

**What organisation is necessary for commissioners to develop outcomes based contracts?**

**The COBIC case study**

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# 1 Methodological points about case studies

The NHS knows that it needs to learn from best practice.

The NHS knows that across the whole service there are a number of very different good examples of excellent practice which the rest of the Service should learn from. The writing and publication of these case studies is one method of trying to diffuse best practice.

But however good the exemplar case study is, the description of a case study on its own very rarely impacts upon the speedy diffusion of best practice. This lack of speed in diffusion is partly because the drivers for organisations for going through the pain of change are not strong enough. Without very strong drivers for change, even a very good case study becomes just an interesting example of how they do things differently in a different place from here.

We need to try and rethink how to write a case study to make it more likely that the example will be followed by others. In terms of the diffusion of innovation writing a case study is a further attempt to PUSH innovation into other parts of the NHS. To diffuse innovation properly there needs to be some more PULL drivers.

This case study as with all others will contain a narrative about what changes the main innovator made in order to create the innovation. It is a story of change and how it is led. However, as with all successful innovation there are a number of circumstances that were specific to this particular example of change which proved to be vital to its success. Every case study has these specific circumstances that are a crucial part of their success. However whilst they are specific to this case study they are rarely specific to the locality that is trying to copy the case study. This means that it is much more difficult for the copier than for the originator.

Therefore after the narrative about the case study we want to outline what the important specific resources were in the case study and try and explain how these resources might be obtained by those that may want to replicate the case study.

## Case studies and integrated care

At the moment there is a great deal of discussion about integrated care in the NHS. This case study is a specific example of how commissioners can catalyse the creation of integrated care by creating the context in which providers respond by integrating care.

It involves commissioners introducing incentives into the market in new and innovative ways and using contractual forms that are new to the NHS. In all cases COBIC contracting replaces a variety of fragmented individually negotiated contracts with a single integrated tender. This forces providers to respond differently, existing suppliers have either to radically change the way in which they work with each other or forgo applying for the contract.

In practice, some existing providers can see this as a problem; others see this as an opportunity to unleash provider creativity. The new contractual form ensures that the organisation that wins the contract becomes responsible for delivering integrated services and improving outcomes for services users. The contract creates a single organisation that has the responsibility for integrating what are very fragmented services, often delivered by multiple NHS organisations whose work is poorly and inefficiently coordinated.

Currently the incentives on these organisation to work together, to stop delivering wasteful care for which they are paid to deliver and to improve the coordination are too weak. Commissioners can change this – and change provider behaviour. This case study shows how this can be done. We are exploring this example because it provides a strong example of how if you want the patient to experience care that is genuinely integrated then you need a contract that will specifically aim for such a service. We believe the principles illustrated in this case study have wide application in the NHS and beyond.

## 2 The COBIC Narrative

### 2.1 *What is in a name? Commissioning for Outcome-Based Incentivised Contracts (COBICs)*

We are not sure if we should or should not recommend organising your commissioning for outcomes around an acronym that nobody understands. When you say the word COBIC as a noun some people immediately say “Sorry could you explain what that means?” and of course this is a useful hook for a discussion. But others in conversation let the acronym glide past and never really understand what you are talking about.

On balance, in an NHS infected as with measles by a rash of acronyms, it has proved useful to have a label that needs explaining since it makes the important point that at the moment the NHS doesn't commission for outcomes and in the future it needs to just that.

### 2.2 *How did COBIC start?*

The first COBIC contract was let in April 2011 when Milton Keynes PCT developed and used the COBIC approach to retender its substance misuse service.

The old service had been developed in the traditional way to provide a service that was essentially about inputs and contained a number of very different fragmented contracts. Those contracts ensured that people who misused substances could be referred to a service. We must of course recognise that this in itself was a step forward and better than what had gone before with large block contracts. Specific contracting for specific inputs meant that new services such as substance misuse could be developed and provided. This had been a considerable step forward from the time that new services would not have been provided unless providers chose to provide them.

The development of commissioners with a remit to understand the health care needs of a population ensured that at least there is a chain of possible relationships between new needs commissioners having the money and the contractual power to commission new services. Having population based commissioners at all is a step forward from just having block contract providers.

However most people work in the NHS to in some way improve the lives of people and remove some of the burden of pain and distress that ill health brings. Often there is a straightforward relationship between an NHS input and an improved outcome Patients have some tests and find they are not ill. They were worried and the tests and the outcome make them less worried. Under these circumstances if you look at inputs they will have a good relationship with outcomes.

But there are a much wider range of other services where there is not as straightforward a relationship between an input and an outcome. Here a new concentration on improving outcomes leads to a very different sort of service.

## Milton Keynes - the first COBIC

The PCT was unusual in that its Chief Executive was also the DPH, and the Director of Strategy and Planning was also the deputy DPH. The PCT strongly believed that its purpose and value chain was to turn tax payer's money into better health, fewer inequalities and to ensure its public had access to high quality services. They made extensive use of programme budgeting and marginal analysis to understand the needs of its population and to develop its health and health care strategy.

In doing so, it became all too clear that an activity based currency for buying health care – as in the misnamed 'payment by results' – did not fit well with this approach. There is no metric than converts the number of outpatient appointments delivered by an institution (or even a speciality) to a measurable improvement in health (or any other outcome except cost, and perhaps waiting time). It was impossible to answer whether buying 750 outpatient appointments rather than 600 outpatients was good for health or not, let alone whether it was good value or not. Worse still, paying providers for activity created powerful disincentives for them to develop innovative ways of providing care that required less expensive activity. It led to the preservation of fragmented pathways of care, and in an attempt to control costs, the centre was forever exhorting commissioners to generate more and more detailed service specifications which too often led to junior or generalist commissioners talking to senior clinicians in a conversation that could have been interpreted as the commissioner trying to tell the provider how to do their job.

The results were, as has been seen up and down the country, of course, predictable. There had to be a better way. And, for us, the opportunity came with the substance misuse service – which was traditionally commissioned, with a high % of the money going to the hospital based element of the service which received payment for the numbers of outpatient consultations they undertook. For years, everyone had known it could be different – more user friendly, more local, less hospitalised, better integrated with probation and other services and so on. So, we sat down with partners, with users and the national treatment agency. We asked "if this was a good service, what would it achieve? How would we – and you – know? And very quickly, people told us that if the service were successful it would keep people in their jobs, keep people in their homes, pick people up on day one when they come out of prison off drugs, not day 21 by which time they would have robbed a house (or several) and be back on drugs. So, we simply asked, if that's what we want, is there any reason that that is not what we should buy – and reward?

So we gave notice on the existing contracts and issued a much more outcome orientated contract. We offered a contract that combined capitation and rewards for improved outcomes. Further, believing there was considerable waste in the current service, we also reduced the money for the service but allowed providers the opportunity to keep the money generated by not delivering unnecessary care. There was considerable provider response – 40 expressions of interest and 10 real bids from public, voluntary and private sectors. The detail of the contract and the selection of the provider were managed by in a process of competitive dialogue (see below).

We let the service to a third sector organisation and the service transformed in weeks, providing measurably better quality and experiences than before – and as a commissioner we saved 25% in year 1. Importantly, most staff welcomed the approach – they felt the outcomes we asked for chimed with the reasons they had chosen to work in substance misuse services and that we the contractual form now allowed them to apply their expertise to deliver the value and outcomes they, the commissioners and service users all wanted.

The second motivation was the desire to reduce the fragmentation caused by having several different contracts with different organisations who deliver a part of that service.

It is often the case that parts of the service are best provided by organisations that specialise in that aspect of the service. So for example an educational programme may be best delivered by ex-users who have some pedagogic training. These may be much better at education than medical staff. However, the medical staff will be essential for another part of the pathway thereby necessitating two contracts. This not only adds to the amount of time spent monitoring several very different contracts, but it means that the service – by definition of the organisation of the contracts for that service - is fragmented.

We were also very aware of Porter's work at Harvard Business School <sup>1</sup>, who for us, was making a cogent case that value and outcomes improved when services and service lines were organised around patient and patient pathways, rather than around provider interests. For the NHS activity based contracting Pb'R' has meant that the services have mirrored the organisation of the providers and NOT the needs of the patient. We needed to escape from the PbR straight jacket that was destroying value and quality, and develop a new contract currency and new contract form.

The Commissioning staff at Milton Keynes developed their first COBICs in order to change that around. But it is important to recognise that the issuing of such a contract deliberately challenges the way in which providers are organised. We believe that this had the potential to be a new catalytic force to accelerate the much needed provider transformation and restructuring that the NHS so desperately needs if it is to meet the sustained financial challenges that lie ahead and at the same time both meet rising demand and improve outcomes.

### *2.3 Why Substance Misuse and Sexual Health services were the first COBICs?*

#### **Substance misuse**

For many years in Milton Keynes substance misuse services were provided by multiple providers. Co-ordination was poor and users found the service complex and often dropped out of treatment. The complexity and fragmentation characterises a wide range of different NHS services. If you have a high level of capacity and fluency with different bureaucracies then patients can find their way through the wide variety of different mechanisms that characterise the very different approaches of different NHS institutions. For most patients this is very difficult. For people who misuse substances this is almost impossible. This raises very severe problems about the efficacy of any substance misuse service that is arranged around a number of different contracts.

Milton Keynes PCT and Milton Keynes local authority jointly developed an understanding of the outcomes that they wanted from the contract. They worked with service users and partner agencies to set the contract outcomes, including keeping people in housing, increasing the % of substance misusers in employment and ensuring that the courts had access to a treatment service as an alternative to imprisonment.

The COBIC found a single provider a national charity called CRI. There have been a number of successful changes and annual spend has been reduced by 20%.

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<sup>1</sup> <http://www.hbs.edu/faculty/Pages/profile.aspx?facId=6532&facInfo=pub>

## Sexual health services

It was similar story with sexual health services – the second COBIC contract let in Milton Keynes. Services were fragmented, bought from multiple providers and probably more hospital based than necessary or desirable. Some apparently simple improvements had proved difficult to deliver – for example ensuring that people with sexually transmitted infections could also receive contraceptive advice at the same consultation. A similar approach of working with users and partners to identify the outcomes sought, followed by competitive dialogue, led to the letting of the contract to a new provider.

In matter of months the service had changed, with many services moving from the edge of town hospital to the city centre (top floor of Boots) and, at last, a ‘one stop shop’ for people with STIs. We learnt a lot from the competitive dialogue, and in this case, if we were doing it again, would think more about the demands we placed on providers – as some dropped out half way through the process.

### *2.4 Problems this process poses for current providers*

The services developed through COBICs are very important services. In many ways life or death for the patients involved. But they have not been at the core of the provision of most NHS providers. Whilst the loss of a fragmented service may mean that a traditional provider lost some business, the development of COBICs for these services did not ‘destabilise’ an institution.

It was important to start the very first COBIC with important services but where the change has not been experienced as a threat to the core of an NHS organisation. As we shall see later on, given the economic crisis facing the NHS from 2013 it is probably important for CCGs to develop this new approach to very important and large services.

It is very important that commissioners developing contracts for outcomes recognise that integrated pathways for outcomes provide two sorts of profound problems for existing providers.

First, most providers have organised their services to provide a small part of a patient pathway. A secondary care acute provider, a primary care nurse, and a community education provider are all responding to a specific contract with a specific service. To meet the contract and to provide the service they have to provide a certain number of those specifics and they meet their contract by doing that. We provided an outpatient appointment within the time set out and we met our contract.

It is not their fault or the fault of any provider if the whole pathway does not work for the patient. Each provider did their bit and hopefully did it very well. Given none of these providers can deliver a whole integrated contract on their own; they don’t as single providers see what is the problem with fragmentation. Most providers recognise that there are problems with handovers, but they see those problems as caused by the other providers that are next to them on the pathway. Acute care complains about the information in the referral letter from the GP. The GP complains at not getting information back from the acute provider.

Probably, they are right to blame each other because the handover is not seen as the service. The commissioned service is the specific interaction.

This frame of thinking is much embedded in most providers of NHS services. Therefore most providers would find it very difficult to respond to a contract which demands an integrated service because no one provider is organised that way. The only way a range of different providers can respond with an integrated pathway is by developing a response to a COBIC in partnership with each other. There will need to be a partnership to deliver any form of integration let alone to deliver a pathway of care.

However, we do not apologise for creating these problems for providers. They are problems we believe that providers need to consider as they lie at the route of much of the poor quality and waste in the service. Just as importantly, we believe that providers have the staff and the expertise which means they are better placed than commissioners to develop the detailed service innovation required to address the problems.

This means that to respond to any form of outcome orientated care contract will mean that none of the existing providers can apply on their own. Potentially for existing providers this is a very significant issue. They either change the way in which they respond to contracts or they will lose all of the business.

Many of the other Right Care Case Studies (Pennine MSK and Bexley Diabetes<sup>2</sup>) are examples of how providers can organise themselves very differently to [provide integrated care. These changes are obviously possible, but they will take some time to develop. This means that those commissioners who are developing COBICs to give existing providers sufficient warning about this very radical change of approach.

The second profound shift for most existing providers is to be able to move from delivering a contract concerning inputs to one that focuses on outcomes. If you have spent 10 years developing services and working to contracts that are all about inputs, suddenly working to outcomes is a very dramatic shift. This does not only involve a contract team thinking differently but will also involve the entire organisation of the provider. So be it.

An orthopaedic surgeon may have become used to working within a structure which means she will have to provide the operation within a certain time period of referral. The operation would have to be successful in its own right and hopefully would not involve a referral back to be an inpatient within 30 days. All of these have become normal for surgeons to work towards.

It would be different if the surgeon had to ensure that the patient could walk up the stairs in 2 weeks and go to the shops within a month. This is not only a shock to some surgeon, but potential could be a real shock to the finance director of the hospital if they did not get paid for their activity. Working to a contract about an outcome may at first sight appear very unfair to the organisation that you are expecting to deliver. Whilst organisations can and should be able to ensure that inputs are delivered, for many health care organisations the delivery of an outcome seems unfair because in essence it involves something that is beyond the control of the organisation contacted to deliver it.

The surgeon may feel that it is unfair to judge the success of her work around the expectation of her patient being able to walk up the stairs in 2 weeks because a lot will depend on the quality of other services after the operation, or the quality of the nutrition that they had both in the hospital and home. This is beyond the control of the surgeon.

But this is the essence of the argument for outcomes. If the NHS is to be judged on a successful outcome then everyone who does not see that outcome as their business has to work towards that successful outcome. Payment for outcomes forces the health care providers to work outside of their particular part of the pathway and to think of how the whole outcome is achieved. The surgeon becomes involved in the physiotherapy and the physio becomes involved in the nutrition.

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<sup>2</sup> Right Care Casebooks are published at: <http://www.rightcare.nhs.uk/index.php/tools-resources/casebooks/>

## 2.5 Commissioners need to help develop a market in provision for integrated outcome based services

The previous section outlines some of the very radical changes that are necessary for providers to develop services that are both integrated and aim to provide outcomes. There are very few if any providers who can simply move from their current pattern of work to one that organises an integrated pathway without some difficulty.

One of the models we have explored for changing the way in which provider work is that of the Accountable Lead Provider (This is outlined at <http://www.rightcare.nhs.uk/index.php/tools-resources/casebooks/>).

If the commissioner expects, once they have developed an outcome based contract, that providers will be able to simply reply to that contract, then they are not recognising the scale of change that will be necessary. Indeed if they underestimate the scale of change necessary, they will probably end up with no providers able to meet the requirements of the contract.

Commissioners need to recognise that in nearly every locality, they are creating a new market in outcome based health care. Because of this they may need to do much more than they have in the past in discussion with existing and new providers how different this approach is to the norm. The issuing of the contract will not achieve this on its own.

One way of doing this is for commissioners to run a competitive dialogue process. This encourages commissioners and providers to have a period of time when they are openly, fairly and within the law discussing the different ways in which the outcomes can be commissioned and provided. So far, we have been surprised at the extent and quality of providers coming forward to respond to COBIC contracts. It remains to be seen how providers respond as the scale of the COBIC contracts we – and other commissioners – seek to let increases.

In developing an outcome based contract this is important because it recognises that commissioners need to engage in a dialogue with providers to work through how outcomes can be developed delivered and measured. If commissioners try to do this on their ‘side of the wall’ on their own, they will find this a very hard task.

Similarly because most providers have never delivered a contract for outcomes they will need to engage in discussion before putting in their final tender to find out how this will work.

## 2.6 The development of the COBIC board

In terms of the specific development of COBIC what had started as a PCT led initiative in Milton Keynes developed into a COBIC developmental project board which involved a much broader range of individuals from a range of different parts of the NHS. This involved the two authors. Both of us had worked at a national level in the DH and had worked at a regional and local level in commissioning. Muir Gray, the “*NHS Knowledge Tsar*”, was a member of the board because he had an interest in developing patterns of delivery that went beyond the existing organisation of providers to a radically different method of providing care between existing organisations

Diane Gray, a public health doctor and Harkness Fellow had helped develop the approach as Director of Strategy and Planning in Milton Keynes, Jake Arnold-Forster, previously Chief Executive of Dr Foster, brings national expertise and contacts that have proved particularly helpful in relation to the law, contract regulation and procurements and in working with and across private, public and voluntary sectors. Nick Georgiou has extensive experience of local government acquired as Director of Social Services and Stephen Richards, an experience GP leader and now lead clinician

## Running a competitive dialogue

**There are many ways of running a competitive dialogue. This is one way of doing it. This form of competitive dialogue is one way of developing a market for these new products that both provide integrated care and provides health care outcomes.**

First, the CCG issues the initial specification to start the dialogue. Before this is issued it is wise to prepare existing and other possible providers in ensuring that there is a market of different providers taking any interest at all. This initial work will also ensure that potential providers recognise that the aim of the dialogue is for commissioners to better develop the outcomes and the incentives that will go into the final contract.

Commissioning staff run the initial explanatory session for all of those who express an interest in the tender. They explain how this process is very different from previous contracting and will almost certainly need different providers to work together into a single bid to ensure that there is a strong patient pathway. Here the commissioners need to make it clear that they do not want several different contracts for different parts of the pathway, but want a single integrated contract. This will probably require providers to work together to develop an integrated approach. It is important to stress this point early on because it is counter-intuitive when compared to most previous contracting for fragmented provision.

The next stage is the submission of expressions of interest in reply to the initial specification. It is almost certain that the local authority and NHS commissioners will want to work together to commission a single integrated health and social care pathway. These joint commissioners can form a panel to select the best 4 or 5 to engage in the rest of the dialogue.

There are three (or more) different rounds of meeting where these selected bidders that have got through the initial process dialogue with commissioners about possible outcomes.

The first looks at the service delivery model and how the providers and commissioners will agree and develop the health care outcomes. The second will look at how the different providers will work together to develop a truly integrated service and how new value will be created and incentivised by that service. It is important that a leading GP commissioner and a local authority commissioner attends each round together with a relevant patient group

The specification is then refreshed and goes out to the existing bidders for them to resubmit anew.

There is then a third round of discussions with each bidder which discusses their refreshed bid. This discussion looks at how the service delivery model will deliver the specified outcomes and at how new forms of value are incentivised in the contract.

After this dialogue a new detailed specification is drawn up by commissioners and is then put out to tender for the formal legal process. The new tender is replied to and the normal form of legal contracting takes place leading to an award of the contract.

Because they are developing integrated services aiming at outcomes the actual mobilisation for these new contracts will be more difficult than for previous and other contracts and if time is not to be wasted there will need to be a joint effort between commissioners and integrated providers to solve the problems of mobilisation. This will need the active involvement of GPs in the process.

There will also be a joint communication plan from GP commissioners and providers explaining how much better the new integrated outcome based service will be.

of Oxfordshire Clinical Commissioning Group brings an insight into the needs of new commissioners who receive a capitated sum of money and will be held to account for delivering population outcomes. Karen Foster is Business Manager at Solutions for Public Health, an NHS evidence based public health consultancy whose skills fit well with the requirements for developing COBIC contract specifications.

Together, this project board have helped shape and communicate the COBIC concept. A growing number of CCGs have decided they want to try the COBIC approach to commissioning and contracting. Their interests vary – but most are interested in applying the approach to large areas of their work such as mental health services, musculoskeletal services and frailty. We think that this approach to commissioning is going to be important in the reformed NHS. The skills and ways of working that this team have developed have the potential to develop into a specialised form commissioning support that could be of help to large numbers of NHS and local authority commissioners.

## *2.7 The new architecture of commissioning in the NHS and the development of COBIC*

COBIC started as a practice within the commissioning architecture that existed up until 2011- that of PCTs. The new commissioning architecture created by the Health and Social Care Act in 2012 has developed new voices and motivations in NHS Commissioning through the much more developed involvement of GPs.

We would argue that the greater involvement of GPs in commissioning will make it easier to spread COBICs for two reasons.

First most leading GPs have developed their clinical practice through the organisational form of running a small business. Partners in GP practices are classic small business people and therefore recognise that their businesses buy things and pay money for those things. If you do successfully run a small business you get good at this experience of contracting and you recognise that if it is at all possible you want a value for money contract covering a set of outcomes. If you had a set of 20 contracts to provide all of the medical supplies for the practice, it would take some time to manage all of those contracts. Modern business recognise that value for money is delivered through logistics organisations that do some of that work for the original contractor. Leading GPs have a day to day experience of making their money through constructing modern contracts. This is a different experience from PCT officers.

Secondly and more significantly GP commissioners are clinicians. Their work experience has been built around sick people coming to see them on a regular basis. They either deal with the sickness themselves or refer on to other organisations. When you talk to GPs one of their main experiences is that when they refer a patient to someone else, it very often doesn't seem to clinch any outcome. They see patients again and again and again in what they type as a revolving door. NHS services often do not seem to bring anything to a conclusion. One referral leads to another and another and another and then the patient comes back. There are often (in terms of this case study) no outcomes. There are just more and more processes. Therefore many GPs want to develop outcomes for their patients and not to deliver just another set of processes.

Both of these drivers mean that GPs enter the fields of GP commissioning rather hoping that they will be able to develop proper contracts for services for their patients and that those contracts will provide real outcomes for their patients.

Talking to the new Clinical Commissioning Groups about COBICs is a much more fertile discussion than previous local NHS commissioning organisations.

## *2.8 Why the National Commissioning board is interested in COBICs*

The Health and Social Care Act 2012 not only radically changed the local architecture for NHS Commissioning, but it also transformed the organisation of the NHS at the centre. Traditionally for over 60 years the Department of Health has been the national headquarters of the NHS. For much of the last few decades there has been a Chief Executive of the NHS who has usually also been a permanent secretary of the DH. This meant there was - as in all Whitehall departments - a straightforward accountability structure between the Secretary of State and the NHS. Every Monday every secretary of state has a meeting with their senior permanent secretaries and this was replicated in the DH.

The Health and Social Care Act radically changed that by creating a new national quango called the NHS Commissioning Board. This Board is not a Government department but is a distinct organisation from Whitehall with its own chair and non-execs. The Secretary of State in exchange for an annual budget of £85 billion expects the NHS CB to deliver certain activities as a part of what is being called a mandate. In July 2012 the draft mandate was drawn up which if accepted would pledge the NHS CB, in return for the money it is being given, mandate the NHS CB to improve health in a number of domains. Nearly all of these domains concerned the improving of health and health care outcomes. For example, the NHS CB will agree when it accepts the Secretary of State money to improve the outcomes of people who have long term conditions by improving the number of years that they have a higher quality of life. This is a really important part of the reforms where for the first time a national NHS body agrees that what it is driving towards is not more operations or more drugs, but is improving the quality of life for people who are ill.

It is impossible to overestimate this effect of this change. In accepting that mandate on outcomes, the problem for the NHS CB is that the ways they have of influencing actual health care in the ground are through a series of contracts that are all about inputs. The National hospital contract has not up until now asked the provider of health care to mobilise for the health care outcomes in exchange for the money they receive. They have agreed to carry out a certain number of operations where the patients are seen within a certain time frame.

The NHS CB has agreed with the Secretary of State that they will deliver health care outcomes, but the form of contract that it has to hand will only deliver inputs. This is why COBICs and all such contracts looking towards outcomes are of such interest to the NHS CB – and, will become of interest to CCGs and potentially to Local Authorities if they feel responsible for the health of their communities.

COBICs do not need an NHS central sponsor to thrive. They need the space to develop and be implemented in as many Clinical Commissioning Groups and localities as possible. They do, however, need the rules that will govern the operation of the new system to be sufficiently flexible to allow innovation in contractual forms and currency.

## *2.9 COBICs now and in the future*

As of October 2012 there are a number of localities where COBICs are under active consideration for implementation from April 2013. We would be disappointed if there wasn't some part of health care being developed through them covering over a million people. For example, Oxfordshire are developing COBICs for the frail elderly (potentially 5% of the population and 25% of their budget, for maternity services and mental health services; Bedfordshire CCG are in the process of developing a COBIC-style contract for musculoskeletal services and Northumberland CCG is considering the COBIC approach for continuing care and potentially other groups.

The hesitation that CCGs feel is caused by the thought in amongst all of the newness of doing yet something else that is new. It is understandable that CCGs, amongst all the other new things that they have to do, may want to use an existing old fashioned input based contract since providers and

all of us know how not work that contract. However CCGs will not be able to drive to the improved health care outcomes that they want if they use contracts about inputs. The biggest risk that the NHS faces is that nothing really changes. COBIC contracting is a way that commissioners can generate the right sort of change – and in the process, improve value for the tax-payer and outcomes for service users. It works for small services – we will find NCB out soon if it also works for large services.

# 3 Lessons for commissioners from the COBIC case study

## 3.1 Introduction

There are two very different sets of lessons from this case study both of which might involve clinical commissioners taking a risk in developing new forms of contract. First, commissioners may want to work with the COBIC model to develop contracts in their own locality. Already, the COBIC team is developing a standard way of working to introduce COBIC contracting to a health and social care economy. They have also face and answered most of the questions and issues that get raised by commissioners, providers, lawyers, finance teams and regulators who are new to COBIC contracting.

Second they may want to learn the lessons from the case study to develop their own form of outcome based contracts. Whilst both the authors of this case study are active in the development of COBIC and would want to see other CCGs using the model, we are even more interested in CCGs having the capacity to develop their own form of contract that would create an integrated care pathway leading towards outcomes. The NHS needs such contracts to be covering the health care of many millions of people and working with a very wide range of different health conditions. We are therefore drawing lessons from the case study for all local NHS commissioners.

## 3.2 *Recognise the importance of an innovation that works towards health care outcomes and start in your locality with a specific service*

Contracting for an integrated care pathway which leads to health care outcomes is a big step and a big change from existing contracts. However it is what clinicians and the public want to see that NHS health care outcomes can deliver. It is therefore a radical change but goes with the grain of what clinicians and patient groups want to see. Look at the Richmond Group of patient organisations (From Vision to Action April 2012<sup>3</sup>) and you will see how patient organisations really want to see the NHS provide outcomes based health care.

We - and hopefully you - may be doing something radical in developing outcome based contracts but it goes with the direction of many organisations.

It may also be sensible to start with a specific contract that has clearly failed to develop as an integrated service and would gain from so doing. As we have suggested in the body of the case study to deliver integrated health care that will drive towards outcomes health care providers will have to change the way in which they organise service provision radically. This will have a radical impact on existing providers driving them towards very different forms of organisation.

If you start with a large contract you must be prepared for some turbulence in the system and reaction from conservative provider staff more interested in preserving the present form of their institution rather than improving the service to the public. Some people identify themselves by the institution they work for, others by the service they provide e.g. a gerontologist or manager can see

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<sup>3</sup> [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/Richmond-group-from-vision-to-action-april-2012-1.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Richmond-group-from-vision-to-action-april-2012-1.pdf)

their primary allegiance either to the bricks and mortar of their institution or to the older people service. The NHS needs more of the latter. Those that identify themselves with the building tend to struggle with COBIC idea of contracting. Those that identify themselves with a public service embrace it.

### *3.3 Gather people around you who will help you develop the idea*

All of these case studies start by developing in a particular locality. They usually have someone facing a particular local problem with a nexus of very local relationships and they use good leadership skills to construct a local solution to that problem. This is the case for most innovations in the NHS and other services.

The problem for the NHS is that these local innovations are rarely scaled beyond their original locality. What is interesting with the COBIC innovation is their decision to develop a programme board which drew people into the development of the idea that came from outside of their locality. For the NHS this is an unusual way of scaling up an idea but is worth working through.

The staff that developed the first COBIC at Milton Keynes recognised that if they wanted to create a wider movement to develop the idea nationally then they needed a wider set of people with different sets of skills. The development of the COBIC board brought together individuals with a range of different experiences who would.

Each of the people on the development board had different experiences and skills which have helped disseminate this idea beyond the original locality.

### *3.3 Develop your practice and then ask the centre for its agreement*

One of the main problems with NHS culture is the belief by many people within it that permission needs to be granted before they are allowed to develop any innovations. This part of our culture often limits innovation and in this case if the staff developing COBICs had felt they had to ask for permission would have done so in this case.

Whilst it is important to check that innovations are within the law, as this form of contracting is, asking a superior body for permission usually means that the innovation grinds to a halt. The internal to NHS culture aphorism for what is the necessary stance here is to ask for forgiveness after the event rather than permission before it.

The attempt within the reforms to create a new culture of innovation will only work if staff have the ability to get on with the development of new activities. In the case of COBIC there was a discussion in the summer of 2012 with the NHS Commissioning Board, about how COBIC might make the task of the NCB a lot easier since they contracted for outcomes. Given the mandate that the NCB had to work to was aimed at outcomes COBIC might make their overall task easier.

COBIC, as with many innovations, did not need permission, nor does it need endorsement by any NHS superior body.

**The Authors can be contacted through our feedback section on Right Care:**

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