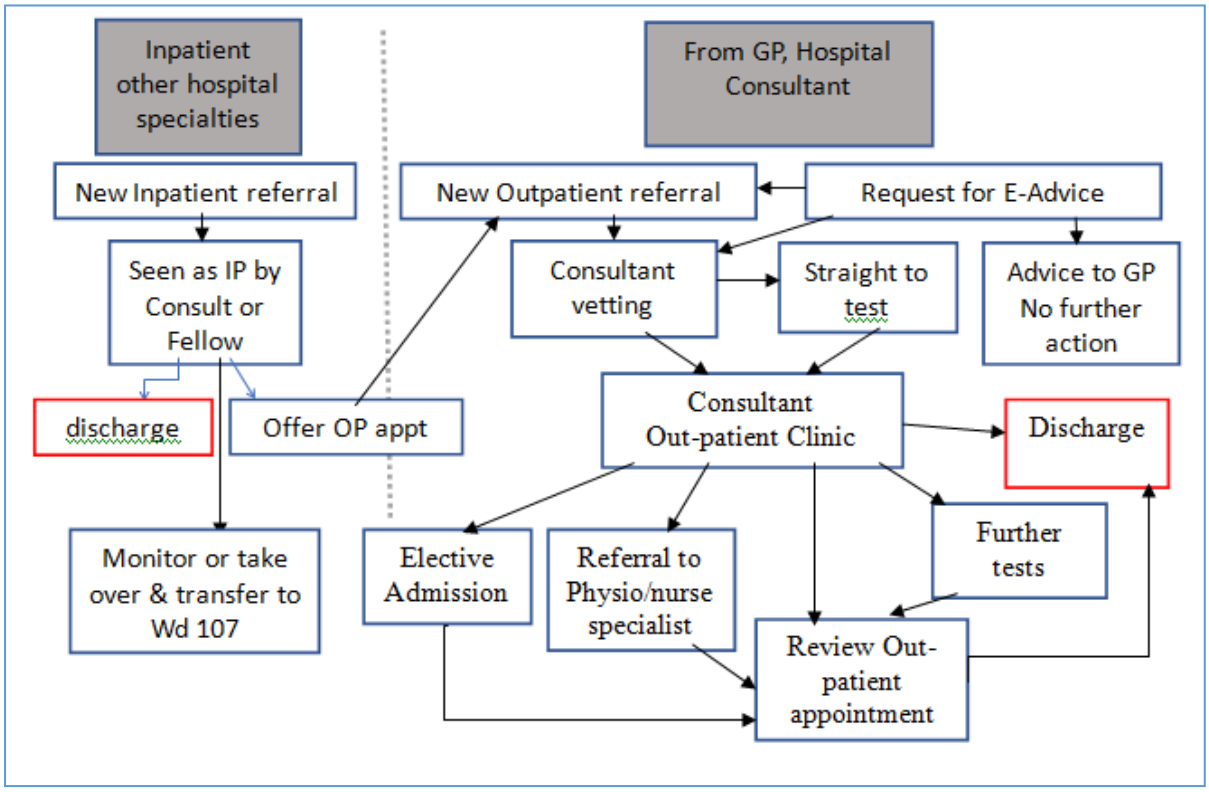


Figure 5: Theatres Patient Pathway and Flow

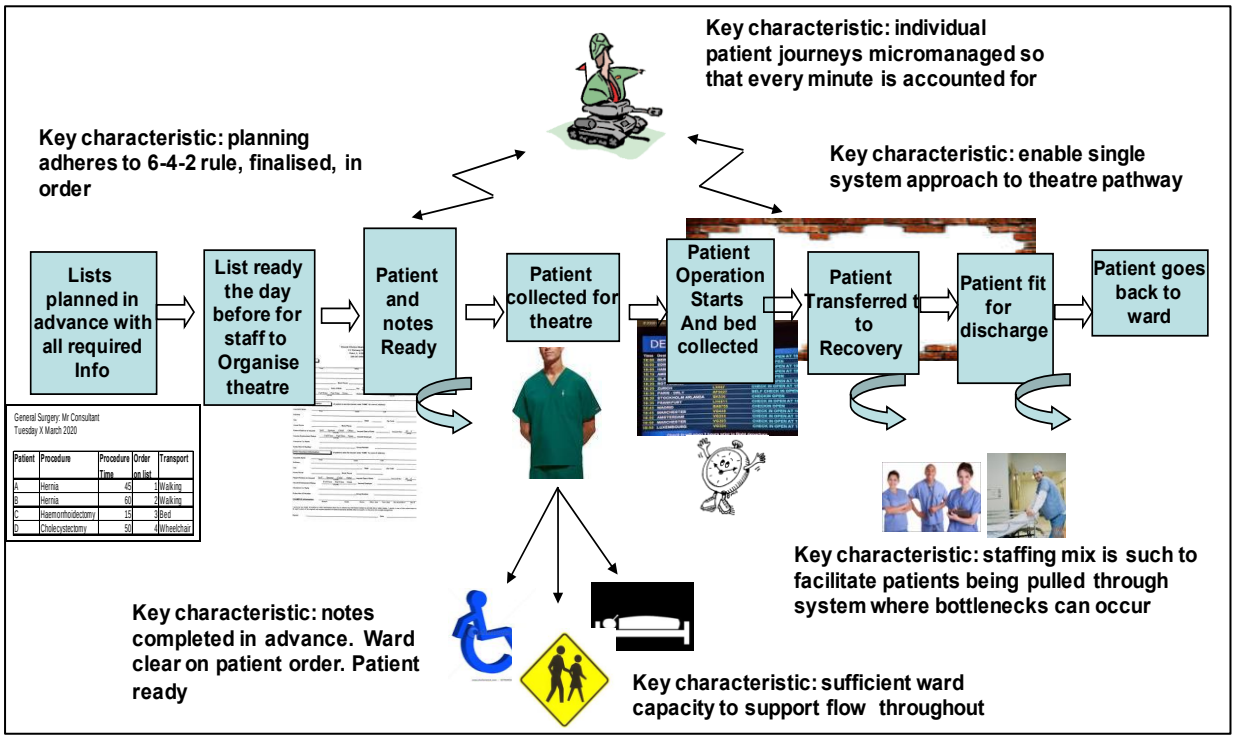
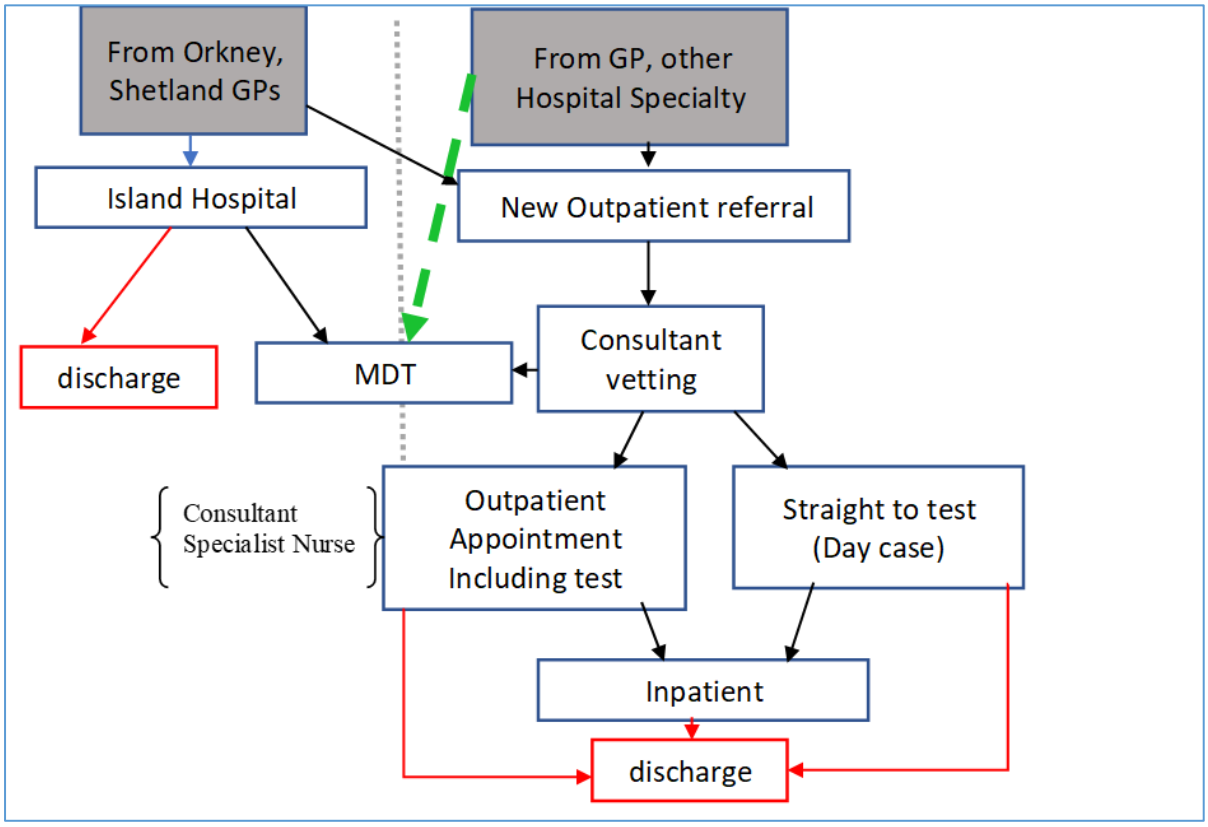


Figure 6: Urology elective pathway and flow



Appendix T
Elective Care Programme — Service Locations/ Associated Assets

Appendix T

Service Locations/Associated Assets

ARI **Cardiology** services are based in:

- Inpatient services: 30 beds in ward 109 and 10 beds in ward 106 (CCU)
- Day case: 12 day beds located in ward 401 incorporating the two cardiac cath labs
- Cardiac Rehabilitation Service – Ashgrove House
- 2 Cardiac Cath Labs in ARI

The main base for **Dermatology** is provided at Burnside House, Foresterhill in Aberdeen, though outpatient and ambulatory services are delivered from a number of other clinic locations across the ARI site, clinics are also held at ward 406 ARI and RACH and at numerous peripheral clinic locations.

Endoscopy services are fragmented and provided via numerous locations, including 4 separate locations on the ARI site:

- The current Endoscopy Unit
- Main theatres
- Radiology (Fluoroscopy Room)
- The Matthew Hay building – 'the bleeding unit' – mainly unscheduled

Also at:

- Dr Gray's Hospital
- The Aberdeen Health Village (via 3rd party)
- Community Hospitals (Aboyne, Chalmers, Peterhead, Kincardine)
- Stracathro Regional Treatment Centre

Within the Foresterhill Site the **Radiology Services** are located in several locations:

- Emergency Care Centre: Medical ambulatory care
- Radiology inpatient department in the yellow zone (Phase 2)

- Radiology outpatient department in the orange zone (East end)
- MRI in Phase 1
- Nuclear Medicine Department orange zone (East End)
- Mobile Units on wards and imaging support for surgical theatres: Woodend, ARI, RACH and the Maternity Hospital
- RACH
- Aberdeen Maternity Hospital
- Cardiac Catheterisation (Ward 401)
- Woodend, Dr Grays and ARI – image guided biopsies and image guided injections

Detailed table of Radiology service lcoations

Location	Service
Aberdeen Health and Community Care Village	General Ultrasound General Radiology
Aberdeen Royal Infirmary	General and specialised Ultrasound General Radiology Cardiac Catheterisation (Ward 401) Computer Tomography Dental radiography including Cone Beam CT Fluoroscopy Interventional Inpatient (yellow zone) Nuclear Medicine MRI Mammography
Aboyne Hospital	General Radiology
Banchory	General Ultrasound

Chalmers Hospital	General Ultrasound General Radiology
Dr Gray's Hospital	General Ultrasound General Radiology Computer Tomography Dental Radiography Fluoroscopy
Fraserburgh Hospital	General Radiology
Jubilee Hospital (Huntly)	General Radiology
Kincardine Community Hospital	General Ultrasound General Radiology
Leanchoil Hospital (Forres)	General Radiology
Peterhead Hospital	General Ultrasound General Radiology
Royal Aberdeen Children's Hospital	General Ultrasound General Radiology Dental Radiography Fluoroscopy
Seafield Hospital (Buckie)	General Radiology
Stephen Hospital (Dufftown)	General Radiology
Turner Hospital (Keith)	General Radiology
Turriff Hospital	General Ultrasound General Radiology
Woodend Hospital	General Ultrasound General Radiology MRI Fluoroscopy

Respiratory services are delivered in the following locations:

Outpatient and ambulatory care sessions are currently delivered in numerous locations as follows:

- Clinic C, ARI (this includes the offices for the specialist nurses and the secretarial staff for the service)
- Out-patient Department, Dr Gray's Hospital, Elgin
- Out-patient Department, Chalmers Hospital, Banff
- Out-patient Department, Peterhead Community Hospital
- One Treatment/Procedure Room, Ward 107, ARI
- Physiotherapy Department
- An oxygen clinic is health within Clinic C, ARI
- Pulmonary Function Laboratory within the Rotunda building
- East End Corridor, ARI for walking tests
- Patient Hotel at ARI for Sleep test (one patient per week for full comprehensive testing)

Respiratory Inpatient and day treatment areas include:

- 30 inpatient beds on Ward 107, ARI
- Five patients on average 'boarded' on other wards
- Short Stay Suite
- Endoscopy Suite (for Bronchoscopy)
- The treatment room on Ward 107 is used for day attenders, typically pleural procedures. There is limited space to do this and issues relating to patient safety and dignity.

Theatre service configuration

Currently, the services are delivered via:

- Main Theatres ARI (17 theatres and one recovery area, including three emergency theatres)
- Surgical Short-Stay Unit/23 hour - two theatres, two procedure rooms and a recovery area

- Level 0 theatre – two theatres (2nd theatre not staffed) one recovery area
- Ward 202 – Urology Day Case theatre & recovery/ward area
- Woodend – six theatres and two recovery areas
- Dr Gray's – four theatres and one endoscopy room, recovery area

Urology Services are delivered in the following locations

ARI:

- Day Case – Ward 202
- Inpatients – Ward 209
- Short Stay Inpatients – Ward 211
- Outpatient Clinics A, B, C and G
- Ward attenders visit the procedure room on Ward 209 (small)
- A corner room on Ward 209 has been converted to create a urology diagnostics suite

Dr Gray's Hospital, Elgin:

- One Theatre Session per week (seven patients per list)
- Use of day patient ward
- Flexible cystoscopies are done in a treatment room adjacent to theatres
- Inpatients – Ward 5 shared surgical
- Out-patients – One clinic and it is shared with other specialties

Abbreviations

NHS Grampian Elective Care Programme

Abbreviations

ACHD	Adult Congenital Heart Disease
AEDET	Achieving Excellence Design Evaluation Toolkit
AHP	Allied Health Professional
AHV	Aberdeen Health and Community Care Village
AMD	Age-related Macular Degeneration
AMG	Asset Management Group
ANCHOR	Aberdeen and North Centre for Haematology Oncology and Radiotherapy
ARI	Aberdeen Royal Infirmary
BADS	British Association of Day Surgery
CCU	Coronary Care Unit
CDF	Clinical Development Fellow
CDM	Construction Design Management
CIG	Capital Investment Group
COPD	Chronic Obstructive Pulmonary Disease
COS	Clinical Output Specification
CT	Computed Tomography
DOSA	Day of Surgery Admission Suite
ECG	Electrocardiogram
ENT	Ear, Nose & Throat
EP	Electrophysiology
ERCP	Endoscopic Retrograde Cholangiopancreatography
ETT	Exercise Tolerance Testing
EUS	Endoscopic ultrasound
FBC	Full Business Case
FEVAR	Fenestrated Endovascular Aortic Repair
FNA	Fine Needle Aspirations
FS2	Frameworks Scotland 2
GP	General Practitioner
HAI	Healthcare Associated Infection
HDU	High Dependency Unit

HFS	Health Facilities Scotland
HLIP	High Level Information Pack
HSCP	Health and Social Care Partnership
IA	Initial Agreement
ICU	Intensive Care Unit
IR	Interventional Radiology Theatre
LDP	Local Delivery Plan
LOS	Length of Stay
MCN	Managed Clinical Network
MDT	Multi Disciplinary Team
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
NDAP	NHSScotland Design Assessment Process
N2R	New to Return
NEC3	New Engineering Contract
NHS	National Health Service
NHSG	NHS Grampian
NoS	North of Scotland
OBC	Outline Business Case
OJEU	Official Journal of the European Union
PA	Physician Associate
PCI	Percutaneous Coronary Intervention
PD	Project Director
PET	Positron Emission Tomography
PSCP	Principal Supply Chain Partner
RACH	Royal Aberdeen Children's Hospital
SCIM	Scottish Capital Investment Manual
SGHSCD	Scottish Government Health and Social Care Directorate
SHC	Scottish Health Council
SLA	Service Level Agreement
SRO	Senior Responsible Owner
TAVI	Transcatheter Aortic Valve Implantation

TOE	Trans-oesophageal Echocardiograph
TOM	Target Operating Model
TTG	Treatment Time Guarantee
UCAN	Urological Cancer Charity