Full Business Case

Project Title	Children's Therapies Recommissioning		
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1. Executive Summary

In autumn 2015 an outline business case recommending the recommissioning of Children and Young People's (CYP) speech and language therapy (SALT), occupational therapy (OT) and physiotherapy (PT), as a single, integrated service, was accepted by the CYP Joint Executive Team (JET). The scope and procurement options for the service were then explored and public engagement undertaken. In May 2016 the CYP JET recommended that the full business case was progressed to decision through the Buckinghamshire County Council (BCC) and Clinical Commissioning Group (CCG) governance processes. This paper presents the full business case for the recommissioning, incorporating a triangulation of needs assessment, budget considerations, national policy, best practice, procurement regulations, and known risks, and proposes a commissioning plan for approval as follows:
Tender for an integrated service, which will provide a better quality service for CYP for no additional investment. Maintain existing funding levels because a reduction in preventative services (universal and targeted) will increase statutory assessments and put additional pressure on High Needs Block funding that is already over-heating.

2. Background and Reasons

2.1 Current Commissioning Arrangements

Appendix 1 outlines the commissioning and funding arrangements for each therapy service.

The CYP therapy services are delivered according to tiers of intervention – the Balanced System® model. The 2014 Code of Practice for Special Educational Needs and Disability (SEND) 0-25 sets out a responsibility for services to be jointly commissioned to meet SEND both through the Local Offer and for children and young people with Education, Health and Care Plans (EHCPs); children with SEND can be with and without an EHCP. The Code of Practice recognises the benefits of a tiered offer across universal, targeted and specialist provisions and is observed to be effective nationally through Department for Education (DfE) commissioned reviews such as the Bercow Review (2008) and the Better Communication Research programme (2012). CYP with EHCPs may have specified interventions at a universal, targeted and specialist level; 'statutory' provision is not limited to 'specialist' provision.

Since individual therapy services were jointly commissioned (SALT 2011/12, OT 2013), BCC and the Buckinghamshire CCGs have been able to effect significant positive changes in terms of both outputs and outcomes. To illustrate, joint commissioning and service redesign has:

- Achieved cumulative savings of over £2m (CCGs £789k and BCC £1.45m [£1.4m High Needs Block [HNB] and £50k core])
- Increased reach and activity by 30%
- Reduced Statements/EHCPs with SALT or OT as an educational need by 65%
- Reduced access times to average of 6-10 weeks (prior to recommissioning, wait times were 40 weeks for SALT and 104 weeks for OT)

This recommissioning takes service transformation to the next stage through proposing that therapy services are provided through a single, integrated service which will further increase efficiencies and effectiveness. An OCB feasibility study also concluded that integration was the preferred option.

2.2 Project aims

The aim of the project is to recommission CYP services in a more integrated way in order to:

- Streamline services for the 21% CYP accessing a combination of two or more therapy services e.g. through reducing duplication, and improving coordination, communication, and shared decisions that consider the whole child holistically.
- Explore scope for cost avoidance through absorbing growth within a flat cash budget; adopting a more fluid and cross-therapy workforce model; continuing to invest in universal and targeted services which through early intervention, prevention and inclusion reduce requirement for specialist services; and incentivising providers to adopt innovative ways of delivering services.
- Enhance the Balanced System® model that has achieved good outcomes so far and focuses on early intervention and secondary prevention to ensure CYP are seen at the most appropriate tier of provision and ensure BCC and CCG statutory requirements are delivered alongside best practice and maximum value for money.

2.3 Service User Engagement

A comprehensive communications plan was implemented and public engagement undertaken in January 2016 to gather feedback on the current services and float the idea of a single service. Over 300 people (approx. two thirds parents) took part in the engagement activities, either through an online survey or face to face meetings. 61% thought joining up the services was a good idea in principle and a further 28% wanted more information before being able to decide. The newly established BCC Youth SEND forum has advised how to engage and involve CYP using therapy services in the recommissioning process, and these initiatives will be employed as part of the next stage of public consultation, which will be available at www.bucksfamilyinfo.org.

3. Needs analysis and future scenarios

3.1. Current need and provision

The needs assessment has taken account of national data (e.g. IMD, child poverty and population data), prevalence and predictive tools for particular conditions, local schools data (e.g. pupil numbers and attainment), local SEN data, and therapy-service specific data (e.g. caseload, workforce, activity).

Buckinghamshire is generally affluent whist also having pockets of deprivation, notably in Aylesbury where 8% Lower Super Output Areas (LSOAs) are ranked as relatively deprived[1] and 25% children are in low-income households[2]. The needs analysis compared expected levels of need with current service activity per geographic area. Key points:

- Referrals to all three therapies from Wycombe are above what would be expected.
- Referrals and caseloads in Aylesbury for OT and SALT are below that expected. PT waiting lists and caseload in Aylesbury are considerably higher than expected.
- The demand in Chiltern and South Bucks for SALT for CYP with EHCPs is higher than would be expected.

3.2. Assessment of current budget against demand

In 2013 the CCGs commissioned an independent review of PT services and through this it was identified that **the PT service has significantly lower staffing levels than the other therapy services for the level of demand**, however the staffing shortfall has not been funded since the report was finalised.

The current funding for SALT and OT is providing an adequate level of service provision however pressure on these services is arising from the increasing demands of the SEND process, and the challenge of balancing the development of a sound Local Offer through targeted services, with the rising levels of EHCP need being identified:

- Buckinghamshire has higher than average EHCPs and lower than average SEN support, and CYP are more likely to attend special schools[3].
- Between 2014/15 and 2015/16 there was a 43% increase in assessments undertaken and 31% increase in EHCPs issued[4].
- Between 2009 and 2015 the rate of growth in demand for statutory services increased 5½ times faster than the rate of population increase.
- Between 2009 and 2013 the number of CYP with multiple disabilities increased 63%.
- OT statutory assessments Jan-Feb 2016 shows an increase of 68% compared with the same period 2015.

[1] Indices of Multiple Deprivation (IMD) published 2015
[2] HMRC Child Poverty Statistics published 2015
[3] Indicative findings from SEND review (in draft), author Penny Richardson
[4] Ibid

At present, SALT specialist tier interventions represent 77% of SALT HNB funding. The remainder of SALT HNB funding and most of the CCG contribution funds targeted tier interventions which not only fulfil the statutory duty to provide services for CYP with SEND but without an EHCP, but have been critical in changing the shape of the SALT service from predominantly statutory work to only 16% of caseload with EHCP. Similarly, significant redesign of the OT service now means that 30% of OT HNB contribution funds specialist tier interventions[5] and the remainder of HNB funds targeted interventions. Through implementing the link therapist model in schools the OT service has enabled a 94% increase in school advice referrals and reduced the number of OT hours on Statements/EHCPs by 51% since 2013. A system-wide response to the steep and steady increase in ECHPs over the last few years should include building capacity, confidence and competence in mainstream education settings to support and enable them to meet the needs of CYP before the point of statutory assessment. An integrated therapies service would contribute towards achieving this through continuation and extension of the universal and targeted provision offer.

3.3. Assessment of impact of disaggregation of education provision from health provision

The impact of disaggregation would be in reduced quality of services to CYP, families and schools; a child requiring therapy might need to be seen by two therapists for the same specialism (e.g. one OT for education and one OT for health). Disaggregation would make the service disjointed and fragmented and would require an enormous of work for no gain. CCGs may feel the need to consider this option however extreme caution is advised and this cannot be a recommended step.

3.4. Impact of Department for Education (DfE) consultations

In March 2016 the DfE launched two consultations proposing changes to schools funding. Implications for the therapies recommissioning project arise because the majority of BCC contribution to pooled budgets for jointly commissioned therapy services comes from the HNB funding, which the government proposes will be re-calculated based largely on deprivation indicators. Current predictions are up to a **£20m reduction which represents c27% of HNB funding**. Risks are:

- The funding formula and allocations will not be released until later in the year. The OT contract currently in place does not allow for further extension under EU procurement regulations so the service must be recommissioned 16/17.
- It has not been decided how the impact of a reduction would be absorbed. Therapy services are already extremely lean and if reductions to HNB for therapies are made the services may not be viable and access for CYP will be affected (see section 3.5).
- Proposed changes will prevent Local Authorities from being able to transfer funding from one funding element to another, therefore, if reductions to HNB cannot be met or pressure on HNB continues to increase, there would be pressure on BCC core funding.

[5] Hours on Statements/EHCPs only; figure excludes other work such as statutory assessments etc.

3.5. Assessment of impact of a reduction in HNB funding

This section models the effect on therapies services if the predicted HNB funding reduction was to be met through all SEND provision absorbing a percentage reduction. Appendix 2 shows how different percentage reductions would affect staffing.

The impact of a 5-10% reduction in HNB funding would be seen in the volume of services delivered and waiting times, and at the higher end would have a significant impact. In the medium term this would reduce the ability of the service to offer consistent high level targeted interventions in schools, which would be counter-productive, and a potential increase in requests for statutory assessment in an already over heated area is a strong possibility. Mitigating factors are that an integrated model will buffer at a universal and targeted level to some degree and there is potential for schools to commission additional services although this is not a certainty.

A 20% or greater reduction in HNB funding represents a reduction that would only be met through cutting areas of service delivery, if the impact of reduced volume is not going to make the whole service delivery level unacceptable. The options for ceasing elements of service provision at this level will have an impact on the delivery of a Balanced System® model and the likelihood of reverting to the service models of 10 years ago which were generating increasing and uncontrolled demands on the BCC budgets. Increased demand for statutory assessment and tribunals are highly likely. Furthermore this option is likely to be deeply unpopular with families and stakeholders and risks creating lack of public confidence in the service and reputational damage to commissioning organisations.

The scenarios described above consider the impact of a reduction based on current levels of SEND demand however, as highlighted in section 3.2, SEND demand is increasing steeply. If targeted tier services are reduced, in the short term it would appear to be a saving but it would quickly cost more because statutory assessment would become the only access route for therapies. Therefore, maintenance of current HNB funding levels is strongly recommended.

3.6. In scope for recommissioned therapy services

- Devolved CYP equipment budget (c£350k pa) to give greater control over spend and visibility on decision making. This has been agreed in principle with budget holders.
- Tribunals work (c£60k pa) that is currently paid separately to providers.
- Resolution of border and boundary issues and alignment across therapies to improve consistency and reduce access complexities; the current provision represents a disjointed and confusing offer for CYP and families.

3.7. Out of scope for recommissioned therapy services

- Social care housing adaptations OTs, who will remain in BCC Social Care team.

- Special schools, which have a devolved budget (the new contract will allow scope for special schools to contract directly with the new integrated service if they choose to).
- Provision for 19-25 year olds during year one of the contract, which will provide a baselining period after which commissioners can make an informed assessment and decision about how to most appropriately commission therapy services for this cohort. This would be achieved through review of numbers and needs of the young people coming up through the service and discussion with providers regarding appropriate therapy provision, which may not be a natural extension to the CYP therapies service due to differences in requirements of clinical competencies.

4. Business Options

4.1. The commercial strategic options appraisal has been based on:

- Advice from BCC and CCG procurement leads and BCC legal department;
- Market engagement exercise with existing and potential providers in January 2016 to assess potential interest in an integrated, jointly commissioned contract and market testing with current providers in April 2016 to respond to alternative commissioning approaches in light of the DfE consultation;
- Consideration of current austere and uncertain financial climate generally and recalculations of schools funding specifically;
- Consideration of implications of changes in procurement legislation governing CCGs with effect from 18th April 2016;
- Outcomes for and impact on CYP;
- Compliance with legislation;
- Best practice;
- Strategic fit (national and local);
- Assessment of need;
- Risks;
- Financial viability (to commissioners and providers).

4.2. Market View

Soft market testing suggested that there is limited interest in providing county-wide integrated therapies services (only three responses were received to the invitation for expressions of interest). The providers that were interested said their preferred commercial strategy would be competitive tender because they felt it was easier to achieve full integration with a single provider. Later conversations with existing providers highlighted that providers are reluctant or unwilling to bid for a disaggregated service on principle because it does not support the best approach for CYP (this also indicates a maturity in the market understanding of service delivery best practice). Providers indicated they would be unlikely to bid for a service they considered unviable.

4.3. Table of business options

Option	Option 1	Option 2	Option 3	Option 4	Option 5
Description	Do nothing	Tender for specialist-tier only	Tender separately for education provision and health and social care provision	Extend current services with possibility of integrating OT and PT	Tender for single, integrated service comprising SALT, OT and PT with flat cash envelope
Benefits	None	• Short term savings through decommissioning lower tiers of provision.	None	• Achieve a degree of integration as there are areas where OT and PT can share some workforce and these services are currently with the same provider. • OT and PT combined would still be an improved service for CYP. • Services remain in place for 2017/18.	• Achieve best possible outcome and service effectiveness for CYP. • Achieve full efficiencies of integrated workforce model. • Cost avoidance through absorbing new growth/ complexity of need and increased staffing for PT without needing additional investment. • Providers very likely to bid.
Risks	• Breaches EU procurement legislation. • Costly spot purchasing when contracts expire. • Service delivery stops for BCC-funded OT.	• Effective service delivery needs all three tiers to work effectively. • Medium-term increase in demand on specialist provision and increased cost at higher rate. • Stakeholders view early intervention as essential for effective provision. • Providers unlikely to bid.	• Does not meet legislative requirements of joint commissioning. • Long term consequences of undoing benefits of jointly commissioned services to date. • Increased complexity for CYP. • Increased admin/management time and reduced clinical time. • Reduced economies of scale as two separate contracts.	• Does not achieve full benefits of integrating all 3 therapies. • Step backwards for joint commissioning in Bucks. • Breach procurement regulations requiring tender to take place. • Risk of challenge from other providers. • Potential higher cost of services from 2017/18.	• BCC would need to commit now to a funding envelope for the contract term, in order for a competitive tender to take place. • Funding partners would need to agree to co-commission services when BCC is facing financial uncertainty around HNB funding.

4.4. Recommendations

1. **Progress business option 5 to tender for a jointly commissioned integrated therapies service with existing funding envelope.**
2. **Delegated authority is given to an officer at the point of contract award and at the point of contract extension.**
3. **BCC and CCGs to act on taking forward the strategic leadership and ownership of identification, assessment, co-ordination and outcome monitoring of SEND across the whole system.**

4.5. Benefits

- Cost avoidance through 1) absorbing new growth and increased complexity of need without requiring additional investment 2) raise PT staffing to adequate levels without requiring additional investment.
- Improved efficiency and quality through streamlined processes and systems and enabling clinicians to work seamlessly to provide services.
- Inclusion and prevention through enabling mainstream schools to support CYP with SEND needs.

4.6. Dis-Benefits

- BCC would have to commit to a funding envelope before the outcome of the HNB allocation is known. However, the risk of committing to a long term (recommended 5 year) funding envelope in the face of financial uncertainty must be balanced against risks arising through delaying a decision and being forced to extend current contracts with existing providers, thereby breaching EU procurement regulations and having to commission services at potentially higher cost.
- CCGs would need to consider their response to a partnership approach to commissioning where BCC faces particular financial challenges. However this needs to be balanced against the benefits of jointly commissioning services which complies with legislation, and maximises cost effectiveness and quality of provision for CYP.

4.7. Risks (see Appendix 3)

4.8. Dependencies

This FBC assumes that the DfE proposals will be implemented as set out in the two consultations.

4.9. Costs

- Project management and clinical expertise (agreed).
- Potential costs arising from TUPE, equipment/IT audit, and pump-priming assistive technology development.

4.10. Contract particulars and developments

- A long contract term (5 years plus option to extend) is recommended to allow time for the service to settle and start delivering outcomes before the next re-tendering process, and incentivise providers to put effort and investment into the service. Learning from other areas suggests it takes min. 18 months to achieve complete service transformation of this scale.
- Incentivise the provider to continuously improve processes to improve efficiency, and invest in technology-enabled care to increase cost-effectiveness of services. The service is unlikely to be able to achieve new ways of working from year one while integrating three previously separate services but should be expected to see visible results from year three onwards.
- Contract year one would enable a baselining period for assessment of 19-25 need as per section 3.7 to facilitate informed commissioning decisions for the remainder of the contract term. This year would also enable the development of unit costs in preparation for being able to deliver personal budgets through the EHCP process.
- Encourage current and future education commissioners (e.g. schools, academies and multi-academy trusts [MATs]) to commission further therapy provision as part of their delivery of the Local Offer for CYP with SEN who may not have EHCPs and to raise overall attainment.

4.11. Timescale

Milestone	Timescale
Commissioning approach agreed and approved	April – June 2016
Tender documentation produced	June – July 2016
Final public consultation before tender	June – July 2016
Combined PQQ and ITT	August – September 2016
DfE allocations made available	*Autumn 2016*
Tender evaluation and decision	October 2016
Approval and contract award	October – November 2016
Transition/mobilisation plan developed	November – December 2016
Contract worked up	January – March 2017
Contract start date	1st April 2017
Phased mobilisation	April – September 2017
Service go-live	September 2017

Appendix 2: Financial modelling for possible reductions in High Needs Block Funding

Reduction from DSG High Needs Block element only	Speech and Language Therapy		Occupational Therapy		Total
	£	Possible staffing reduction	£	Possible staffing reduction	
5%	40,075	0.8x Band 6 Or 1.2x Band 5	33,806	1x Band 5	73,881
10%	80,149	1x Band 6 + 1x Band 5	67,611	2x Band 5 Or 0.5x Band 6 + 1x Band 5	147,760
20%*	160,298	2x Band 6 + 2x Band 5	135,222	3x Band 6 Or 2x Band 6 + 1x Band 5	295,520

*A reduction of 7 therapists across both therapy specialisms is equivalent to an entire geographic team

Appendix 3: Summary Project Risk Assessment as at June 2016

Description of Risk	Impact	Likelihood	RAG
If there is either too much detail or lack of robustness in the specification there is a risk the contract will not deliver the required outcomes.	2	1	L
Any potential reductions for funding risks generating negative response from public and stakeholders.	1	1	L
If few tenders are received then a competitive price may not be achieved.	3	1	M
Contract Standing Orders have already been breached in order for the current OT contract to be extended during 2016/17 for the purpose of recommissioning; if a decision was taken to extend current contracts past March 2017 there is a risk that a second breach would not be acceptable to S151 officers.	3	2	M
Loss of key project personnel or delays in decision making due to BCC restructure and CCGs' federation risks project milestones being missed.	3	2	M
Mechanisms to fund and deliver Personal Budgets must be considered in the design of new services however a high uptake risks financial instability for the provider and pressure on commissioners, reduced ability to maintain service provision and less efficient use of resources.	5	1	H
If statutory assessments and EHCPs continue to rise at the present rate without system-wide leadership and intervention, there is a risk that even an integrated service with flat funding may not be able to match demand and provision and targeted provision will be reduced, leading to increase in specialist provision and hours on EHCPs.	5	4	E

Impact x Likelihood = numerical risk score Impact x Likelihood RAG rating is established using matrix below

		Impact				
		1	2	3	4	5
Likelihood	1	L	L	M	H	H
	2	L	L	M	H	E
	3	L	M	H	E	E
	4	M	M	H	E	E
	5	M	M	E	E	E