Lochaber RGH Options Appraisal Non-Financial Benefits Assessment

Summary Report v2 – 22nd May 2026

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1 Non-Financial Benefits Options Appraisal Report

1.1 Introduction

This report summarises the non-financial benefits assessment undertaken to support the development of the Outline Business Case for the Lochaber Rural General Hospital project. It describes the approach followed, the workshops convened, the agreed non-financial benefit criteria, and the outcomes of the ranking, weighting and scoring exercises. The purpose is to set out the evidence base generated through this strand of the options appraisal process.

This report does not identify a preferred option. The non-financial assessment is one component of the overall appraisal required for the Outline Business Case. The final recommendation will be determined by NHS Highland (NHSH) following completion of the financial analysis, whole-life cost assessment, risk analysis and value-for-money comparison undertaken by the NHS Highland Finance team.

1.2 Context and programme position

The Lochaber RGH project has progressed through earlier stages of the Scottish Capital Investment Manual process. Following the Strategic Assessment and Initial Agreement, the project was re-mobilised in 2025 and has entered the Outline Business Case phase. The options appraisal work undertaken in February 2026 forms a core element of the OBC, informing the assessment of service models and infrastructure options.

Programme milestones relevant to this appraisal include the completion of Stage 3 design in January 2026, the planned completion of the Outline Business Case in May 2026 and subsequent design and construction stages extending through to hospital opening.

1.3 Scope of the non-financial benefits assessment

The non-financial benefits assessment focuses on how well each shortlisted option performs against a set of agreed criteria aligned to the project's investment objectives. The assessment reflects stakeholder judgement about service quality, clinical effectiveness, workforce sustainability, accessibility, environmental considerations and the wider functioning of the health and care system.

All financial considerations, including capital and revenue costs, whole-life costing, financial benefits and risk analysis, remain outwith the scope of this report and will be produced separately by the NHS Highland Finance, Capital Planning and Leadership teams.

1.4 Workshop arrangements and participation

Two workshops were held to undertake this assessment:

- A benefits development and validation workshop held on 19th February 2026
- A full options appraisal workshop held on 24th February 2026

Both sessions involved representatives from:

- Lochaber RGH service leads
- NHS Highland leadership team
- External, public or wider system stakeholders

In total, 27 participants took part in the scoring exercise on 24 February, consisting of:

- 12 NHS Highland Leadership Team participants
- 9 RGH service leads
- 6 public, external or other stakeholder representatives

The workshops were supported by facilitators from Buchan + Associates (B+A) and the NHS Highland Capital Planning and Transformation teams. Facilitators did not participate in the scoring process.

The full list of participants is provided in Appendix A.

2 Approach and methodology

2.1 Overview of the methodological framework

The approach to the non-financial benefits assessment was aligned to the requirements of the Scottish Capital Investment Manual. Consistent with national guidance, the non-financial assessment was undertaken separately from the financial analysis to ensure objectivity and transparency in evaluating the relative merits of the shortlisted options.

The methodology involved:

- defining and validating a set of non-financial benefit criteria
- ranking the criteria in terms of absolute importance
- weighting the criteria using a structured paired-comparison method
- scoring each shortlisted option against each criterion on an individual basis
- aggregating scores and weights to produce total weighted non-financial benefit scores
- undertaking sensitivity testing to assess the robustness of the results

2.2 Workshop-based assessment process

The assessment was structured around two workshops.

2.2.1 Benefits development workshop – 19th February 2026

The first workshop focused on the development, refinement and validation of the draft non-financial benefit criteria. This draft was generated by the NHSH internal core project team for the Lochaber redesign project, facilitated by B+A. Attendees included representatives of the Lochaber RGH service leads, the NHS Highland leadership team and public or external stakeholders. The session examined the draft criteria, their

alignment with the project's investment objectives and the extent to which they differentiated between options. Minor adjustments were made to ensure clarity, avoid overlap, and clarify features of the benefits to assist with consistent interpretation during scoring.

2.2.2 Options appraisal workshop – 24th February 2026

The second workshop undertook the full non-financial appraisal. The session included:

- recap of the option shortlist
- review of the validated non-financial benefit criteria
- facilitated group discussion to rank criteria
- paired-comparison exercise to weight criteria
- individual scoring of each option against each benefit criterion
- collection of scoring sheets for post-workshop processing

Each participant completed scoring independently using a ten-point scale ranging from "10 - could hardly be better" to "1 - could hardly be worse", as set out in the agreed scoring criteria. Facilitators supported the process but did not participate in scoring.

Basis for participant scoring and decision-making

Prior to undertaking the scoring exercise, each shortlisted option was presented in a standardised format, including its proposed service configuration, key features, and associated high-level facility implications. The agreed non-financial benefit criteria were also reviewed, including their definitions and key features, to ensure a consistent understanding across all participants.

The workshop was facilitated to allow participants to discuss the options and criteria in detail, test assumptions, and clarify any areas of ambiguity. This process enabled a shared understanding of the material presented, while allowing for the exploration of different perspectives across the participant group.

Scoring was then undertaken on an individual basis using the agreed ten-point scale, ranging from "10 – could hardly be better" to "1 – could hardly be worse". Participants were asked to assess the extent to which each option met each criterion, drawing on the information presented, the facilitated discussion, and their own professional knowledge and experience. Participants were specifically instructed to score each option against each criterion on its own merits, rather than comparatively between options.

The approach was designed to support informed judgement rather than prescriptive scoring. While discussion was used to support consistency of interpretation, individual scores reflected each participant's own assessment.

The composition of the workshop was structured to include representation from NHS Highland leadership, clinical and operational service leads, and external or public stakeholders. This ensured that a range of relevant perspectives was reflected in the

assessment. Facilitators supported the process and ensured consistency of approach but did not participate in scoring or influence individual judgements.

2.3 Shortlisted options

Six options, including the baseline "Do minimum", were presented consistently across both workshops. These were:

- Option 1 – Do minimum (maintain existing arrangements)
- Option 2 – Core Rural General Hospital model
- Option 3 – Core RGH model plus intensive rehabilitation
- Option 4 – Option 3 plus increased elective activity
- Option 4a – Option 4 limited to elective day-case surgery
- Option 5 – Ambulatory care services only

All these options (except for option 4a) were presented in the Initial Agreement Business Case approved by Scottish Government. Option 4a was added to the range of options to represent alignment with wider NHSH strategic transformation work exploring the provision of General Surgery Services.

A summary of each option's features, advantages and disadvantages was provided to participants to ensure a common reference point during scoring (Appendix B). No changes were made to the option descriptions between workshops.

2.3.1 Clarifications and issues raised during option presentation

During the presentation of the shortlisted options, participants sought clarification on several points relating to underlying assumptions, scope of service change and operational implications. A factual summary of these discussions, including the queries raised and the clarifications provided, is included in Appendix C for transparency and completeness. Only the agreed outcomes of these exercises are presented in the main body of this report.

2.4 Development of non-financial benefit criteria

The non-financial benefit criteria were initially drafted by B+A in collaboration with NHS Highland. The criteria were designed to reflect the agreed investment objectives in the Initial Agreement and to differentiate meaningfully between the shortlisted options.

During the 19th of February workshop, participants reviewed the draft criteria and suggested refinements focusing on:

- clarity of wording
- removal of overlap between criteria
- ensuring the criteria reflected outcomes rather than solutions
- ensuring all stakeholders could apply the criteria consistently

The final agreed criteria were then used without amendment during the 24th of February appraisal. (Appendix D)

2.5 Ranking of benefit criteria

Participants carried out a facilitated ranking exercise to determine the absolute order of importance of the eight criteria. This was undertaken through group discussion, informed by the investment objectives and the relative priorities identified during the 19 February session. The final ranking, and key elements of discussion is presented in Section 4.

2.6 Weighting of benefit criteria

The weighting exercise applied a paired-comparison method, where each criterion was compared with the next in rank order using a scale of 95 (near-identical importance) to 5 (very different). This generated raw weights which were then converted to proportional weightings summing to 100 per cent.

The final weighting table is included in Section 4.

2.7 Scoring process

Each participant completed scoring independently using the agreed ten-point scale. Scores were recorded for each option against each benefit criterion and collected at the end of the workshop for aggregation and analysis.

The basis on which participants formed their judgements is set out in Section 2.2.2 and the aggregated scoring output is presented in Section 5.

2.8 Sensitivity testing

Following aggregation of scores and weights, a series of sensitivity tests were undertaken to assess the stability of the results. These included:

- removal of the highest-weighted criterion
- application of equal weightings
- comparison of results across stakeholder groups
- examination of the impact of marginal score changes

3 Non-financial benefit criteria

3.1 Overview

The non-financial benefit criteria were developed to reflect the investment objectives set out in the Initial Agreement for the Lochaber RGH project. They were initially drafted by B+A and NHS Highland, and subsequently reviewed, refined and validated with stakeholders at the workshop held on 19 February 2026.

The purpose of the criteria is to assess the degree to which each shortlisted option supports service quality, clinical effectiveness, accessibility, workforce sustainability,

environmental performance and wider system functioning. The criteria have been designed to:

- align with the investment objectives
- focus on outcomes rather than solutions
- avoid duplication or overlap
- differentiate between options
- support consistent interpretation and scoring across participants

The validated criteria were then used in full during the options appraisal workshop on 24th February 2026. The benefits presented on the 24th of February had been updated to reflect feedback and discussion captured during the 19th of February session.

3.2 Final agreed benefit criteria

The final eight non-financial benefit criteria, as confirmed during the 19th of February workshop, are set out below. These definitions and associated features were provided to all participants in the scoring workshop to support consistent application.

A1 – Patient care experience

The extent to which the option supports a positive patient experience and respects dignity across all healthcare interactions. This includes the degree to which patient care and safety are optimised through locally delivered, high-quality clinical services and reduced travel requirements. Key features include maximising clinical services delivered in Lochaber, improving quality of care and reducing unnecessary travel time.

A2 – Supports workforce needs from an employee and employer perspective

The extent to which the option supports the local workforce by improving recruitment, retention, training opportunities and career development. Key features include enhancing recruitment, enabling access to appropriate training and supervision, maintaining skills and supporting effective local and regional professional networks.

A3 – Workforce model is sustainable in the medium to long-term

The extent to which the option enables a viable, sustainable workforce model given national and local staffing pressures. This covers the ability to maintain consistent service delivery with sufficient staff possessing appropriate skills, while enabling evolving models of education and reducing reliance on unsustainable staffing patterns.

A4 – Function and quality of the physical environment

The extent to which the option delivers a modern, flexible healthcare environment that supports high-quality health and care delivery. This includes patient flow, accessibility, departmental adjacencies and the therapeutic quality of the environment. Additional features include patient privacy, reduced hospital-acquired infection risk, access to external space and the ability to adapt and expand the estate.

A5 – Capacity and flexibility to meet anticipated service demand

The extent to which the option provides sufficient capacity to meet current and future demand, including flexibility to accommodate changes in care models and patterns of need. Features include the ability to deliver local services for patients in crisis, enable additional services if required, and ensure consistent utilisation across the week.

A6 – Improved clinical effectiveness and 21st century RGH care

The extent to which the option supports optimal clinical outcomes, reduced admissions, reduced length of stay and more effective patient pathways. Key features include improving productivity, enabling day-case treatment models, reducing avoidable admissions and supporting timely discharge and access to care.

A7 – Supports optimal whole-system working

The extent to which the option contributes to effective functioning of the wider NHS Highland system and community services. This includes relieving demand on other care settings, supporting multi-agency approaches and enabling more coherent patient pathways across organisational boundaries.

A8 – Environmental impact and climate change

The extent to which the option supports delivery of Scottish Government climate targets by minimising environmental impact. This includes improving building energy efficiency, enabling movement towards net-zero carbon, reducing travel for services and supporting adoption of sustainable technologies.

3.3 Use of criteria in the appraisal

These eight criteria formed the basis for the ranking, weighting and scoring exercises undertaken during the 24th of February options appraisal workshop. They were presented to participants with descriptions and key features to ensure a shared understanding, and participants confirmed they were sufficiently clear, distinct and aligned to the investment objectives prior to scoring.

4 Ranking and weighting of benefit criteria

4.1 Overview

The ranking and weighting exercises took place during the options appraisal workshop on 24th February 2026. These exercises were undertaken to determine the relative importance of each non-financial benefit criterion prior to the scoring of options. This approach is consistent with NHS Scotland capital investment guidance, which requires both an absolute ranking and a relative weighting of criteria when assessing non-financial benefits.

The final ranking reflects the collective judgement of participants regarding the order of importance of the eight non-financial benefit criteria. The subsequent weighting exercise applied the paired-comparison method to assign a proportional importance (expressed as a percentage) to each criterion.

4.2 Ranking of benefit criteria

Participants undertook a facilitated discussion to agree the absolute ranking of criteria. The final ranking is shown below and reflects the consensus view reached on 24th February 2026.

Final rank	Reference	Benefit criterion
1	A1	Patient care experience
2	A6	Improved clinical effectiveness and 21st century RGH care
3	A3	Workforce model is sustainable in the medium to long term
4	A4	Function and quality of the physical environment
5	A7	Supports optimal whole system working
6	A2	Supports workforce needs from an employee and employer perspective
7	A5	Capacity and flexibility to meet anticipated service demand
8	A8	Environmental impact and climate change

This ranking was subsequently used as the basis for the weighting exercise.

4.3 Discussion of ranking exercise (qualitative summary)

During the ranking exercise, participants discussed the importance of the eight non-financial benefit criteria and sought clarification on how specific aspects of the criteria should be interpreted in practice. A factual summary of the points raised during this discussion, including the areas where views differed before consensus was reached, is provided in Appendix D. Only the final agreed ranking is presented in the main body of this report.

4.4 Weighting methodology

The paired-comparison method was used to allocate weights. Under this approach, each criterion was compared with the next in rank order using a nine-point scale ranging from 95 (very similar importance) to 5 (very different importance).

The raw comparison scores were converted into proportional weights that sum to 100 per cent, reflecting the relative influence of each criterion in the non-financial assessment.

Participants confirmed that the weighting outcomes appropriately reflected the relative importance of the criteria and were consistent with the ranking exercise.

4.5 Final weighting results

The final raw weights and proportional weights are shown below.

Benefit criterion	Paired comparison score	Raw weight	Weight (%)
A1 – Patient care experience	100	100.0	15.3
A6 – Improved clinical effectiveness and 21st century RGH care	95	95.0	14.6

A3 – Workforce model is sustainable in the medium to long term	95	90.3	13.8
A4 – Function and quality of the physical environment	90	81.2	12.4
A7 – Supports optimal whole system working	95	77.2	11.8
A2 – Supports workforce needs from an employee and employer perspective	95	73.3	11.2
A5 – Capacity and flexibility to meet anticipated service demand	95	69.6	10.7
A8 – Environmental impact and climate change	95	66.2	10.1
Total	—	652.7	100.0

Notes on the structure

- The paired comparison score is the direct value participants applied.
- The raw weight is the cumulative effect of the paired-comparison process.
- The weight (%) column is the normalised proportional weighting.

These weights were then applied directly to the aggregated scoring outputs to generate the weighted non-financial benefit results presented in Section 5.

5 Results of scoring and sensitivity testing

5.1 Overview

This section presents the results of the non-financial benefits scoring undertaken during the options appraisal workshop on 24th February 2026. The results reflect the combined effect of:

- individual scores submitted by 27 participants
- the agreed weighting of the eight benefit criteria
- the aggregation of weighted scores across all criteria

The outputs represent the total weighted non-financial benefit scores for each option. They do not form a recommendation on preferred option and must be considered alongside financial analysis, risk assessment and overall value-for-money considerations, which remain under preparation by NHS Highland.

5.2 Weighted scoring results

Weighted scoring results represent the final non-financial outcome and are based on the application of the agreed percentage weightings to the aggregated raw scores.

The weighted scoring exercise undertaken on 24th February 2026 produced a clear ordering of the six shortlisted options.

Option 4 – the Core Rural General Hospital model with increased elective care activity – achieved the highest total weighted non-financial benefit score at 756.6, reflecting consistently strong performance across all criteria and particularly high scoring in patient care experience, clinical effectiveness and workforce sustainability.

BENEFIT CRITERIA		WEIGHT %	1 - Do Nothing / Do Minimum		2 - Core Rural General Model		3 - Core RGH Model + Intensive Rehabilitation		4 - Option 3, with increased Elective Care activity		4a - Option 4, limited to Day Case surgery only		5 - Ambulatory Care Services only	
		W	SCORE	W x S	SCORE	W x S	SCORE	W x S	SCORE	W x S	SCORE	W x S	SCORE	W x S
1	Patient care experience	15.3	3.4	52.8	7.3	111.8	7.9	121.4	8.6	132.2	6.5	99.9	3.2	48.8
2	Improved Clinical Effectiveness and 21st Century RGH Care	14.6	2.9	42.6	6.0	87.3	7.2	105.1	7.3	106.2	6.0	86.8	3.4	49.1
3	The workforce model is sustainable in the medium to long-term	13.8	1.9	26.6	7.0	97.3	7.3	100.4	7.7	107.0	6.3	87.6	3.2	44.6
4	Function and quality of the physical environment	12.4	1.6	19.4	8.3	102.8	8.0	99.5	8.2	102.3	7.6	94.0	6.6	81.6
5	Supports optimal whole system working	11.8	2.8	33.3	6.0	70.5	6.3	74.4	6.1	72.2	5.4	63.9	3.6	42.9
6	Supports workforce needs from an employee and employer perspective	11.2	2.8	31.2	7.0	78.6	7.8	87.3	8.1	91.1	6.3	71.1	3.3	36.6
7	Capacity and flexibility to meet anticipated service demand	10.7	3.3	35.6	6.7	71.5	7.2	76.7	7.5	80.2	6.0	64.0	3.6	38.7
8	Environmental Impact and Climate Change	10.1	4.7	47.3	6.3	63.4	6.5	65.7	6.4	65.3	6.6	66.4	5.4	54.8
	TOTAL	100.0		288.7		683.2		730.6		756.6		633.7		397.0
	RANK			6		3		2		1		4		5

Option 3 – the Core RGH model with intensive rehabilitation – ranked second with a weighted score of 730.6, demonstrating strong alignment to the benefit criteria but with slightly lower scores than Option 4 in several of the highest-weighted areas.
Option 2 – the Core Rural General Hospital model – ranked third with 683.2, indicating positive performance across all criteria but a lower overall benefit profile compared with the two expanded service models.

Option 4a – the elective day-case model – achieved a weighted score of 633.7, placing it fourth and reflecting reduced performance under criteria relating to clinical effectiveness and system working due to the exclusion of inpatient general surgery.

Options 5 and 1 – the Ambulatory Care Services model and the Do Minimum baseline – received weighted scores of 397.0 and 288.7 respectively, reflecting substantially lower alignment with the agreed benefit criteria, particularly in relation to patient experience, clinical effectiveness, workforce sustainability and wider system impacts.

The results show a clear separation between the higher-scoring options (4, 3 and 2) and the remaining options, indicating a consistent stakeholder view regarding the relative non-financial merits of the service models considered.

5.3 Interpretation of weighted scores

The weighted scoring results indicate a clear separation between the highest-performing options and the remainder, with Options 4, 3 and 2 achieving consistently strong scores across the highest-weighted criteria.

The spread of total weighted scores shows that the relative ranking is driven primarily by performance under A1 – Patient care experience, A6 – Improved clinical effectiveness

and A3 – Workforce sustainability, all of which carry substantial weighting and show marked variation across options.

The results also show that lower-scoring options performed consistently less well across almost all criteria rather than being disadvantaged by any single criterion. Overall, the pattern of scoring demonstrates strong differentiation between the broad service models under consideration, with limited clustering that might otherwise indicate ambiguity or uncertainty in stakeholder judgement.

5.4 Sensitivity testing

Sensitivity testing was undertaken to assess the robustness of the weighted results and to determine whether small changes in assumptions or scoring could materially alter the ranking of options. This aligns with SCIM guidance on the need to explore the stability of outcomes under reasonable variations.

Sensitivity testing covered three areas:

- Removal of the highest-weighted criterion
- Application of equal weights across all criteria
- Marginal score change testing (small adjustments to one option under one criterion)

5.4.1 Test A – Removal of highest-weighted criterion

This test assesses whether the removal of Criterion A1 – Patient care experience (the highest weighting at 15.3 per cent) changes the ranking of options.

BENEFIT CRITERIA		WEIGHT %	1 - Do Nothing / Do Minimum		2 - Core Rural General Model		3 - Core RGH Model + Intensive Rehabilitation		4 - Option 3, with increased Elective Care activity		4a - Option 4, limited to Day Case surgery only		5 - Ambulatory Care Services only	
		W	SCORE	W x S	SCORE	W x S	SCORE	W x S	SCORE	W x S	SCORE	W x S	SCORE	W x S
1	Patient care experience													
2	Improved Clinical Effectiveness and 21st Century RGH Care	14.6	2.9	42.6	6.0	87.3	7.2	105.1	7.3	106.2	6.0	86.8	3.4	49.1
3	The workforce model is sustainable in the medium to long-term	13.8	1.9	26.6	7.0	97.3	7.3	100.4	7.7	107.0	6.3	87.6	3.2	44.6
4	Function and quality of the physical environment	12.4	1.6	19.4	8.3	102.8	8.0	99.5	8.2	102.3	7.6	94.0	6.6	81.6
5	Supports optimal whole system working	11.8	2.8	33.3	6.0	70.5	6.3	74.4	6.1	72.2	5.4	63.9	3.6	42.9
6	Supports workforce needs from an employee and employer perspective	11.2	2.8	31.2	7.0	78.6	7.8	87.3	8.1	91.1	6.3	71.1	3.3	36.6
7	Capacity and flexibility to meet anticipated service demand	10.7	3.3	35.6	6.7	71.5	7.2	76.7	7.5	80.2	6.0	64.0	3.6	38.7
8	Environmental Impact and Climate Change	10.1	4.7	47.3	6.3	63.4	6.5	65.7	6.4	65.3	6.6	66.4	5.4	54.8
	TOTAL	84.7		235.9		571.5		609.2		624.4		533.9		348.2

The removal of Criterion A1 – Patient care experience, which carried the highest weighting at 15.3 per cent, did not materially alter the relative ranking of options. When this criterion was excluded and the remaining seven criteria were re-weighted proportionally, Option 4 remained the highest-scoring option with a total weighted score of 624.4, followed by Option 3 at 609.2 and Option 2 at 571.5. Option 4a continued to rank fourth at 533.9, while Options 5 and 1 remained the lowest-scoring options with totals of 348.2 and 235.9 respectively.

The ordering of all six options was therefore unchanged from the primary weighted analysis. The overall spread between Option 4 and Option 3 narrowed slightly but remained sufficient to demonstrate that the preferred option under the non-financial assessment is not dependent on the weighting applied to A1. This indicates that the results are robust to the removal of the most influential criterion and that no single criterion is disproportionately driving the outcome.

5.4.2 Test B – Equal weighting across criteria

This test applies a uniform weighting of 12.5 per cent to each criterion, replacing the paired-comparison weightings, to determine whether the final ranking is dependent on the agreed weights.

BENEFIT CRITERIA		WEIGHT %	1 - Do Nothing / Do Minimum		2 - Core Rural General Model		3 - Core RGH Model + Intensive Rehabilitation		4 - Option 3, with increased Elective Care		4a - Option 4, limited to Day Case surgery		5 - Ambulatory Care Services only	
		W	SCORE	W x S	SCORE	W x S	SCORE	W x S	SCORE	W x S	SCORE	W x S	SCORE	W x S
1	Patient care experience	12.5	3.4	43.1	7.3	91.2	7.9	99.1	8.6	107.9	6.5	81.5	3.2	39.8
2	Improved Clinical Effectiveness and 21st Century RGH Care	12.5	2.9	36.6	6.0	75.0	7.2	90.3	7.3	91.2	6.0	74.5	3.4	42.1
3	The workforce model is sustainable in the medium to long-term	12.5	1.9	24.1	7.0	88.0	7.3	90.7	7.7	96.8	6.3	79.2	3.2	40.3
4	Function and quality of the physical environment	12.5	1.6	19.4	8.3	103.2	8.0	100.0	8.2	102.8	7.6	94.4	6.6	81.9
5	Supports optimal whole system working	12.5	2.8	35.2	6.0	74.5	6.3	78.7	6.1	76.4	5.4	67.6	3.6	45.4
6	Supports workforce needs from an employee and employer perspective	12.5	2.8	34.7	7.0	87.5	7.8	97.2	8.1	101.4	6.3	79.2	3.3	40.7
7	Capacity and flexibility to meet anticipated service demand	12.5	3.3	41.7	6.7	83.8	7.2	89.8	7.5	94.0	6.0	75.0	3.6	45.4
8	Environmental Impact and Climate Change	12.5	4.7	58.3	6.3	78.2	6.5	81.0	6.4	80.6	6.6	81.9	5.4	67.6
	TOTAL	100.0		293.1		681.5		726.9		750.9		633.3		403.2

Applying equal weighting across all eight non-financial benefit criteria did not change the overall ranking of options. When each criterion was assigned a weighting of 12.5 per cent, Option 4 remained the highest-scoring option with a total of 750.9, followed by Option 3 at 726.9 and Option 2 at 681.5.

Option 4a continued to rank fourth with 633.3, while Options 5 and 1 remained the lowest-scoring options with totals of 403.2 and 293.1 respectively. The relative positioning of all six options was therefore identical to that observed under the primary weighted assessment.

The use of equal weighting also mirrors the effect of the raw, unweighted scoring results and confirms that the final ranking is not dependent on the distribution of weights agreed during the paired-comparison process. The consistency of results between the weighted and equal-weight assessments indicates that no single weighting assumption exerts undue influence on the outcome and that the appraisal is stable when all criteria are treated as having equivalent importance.

5.4.3 Test C – Marginal score change testing

The marginal score-change sensitivity tests were selected to assess whether small, plausible variations in participant scoring could alter the relative ranking of options. Given the distribution of weighted totals, only Options 4 and 3 were close enough in score for such variations to have the potential to influence the outcome.

The criteria chosen for testing were those where Options 4 and 3 both performed strongly and where the weighted differences between them were narrow, particularly under Criteria A6, A4 and A1. These criteria also carry comparatively high or moderate weightings and therefore represent realistic points at which small changes could have a measurable effect.

The adjustments applied in these tests consisted of changes of one point in the average criterion score for one option only, reflecting the scale of variation that might reasonably arise from individual judgement differences during the scoring process. Together, four tests provide a proportionate assessment of the robustness of the non-financial appraisal under marginal scoring variation.

Test C1 – Increase Option 3 score for A6 (Improved Clinical Effectiveness) by +1

Increasing Option 3's score for Criterion A6 by one point resulted in a modest rise in its total weighted score, reflecting the relatively high weighting attached to this criterion. However, even with this adjustment, Option 3 did not exceed the weighted total for Option 4, and the overall ranking of options remained unchanged. This indicates that although A6 is an influential criterion, small changes in scoring for this criterion are not sufficient to alter the preferred option.

Test C2 – Increase Option 3 score for A4 (Physical Environment) by +1

The +1 adjustment to Option 3's score for Criterion A4 produced a small increase in its total weighted score, consistent with the medium-level weighting of this criterion. The relative difference between Options 3 and 4 narrowed slightly, but Option 4 retained a higher total weighted score. The ranking therefore remained stable. This demonstrates that the appraisal is not sensitive to small variations in scoring for A4.

Test C3 – Increase Option 3 score for A1 (Patient Experience) by +1

A one-point increase in Option 3's score for the highest-weighted criterion, A1, produced the largest marginal increase across the three upward adjustments tested. Despite this, Option 3's total weighted score remained below that of Option 4. Although this test produced the greatest narrowing of the gap between the two highest-scoring options, it did not alter their relative positions. This indicates that the preferred option is robust even when the most influential criterion is varied within a plausible range.

Test C4 – Reduce Option 4 score for A6 (Improved Clinical Effectiveness) by −1

Reducing Option 4's score for Criterion A6 by one point produced the most stringent downward test of ranking stability. Even with this reduction, Option 4 continued to score higher than Option 3 in total weighted terms, and the ranking of options remained unchanged. This confirms that the outcome is not dependent on fine-margined scoring differences for A6 and that Option 4's lead is resilient to reasonable downward variation.

The results of the four marginal score change tests demonstrate that small adjustments to individual option scores do not materially affect the relative ranking of options. In all cases, Option 4 remained the highest-scoring option, and Option 3 remained second. The ranking was therefore stable across variations affecting both high-weighted and medium-weighted criteria. These findings indicate that the non-financial appraisal is robust to plausible variations in participant scoring and that minor judgement differences would not be expected to alter the outcome of the assessment.

5.4.4 Stakeholder subgroup analysis

The subgroup analysis shows that all three participant groups followed the same overall pattern of results, with Options 1, 2, 4a and 5 occupying consistent positions across all datasets.

All groups identified Option 4 as either their first or second choice and Option 3 as one of the two highest-scoring options, indicating a high degree of convergence around the relative merits of the expanded Rural General Hospital models.

The RGH service leads and public/external stakeholders produced results that matched the combined ranking exactly, with Option 4 achieving the highest weighted total, followed by Option 3 and then Option 2.

The NHS Highland Leadership Team also scored Options 3 and 4 significantly higher than the other options, but with a marginal preference for Option 3 over Option 4 when considered independently. The difference between Options 3 and 4 within the

Leadership Team's results was small, and both options scored substantially above the remaining options.

Overall, the subgroup analysis confirms a strong level of consistency in the relative ordering of options across participant categories, with only minor variation in the ordering of the top two options. This indicates that the combined results are not unduly influenced by any one stakeholder group and that the non-financial assessment is robust when examined from multiple stakeholder perspectives.

5.5 Summary of findings

The non-financial benefits assessment produced a clear and consistent ranking of the shortlisted options, with Option 4 achieving the highest total weighted score, followed by Options 3 and 2. Options 4a, 5 and 1 scored substantially lower across the agreed benefit criteria. The pattern of results reflected strong differentiation between the expanded Rural General Hospital models and the more limited service configurations and was driven primarily by performance under the highest-weighted criteria relating to patient experience, clinical effectiveness and workforce sustainability.

The sensitivity analyses demonstrated that the outcome of the assessment was robust when tested against variations in assumptions and scoring. Removing Criterion A1 – the highest-weighted criterion – did not change the overall ranking of options, and the margin between the two highest-scoring options narrowed only slightly. Applying equal weighting across all eight criteria, which mirrors the effect of examining the raw scoring results, also reproduced the same ordering, confirming that the results were not dependent on the agreed weighting structure. The marginal score-change tests, designed to assess whether small adjustments in judgement could affect the outcome, similarly showed no change in the ranking of options, even when adjustments were applied to the criteria where Options 4 and 3 were most closely matched.

The subgroup analysis indicated a high level of convergence across participant groups. The RGH service leads and public and external stakeholders produced rankings identical to the combined result, with Option 4 clearly preferred. The NHS Highland Leadership Team also identified Options 3 and 4 as the strongest options, with only a modest difference in ordering between them and a substantially lower scoring profile for the remaining options. This variation was limited in scale and did not alter the combined ranking when all participant scores were aggregated.

Taken together, the primary weighted results, sensitivity testing and subgroup analysis provide a consistent and stable assessment of relative non-financial benefits. The preferred option under the non-financial appraisal remains the same across all tests, and no individual criterion, weighting assumption or stakeholder subgroup exerts disproportionate influence on the final ranking.

6 Appendix A – Attendees

Facilitators

Name	Organisation
Gillian Bratt-McManus	Buchan + Associates Ltd.
Iain Buchan	Buchan + Associates Ltd.
Donna Fraser	NHS Highland
Elspeth Skinner	NHS Highland
Gordon MacLeay	NHS Highland
Heather Cameron	NHS Highland
Kay Cooper	NHS Highland
Nicki Sturzaker	NHS Highland

Scoring Participants

Name	Organisation
Aileen MacLean	NHS Highland – RGH Service Lead
Arlene Johnstone	NHS Highland – Leadership Team
Bruce Tulloh	NHS Highland – RGH Service Lead
Duncan Scott	NHS Highland – Leadership Team
Eilidh MacDonald	NHS Highland – RGH Service Lead
Emma Oates	NHS Highland – RGH Service Lead
Evelyn Gray	NHS Highland – Leadership Team
Gareth Adkins	NHS Highland – Leadership Team
Gavin Sell	Highland Council Project Manager – Integrated Services (Adult)
Grace Cuthbertson	NHS Highland – RGH Service Lead
Harry Tedstone	NHS Highland – Leadership Team
Heather Andrews	NHS Highland – RGH Service Lead
Helen Cree	NHS Highland – RGH Service Lead
Heledd Cooper	NHS Highland – Leadership Team
Lyn Kilpatrick	Voluntary Action Lochaber
Jennifer Davies	NHS Highland – Leadership Team
Jo McBain	NHS Highland – Leadership Team
John Gillespie	Caol Community Council
Juliet Evans	NHS Highland – RGH Service Lead
Katherine Sutton	NHS Highland – Leadership Team
Lesley Pow	NHS Highland – RGH Service Lead
Louise Bussell	NHS Highland – Leadership Team
Mike Hayward	NHS Highland – Leadership Team
Niall Lloyd	NHS Highland – RGH Service Lead
Patricia Jordan	Fort William & Torlundy Community Council
Richard MacDonald	NHS Highland – Leadership Team
Morag Stewart	Sunart Community Council
Arthur Cowie	Lochaber Disability Access Panel

7 Appendix C – Options

7.1 Option 1 – Do Minimum

Key Features	
Maintain existing arrangements for the delivery of Rural General Hospital services in Lochaber. The assumption would be that demographic changes would drive demand growth (particularly in older age groups), but that the model of care would remain the same as presently delivered, with ongoing Business-As-Usual service improvement where possible.	
Advantages	**Disadvantages**
▪ Public familiarity with the current service configuration and hospital layout ▪ Central location of hospital in town centre, close to other amenities ▪ Minimal environmental impact in terms of new embodied carbon, as no new construction	▪ Inability to deliver new and efficient models of care due to capacity constraints and a greater need for out-of-area support ▪ More limited ability to reduce number of patients requiring travel to Raigmore for treatment ▪ Maintains pressure on busy Raigmore site for service delivery ▪ Continued inappropriate use of ward accommodation to deliver ambulatory care ▪ Existing infrastructure does not provide the scope or flexibility to implement service improvements ▪ Continued poor privacy and dignity for patients ▪ Limited ability to provide an appropriate 'Place of Safety' for people in crisis ▪ Difficulty maintaining infection prevention and control standards due to lack of single rooms and ensuite facilities ▪ Inability to separate staff, patient, visitor and facilities management flows ▪ Likely to experience service disruption due to aged/ failing infrastructure ▪ Risk of building failure at an unknown point, jeopardising ability to deliver services ▪ Ongoing difficulties with staff recruitment and retention ▪ Negative impact on staff morale ▪ Failure to meet public expectations for improved hospital infrastructure ▪ Hospital location distant from Health Centre, limits collaboration and wastes staff time moving from one to another ▪ Poor ability to support Scottish Government climate change targets through high levels of operational carbon over lifetime

7.2 Option 2 – Core RGH Model

Key Features

This model focuses service provision within the proposed new development on the scope and range of services defined by clinical and operational colleagues in February 2022 and agreed across multiple RGHs within NHS Highland. It provides a range of ambulatory and inpatient services in a new RGH environment, complemented by community-based services delivered locally, with access to specialist acute services for local residents hosted by Raigmore or, where clinically appropriate, by a tertiary centre in the central belt.

Advantages

- Improved patient experience, satisfaction and outcomes
- Increased capacity to deliver planned ambulatory care such as outpatient dialysis, Systemic Anti-Cancer Therapy (SACT), and infusions
- Inpatient environment not disrupted by ambulatory care activity
- 100% single rooms improve privacy, dignity and the potential to reduce hospital acquired infections. This simplifies operational management and reduces patient moves.
- Implementation of a Same Day Emergency Care (SDEC) model, reducing hospital admissions
- Ability to optimise the environment for people in crisis – Place of Safety
- Enables some reduction in the need to travel to Raigmore Hospital for services
- Future workforce model reduces reliance on locum/agency staffing
- Improved recruitment and retention, and staff morale
- Provision of new facilities in accommodation that is flexible and easily reconfigured for future service change
- Improved separation of staff, patient, visitor and facilities management flows
- Proximity of proposed hospital location to the Health centre helps promote collaborative working and minimises staff travel between the two sites
- Future-proofs ability to respond to changes in demand
- Improved ability to support Scottish Government climate change targets through lower levels of operational carbon over the lifetime of the building

Disadvantages

- Proposed hospital location is outside the town centre area
- Construction means localised environmental impact, and increase in embodied carbon

7.3 Option 3 – Core RGH model + Intensive Rehab

Key Features	
This option recognises local challenges in supporting the Health and Care system and builds on Option 2. Services will be designed to improve and support system-wide flow reflecting the unique challenges of delivering services in a rural geography. The focus will be on supporting patients' transition from hospital to home or a homely setting, with intensive rehabilitation input for complex rehabilitation pathways. Services will be designed to support patients who live locally to return home more quickly, and to support their continued improvement and reablement until their goals are achieved.	
Advantages	**Disadvantages**
▪ As Option 2 ▪ Rehabilitation patients' condition is functionally optimised, improving self-confidence and enhancing the potential for discharge to home ▪ Overall potential to reduce the length of hospital stay and enable independence ▪ Enhances multi-disciplinary team and multi-agency working ▪ Potential for improved job satisfaction for Therapy and Healthcare Support workers, with staff working to the top of their licence	• Ability to implement a sustainable workforce model to deliver the intensive rehabilitation model is challenging – note national workforce pressures • Construction means localised environmental impact, and increase in embodied carbon

7.4 Option 4 – As Option 3 with increased elective activity

Key Features	
This option builds on the scope of services outlined in Option 3 by further broadening surgical and outpatient services in Lochaber, thereby reducing the need for travel to and activity on the Raigmore site. This option would aim to optimise the number of patients able to access treatment locally. Optimisation of operational processes for scheduling planned treatments should ensure that where local delivery is possible, patients are made aware of this choice.	
Advantages	**Disadvantages**
▪ As Option 3 ▪ Reduction in patient travel ▪ Potential to strengthen pan-Highland staff networking and co-ordination of service provision ▪ Improved access and waiting time performance for NHS Highland ▪ Capacity offers the potential to broaden the range of specialties delivered locally	▪ Continued risk of disruption from emergency surgical activity in the inpatient environment ▪ Elective activity may be disrupted by emergency activity in theatre ▪ Reliance on Raigmore based clinicians' job planning and Raigmore recruitment ▪ Additional activity often delivered by locum staff ▪ Construction means localised environmental impact, and increase in embodied carbon

7.5 Option 4a – As Option 4, limited to day case General surgery only

Key Features	
In line with NHSH Strategic transformation programmes of work, this option seeks to maintain specialist skills in surgical interventions locally in Lochaber and to ensure rapid access to more complex general surgical services requiring an inpatient admission in an appropriate alternative setting. Local surgical services in the RGH would operate under a comprehensive elective day case model.	
Advantages	**Disadvantages**
▪ All Option 4 ▪ Day surgery not impacted by emergency activity i.e. reduction in cancellations ▪ Patients requiring inpatient-based surgery access specialist care directly ▪ Improves the ability to recruit (nursing) by removing the need for out of hours working ▪ Surgeons not required to undertake infrequent emergency procedures in pressurised circumstances ▪ Clearer pathways for patients requiring complex surgical interventions	▪ Increased requirement for small numbers of patients to travel for inpatient and emergency surgery ▪ Increased demand on SAS ▪ More travel for some visitors and families ▪ May extend the time until surgery for very limited number of patients ▪ Construction means localised environmental impact, and increase in embodied carbon

7.6 Option 5 – Ambulatory Care Services only

Key Features	
This option envisages a radical redesign of local services and a shift away from the RGH core services described in Option 2. It would do so by developing an ambulatory care centre in Lochaber, maximising services that can be delivered locally in community and ambulatory care settings. This option seeks to provide outpatient, minor injuries, and ambulatory care facilities, such as renal dialysis, chemotherapy, and medical investigations and day case surgery and endoscopy, locally in a new development. This will be supported by an optimised set of community and primary care-based services, in alignment with only the ambulatory aspects of the RGH core clinical model in option 2. This model would shift any acute-based inpatient services from Lochaber to the Raigmore hospital campus in Inverness or to Lorn and Islands hospital.	
Advantages	**Disadvantages**
▪ Reduced requirement to recruit and retain specialist staff in Lochaber ▪ Focus of clinical model on ambulatory care ▪ Potential to create more efficient, high-quality day surgery and ambulatory services	▪ No longer appropriate as Place of Safety, impacting residents, police and SAS partners ▪ More travel for patients and families for inpatient treatment and care ▪ More travel for Scottish Ambulance Service ▪ Reduced breadth of experience opportunities for Resident doctors ▪ Reduced employment opportunities for staff ▪ Patient and public expectations unmet ▪ Increases pressure on Raigmore and/or other NHSH hospitals for service delivery ▪ Construction means localised environmental impact, and increase in embodied carbon

8 Appendix D – Questions and Clarifications on Options

- Participants sought to clarify whether reference to the "Model of Care" throughout the options as focussed on the "health" care model, or the wider "social care" model.
    - The team confirmed the focus was on the "health" model of care.

- Clarification was asked regarding assumptions made in relation to the Social Care services, and whether improvements in e.g. attendances and admissions had been assumed, influenced by transformation work in Social Care.
    - The group confirmed that there was an assumption that community-based health and social care services would continue to be improved, would be assumed to be in place to support patient flow and aid in reducing delayed discharges.

- Regarding Option 2, the attendees queried whether the services would be the same as those currently on offer, just located in a anew facility.
    - The project team agreed that all existing services would be provided under option 2, and that there would be additional services on offer such as Same Day Emergency Care (SDEC), including more rapid access to labs and radiology diagnostics, as well as increased capacity in this option for services such as Renal dialysis, SACT (Chemotherapy) and medical infusions.

- There was some discussion around potential concerns of the 100% single room environment. Participants acknowledged this is a Scottish government mandate, but voiced concerns over appropriate safety measures for patients, particularly more vulnerable or mobility impaired individuals, people suffering from seizures etc.
    - Staff described the different elements which contribute to mitigating any such concerns, such as training, equipment and monitoring, as well as thoughtful departmental layout and design for visibility, and operational management procedures placing patients requiring more careful observation closest to nursing hubs.
    - There was an acknowledgement that the single room model required higher levels of staffing and that this would be noted in the workforce planning.

- Option 2 presents the location "further from the town centre" as a disadvantage, as previously voiced by some community stakeholders. Some attendees countered that the expansion of the town in the same area as the proposed hospital development meant it would be better placed for many than the existing

site. Opinions varied on the relative merits, disadvantages of this location. It was suggested there was a need to work with partner agencies to ensure appropriate infrastructure links were in place to facilitate travel to the new site.
    - NHS Highland team members agreed on the need for travel infrastructure and indicated they are involved in these discussions with partners already.

- As Option 3 was presented and the intensive rehab model explained in more detail, participants asked for clarification on whether rehab services were included within the option 2 model.
    - Project team members confirmed there was a general rehab model assumed in option 2 and even assumed as ongoing service improvement work in option 1. The intensive rehab model represents a further enhancement to this for more complex patients.

- Attendees sought to clarify whether this enhanced service in Option 3 would impact on community service teams.
    - The project team clarified that it may reduce demand on community teams.

- A point of clarification was raised regarding the specific language used in relation to the rehab model proposed in Option 3. It has previously been referred to as both "enhanced" and "intensive" – is the same thing meant by these or do they differ?
    - The team responded that the use of "enhanced" was thought clearer and simpler to understand than "intensive" but that the two were intended as largely interchangeable. The model and rationale behind the service does not differ.

- Participants wished to confirm whether previous discussions of a "care village" approach to rehab, rather than this service as an integrated part of the hospital, was still in discussion.
    - Team members clarified that to support a viable RGH option in Fort William, the beds supporting rehab had to be assumed as an integral part of the hospital. While there are still staff with an interest in developing a different approach to this, only the hospital model is currently being considered in scope as part of the Lochaber redesign project.

- The intensive rehab model explanation indicated that providing this service in the hospital may mean extending the length of stay for a small proportion of patients, questions were asked on whether these length of stay increases had been factored into bed modelling and capacity planning.
    - The team countered that while certain individuals may experience a longer length of stay, this service would ensure that in the round delays are reduced, and length of stay on average should reduce.
    - Further discussion ensued on the historic data and assumptions used for capacity modelling, and whether account had been taken of more recent

changes. More recent data shows attendances and admissions broadly in line with historic levels, but increased levels of delayed discharged and longer average length of stay as a result. Further concerns were expressed that data may not clearly show the pressures in the system.

- Option 4 was presented and discussion centred on whether the use of the second theatre for endoscopy presented a barrier to undertaking emergency surgery.
    - Staff clarified that they saw the addition of a second theatre as a significant advantage, and that although intended to be used for endoscopy several times a week, this did not hamper emergency surgery. Staffing levels are such that it would not be possible to run elective theatres alongside both endoscopy and emergency surgery at the same time, so only two theatres could be staffed. Emergencies are rarely so urgent hat they require immediate intervention, and operational planning for surgery within a few hours of admission is appropriate in most cases.
    - Others highlighted that the challenges surrounding job planning, recruitment and freeing up staff time from Raigmore -based Clinicians to travel and be available to provide additional services at the RGH should not be underestimated.

- The rationale for and premise of Option 4a was presented to the group, and concerns were raised regarding the patient experience, and the volumes affected by this proposed arrangement.
    - There was clarification that surgical assessment would be provided by Rural Emergency Practitioners in this model, and that it was recognised they required upskilling for this role. It was not the intention that surgeons undertaking elective activity would be interrupted by unscheduled care presentations requiring surgical assessment.
    - Figures were presented indicating 20-30 patients per week currently referred for surgical assessment, and that ~5 of these would likely result in a procedure. Concern was expressed around increased pressure on Raigmore without the ability to observe patients locally as inpatients before reaching this conclusion.

- The option disadvantages note the increased need for patient transport and impact on SAS and RMS services. Attendees asked if there had been discussion with these partners around this.
    - Discussions have not been held in detail, as the option has only recently been added for internal consideration. There is a recognition that such discussions would be necessary if the option receives support in the options appraisal process.

- Following the presentation of Option 5, a clarification question was asked regarding the provision of maternity services.

  - The team clarified that a Midwifery led birthing unit would still be included as part of this development, and that the choice of location for birthing always remained with the individual woman using the service.

- Similarly, clarification was sought on whether this model would see lab services delivered locally.
  - The team responded that in this model, lab services were assumed to be delivered centrally for NHS Highland which led to further concern about the ability to support the maternity services on offer with a lab located offsite.

- Concern was expressed that in removing the inpatient services in Option 5, this may present an increased risk to the residents of the locality. Further concern was raised about the impact on local employment, with nursing and medical staff groups as well as support workers and facilities assistants requiring redeployment, with the idea raised that some would perhaps choose to leave the NHS and find alternative employment.

- Participants queried what the impact could be on local community-based services.
  - An initial response indicated very little impact on social care services, but when the role of Hospital at Home services was brought into discussion, with a lack of clarity in how this service might operate in this context, perception shifted that it could be an approach which further increased demand on care services.
  - Others felt that the introduction of a robust Hospital at Home model as part of this service option could offer considerable advantages, and change the profile of currently presented disadvantages associated with this option, particularly if combined with mobile diagnostic services.

9 Appendix E – Benefits criteria

Investment Objective	Ref.	Benefit Title	Description	Key Features
To deliver **RGH services locally wherever possible** and adapt to the unique and **changing needs of the population** in the remote and rural locality of Lochaber which is recognised as The Outdoor Capital of the UK.	**A1**	Patient care experience	The extent to which the option supports a positive patient experience and respects dignity across all Healthcare interactions. Patient care and safety are optimised through innovative service solutions, delivered locally wherever possible.	• Clinical services delivered in Lochaber are maximised • A broad range of services is available locally • Quality of care is improved • Reduces unnecessary travel time

Investment Objective	Ref.	Benefit Title	Description	Key Features
Develop a **sustainable RGH service** which optimises the skills of the **local workforce,** improves **recruitment and retention**, and offers enhanced opportunities for **training**, including planned collaboration with other local agencies.	A2	Supports workforce needs from an employee and employer perspective	The extent to which staff see Lochaber RGH as a good place to work, develop their skills and pursue their careers.	• Enhances recruitment and retention • Supports staff to access relevant experience & training • Enables staff to maintain high levels of competency • Enables career progression • Local support and supervision from a breadth of professions • Supports networking

Investment Objective	Ref.	Benefit Title	Description	Key Features
Develop a **sustainable RGH service** which optimises the **skills of the local workforce**, improves **recruitment and retention**, and offers enhanced **opportunities for training**, including planned collaboration with other local agencies.	**A3**	The workforce model is sustainable in the medium to long-term	In the face of national staffing shortages, the extent to which the option delivers an achievable workforce model with sufficient staff with the requisite skills to consistently deliver services of expected quality to local residents.	• Supports evolving models of education for role enhancement • Service models are sustainable system-wide • Encourages local staff recruitment • Improves work-life balance by reducing on call requirements

Investment Objective	Ref.	Benefit Title	Description	Key Features
Provide a **modern flexible** healthcare facility which supports the provision of a **21st century RGH model of care** focused on patients and families.	**A4**	Function and quality of the physical environment	The extent to which the option delivers a modern environment designed to support the delivery of Health and Care. Patient flow is streamlined, with easy accessibility and optimal departmental adjacencies enabling an effective use of space, neither overcrowded not under-utilised.	• Enhances patient privacy, dignity and confidentiality • Improves the therapeutic environment and outcomes • Access to green and external space • Minimises unnecessary patient movement • Improved department adjacencies • Reduces service interruptions • Ability to adapt and expand in future • Reduces HAI

Investment Objective	Ref.	Benefit Title	Description	Key Features
Provide a **modern flexible healthcare facility** which supports the provision of a **21st century RGH model of care** focused on patients and families.	A5	Capacity and flexibility to meet anticipated service demand	The extent to which the option provides capacity to meet demand and accommodate changes in patterns of care and the needs of the population over the longer term. It should be flexible enough to accommodate future physical expansion.	• Capacity to deliver services for patients with Mental Health crisis • Enables capacity to deliver additional services • Supports flexibility in the estate • Investment in building enables assured local service delivery • Enables consistent use of all spaces across the week

Investment Objective	Ref.	Benefit Title	Description	Key Features
Provide a **modern flexible healthcare facility** which supports the provision of **a 21st century RGH model of care** focused on patients and families.	A6	Improved Clinical Effectiveness and 21st Century RGH Care	The extent to which the option supports reduced admissions, shortened length of stay, and optimal patient safety and clinical outcomes. Lowering stress levels for patients, staff, and relatives with easier journeys and care in the right place at the right time with better clinical outcomes.	• Improves throughput, productivity a nd efficiency of the patient journey • Reduces average length of stay • Reduces the number of avoidable admissions • Reduces delays in receiving packages of care • More treatments on a day case basis

Investment Objective	Ref.	Benefit Title	Description	Key Features
Provide a **modern flexible healthcare facility** which supports the provision of a **21st century RGH model of care** focused on patients and families.	**A7**	Supports optimal whole system working	Relieves demand on other NHS care settings. Supports working with community partners to rebalance service provision and optimisation of the patient pathway.	• Promotes multi-agency and multi-disciplinary working • Enables partnership working within the local community • Services are more person-centred • Optimises and balances demand and capacity across NHSH sites • Contributes to wider community setting

Investment Objective	Ref.	Benefit Title	Description	Key Features
Deliver **services and infrastructure** which will **minimise environmental impact** and deliver to Scottish Government's **climate change targets**, now and in the future.	**A8**	Environmental Impact and Climate Change	Deliver services and infrastructure which will minimise environmental impact and deliver to Scottish Government's climate change targets, now and in the future.	• Improves building energy efficiency per m2 • Enables a move to net zero • Travel for services is minimised for patients and families (reduces carbon footprint) • Enables the use of new energy technologies and sources

10 Appendix F – Discussion during Ranking exercise

At the outset of the ranking exercise, participants were invited to identify which of the non-financial benefit criteria they considered to be the most important. Volunteers were sought in the room to voice their thoughts, with at least one representative from each stakeholder group providing their initial views before wider contributions were sought from others who felt strongly.

This approach enabled an initial capture of priority areas across the groups and allowed the facilitation team to note the distribution of first, second and third preferences as an early indicator of where consensus or divergence might exist before moving into structured discussion.

Following the initial identification of priority criteria, participants were invited to indicate their preferred option for the highest-ranked criterion through a show of hands. Two candidate criteria were presented at each stage, and participants signalled their support for one of the two. This process was undertaken sequentially from first to eighth place. After each indication of preference, the group moved into open discussion, with participants from all stakeholder groups invited to present either supporting or alternative views. The facilitation team ensured that differing perspectives were considered, and the discussion continued until participants indicated that they were ready to agree a consensus position on the ranking before moving on to the next pair of criteria.

10.1 Determining benefits ranked 1 and 2

- An initial view was expressed that the Patient Care experience (A1) was the most important aspect and should be considered first.
- This view was challenged and an assertion made that the clinical effectiveness (A6) was the reason for the service, and this should be ranked 1, as the patient care experience would be a consequence of this.
- Several agreed with this view, and added elements such as alignment to population-based planning, future focus and added that Whole system working (A7) was equally important in helping keep people out of hospital.
- Others felt that the compelling driver for the project was the state of the existing infrastructure and that this should be ranked most important (A4), and that it too would be something that influenced patient care experience.

Opinions were gathered round the room, and a majority in favour of either A6 or A1 emerged. When participants were asked to choose between these two, they felt they were closely linked, but an overall consensus was reached that A1 was the most important, followed by A6 and that weighting at the next stage should reflect this close debate.

- Attendees were asked to propose a benefit which was the next most important, and workforce sustainability (A3) was highlighted and discussed. There was little debate on this as being the next most important, though some still felt the function and quality of the infrastructure was more important. Consensus was reached on Workforce sustainability ranked 3rd and Functional quality (A4) 4th. The team agreed that the function of the physical environment should have greater emphasis in this benefit than the quality of the finish. Participants felt that the function and quality of the physical environment was an enabler to realising many of the other benefits.
- Picking up the earlier discussion about the importance of whole system working, this was proposed by some attendees as the net most important benefit. While some challenge was levelled that much of this could be done independently of any new option, the group agreed on this as the benefit to be ranked 5th.
- There was significant debate over the placement of the benefits ranked 6 and 7, between supporting the workforce (A2) and providing Capacity and flexibility to meet demand (A5). Attendees requested that this benefit be reframed as relating to "need" rather than "demand". After thorough discussion and debate, the group agreed by a narrow margin to rank A2 in 6th position and A5 in 7th position. Again, given the closeness of this debate, the team agreed the weightings should reflect this at the next stage.
- The final benefit was Environmental impact (A8), and the group were content to rank this 8th, though there was a request from attendees to elaborate more on the differences between the options regarding this benefit. Colleagues from NHSH Capital planning described some of the relevant elements of this benefit, and how the options might differ in this regard.