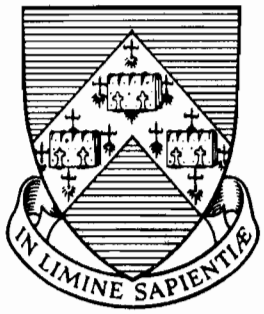

UNIVERSITY
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INSTITUTE FOR RESEARCH IN THE SOCIAL SCIENCES
CENTRE FOR HEALTH ECONOMICS

Provision of Decentralised Mental Illness Services - An Option Appraisal

by

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DISCUSSION PAPER 5

PROVISION OF DECENTRALISED MENTAL ILLNESS SERVICES - AN OPTION APPRAISAL

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* The authors acknowledge the substantial input into this appraisal made by the officers of the District concerned. Production of the report was truly a team effort.

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Preface

This paper consists of the report of an option appraisal. It is exactly in the form in which it was presented to the Management Team and the Authority in the District to which it relates. The only changes are that fictitious names have been substituted for the originals to maintain anonymity. The purpose in publishing the report is to provide an example of how an appraisal may be conducted and presented. The appraisal is not claimed to be a "model" one in the sense that others should slavishly follow it or in the sense that it is perfect. However, we do believe it was adequate for its purpose - aiding a decision on a fairly complex service development and that others may find it useful to follow its spirit.

1 Background

1.1 At present, services for the mentally ill in north Midshire are centralised to a considerable degree in a large institution, High Ridge hospital. This centralisation is consistent with the aims of the Joint Strategy for Mental Illness services in Midshire agreed between Midshire Health Authority and Midshire County Council, and with the objectives of the Midshire Health Authority's Strategic Plan. The thrust of the Strategic Plan is towards better integration of patients with the community, and increased liaison between clinical specialties. The Plan envisages the development of decentralised acute services in the Almhurst sector as forming an early part of the strategy and acting as a pilot scheme for the north Midshire mental health unit.

1.2 This paper identifies the options available to carry this strategy forward; the criteria by which they should be judged; and makes an appraisal of the alternatives. 'A project team was set up to carry out the option appraisal, consisting of two planners, a nursing officer, a local authority representative, the unit administrator directly affected, two consultant psychiatrists, works and finance officers and two consultant economists.

2 Objective

2.1 The objectives of the service development are two-fold. First, to provide services for patients in the Almhurst sector which are more in keeping with a comprehensive, integrated service for the mentally ill and their families than is at present the case. Secondly, to evaluate those services with a view to providing them in other sectors.

3 The Elderly Mentally Infirm

3.1 The Plan and joint strategy envisage the decentralisation of services for the Elderly Mentally Infirm (EMI) as well as acute services for the mentally ill. In view of this and in view of the interest recently shown by Authority members, the possibility that the EMI should be included in this appraisal was considered by the project team.

3.2 For two reasons it was judged to be preferable to restrict the pilot exercise in the Almhurst sector, as originally intended, to the acute services. These are set out below.

a) It was felt that differences in outcome for the EMI would be hard to observe in the Almhurst sector and that therefore decentralisation of EMI did not form an appropriate part of this pilot scheme, given the emphasis being placed on evaluation.

b) It was considered highly desirable for therapeutic reasons to keep acute and EMI patients to a large degree separate. It would be desirable for the EMI to be housed in a different part of any building chosen at the very least and possibly separately altogether. Thus, postponement of decentralisation of EMI services is unlikely to pre-empt options for acute services. Nor does it seem that simultaneous implementation would give significant cost savings. Thus, acute services and EMI can be and are best considered separately. This course was adopted. However, in identification of sites, consideration was given to the possibility of extension in future years to take EMI patients.

3.3 In the process of consideration of EMI, the project team noted that there was an inconsistency between assumptions made in the Plan and a DHSS study on the rate of decline of old-long-stay patients. A key objective of the Strategic Plan is the closure of High Ridge hospital in 10-15 years' time. This is achievable, given current capacity, provided the assumption made in the Plan is correct, that there will be a rapid decline in the number of long-stay patients currently concentrated in High Ridge. However, the DHSS study suggests that if North Midshire is typical, there would still be a need for around 120 long-stay beds in 10 years' time and 70 in 15 years' time. On current plans, there might be a shortfall of capacity of 20-70 beds depending on exactly when High Ridge was closed.

4 Options

A number of options have been considered by the project team:

4.1 Option 1: Do nothing: This involves continuing to provide services exactly as at present.

4.2 Option 2: Augmented baseline: This option involves improving community services for all sectors in North Midshire without decentralisation. The exact nature of this option could be varied but a probable configuration would involve a number of additional facilities which have been suggested as desirable for North Midshire in the short term, regardless of whether decentralisation takes place. These facilities fall into two groups. The first group contains facilities which by their nature serve all the sectors. The second group contains those that would be provided on a sectoral basis.

4.2.1 Shared facilities

(a) Rehabilitation group home (halfway house). A MIND proposal is on the stocks, providing 7 places for all of North Midshire.

(b) Group homes with high level of support. Accommodation for 4 or more people, excluding staff, where meals and personal care are provided. Eight places needed for North Midshire.

4.2.2 Sectorised facilities

(a) Community psychiatric nurses to extend co-ordinated emergency cover from 5 to 7 days. One extra WTE needed per sector.

(b) Dedicated transport: a minibus and driver at the disposal of the consultants. One needed per sector.

4.3 Option 3: Minimum development

This option would take as a base the improvements in community services outlined in Option 2. It would add improvements to the accommodation at Crayke Villa, West Court (on the High Ridge site) and build a new day hospital for 35 places in a convenient location in Almhurst.

4.4 Option 4: Decentralisation with acute beds at the Old Hall

This is one of four decentralisation options which differ only in respect of the form and location of the building provided for the hospital services. Only this option is described in full, with the remaining options described in terms of differences from it. The starting point for all of the decentralisation options is the improved community services described in Option 2.

4.4.1 Hospital facilities

(a) In-patients: 15 beds for acute patients from Crayke Villa would be provided at the separately standing Old Hall on the Almhurst DGH site. This is a reduction in in-patient beds from the present 20. Crayke Villa could be closed or taken over by another user.

(b) Out-patients: At present 2 sessions per week are held at Almhurst DGH and approximately 2 per week at Crayke Villa with some patients from outlying parts of the sector seen at other centres. This number of sessions would be sufficient after decentralisation. The 2 sessions at Almhurst DGH would transfer to the new unit in the Old Hall, releasing out-patient facilities at Almhurst DGH.

(c) Day hospital places: At present 20 places are provided at High Ridge. With the reduction in in-patient beds additional day hospital places would be needed in their place. A total of 35 is judged sufficient to meet known needs.

Annex B shows the schedule of accommodation for a combined in-patient, out-patient and day hospital unit. Annex C shows the nurse staffing implications. Staff at present using the Old Hall will have to be re-accommodated.

4.4.2 Community services

Services required over and above those mentioned in Option 2 would be:-

(a) Hostel accommodation - residential warden giving minimal support. At present, MIND has a 13-place hostel in Almhurst. An additional 12 places of this

type would be needed for the Almhurst sector. This would require District Council and/or Housing Association support for providing the housing and voluntary sector/housing Association/governmental support for the staff.

(b) Group Homes - minimal support - This would be a Midshire County Council responsibility. Two homes of 3 places each already exist for the Almhurst sector, and a further home of 3-4 places would be needed.

(c) Day Centres - An additional 6 places for the Almhurst sector are needed and these are likely to be provided by the new day centre planned some ten miles away.

(d) County Council staff - On decentralisation an additional ½ - 1 social worker would be needed.

(e) Health Service Staff - 1 - 1½ additional community psychiatric nurses would be needed, in addition to the one required for the extension of emergency services (see Option 2). One peripatetic occupational therapist would be needed, and an increase in portering staff of 0.25 w.t.e.

4.5 Option 5: Decentralisation with acute beds at newly built site on Almhurst DGH site.

Otherwise as in Option 4.

4.6 Option 6: Decentralisation with purpose-built acute unit and day hospital in Almhurst (not at DGH).

Two out-patient sessions would remain at Almhurst DGH. Otherwise as Option 4.

4.7 Option 7: Decentralisation with acute beds and day Hospital in converted building in Almhurst (not DGH).

Otherwise as in Option 6.

5 Feasibility of Options

5.1 Considerations of feasibility have led us to drop from further consideration in this document Option 6 and 7. In the case of Option 6, no suitable site could be identified, and in the case of Option 7 no building large enough to accommodate the combined acute unit could be found currently on the market. In both cases both local authorities and Estate Agents were approached.

5.2 The residential homes in the community need support for the housing element either from the District Council or a housing association. Their staffing and organisation require support from a variety of voluntary and public sector agencies. Discussions are in progress to ensure that the necessary co-operation would be available.

5.3 A trawl of Estate Agents found a number of properties on the market suitable for conversion to Group Homes. For the 12-place hostel no single house of the right size was found. The notional costings used in this document are based on the conversion of one house to provide 5 bedrooms and a warden flat, and a second house in the next street to provide a further 6 bedsitters. This arrangement was regarded as being as suitable as a single house.

6 Criteria For Comparison Of Options

The project team agreed a list of criteria on which the various options should be compared.

1 Normality for the patients. This has several elements, among the most important of which are:

(a) Contacts with families either through increased time in their own home or through more visits by relatives;

(b) the opportunity to perform normal activities of daily living such as cooking or shopping for themselves.

2 Contact with therapists - degree of "disappearance" of patients while on site (i.e. the degree to which patients are able to wander away to non-therapeutic areas and to fail to attend for therapy).

3 Quality of accommodation:

(a) stairs or similar problems for aged or cardiac patients.

(b) general "niceness", quality of repairs and environment.

4 Allows preferred therapy to take place.

The present arrangements do not allow to the desired extent treatment of conditions such as agoraphobia, anorexia nervosa, post-natal illness, or therapeutic methods such as behaviour therapy, group therapy and family therapy.

5 Staff morale

(a) turnover

(b) sickness absence

(c) ease of staffing

6 Travel time

(a) for patients

(b) for relatives

7 Reduction in "stigma"

(a) patients (or potential patients) who would not come to High Ridge, becoming willing to present for treatment

(b) friends' and relatives' comfort about visiting.

8 Liaison with other specialities. In particular contacts between psychiatry and geriatrics.

9 Minimising escort work between site and DGH for access to X-ray, path., etc.

(a) costs (we have attempted to reflect these in the costing figures)

(b) loss of staff therapeutic time.

10 Timing - when the new service becomes available.

11 Flexibility

(a) the ability to change the arrangement of care if it proves unsatisfactory

(b) the ability to extend to EMI in due course.

12 Costs of provision including those saved through closure or released space and the opportunity costs of premises consumed.

7 Costs

7.1 The capital, revenue and annual equivalent costs of the various options are shown in Annex I and their derivation expanded slightly in Annex II. The costing is complex, partly because some costs derived from using shared facilities had to be apportioned and partly because costs fall on so many different agencies. In addition, presentation of revenue costs was made more complex by the number of joint finance proposals which involve tapering arrangements on revenue costs. Thus, where tapering arrangements are involved, revenue costs shown are first full year revenue costs only. Finally, there is the problem of the baseline against which to compare costs. The developments described in Option 2 are already being undertaken or are assumed to be committed. Thus, any decision to decentralise would start, in terms of adding costs and benefits,

on the assumption that the Option 2 changes had already occured. For completeness we show the costs of Option 2 in a separate table. All costs shown for other options are new ones which would be incurred as a consequence of a decision to implement that option.

TABLE 1

Costs of Option 2 (£ thousand)

Agency	Capital	Revenue	Annual Equivalent
All	123.0	38.9-40.5	45.4-47.8
Midshire Health Authority	28.0	31.5-32.3	34.8-34.9
Other Central Governmental	20.0	2.4-2.5	7.5-8.3
Midshire County Council	-	4.9-6.5	4.2-5.6
Voluntary Agencies	75.0	-	4.0

TABLE 2

All Public Sector Costs (£ thousand)

Option	Capital	Revenue	Annual Equivalent
3: Minimum Development	283.4	14.6	27.3
4: Old Hall Conversion	294.7	40.0-51.5	55.6-67.1
5: New Build. Almhurst DGH	588.4	42.0-53.5	70.4-81.9

TABLE 3

Midshire Health Authority Costs

(£ thousand)

Option	Costs		
	Capital	Revenue	Annual Equivalent
3: Minimum Development	283.4	14.6	27.3
4: Old Hall Conversion	92.1	32.4-41.2	33.8-40.2
5: New Build. Almhurst DGH	385.8	34.4-43.2	48.7-55.1

TABLE 4

Other Central Government Costs

(£ thousand)

Option	Costs		
	Capital	Revenue	Annual Equivalent
3: Minimum Development	-	-	-
4: Old Hall Conversion	20.0	4.0-6.8	1.6-2.0
5: New Huild. Almhurst DGH	20.0	4.0-6.8	1.6-2.0

TABLE 5

Midshire County Council Costs (£ thousand)

Option	Costs		
	Capital	Revenue	Annual Equivalent
3: Minimum Development	-	-	-
4: Old Hall Conversion	-	10.3-15.8	9.2-13.9
5: New Build. Almhurst DGH	-	10.3-15.8	9.2-13.9

TABLE 6

Costs falling on other agencies (voluntary)

(£ thousand)

Option	Cost		
	Capital	Revenue	Annual Equivalent
3: Minimum Development	-	-	-
4: Old Hall Conversion	182.6	1.3	10.9
5: New Build. Almhurst DGH	182.6	1.3	10.9

7.2 It should be noted that no financial opportunity cost has been allowed for the capital value of the Old Hall. This is because it is already owned and could not easily be sold. It is currently occupied on a temporary basis. This means that some costs such as heating and cleaning are already being incurred and would increase but little if used by services for the mentally ill. However, the current occupants must be rehoused permanently somewhere else and costs will be incurred there. This is allowed for in the costings, which include 4,000 sq ft of new accommodation for this purpose.

7.3 Similarly, no opportunity cost is included for land in the case of the new building on the Almhurst DGH site, as the land is already owned and could not readily be sold.

7.4 Fees of 10% have been allowed in development options, but nothing for any unusual expenses to do with the sites, as these at present are unknown, though nothing substantial is expected.

7.5 We have not considered Options 6 and 7 for reasons of feasibility but it is estimated that the revenue costs of Options 6 and 7, should they prove feasible, would be little different from those of Options 4 and 5. Some extra transport for meals would be involved, costing around £2,000 per annum.

8 Comparison of Options Against Criteria

8.1 Option 2 (augmented baseline)

Compared with doing nothing, this might provide more patients with a degree of normal living. It might improve contact with therapists and reduce patient travel time. The improvements would be modest.

8.2 Option 3 (minimum development)

Some kinds of therapy would become possible with the additional space provided (e.g. group therapy) and additional contact with therapists would be allowed. Stigma would be reduced for patients attending the day hospital and staff morale would be improved by better working conditions, but there would be only a little improvement in the in-patient unit.

8.3 Option 4 (conversion of Old Hall)

A great improvement in normality for patients can be expected as more will live in the community and the remaining in-patients can expect more visitors. Contact with therapists should improve in a small combined unit. The accommodation will be much improved for all concerned and staff morale should improve greatly. Travel time will be reduced for some visitors, but there may not be much difference for patients attending the day hospital. Stigma should be greatly reduced and the full range of therapies mentioned above will now become possible. Liaison with other specialties could increase greatly. There should be some reduction in the time and costs of escort work. though much of this wil be cancelled out by escorting patients to ECT, which will remain at West Court. This option preserves flexibility as it does not rule out any future options for the elderly mentally infirm.

8.4 Option 5 (New building on Almhurst DGH site)

This option offers much the same benefits as Option 4.

8.5 Table 7 sets out in a numerical framework how the options perform against one another. The various options are scored 1-10 according to the degree to which they meet the stated criteria. In turn each criterion was weighted against the other criteria so that scores could be multiplied by weights to give an overall numerical assessment of the performance of a particular option.

TABLE 7

Weighting and Scoring of Options Against Criteria

Criterion:	Normal--ity	Contact With Therapists	Quality Of Action	Allows Pref Therapy	Staff Morale	Travel Time	Stigma	Liaison W other Specialties	Timing	Flexi-bility	Total Score (weighted)
Option											
Do nothing ie existing service	3	5	4	6	2	3	2	2	10	2	426
Augmented Baseline	5	6	4	6	3	4	2	2	8	3	458
Minimum Development	7	8	5	8	6	4	4	4	6	1	573
Convert° Old Hall	9	9	7	9	9	6	8	6	7	7	801
New Build DGH Site	9	9	9	9	9	6	9	6	3	8	790
Weights for criteria (sum to 100)	17	5	8	20	7	2	13	8	12	8	

Scores can range from 1-10. No service at all would rate a zero. Any provision of service must score at least one.

9 Comparison of Options

9.1 Comparing options is made unusually complicated by the fact that costs fall on several different pockets, coming both from different agencies and from different NHS budgets - main and joint finance. To some extent the attitude to the worth of the alternatives depends on the relative weight attached to the different costs.

9.2 Looking first at the Total Costs falling on the public sector we can see that there is a simple progression with the best scoring options costing more than those that score less well. Only Options 4 and 5 truly achieve the objectives, set out in the District Strategic Plan, of providing a decentralised service and they are about three times as expensive in terms of both capital and revenue as the most expensive 'partial' alternative. The improvements in criteria score offered by Option 2 over Option 1 and Option 3 over Option 2 respectively are about in proportion to the differences in costs between those options. Option 4 is cheaper than Option 5, both in capital and revenue and the two are similar in benefit terms.

9.3 Broadly, the same picture holds when we consider health authority costs alone (including joint finance). The main difference in the comparison relates to Option 3, the minimum development, which looks expensive in capital terms, given its contribution to service improvement. Options 4 and 5 persist in the same relation to one another and to Option 2.

9.4 It would appear that the choices are as follows: first, only to undertake those minimum changes already in the pipeline, of the augmented baseline, Option 2, as a small step towards improving services. This does not go very far down the road of implementing District strategy, but it costs commensurately little and does not take the direction of progress away from ultimately fulfilling the strategy. Secondly, to opt for the minimum development of

Option 3: this seems rather expensive in capital terms to the Health Authority relative to the service improvements it provides. Further, it reflects a departure from the appropriate direction of the decentralisation strategy. On balance, it is not recommended. Thirdly, the authority can implement the strategy by choosing one of Options 4 or 5. These two options are virtually indistinguishable in terms of service benefit. Converting the Old Hall is cheaper in both capital and revenue terms. However, at this stage, a further consideration enters the argument, that is the opportunity cost of the Old Hall, i.e. the next best alternative use to which it could be put. The choice between Options 4 and 5 probably hinges on the value ascribed to the opportunity to use the Old Hall for other purposes and we therefore discuss it below.

9.5 If the New Build option were chosen and the existing occupants of the Old Hall were rehoused, then the Authority would have available the Old Hall for other purposes. The main alternative bid for the Hall involves the transfer of the School of Nursing from Almhurst to the Old Hall, to release space for more beds. For example, acute geriatric beds or a joint geriatric/orthopaedic ward could be provided at the DGH. Such a development would, of course, involve the costs of conversion of the area vacated at Almhurst DGH to whatever purpose was regarded as appropriate (perhaps £200,000). The DMT will need to judge whether the undoubted advantages the Old Hall has as accommodation to support decentralisation of Mental Illness services are greater than the advantages which would follow if the Hall were used indirectly to provide more acute beds at Almhurst DGH.

10 Conclusions

10.1 If this development is not felt to justify substantial expenditure at the moment, then the choice lies between Options 2 and 3. Pursuing 2 means doing no more than sticking to what is already planned, while 3 has an element of further improvement to accommodation and the addition of a day hospital. Option 3 is not expensive relative to the benefits it provides in total cost terms but it is expensive in terms of those costs falling on Midshire Health Authority. A "wait a little while" decision would therefore favour Option 2 over Option 3.

10.2 If the development is felt to justify expenditure of the order involved in Options 4 or 5 then Option 4 provides slightly more benefit points because of its superior timing - it offers accommodation sooner than in the case of a new build - at a cost of about £300,000 less in capital terms and about £15,000 less in annual equivalent terms. If a lower weight is given to timing, Option 5 achieves a higher benefit score than Option 4 but the difference in benefits provided by the two options remains quite small. On balance, therefore Option 4 is to be preferred.

If the District intends to implement its strategy during the next capital cycle then the recommended option is Option 4.

Annex B

DECENTRALISATION OF ACUTE M I SERVICES IN ALMHURST

SCHEDULE OF ACCOMMODATION

I/P Accommodation - (15 patients)

1	1 room x 5 beds (male dorm)	70 sq ft per patient
2	1 room x 5 beds (female dorm)	" "
3	1 room x 5 beds (female dorm)	" "
4	1 room x 2 beds (side room) + w/h/b	" "
5	1 room x 2 beds (side room) + w/h/b	" "
6	1 room x 1 bed (side room) + w/h/b	110 sq ft
7	1 room x 1 bed (side room) + w/h/b	" "
8	1 mother and baby room (includes w/h/b)	120 sq ft
9	1 clinical room (includes w/h/b)	160 sq ft
10	1 kitchen - for beverages - for use by mother/baby should include washing facilities - machine/ drier etc - for therapy	200 sq ft
11	1 bathroom (male)	
12	1 bathroom (female)	
14	Linen store	60 sq ft
15	Sluice room	100 sq ft
16	Toilets - 2/3	

Day Patient Accommodation - (35 Patients)

1	1 sitting room/day room	41 sq ft per patient
2	Activities room (includes sink) - for therapy	120-160 sq ft
3	Games room (To be shared with	200 sq ft
4	Therapy room x 2 in-pateints)	120 sq ft
5	Workshop (includes sink)	100 sq ft
6	2/3 toilets	

Shared Rooms (I/P:D/P)

1	Quiet room	120 sq ft
2	Hair-washing/beauty room (includes sink)	100 sq ft
3	Dining room (50 patients)	13 sq ft per patient
4	Kitchen - for snacks - for therapy	200 sq ft

O/P Accommodation (approx 20 patients a week)

1	Waiting area	15 sq ft per patient
2	1 x clinical room (includes w/h/b)	160 sq ft
3	2 x consulting rooms	120 sq ft each

Annex B
Page 2

SCHEDULE OF ACCOMMODATION

Office Accommodation

1	2 Sisters' offices (includes w/a/b)	100-120 sq ft
2	Office x 1 - Consultant	100-120 sq ft
3	Office x 2 - Secretaries	100-120 sq ft
4	Office x 1 - Community Psychiatric nurses (approx 5)	120 sq ft
5	Office x 1 - Social workers (approx 3-4)	120 sq ft
6	Office x 2 - Psychologists/other medics	120 sq ft
7	Staff Room	120 sq ft

Annexe C

Nursing Requirements - Acute M I Service - Almhurst

Present staff in post

Day duty

Ch nurse/sister	2.00
Staff nurse	2.00
State Enrolled Nurse	2.00
Nursing Assistant	1.86
	(2 nurses)
Student - on average 1 per shift	

Night duty

Ch nurse/sister	1.00
Staff nurse	1.00
Nursing Assistant	2.00

Day Hospital

Ch nurse/sister	1.00
Staff nurse	1.00
Nursing Assistant	0.75

Desirable staffing level re: decentralisation

Day duty

Ch nurse/sister	1.00
Deputy Ch nurse	1.00
Staff nurse	2.00
State Enrolled Nurse	2.00
Nursing Assistant	1.86
	(2 nurses)

Night duty

Ch nurse/sister	1.00
staff nurse	1.00
Nursing Assistant	2.00

Day Hospital

Ch nurse/sister	1.00
Staff Nurse	1.00
State Enrolled Nurse	1.00
Nursing Assistant	1.50
	(2 nurses)

Travelling Expenses

Nursing Officers presently covering High Ridge and West Court will need expenses if covering a further unit in Almhurst:

1 Nursing Officer
1 Nursing Officer (nights) — Approx £500 per year.

COSTS

Option 2 / Augmented Baseline		ALL AGENCIES Costs	ALL AGENCIES AEC	MIDSHIRE HEALTH AUTHORITY Costs	MIDSHIRE HEALTH AUTHORITY AEC	OTHER CENTRAL GOVERNMENT Costs	OTHER CENTRAL GOVERNMENT AEC	MIDSHIRE COUNTY COUNCIL Costs	MIDSHIRE COUNTY COUNCIL AEC	OTHER AGENCIES Costs	OTHER AGENCIES AEC
½-way house	Cap	75,000[2]	3,960							75,000	4,000
	Rev	10,000	10,000	5,000	8,960	5,000	1,035				
x group home	Cap	40,000[2]	2,112	20,000	1,056	20,000	1,056				
	Rev	4900-6500	4900-6500	2450-7250	347-460	2450-3250	347-460	4900-6500	4203-5576		
Emergency Cover	Rev	14,000	14,000	14,000	14,000						
Dedicated Transport	Cap	8,000	422	2,000	442						
	Rev	10,000	10,000	10,000	10,000						
TOTAL	Cap	123,000		28,000		20,000				75,000	
	Rev	33900-40500		31450-72250		7450-8250		4900-6500			
	AEC		45400-47800		34785-34878		2432-2551		4203-5576		4,000
Option 3 / Minimum Development											
Improve West Villa	Cap	79,200	4,182								
	Rev	1,500	1,500								
Day Hospital	Cap	204,200	9,779								
	Rev	13,100	11,807								
TOTAL	Cap	283,400		223,400							
	Rev	14,600		14,600							
	AEC		27,268		27,268						

Notes: (1) Where revenue costs change over time because of tapering arrangements under joint finance, first year costs are shown. AECs take account of full taper.

(2) These costs are seen as unavoidable costs associated with developments in Almhurst even though other sectors are also involved.

(3) Annual equivalent costs are calculated over sixty years using a discount rate of 5%.

COSTS

Option 4		ALL AGENCIES		MIDSHIRE HEALTH AUTHORITY		OTHER CENTRAL GOVERNMENT		MIDSHIRE COUNTY COUNCIL		OTHER AGENCIES	
		Costs	AEC	Costs	AEC	Costs	AEC	Costs	AEC	Costs	AEC
Old Hall Conversion											
Convert Old Hall	Cap	72,100	3,807	72,100	3.307						
Etc	Rev	6,700	6,700	6,700	6,700						
Hostel	Cap	122,600	9,641							182,600	9,641
	Rev	1,700	1,300							1,300	1,300
Group Home	Cap	40,000	2,112	20,000	1,056	20,000	1,056				
	Rev	2,500	2,500	1,250	177	1,250	177	2,500	2,145		
Day Centre	Rev	2,300	2,300					2,300	2,300		
Social Worker	Rev	5500-11000	5500-11000	2750-5500	389-779	2750-5500	398-779	5500-11000	9718-9436		
	Rev	12000-18000	12000-18000	12000-18000							
	Rev	9,700	9,700	4,700	9,700						
TOTAL	Cap	244,700		92,100		20,000				182,600	
	Rev	40000-51500		32400-41150		4000-6750		10300-15800	9163-13881	1,300	
	AEC		55560-67060		33829-40214		1422-2012				10941
Option 5											
New Building Almhurst DGH											
New Build acute unit	Cap	365,800	17,518	365,800	17,518	AS OPTION 4		AS OPTION 4		AS OPTION 4	
	Rev	8,700	7,841	8,700	7,841						
As Option 4	Cap	222,600	11,753	20,000	23312-29712						
	Rev	33300-44800	33300-44800	29700-34450							
TOTAL	Cap	588,400		385,800		20,000				182.600	
	Rev	42000-53500				4000-6750		1030-15800		1.,300	
	AEC		70412-81912	34400-43200	48621-55071		1622-2012		9163-13881		10941

Appendix II

Costs of Options - All Public Sector Costs

Option	Resource	Capital (incidence)	Revenue- Full Year Cost (incidence)
Option 1 Do nothing			
Option 2	½ Way House	75,000	10,000
Augmented Base	2 x group homes-high support		8,000-11,200 staff
	(30-45 hrs care assistant)	80,000	1,800 running
	Dedicated transport	8,000	10,000
	Emergency cover	0	14,000
	Total		
Option 3 Minimum Development	Improve West Villa	79,200	1,500
	Build new day hospital	204,200	7,700 staff
	(35 places)		5,400 running
	Total	283,400	14,600
Option 4	Conversion Old Hall	72,100	
	Close West Villa	0	
Old Hall Conversion	Close High Ridge day hospital	0	net 6,700
	Rehouse occupants Old Hall	0	
	Release out-patients DGH	0	0
	Hostel (2 houses)	182,600	1,300
	1 x group home - min support	40,000	900 running
	(15 hrs care assistant)		1,600 staff
	Day centres	0	2,300
	½-1 Social worker	0	5,500-11,000
	Community psychiatric nurses	0	12,000-18,000
	Occupational therapist	0	9,700
	Total	294,700	40,000-51,500
Option 5 New build on DGH site	New building for acute unit	365,800	8,700 net
	Otherwise as option 4	222,600	33,300-44,800
	Total	588,400	42,000-53,500

Appendix III

Weight on timing - sensitivity test

	Scores		
	1 Weights as paper	2 Timing = 8 4 points distr proportionately	3 Timing = 4 8 points distr proportionately
Option 1	426	399	373
Option 2	458	441	425
Option 3	573	570	569
Option 4	801	803	814
Option 5	790	809	832

Weights

Set A									Timing	Total
18	5	8	21	7	2	14	9	8	8	100
Set B										
18	6	8	21	8	3	14	9	4	9	100

Scores	Set A	Set B
Option 1	399	371
Option 2	438	425
Option 3	572	567
Option 4	805	808
Option 5	811	831

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