Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Protect Life Strategy: Public Health Agency

16 October 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Ms Mary Black	Public Health Agency
Dr Eddie Rooney	Public Health Agency
Mr Peter Wilson	Public Health Agency

The Chairperson: Eddie, Mary and Peter, you are very welcome. We are pushed for time today as we have a heavy agenda, so we will move straight into it. We will take a 10-minute presentation from you, and then I will open it up to members. I ask members again to be succinct with their questions. Eddie, perhaps you will decide which of you needs to respond to each question. That will hopefully cut down on the time a bit.

Dr Eddie Rooney (Public Health Agency): Thanks very much for the invitation. By way of introduction, Mary Black is the assistant director who looks after key health improvement; she is the interface with the voluntary and community sector. Peter Wilson is from the procurement side.

I will say at the outset that we are a regional body, but we are also a local body. Although the focus has been on Belfast, we hear the same stories from many other areas. As you will pick up from the presentation, we are sympathetic to what the voluntary and community sectors are saying. We realise that we are going through a big change in the procurement processes in the system. It has been a huge learning experience for all of us. There is a commitment among us all to get the right outcomes for communities.

As an organisation, we are required to operate within the public contracts regulations, which were set in 2006. Where they do not apply in full, we are required to work within the spirit of those regulations as well as the Executive's procurement policy. The presumption underpinning them is that goods and services will be acquired through contractual arrangements following public competition, taking into

account securing best value for money. Those are the parameters that have been set for the system, and that is the bar that has been set.

When it was established in 2009, the Public Health Agency (PHA) took over responsibility for a large number of contracts, particularly in health improvement, which originated in the legacy health and social care bodies, and included approximately 70 contracts for Protect Life and mental health promotion services. The vast majority of those contracts have been rolled forward on an annual basis. We have had many concerns from across the country from voluntary and community sector organisations about our contracting arrangements. That has been particularly the case for Protect Life. Key concerns include the annual rolling forward of contracts, which makes it difficult to plan effectively for the longer term; the need for greater stability and longevity of contracts, because we are dealing with issues that do not go away and will be continued; the fact that needs have changed over time and that services need to be reconfigured to reflect that. The term, "a level playing field" is used with a lot of passion in places, because people really do want a level playing field to enable new service providers to be afforded the opportunity to bid for contracts for the provision of services; and the alignment and procurement of services to the new Protect Life strategy, which is expected in one year to 18 months' time. The alignment issue has been very important. From our point of view, it is also important to note that the independent evaluation of the implementation of Protect Life highlighted that issue as a recommendation, and that was to increase stability to address the issue of non-recurrent resources on a year-on-year hand-to-mouth existence. The funding to the community and voluntary sector should be provided for a minimum of three years for suicide prevention supports and initiatives.

Those concerns have also been expressed in the Public Health Agency (PHA), and the PHA board has been very supportive of the development of a procurement plan that will go right across the PHA to all our funding areas and will strengthen long-term strategic planning. It has also been a priority underpinned by a health and social care audit, which has been telling us that we need to commence the implementation of a procurement action plan to ensure value for money for voluntary organisation contracts. We are taking it very seriously right across the organisation, and it is across all areas of funding.

The procurement plan will be phased over three to four years and will cover more than 20 areas for tender. In the plan, suicide/mental health procurement will be taken forward in three phases, with the intention of having all contracts renewed by September 2015. In the first phase, the schedule includes taking forward the implementation of some of the new services funded under the Programme for Government, including support for vulnerable groups, new community-based self-harm, and family support services and training. The second phase will include the commissioning of counselling, and complementary therapies and further training. The third phase will include the commissioning of bereavement support services, community building, and capacity and further training. It is anticipated that the first new contract will not be awarded until April 2014.

With regard to community capacity, two recurring issues that are relevant to procurement have been raised in discussions with a wide range of the voluntary and community sector groups. The first relates to the support and training to prepare organisations for the process. We have had involvement with our stakeholders already in discussions, and it is intended that those will continue within the parameters permitted in preparation for a new procurement process.

Through a range of meetings and workshops, we have already worked on the development of core standards that will be used to ensure the development of high-quality services. Further workshops are planned to help to roll out the implementation of those standards. In addition, support and training to build capacity and support in the understanding of procurement is available from a range of sources. That includes the Central Procurement Directorate, Invest NI, InterTradeIreland, local councils, tradesocial.net and PALS; our own health and social care bodies and the Public Health Agency will also hold awareness briefing sessions. Now, it does not follow that that is adequate to meet the needs of the community and voluntary sector that have been expressed here today, but it is important that everybody needs to be aware of all of the potential sources, and to make sure that we are availing of those sources and that we get as much help as possible, and certainly the help that is available.

The second issue is a wider concern that has been raised about the cumulative impact of the procurement processes emanating from different parts of government and the statutory sector. The concern is that the net result of those could be a weakening of community capacity, particularly in areas of high social deprivation. That does not mean that anybody is planning to do that, but that is the way it will turn out if we find that the local community is not at the other end of the various contracts. It is a concern that is shared by the PHA. We have a specific remit to enable people to

increase control over and improve their health and social well-being. That is a function of the PHA under the health and social care legislation. It is one of the few bodies that have that in its legislation.

We have also developed our own strategic aims around the work of Sir Michael Marmot, which has been undertaken by the World Health Organization and subsequently adopted through the UK Government. That includes specifically maximising people's capability to control their own health and well-being, creating fair employment and ensuring a healthy standard of living, and developing healthy and sustainable places and communities. That is at the heart of what our organisation needs to be doing, because our locus is working in areas of highest deprivation, and it is an enabling role. We are in discussion with our procurement and legal advisers to explore the potential for incorporating those aims, where appropriate and possible to do so, in appropriate social clauses for inclusion in future contracts arising from our procurement plan across the full range of our procurement, but we are still at the development stage on that.

Adapting to the new processes has been a challenging new world for all of us. A lot of work has been done and a lot more has to happen. That work has to be through engagement with the various service providers as well as within the statutory organisations. We fully recognise that to ensure that there is strong capacity to maximise the benefit for citizens we have to get it right; so, we will continue to work within the parameters of the system to secure that, and we are certainly listening very carefully to suggestions that will help us to develop that.

The Chairperson: Thank you. You mentioned supporting training and capacity building. I would like to explore that a wee bit more, given that there are constraints on you heading the procurement processes.

If you have identified that the process could weaken community capacity, then I am conscious of your role in the Department; but, ultimately, to strengthen community capacity, one issue might be the insertion of social clauses and community benefit clauses. One lesson that we have learned through these institutions has been to ensure that such clauses are inserted at the beginning of contracts. Is the PHA actively suggesting this? It is not, and should not be, rocket science. This point has been made previously in many discussions, and with local knowledge, particularly when you are dealing with an issue as sensitive as this. Eddie, you know some of the work that has taken place in Derry in relation to this. Are you actively doing it or are you lobbying the Department to do it? If we are collectively identifying a problem, is this being viewed as a solution?

Dr Rooney: It is certainly one aspect of it. I do not think it is the whole solution, but we are actively looking at how we can adopt it in our procurement processes. Our focus is not on specific groups or areas but on how we can ensure that the best services arrive at the citizens to give us the best chance of positive outcomes.

In many ways, it is a developing science across all aspects of government. There are certainly some effective social clauses in certain areas, and we are actively looking at how we can develop it in our area to ensure that strong community capacity remains a key feature at the other end of a procurement process.

The Chairperson: I just want to be very clear that this is not a lobby for any particular group or project; it is about saying that vital work is taking place and that we cannot negate that work; we need to support and enhance it.

Mr Beggs: Before we go on, the discussion originally was about suicide prevention. It is becoming much wider, and because issues are overlapping I wish to declare an interest as a member of the Carrickfergus committee of the drugs and alcohol advisory group.

The Chairperson: I appreciate that.

Mr McKinney: I appreciate what you said about looking for positive outcomes. The Chair suggested social clauses as a potential solution. However, can we first agree what the problem is? I ask you directly: is the procurement system that you now propose — in the time frame that you propose it — likely to deliver those positive outcomes?

Dr Rooney: I believe that the procurement process, with the time frame that we have, which we have adapted to allow sufficient preparation, will take account of these issues. Where we feel that we cannot do that, we would amend it.

Mr McKinney: No. With respect, that is not the question I asked, which was this: will the proposal that you have, in the time frame that you indicate, deliver the positive outcomes that you referred to — community capacity and the positive outcomes that those groups want to deliver?

Dr Rooney: We are in a process and I believe that at the end of that process we will deliver that outcome. That is certainly our aim.

Mr McKinney: You also referred to "phased" procurement. In the case of these specific groups, can some of the phasing be changed to allow for the suicide prevention groups to engage in procurement at a later stage in that phase? Would that be possible?

Dr Rooney: We have continually reviewed the phasing of all of our procurement exercises to allow for sufficient development time. There is a balance to be struck. For us, there is also the issue of delay and making sure that within the period of any re-phasing we are not continuing with some of the problems, on the negative side of things, that have also been raised and have become a recurring theme in all our discussions: we must try to get stability into the system and longer-term contracts. Those things are interlinked, so there is a trade-off and a balance needed.

Mr Brady: Thanks for the presentation. I, too declare an interest as a non-executive member of the committee of the Confederation of Community Groups. I know, Eddie, that having visited smaller groups, you are aware of work that has been done in my constituency. It is interesting, because I sit on the Social Development Committee and Pam used to do so as well, and the Department for Social Development is reducing the funding for larger groups such as Volunteer Now etc. The Department's rationale is that funding will be targeted at smaller front line organisations that deal daily with particular issues.

It seems to me that we are hearing today that there is a fear that larger groups may be more successful than smaller ones in the tendering process. Is that a real fear? How will the PHA be fair and equitable in the tendering and procurement process?

Larger groups have the resources to tender. However, you mentioned value for money, and that is not necessarily always the cheapest: in many cases, it is the most effective. Many smaller groups have the capacity to be effective. What are your thoughts on that?

Dr Rooney: Again, this is a challenge for the system as we move into what is a new procurement world for us. I am not clear that the difference is necessarily between small and big. There is the issue of trying to capture what it is in that locality that is so critical to delivering an effective service, and making sure that whatever comes at the end of a procurement process captures that and does not leave it behind by ignoring it or not being aware of it.

I think that this is a challenge. I do not think — and this is something that we need to be conscious of — that, necessarily, more of the same will be at the other side of this, nor should it be. There is a need for what is very much a common debate to ensure that we get the best. Best value does not necessarily mean cheapest. However, it does mean the best outcomes and chances for successful outcomes in very challenging areas.

Our view, at the heart of the PHA, is that if we lose the critical element of local community input, it will make the task more difficult. It is about ensuring that the processes are designed in a way that allows that input. We have to work within the parameters of the procurement process. We cannot stack it in the other direction and put in barriers that exclude. In this world, there will be a lot of searching for collaborations, ways that we can work together, and how to complement skills, because the citizen needs access to a range of skills and services and different ways of delivering them. There are a lot of challenges for us. What we would like to ensure is that we do not end up at the other side of the process without having addressed those challenges and giving it a fair wind.

Mr Brady: As somebody who worked in the advice sector for a long time, I dealt with a complex benefits system etc. For groups dealing with suicide awareness and prevention, much more sensitivity and, possibly, confidentiality, to a greater or lesser extent, is involved. Those groups have to deal with a different perspective and in a different context. If somebody comes in to ask you about benefits, that is relatively straightforward. If somebody comes in to ask about suicide prevention or awareness, that is a much more complex, longer, drawn-out type of issue. That also has to be factored in.

Ms Mary Black (Public Health Agency): I will just add the issue of standards to that? That is why so much attention is being devoted to the development, with our partners in the community and voluntary sector, of core standards and standards of service for specific areas. It is precisely because of that kind of sensitivity. Those are the sort of things that we will be looking for and preparing people for, as best we can, in the procurement process. However, it is not true to say that this will be a straightforward process, in the sense that everything will come out neatly, because we are involved in a competitive process.

Mr Dunne: Is training being made available for voluntary groups on, perhaps, submitting documents for procurement? I think that you already hinted about that, Mary.

Ms Black: There have been a couple of different things already; one has been the development of specifications that our colleagues referred to, and the second is the work that I referred to regarding the development of standards and consultation on those standards in order to develop them. We need everyone's expertise, obviously. The third bit — and perhaps Peter can pick up on this — is the procurement process itself. They are being planned for the autumn from November onwards.

Mr Dunne: What is being planned?

Ms Black: Workshops on the procurement process itself.

Mr P Wilson: One challenge is to provide a level playing field for all interested parties in order to prevent procurement being challenged or collapsing. We hope to run a series of seminars, workshops — call them what you will — with the PHA, which will be open to anyone to attend. They will take people through how the process will work. If we are going to use the standard electronic portal that is used across the public sector in Northern Ireland, we will provide training as part of the session on how that portal works and how we should use it.

In conducting procurement, we are endeavouring to keep those sorts of things relatively simple and straightforward, rather than overcomplicating them and creating pitfalls for organisations to fall into. We are trying to keep the processes as straightforward and simple as possible so that it requires a minimum of development and training.

The Chairperson: On that issue, can I suggest that there is a mixed message somewhere in the system? Certain organisations — and I am not talking specifically about the ones we met this morning — have said that the PHA cannot provide any role in capacity building or training. Are you saying something different now? This is a vital piece of work, and I think that we are all coming at it from the same point of view. I am being told that the PHA cannot do this because of the tendering processes. Obviously, if a tender is called, you cannot build capacity within a group that will apply. Are you saying something different now?

Mr P Wilson: What we are suggesting is that, generically, it is possible to provide a level of learning and development that is not specifically targeted to any one group or cluster of service providers but will give bidders a sense of what the PHA will look for. It will include the documents that might be requested. Those things are not unusually provided —

The Chairperson: Again, that differs from the information that is in the system. We need you to clarify this. I am taking it at face value. I am hoping that that is a shift in support that can be offered with regard to capacity building. However, we need to tease that out.

Ms Black: I will add to that by saying that it may be a bit of a shift to provide information and support for groups to apply, but the truth of the matter is that even if you do that, there may be winners and losers. That is the bit that you cannot guarantee. That is the bit that has not shifted. The procurement process requires people to engage in it. As Peter outlined, we can help to demystify the process; however, it does not guarantee an outcome.

The Chairperson: OK. I am conscious of time. I know that we have not concluded this discussion, so I suggest that, if members are in agreement, we have the information that you have just referred to on capacity building for groups clarified in writing as to what that would mean; how it would be rolled out and what kind of training would be available. Secondly, the groups have presented those five options. One is within the remit of the Health Committee. Eddie, I suggest that you respond to us on how, potentially, those could be addressed.

Dr Rooney: Could we see a copy of them first?

The Chairperson: Yes. Of course. I am conscious that you have not seen them. If we can share them with you, you could come back to the Committee.

Finally, no one in this room wants to prevent competition or working in the framework we have. However, at some point, particularly on an issue as vital as suicide prevention, we have to compare having a level playing field against the potential reduction in the valuable work that is ongoing, from a community development ethos. We need to get that balance.

Thank you for that. We look forward to you coming back with those answers.