

## 2019/20 PSS CQUIN Scheme

### Indicator Template

**[Section B to be completed before insertion in contracts.]**

### PSS15 Paediatric Movement Therapies

Indicator Name	<i>Paediatric Movement Therapy networked Services</i>
<b>A. SUMMARY of Indicator</b>	
Indicator Sponsor (with email address)	<i>Charlie Fairhurst – Paediatric Neurosciences CRG chair charlie.fairhurst@gstt.nhs.uk</i>
Improving Value Reference	
Duration	<i>Two years. [Specify full duration of indicator, in years]</i>
CCG Complementarity	<i>[Reference any related CCG indicators]</i>
<p><b><u>Problem to be addressed (maximum 150 words):</u></b>  <i>[Briefly characterise the shortfall in quality or efficiency that the indicator is designed to address; detailed evidence should be placed in section D1]</i>            There are a wide variety of treatment options for movement disorders available, but as yet there is no clear structure to ensure equity of access for children in the regions and nationally. There is consequentially disparity of assessment and treatment options.             The development of a clearer focussed evidence base recently has shown that many traditional forms of practice may indeed be clinically ineffective. As yet this evidence base is not clearly reflected in practice.</p>	
<p><b><u>Change sought:</u></b>  <i>[Specify what change in behaviour is sought in general terms, with detailed specification set out in section C4.]</i>            To provide a comprehensive network in each of the four regions for assessment and management of muscle tone difficulties and musculo-skeletal deformity in children, secondary to central nervous system disorders such as Cerebral Palsy or acquired brain injury.             To establish clear pathways of care nationally in line with NICE guidelines, and specialist organisation evidence provision, with the centres meeting up at least bi-annually to agree protocols. (Interventions offered should be as specified in international consensus statements and NICE guidelines. With the use of CPIP there are already APCP derived protocols for standardised recording of hip ranges and prevention of duplication of radiological examination.) Regular meetings to discuss cases to ensure:</p> <ol style="list-style-type: none"> <li>1. Equity - service provision across regional networks; ensure clear appropriate choices are offered at the right time for all children and young people.</li> </ol>	

2. Access – targeted networks incorporating centres of excellence for assessment and intervention, with clear pathways to local teams who provide therapy habilitation.
3. Quality – ensure compliance of national and international guidelines.
4. Reduce individual non-evidence based clinical decision by improving communication within pathways. Agreed and appropriate assessments and outcome measures.
5. Cost saving – prevention of duplication of services. Ensuring adequate volumes of interventions are performed at each centre, thereby optimising expertise.

As part of this network there would also be adoption of international guidelines with a standardised structure of monitoring and managing musculo-skeletal deformity in order to minimise the impact of resultant problems of reduced function / ease of care and increased pain in children and young people with cerebral palsy (CPUP / CPIPS).

Children with Cerebral Palsy are by far the largest group of individuals with motor disorders seen in the UK population. The goals of the Cerebral Palsy Integrated Pathway (CPIP) are:

1. To assess every child with CP at regular, specified intervals by a specialist specifically trained to work with children.
2. To improve communication between members of the network team involved in the child's care.
3. To detect problems such as tight muscles and joints or hip displacement early, allowing focused more effective treatment.
4. To ensure no child is ever discharged or 'lost' from the system.
5. To ensure equity of access to healthcare for all children with CP.
6. To reduce the number of children suffering a dislocated hip or needing major surgery.
7. To collect information to guide service development and enable high quality research, thereby continuing to improve the lives of children with CP.
8. To prevent duplication of radiographical examination of the hips and create a structure to minimise the numbers of X-Rays performed over the young person's childhood.

The next stage of the CQUIN is to ensure each network reviews the range of invasive interventions to manage this group of young people with movement disorders, to ensure equity of access to the clearest evidence based approach for children.

This, and regular regional meetings, would also lead to a reduction of service duplication with fewer centres focussing on aspects of invasive intervention such as SDR, ITB or DBS, as well as ensuring equity of access, clarity of outcome measures and reduction in costs, without creating a risk to network provision.

At present the overarching management of movement disorders in children is included in the specialist Paediatric Neurosciences - Neurodisability (E09/S/c) service

specification. Specialist Orthopaedic services are incorporated within Specialised Surgery in Children (E02).

This CQUIN incentivises the principal aims of the service specification which are:

- Improve the health outcomes for children and young people who have a neurodisability.
- Early, appropriate and cost-effective care.
- Increase the focus on improving children’s lives by ensuring that professionals work together across organisational boundaries.

**B. CONTRACT SPECIFIC INFORMATION** (for completion locally, using guidance in sections C below)

<b>B1.Provider</b> (see Section C1 for applicability rules)	<i>[Insert name of provider ]</i>
<b>B2. Provider Specific Duration.</b> What will be the first Year of Indicator for this provider, and how many years are covered by this contract?	2019/20 2020/21 <i>[Adjust locally]</i> One/two years <i>(Adjust locally)</i>
<b>B3.Indicator Target Payment</b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN indicator should achieve payment of: Target Value: <i>[Add locally ££s]</i>

**B4. Payment Triggers.**

The triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the indicator, are set out in Section C4.

Relevant provider-specific variation, if any, is set out in this table.

*[Adjust table as required for this indicator – or delete if no provider-specific information is required.]*

Provider specific triggers	2019/20	2020/21
Trigger 1:		
Trigger 2:		

Trigger 3:		
Trigger 4:		
Trigger 5:		

#### B5. Information Requirements

Obligations under the indicator to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
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#### B6. In Year Payment Phasing & Profiling

Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.

*[Specify variation of this approach if required]*

Rules for in year payment and partial payment	
Year 1 Q1	10%
Q2	20%
Q3&Q4 Combined	70%
Year 2 Each qrtr	As per year One

### C. INDICATOR SPECIFICATION GUIDE: STEP CHANGE INDICATORS

#### C1. Providers to whom Applicable

Nature of Adoption Ambition:	<i>[characterise the providers for whom this indicator is applicable: eg all providers of service XYZ]</i> 17 well established centres, (with clear pathways of referral centres) offering many areas of interventions that are needed to facilitate collaborative working with partners. There will therefore be 1-2 hosts per region who will co-ordinate communication and pathways between other centres.
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List of Providers for whom Indicator is Applicable	<i>[List all providers to whom the indicator should be offered.]</i> <b>North</b>
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	Newcastle Leeds Manchester Alder Hey Sheffield  <b>Midlands and East</b> Nottingham Birmingham Oswestry RJA Coventry Cambridge  <b>South</b> Southampton Bristol Oxford  <b>London</b> GOSH KHP – Evelina-GSTT/ Kings St George’s Chelsea and Westminster
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**C2. Provider Specific Parameters**

The indicator requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)

N/A

**C3. Calculating the Target Payment for a Provider**

The target overall payment for this indicator (the payment if the requirements of the indicator are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

Year One: £160,000 per centre

Year Two: £160,000 per centre

Year Three: £160,000 per centre

See Section D3 for the justification of the targeted payment, including justification of the costing of the indicator, which will underpin the payment.

#### C4. Payment Triggers and Partial Achievement Rules

##### Payment Triggers

The interventions or achievements required for payment under this CQUIN indicator are as follows:

*[Set out the processes, behavioural changes and outcomes against which some portion of the payment should be made, in terms of inputs or processes, information flows, and/or patient outcomes.]*

Descriptions	First Year of indicator	Second Year
<b>Trigger 1: MDT assessment</b>	<p><u>Establish a virtual MDT within each network where all children who meet the agreed criteria are assessed within 18 weeks of referral. A comprehensive list of assessments to be completed based on international guidance.</u></p> <p>1. <u>At least 80% in Year 1</u> of (newly referred) patients (the denominator) to achieve both numerator conditions –</p> <p><b>Numerator:</b> Number of patients who are seen within movement therapy services:</p> <p style="padding-left: 40px;">A. undergo a virtual MDT review within 18 weeks of referral carried out by an interdisciplinary and multidisciplinary panel, recommending specific to</p> <p style="padding-left: 40px;">B. have CPIP assessments entered onto the regional and National Database.</p> <p><b>Denominator:</b></p> <p style="padding-left: 20px;">a. Number of children referred for consideration of movement therapy within region and assessed within 18 weeks</p> <p style="padding-left: 20px;">b. Numbers of children with Cerebral palsy within each region and assessed within 18 weeks</p> <p>2. <u>Hosts are required to produce an end of year CQUIN report for each centre, standardised across all centres.</u> This will be co-ordinated by the host in each region and will include information to support improved outcomes such as reduced DNAs, reduced hospital admissions etc. and / or improved clinical outcomes. This data will be taken from the database and a template for submission of the report by providers will be agreed prior to Q2 submission by the regions.</p>	As Year 1, but 90%.

<p><b>Trigger 2</b></p> <p><b>Oversight of local network service provision to achieve quality.</b></p>	<p>Progress against all the following:</p> <ul style="list-style-type: none"> <li>• CPIP: to have the Protocol of review and assessment already agreed – as per National guidelines assessed every child with CP at regular, specific intervals by a specialist specifically trained to work with children by end of Q2 - Year One. We expect &gt;80% by end of Year One of these children to be seen by these clinicians. We expect Data acquisition regarding CPIP uptake to be part of this process.</li> <li>• To ensure <b><i>no child is ever discharged unnecessarily or 'lost' from the system.</i></b> We aim to ensure equity of access across all regions for children, young people and families in England.</li> <li>• To <b><i>reduce</i></b> the number of children suffering a dislocated hip or needing major surgery. Data acquisition in line with CIPIS should be part of: Surgical procedures performed / Botulinum injections to hips / intra-articular steroid injections and Rates of Surgical intervention – soft tissue, Osteotomy or removal. The Host per Region to organise the set of data to be collected which within the run of the CQUIN will aim for reduction of the number of children suffering a dislocated hip or needing major surgery.</li> <li>• We need to see a <b><i>reduction</i></b> of preventable duplication of radiographical examination of the hips and create a structure to minimise the numbers of X-Rays performed over the young person's</li> </ul>	<p>As year one.</p>

	<p>childhood. CPIP outlines the number of Radiological interventions performed. Local audit to be completed by end of Q1 - Year One and used as comparative data for improvement.</p> <ul style="list-style-type: none"> <li>• By end of Year one to ensure adequate volumes of interventions. Suggestions such as: Therapy: In line with evidence base / Orthotics: EBM / Equipment: Medical interventions / Co-ordination of medication use / Invasive / BTX-A / Orth Surgery / Neurosurgery – ITB/SDR/ DBS</li> </ul> <p><u>We expect all centres to be in a position to assess every child with CP at regular, specific intervals by a specialist specifically trained to work with these children: to reach &gt;80% by end of Year One: All Centres. &gt;90% Year Two.</u></p> <p><u>A Protocol of review and assessment to be agreed by Q2 – Year One: All Centres</u></p> <p><u>Data acquisition regarding CPIP uptake to be part of this process: All Centres as per Trigger 4</u></p> <p><u>Local audit to be completed by end of Q2 - Year One and used as comparative data for improvement in a number of areas including:</u></p> <ol style="list-style-type: none"> <li><u>minimise the numbers of X-Rays performed over the young person's childhood (also see Trigger 4)</u></li> <li><u>To reduce the number of children suffering a dislocated hip or needing major surgery</u></li> <li><u>Any other areas the clinical team sees necessary.</u></li> </ol>	
<p><b>Trigger 3 Host and Centre network model</b></p>	<p>All Providers who undertake this CQUIN will be expected to develop and deliver the network model working alongside all clinicians involved in the patient care.</p> <p>This includes Primary care and secondary care to ensure robust management and treatment plans are in place for each child. This will include clear</p>	<p>As year one</p>



	<p>information about responsibility for the patient, future management, prescribing, and therapy and equipment provision as well as information about admissions and need for reviews post-intervention. Specialist Centres are expected to arrange an initial network meeting with local providers within their own network. Local networks will be identified by the specialist centre, in order to define their geographical area of oversight and the patient groups.</p> <p>They will be expected to work regionally and nationally to describe and develop care pathways in line with agreed NICE guidelines and International Evidence Based statements. They will need to implement treatment protocols need to be implemented, including shared care arrangements and delivery of high cost drugs, and horizon scan areas of concern.</p> <p>Regionally the current Movement therapy leads in each centre should meet at least quarterly. It would be expected that the regional networks would co-ordinate pathways, governance and training.</p> <ul style="list-style-type: none"> <li>• <u>A Network to be established per region by end of Q1 – Year One. This means the Host per region to:</u> <ul style="list-style-type: none"> <li>a. <u>organise and confirm the start of the scheme</u></li> <li>b. <u>start the initiation of pathway discussions</u></li> <li>c. <u>agreement of allocating equal responsibilities within the Region. We expect to have these in place by end of Q1 - Year One.</u></li> </ul> </li> <li>• <u>Every Network to adopt the international protocol for CPIPs as outlined by APCP and BSCOS by end of Q2 - Year One. We expect the co-ordination of movement therapy pathways to be in place regionally by end of Q2 - Year One. We expect education of community paediatric (esp.</u></li> </ul>	
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	<p><u>physiotherapy) of appropriate pathways in Q3 - Year One.</u></p> <ul style="list-style-type: none"> <li>• <u>At end of Year One a National meeting for co-ordinating centres to be organised by all the Hosts.</u></li> <li>• <u>Network members to be meeting every quarter (first meeting by not later Q2 - Year One). It is the responsibility of the Host to organise. We expect the co-ordinators between sites and PT reps to meet monthly.</u></li> <li>• <u>Each network to review the range of intensive interventions and data collected per network meeting.</u></li> <li>• <u>To have agreed by:</u> <ul style="list-style-type: none"> <li><u>Year One - Q1 responsibilities and structure per Regional teams;</u></li> <li><u>Year One - Q2 development and implementation of clear pathways;</u></li> <li><u>Year One – Q3 have everything agreed and teams operate as normal.</u></li> </ul> </li> <li>• <u>The Hosts to have their necessary resources in place by end of Q2 – Year One (Programme Coordinator, Therapist etc.)</u></li> <li>• <u>Website: Website for CPIP in place already: by end of Q2 – Year One. The Host will co-ordinate the CPIP structure accessing input by all providers within Region.</u></li> <li>• <u>Reduce individual non-evidence based clinical decision by improving communication within pathways. We expect this to be achieved by confirming quarterly meetings within regions and</u></li> </ul>	
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	<p><u>the use of EBM – NICE guidelines / International Consensus.</u></p> <ul style="list-style-type: none"> <li>• <u>By end of Year one to ensure adequate volumes of interventions.</u> Suggestions such as: <ul style="list-style-type: none"> <li>Therapy: In line with evidence base / Orthotics: EBM / Equipment: Medical interventions / Co-ordination of medication use / Invasive / BTX-A / Orth Surgery / Neurosurgery – ITB/SDR/ DBS</li> </ul> </li> <li>• <u>Per region an annual report to be produced on the performance of services</u> (Host to coordinate with the collaboration of centres where which centre writes its chapter). Expected to be ready by Q1 – Year Two.</li> <li>• <u>Patient Questionnaire</u> to run once a year by end of Q3 -Year One and to compare with the second year’s questionnaire at end of Q3 - Year 2. Increase in satisfaction is positive measure. It can be co-ordinated by CDCs (Child Development Centres).</li> </ul>	
<p><b>Trigger 4</b></p> <p><b>Data</b></p>	<p>The lack of data collection nationally means that it is difficult to accurately assess and compare the numbers of people accessing services for assessment and intervention. It is very difficult for decision makers to plan services effectively to meet the needs of this group in appropriate ways across the clinical pathway, or to identify whether the right people are accessing the services they need. Hence, in line with the protocols already agreed by key drivers – APCP / BSCOS / BACD – the specialist centres will establish full data set and collection of CPIP data with their regional clinical network. Confirm which data to be collected by Q2 - Year One, after the Q1 audit has been completed. Collection of data and reporting to local commissioners is expected from Q3 of Year One. Data from the initial assessment to be entered.</p>	<p>As year one</p>

	<ul style="list-style-type: none"> <li>• <u>To collect information to guide service development and enable high quality research, thereby continuing to improve the lives of children with CP. By end of Q2 - Year One all centres: Data acquisition in line with NCEPOD recs - NG62 4-5 Q &amp; S data sets.</u></li> <li>• We need to see a reduction of preventable duplication of radiographical examination of the hips and create a structure to minimise the numbers of X-Rays performed over the young person's childhood. CPIP outlines the number of Radiological interventions performed. <u>Local audit to be completed by end of Q1 - Year One (also see Trigger 2).</u></li> <li>• <u>Patient Questionnaire to run once a year by end of Q3 - Year One and to compare with Q3 - Year 2.</u> Increase in satisfaction is positive measure. It can be co-ordinated by CDCs (Child Development Centres).</li> </ul>	
<b>Trigger 5 Regional &amp; National contributions</b>	<p>Provision by the programme coordinator and support of a co-ordinated regional overview between centres.</p> <p><u>Contributions towards the costs of regional and national coordinating centres (of £20k and £5k respectively, as set out in section D.3)</u></p>	As year one

**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

Percentages of Target Payment per Trigger	First Year of indicator	Second Year

<b>Trigger 1</b>	30%	20%
<b>Trigger 2</b>	20%	35%
<b>Trigger 3</b>	20%	15%
<b>Trigger 4</b>	10%	10%
<b>Trigger 5</b>	20%	20%
<b>TOTAL</b>	100%	100%

**Partial achievement rules**

**All Years**

**Trigger 1: strictly-proportional**

**Trigger 2: strictly-proportional**

**Trigger 3: all-or-nothing**

**Trigger 4: all-or-nothing**

**Trigger 5: all-or-nothing**

**Definitions**

N/A

**C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**

**Reporting of Achievement against Triggers:**

The Association of Paediatric Chartered Physiotherapists have been co-ordinating National Protocols for the development of CPIP for quality assessment and improvement.

The information from this dataset will be used to produce frequent monitoring reports, including an annual report on the performance of services.

As an output of the Network, the annual report must inform future activity and service development.

**The national system's office will confirm the extent to which cost-reimbursement payments have been earned and are payable.**

**The national system annual report will also allow determination of whether and to what extent success payments are earned**

**Information for Benchmarking:**

**As trigger 4.**

**Information Governance:**

**Reporting Template requirement:**

**C6. Supporting Guidance and References**

**Further details on implementation, and references to documents that will support implementation:**

## **D. Indicator Justification and Evaluation**

### **D1. Evidence and Rationale for Inclusion**

#### **Evidence Supporting Intervention Sought**

- *The characterisation of the problem.*

Movement disorder networks:

Both the NICE Spasticity 2014 and NICE Cerebral Palsy 2017 guidelines developed over the last few years have highlighted the breadth and limited comparative evidence base for interventions used to improve function, care and comfort in children with movement disorders.

NG62 NICE guideline Cerebral Palsy in under 25s: assessment and management  
CG 145 NICE Guideline on Spasticity in under 19s: management

With regards to integration of movement disorder specialists within Regional and National Networks, a recent national audit performed by the British Academy of Childhood Disability also highlighted variance in assessment for, rationale, access, outcome and cost of invasive interventions performed to improve function and minimise deformity to children and young people with complex movement disorders, across England and Wales.

The development of a clearer focussed evidence base recently has shown that many traditional forms of practice may indeed be clinically ineffective. As yet this evidence base is not clearly reflected in practice. The choice of intervention offered was often dependent solely on what the local service provided rather than being based on peer evidence review, national guidelines and international consensus.

- *The choice of behavioural change to remedy the problem -- in terms of its cost-effectiveness.*

Regional networks for movement disorder intervention – working together to organise care pathways with their wider regional network and to minimise duplication of services

Not all centres need to offer all interventions, but there must be a clear pathway agreed within regions of who provides what and where.

As part of this Network, a co-ordinated regional and national multi and inter disciplinary approach to movement therapy will be integrated, ensuring pathways and protocols for what is provided across regions reflects best possible practice.

Evidence that a networked approach to implement a Cerebral Palsy Integrated Pathway: Global evidence base:-

CPUP (Swedish system) was introduced in 1994:

- The number of children with CP in Sweden who suffered a dislocated hip fell from 7.7% to 0.8%.
- The number of children treated with orthopaedic surgery for contracture or skeletal deformity fell from 40% to 15%.

Since 2013 CPIPS (Scotland) set up a patient management system based on the same clinical examination and radiological examination rationale. This formalises best practice as per the rest of the UK but provides a traffic light data base for assessment and intervention.

All 14 Scottish Health Boards take part.

2031 Patients are on the system, >95% of Scottish CP population.

The change in prevalence of hip displacement requiring surgery between pre and post surveillance population in Scotland has altered from 12.1% to 10.0% as earlier, less costly hip surgery prevents progression.

### **Rationale of Use of CQUIN incentive**

**CQUIN as an instrument is justified if net costs beyond normal service requirements are incurred by providers whilst benefits and cost savings accrue to patients and commissioners.**

■ **the benefits accruing to patients**

- Early intervention can prevent deformity, pain and need for complex surgery
- Ensure equity of access to the pathway for all children with cerebral palsy and avoid geographical variation
- Improve transition to adult services which will positively impact on individuals quality of life

CPIP Scotland survey of parents and carers- asked 12 questions and received 109 responses. The overwhelming majority found that CPIPS improved the care of their child.

CPIP Scotland survey of clinicians -asked 14 questions and received 94 responses. Once again, the overwhelming majority felt that CPIPS improved the care of children with CP.

There are several thousand children in England who would also benefit from specialist MDT review, following agreed protocols to ensure adherence to guidelines regarding

medication choice and regional recommendation for what is and is not appropriate for therapy input.

- Reduction of recurrent appointments at secondary and tertiary referral centres, minimising duplication.
- Reduction of long term pain and movement therapy oral medications
- Reduction of interventions with limited evidence base (e.g. some forms of therapy and orthotic use)
- Focus on appropriate use of intervention on individual function and comfort rather than generic use (e.g. wheelchairs, neurosurgical interventions).

■ cost-savings accruing to commissioners (NHS E, CCGs, other)

Efforts to improve interventions for children with movement disorders in Scotland and in Sweden have seen significant falls in hip displacement requiring costly surgery. Cost saving from reduced surgery (central estimate) £6 million pa across England, with patient benefit (and system cost-savings) from prevented deformity and pain.

This arises as follows:

**Cost Savings- Orthopaedic surgery**

Incidence of CP -**2.5/1000 live births**

Number of live births per year in England- **660,000**

CP cases per year in England (estimated) **1650 children**

Treated with ortho surgery before CPIP **660 children\***

Treated with ortho surgery after CPIP **248 children\***

**Total reduction in orthopaedic surgery 412 children**

**\* CPIP Sweden reduced overall orthopaedic surgery rate from 40% to 15%**

Total reduction in orthopaedic surgery **412 children per year**

Typical cost of orthopaedic surgery **£4 000 - £16 000** per patient (Bilateral hip reconstructions and soft tissue releases)

**Cost Savings-Prevention of hip migration**

- CPIP Sweden reduced hip dislocation rate in CP from 7.7%\* to 0.8%. (*\*It is noted that rate in UK would be higher*)
- Children & adults with dislocated hips require lifelong regular pain medications & increased provision of wheelchairs, orthotics etc.
- Potential to replace (expensive) orthopaedic OPD appointments with (cheaper) Community physio reviews
- Improving symptoms and potentially level of function in the long term means improved clinical and cost effectiveness
- Treating/preventing hip dislocation in CP improves ease of care, thus reducing impact on resources.



In CPIP, pilot data from Southwest, the West Midlands and the Sheffield area also shows:

- Estimated operation rates on 10% of children with CP per year and half of these operations are for hip problems (migration or dislocation).
- This equates to just under 3000 children getting orthopaedic operations and 1500 hip surgeries every year in England and Wales.
- This excludes other interventions such as Botulinum Toxin A injections, which are generally performed by Neurology or Neurodisability teams.
- From the experiences of CPUP, this surgical intervention rate could be reduced significantly, perhaps by as much as a half.
- Orthopaedic surgery costs are variable but hip reconstructions can cost £4,000 to £16,000 depending on the magnitude of surgery required.
- If we were to half the number of children needing orthopaedic operations and taking the lowest estimate of costs, this adds up to a potential minimum saving of **£6m per year**.

Other potential benefits include:

- Early detection and treatment of contractures preventing fixed deformities and reducing complex surgeries.
- Reduction in the rates and variance of practice in the use of Botulinum Toxin A injections across Regions.

CPIP Benefit

## **D2. Indicator Duration and Exit Route**

**The appropriate duration of an indicator depends upon how long CQUIN support is required before the change in behaviour sought can be embedded in services specification or otherwise.**

## **D3. Justification of Size of Target Payment**

**The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:**

**There are three elements of cost to be incurred:**

**1. Movement therapy pathways co-ordination, in each of the 17 named centres, already co-ordinating care across the 4 regional networks**

In order to work efficiently, reducing inequity, empowering overall cost saving and ensuring access, within current pathways for care, at 4-5 centres per region, each will need support of:-

Programme Coordinator Band 4 - 0.5 WTE £12½k

Therapist Band 7 - 1 WTE £40k

Admin. Support Band 3 - 0.5 WTE £10k

**Total, with one third overhead costs: £85k**

## 2. Contribution to regional network costs – for each region:

Each host will employ a network manager  
(band 7: c.£40k  
and 0.5-1.0 days per week of the lead clinician. C.£20k  
plus overhead (c one third) = £80k  
**Cost per contributing centre £20k**

Clinical leadership is already assumed to be in place within trust job plans and an expectation will come for regional and national collaboration and co-ordination of pathways.

The administrative support will provide a co-ordinated regional overview between centres and the therapy support will take a lead on education and support of pathways for children, young people and families in each referral pathway. Both will also support CPIP provision across the region.

## 3. Contribution to national centre including costs / resource to deliver CPIP

The current CIPIS provider for database, recording and co-ordination of assessment and output has volunteered to provide data management at a cost neutral amount to other services in the UK. The costs provided are for continued management of that resource across the 4 England regions.

### **Total national cost to coordinating centre (that will then support input across all regions)**

Website Initial set up- £40,000 (Year 1 only)

Website hosting - £20,000 (annual)

Website Support- £10,000 (year 2 onwards)

I.e. in the first year £60,000

Subsequent years £30,000

Training for physiotherapy supervisors via APCP for programme - £10k (estimate)

**Total cost (first year) £70k**

**Cost per contributing centre c.£5k**

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**TOTAL costs per centre: £110k per centre**

Total £110,000 plus £50,000 CQUIN bonus = £160,000 per centre.

## **D4. Evaluation: Approach, data and resources**

### **Evaluation Approach:**

#### **Information for Evaluation**

*[Information flows required for evaluation should be referenced here, building on those set out at C5]*

#### **Resources for Evaluation**