

Modernising Commissioning: Increasing the role of charities, social enterprises, mutuals and cooperatives in public service delivery.

**Response from The Stroke Association
December 2010**



About The Stroke Association

The Stroke Association is the only UK-wide charity solely concerned with combating stroke in people of all ages. We fund research into prevention, treatment and better methods of rehabilitation and help stroke survivors and their families directly through our website, information and national helpline.

We also provide a range of services including support for people with communication difficulties as a result of stroke, family support, information services and welfare grants. In addition we campaign, educate and inform to increase knowledge of stroke and act as a voice for people affected by stroke.

Information on stroke

A stroke affects the brain when the blood supply to a part of the brain is cut off by a blockage (ischaemic stroke) or by a bleed (haemorrhagic stroke). There are approximately 110,000 strokes and 20,000 transient ischaemic attacks (TIAs), also known as mini-strokes each year in England alone.

Stroke is the third most common cause of death in England, and the largest cause of severe adult disability. Around 300,000 people are living with moderate to severe disability as a result of stroke.

Stroke is also one of the most expensive conditions, with direct care costs to the NHS of £3 billion each year, within a wider economic cost of £8 billion a year.

Impact of stroke

While one third of people who have a stroke will make good recovery, one third will have long-term disability and one third will die as a result of their stroke. Those who survive their stroke will need short-term, long-term or life-long services.

The physical impact can leave people with mobility problems that make managing everyday life difficult without carer, therapist and technological support. Problems with continence, swallowing and nutrition, vision, and difficulty with speaking, reading and writing can impact on dignity, health, and everyday communication. Cognition can be significantly affected with problems with memory, understanding, information processing, attention and decision-making. The emotional impact is large, with half of survivors experiencing depression at some time during the first 2 years of a stroke.

With multiple and complex needs, stroke survivors and their families have need of many services ranging through physiotherapy, speech and language therapy,

cognitive, psychological and emotional support, family support, occupational therapy, social activities and social services.

Response to Modernising Commissioning: Increasing the role of charities, social enterprises, mutuals and cooperatives in public service delivery.

The Stroke Association is a major provider of Life After Stroke services that meet a wide range of needs for approaching half of all stroke survivors. We currently have 350 contracted services in England funded by the NHS or social services that support 35,000 stroke survivors and their families. We have three Core Services: Information, Advice and Support Service, Stroke Prevention Service and our Communications Support Service. As such we are an example of a civil society organisation that currently provides services, with plans to expand and are well placed to respond to this paper. As our services span health and social services, two thirds of our services are funded by the NHS and one-third by local authorities.

The Stroke Association is a charity that is already providing services and is committed to continuing and expanding our innovative services for people surviving a stroke. However, in order to do so, commissioning needs to be improved so that we have stability, continuity, and sustainability of our services.

We are therefore pleased that there is recognition that tendering processes at present are too bureaucratic, and must be streamlined to make them less inhibiting for organisations such as ours that may be delivering relatively small services in some areas. The introduction of standard PQQs could be a big step forward in dealing with these issues.

We are encouraged to see that PQQs could be completed on-line and held centrally, therefore being available to all commissioners, which removes the need to repeatedly submit PQQs on a tender-by-tender basis. However, we feel that the use of standard PQQs should be widened to cover all NHS and local government public contracts. Similarly the scope of the Contracts Finder portal being proposed should be widened to all NHS and local government tendering opportunities.

Contracts Finder should be developed to store examples of best practice for organisations new to tendering, and further consideration should be given to providing a free or at cost advice/support service to providers, which would stimulate the market, particularly in the early stages of this initiative.

To develop a free market, civil society organisations will need access to data intelligence currently held within public sector bodies and currently not always currently readily available to organisations such as ourselves.

Procurement teams should initiate an early dialogue with the market to give suppliers time to create innovative delivery solutions and explore possible partnerships in advance of tenders being issued. Similarly, procurement timescales should be longer to give smaller organisations realistic amounts of time to complete the necessary paperwork. We would encourage a more flexible approach where organisations can tender for a portion of a contract where appropriate in partnership or as a separate provider.

It is unclear from the consultation whether the aspirational target of 25% of contracts for SMEs also includes civil society organisations. If civil society organisations are not included, we strongly encourage them to be so, and would then be able to support this commitment.

The Stroke Association is concerned that any outcomes used for payment by results should be achievable and proportional to the contract. If payments are, for example, held back until the end of the contract, this would have deleterious impact upon the finances of the charity and limit their current ability to carry out their charitable aims. Associated reporting requirements will need to be proportionate and manageable for the organisation to ensure that they focus on service delivery.

In our experience, there is a very wide interpretation of what constitutes outcomes by current commissioners, which presents a considerable challenge to service providers. It would be helpful for service providers and also users of services if standardisation of outcome measures were adopted. Service users would then be able to compare services and exercise choice, and providers would be clear from the outset what services are required and what outcomes to assess.

We would specifically like to see outcome measures covering some aspects of quality of life and well-being, such as being physically active, living independently and returning to work. Consideration should be given to how these might in some cases be based on the patient's personal goals. Consideration should also be given to finding measures that cover emotional and psychological well-being as a quality of life measure.

The Stroke Association is well placed to provide services to stroke survivors and their families as we work closely with them in all our work and have in-depth knowledge of the wide range of issues they face, underpinned by research. The move away from costs of services to price and value of a provider will be welcome if this will enable commissioners to recognise the added value that we bring to any service contract.

Although personal budgets have a place to support individual needs and to exercise choice and control over their lives, it should be recognised that many services must be regarded as universal, including those supporting early intervention and re-ablement. These should continue to be offered through formal, block contracts.

We strongly support the view that patients should be involved in decisions about services that are commissioned. This is essential if services are indeed to become patient-led.

We believe it is important that stroke survivors and their carers have an input to the decisions about the commissioning of their local stroke services because their experience can be invaluable in designing the whole care pathway. Specific mechanisms must be established to enable people, such as stroke survivors, with mobility, communication, visual or cognitive impairments to be consulted

about the commissioning of services and actively participate in Healthwatch at local and national levels.

We welcome the development of the Joint Strategic Needs Assessment Guidance which will be important especially in the field of stroke. The integration of health and social care is crucial to ensure that individual stroke survivors and their families get choice of the full range of services and support that they need. Without this integration there is a great risk that some of the post hospital elements that make up the pathway (that are provided by local authorities or voluntary organisations) may not exist or are not accessed by stroke survivors.

The renewed Compact between Government and civil society sector is a welcome development; however, in The Stroke Association's experience, existing commissioners on the ground are rarely aware of its existence or of its importance. We therefore urge the Government to ensure that the Compact is more widely publicised to current and new commissioners.

The Stroke Association will continue to work with all stakeholders to ensure that the highest quality services are provided for all those that need them.

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