Lifeline Crisis Response Service

Public Consultation Report and PHA Recommendations

21January 2016

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1.0 Introduction

The Northern Ireland Lifeline suicide prevention helpline and associated crisis support service was established in 2007 to provide a 24/7 free to call regional confidential telephone helpline for people experiencing emotional crisis and at immediate risk of suicide or self-harm, with the provision for relevant follow on support services where appropriate.

The service provides additional support to people at immediate risk of suicide or self-harm across Northern Ireland, thereby helping to reduce the levels of suicide and self-harm incidents, as part of a range of measures to tackle suicide under the 'Protect Life' strategy.

The Lifeline service was retendered in 2011 and the current contract awarded initially for a three year period, April 2012 to March 2015, with the potential for a further 18 months extension, to September 2016.

In keeping with Departmental and other requirements, a Strategic Outline Business Case (SOBC) was prepared focused on identifying a Lifeline service model beyond 2015 that would best meet the needs of those at immediate risk of suicide or self-harm, preparing the way for the re-tender of the service. This SOBC took account of the monitoring and evaluation of the existing service, evidence in relation to service models elsewhere, Departmental policy direction and, importantly, stakeholder engagement.

1.1 Development of the Strategic Outline Business Case (SOBC)

The SOBC development was informed by:

- an initial consultation exercise was carried out between 1 April and 24 June 2014
- consideration of data on evidence of need
- a review of relevant policy and strategy
- a review of the current service model structure, activity and performance information
- the identification and examination of relevant models elsewhere.

The SOBC presented a preferred option for the future of the Lifeline Crisis Service which retained many of the key elements of the current service, together with a number of changes. These can be summarised as:

- separation of the telephone crisis helpline from the follow-up support crisis intervention services
- re-focusing of the service on de-escalation, enablement and empowerment

- ‘commissioning’ the telephone crisis helpline directly from the Northern Ireland Ambulance Service (rather than ‘procurement’ from non-statutory providers as at present through a public tender process)
- procuring follow-up services through separate contracts serving the five Local Commissioning Group/Trust geographies
- enhancing follow-up services to expand capacity for psychological therapies, and introducing complementary therapies and face-to-face de-escalation.

As the SOBC proposed a future model for the Lifeline Crisis Response service changed from the current and importantly one moving, in part, from a service which has been procured through public tender to one which is commissioned directly from within the HSC family of organisations, it was appropriate for the PHA to undertake formal public consultation to garner the views of service users, interested organisations and the wider public on the merits or otherwise of this approach and the proposed model in general. A copy of the SOBC is available at http://www.publichealth.hscni.net/sites/default/files/LL%20SOBC%2027%20Aug%202015_0.pd

2.0 Consultation Process

The consultation process included:

- Formal notification via a range of media outlets and network databases containing over 600 organisations to publicise the consultation process
- series of consultation events, which were facilitated as a two-way flow of information and opinion exchange
- participation, facilitating the public to input both verbally through public workshops and in writing through a formal consultation response form
- careful review of all consultation responses, including PHA board consideration.

A total of 26 workshops were facilitated by the PHA, attended by over 300 participants. A copy of the consultation papers is available at: http://www.publichealth.hscni.net/consultation-future-lifeline-crisis-intervention-service-now-closed

The workshops were a mix of public meetings and a series of focused events that targeted specific communities of interests including, service users, staff from the current service provider, young people, Black Minority and Ethnic community, LGBT group, Irish Travellers, deaf community etc., a summary of the equality breakdown is available in appendix 1.

The consultation also attracted significant media attention, initially proactive media from the PHA promoting the consultation and varies events and then coverage related to the current service provider, Contact NI, lobby campaign “Protect Lifeline”. Social media played a significant part in the campaign with 506 people, tweeting 3,077 tweets with the #ProtectLifeine hash tag, which was viewed by an estimated 3,278,250 people. The lobbying messages led to some misleading headlines which impacted on the discussions at the workshops and subsequent responses to the consultation proposals.

A note taker was in attendance at each of the workshops to record the views expressed as part of the process. A total of 159 written responses were subsequently received, 135 in questionnaire format and a further 24 in letter form. The written responses and along with the workshop notes were subsequently coded into three key areas for analysis, they were:

- Responses in support of the proposed service model
- Responses which raised concerns about the proposed service model
- Responses which suggested enhancements to the service model

It should be noted that analysing points raised during the consultation workshops and the submitted written responses cannot be regarded as a “pure” science. The method used for analysis involved reviewing the notes of each workshop and reading each individual response, transferring the relevant feedback into a structured framework of the key points raised and relating them to the relevant question highlighted in the consultation process. It should also be acknowledged that analysing responses was not a simple matter of counting views.

As the future service model for Lifeline has generated significant public interest, the Minister for Health Social Services and Public Safety, Simon Hamilton, has indicated that he wished the PHA to consider its proposals in the light of the consultation responses and submit for his determination a ranked list of viable options as to how the Lifeline service might be shaped and delivered.

The remainder of this paper addresses the consultation proposals, the responses to these from the consultation process, the PHA’s consideration of these and recommendations as to how this should influence the shape of Lifeline. Following the Minister’s decision, the PHA would prepare a Business Case which would inform the commissioning and/or procurement, as appropriate, of the new service**.**

3.0 Summary of Consultation Proposals, Responses and Recommendations

This section describes each element of the proposed Lifeline service model, a brief description of the main themes from the consultation responses, and recommendations to PHA Board. Individual responses and a detailed analysis of those responses are available on the PHA website.

3.1 The Telephone Crisis Lifeline Service Model

What was proposed?

The Lifeline telephone crisis helpline would continue as a free 24 hour service provided by staff with experience and qualifications to de-escalate callers in crisis, assess their care needs, and depending on their needs, arrange appropriate follow up care.

It was recognised that some callers would require direct, immediate referral to emergency services eg crisis mental health teams. Others would receive appropriate help in accessing follow on services (termed 'enhanced signposting'); and others at lowest or no risk would be given information on support services in their area (termed 'signposting').

It was also proposed to have a greater emphasis on empowerment and enablement and refocusing the Helpline service as an immediate crisis intervention service. Empowerment and enablement is a recognised part of mental health care and is appropriate in certain low risk circumstances.

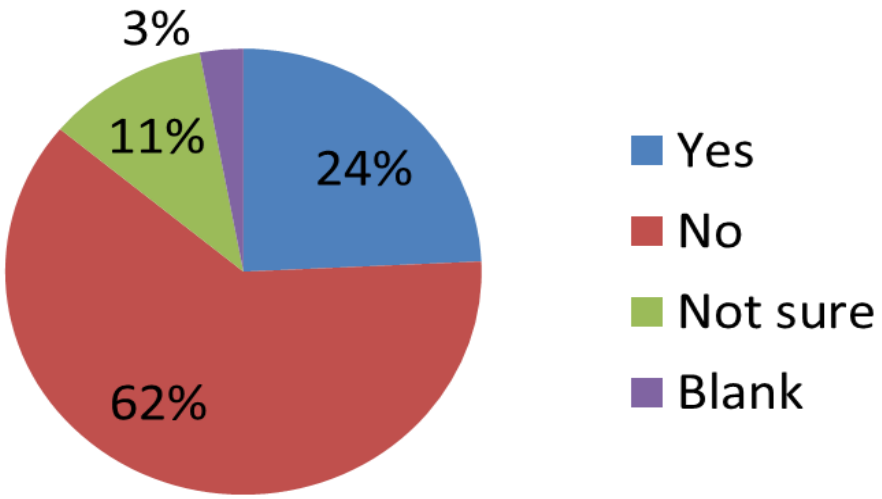
It was further proposed that Lifeline would continue to take calls from people of all ages, including children and young people. Lifeline staff would assess each caller and their further needs and refer or signpost each to an appropriate service. Children and young people assessed as being at minimal risk would be signposted to other services. Those at:

- low risk would be offered enhanced signposting to other services
- high risk would be referred to existing Gateway services
- immediate risk would be referred to emergency services.

What did the consultation responses say?

Of the 135 that were submitted in the questionnaire format, 62% said that they did not agree with the proposed model, while just over 24% supported the proposal (see figure 3 below).

Figure 1: Summary of Responses on Telephone Crisis Helpline Model



While there was broad support for retaining the free 24 hour Lifeline service as a crisis intervention service which can handle calls from people of all ages, many respondents wanted more clarity and reassurance on the skills of the staff who would provide the service. This was particularly an issue for respondents who were concerned that the service would be commissioned from the NI Ambulance Service given that the Ambulance Service does not currently provide that type of service.

Many respondents welcomed the emphasis on person-centred care, and a greater role for empowerment, but there were also significant concerns that some callers may not follow through to contact those services. Many respondents supported the current service model which includes safety check-ins whereby the Lifeline staff call clients back to check on them and how they are managing.

Consideration of the responses

As was proposed, Lifeline would remain as a free 24 hour service focusing on short term support for people in crisis.

To reassure concerns regarding the skills of staff providing the telephone service, the PHA would specify the staff qualifications and experience required to ensure that calls are handled sensitively, appropriately and safely.

To address concerns raised, we would propose to require the presence of more senior staff (supervisors) who can support and provide advice to call handlers, when needed.

In response to concerns regarding the empowerment model and to provide reassurance on the quality of care provided through the future Lifeline service, we would enhance the service by including a requirement for regular independent clinical audits of the service. These audits would include assessment of the appropriateness of care to minimise the risk of over, or under use of follow-up services.

We would also include safety check-in calls as part of the future service to ensure that any caller who needs a safety check-in call would receive it.

The PHA acknowledges the concerns raised in respect of the risk assessment and care pathway for onward support. Accordingly, we would include in the service specification a requirement to ensure that callers who need follow-on counselling would be referred directly to that support rather than being 'signposted'. Protocols would be in developed to ensure safe handover to follow-on counselling.

Lifeline follow-on counselling may not always be the most appropriate service depending on the presenting issue. Some callers would not need direct referral to follow-on counselling and instead, may be given information on support in their area (signposted to that support). The provider of the telephone service would therefore be required to have knowledge of and working relationships with a range of other statutory, community and voluntary service providers. They would also need to demonstrate partnership and collaborative working.

Taking account of the above, the PHA has identified two options for the follow-on support care pathway for consideration. These are:

- **Option 1:** To signpost callers to relevant follow-on Lifeline Crisis Service support dependent on their level of need and, in exceptional circumstances, the helpline provider could directly refer the individual into the appropriate Lifeline Crisis follow-on support; or

- **Option 2:** Following clinical assessment and, dependant on the level of need, the helpline operator would refer the client directly into the relevant Lifeline follow-on support service. For those of low or no-risk of suicide or self-harm, they would then be signposted into other appropriate community based services. The Lifeline Crisis Helpline would also include the provision for check-in/safety checks if deemed clinically appropriate.

Recommendation

The PHA recommendation is that the preferred model proposed in the SOBC should be amended. **Option 2** therefore is now recommended as a first preference, with option 1 as a second preference.

This option would ensure that:

- Lifeline would continue as a free 24 hour telephone crisis intervention service provided by skilled staff with specified experience and qualifications in de-escalating people in crisis, assessing their needs and arranging appropriate follow-on support
- Follow-on counselling or other support would be arranged by direct referral or, where appropriate, by signposting the caller to services in their area.
- Lifeline staff would provide safety check-in calls for callers who need that interim support
- Regular (at least annual) independent clinical audits of the quality and appropriateness of care provided
- Telephone helpline staff have the necessary qualifications and experience backed up by on-site supervision and support by a more senior colleague.

3.2 The Psychological Therapy Service Model

What was proposed?

Psychological therapy should continue to be part of the Lifeline crisis response service and that this should be available in each of the five Local Commissioning/Trust areas.

Access to follow-on psychological therapy would be through the 24 hour telephone crisis helpline service and, following initial risk assessment, available for adults aged 18 years and over. It was acknowledged that the service may also be suitable for some people under 18 years.

It was also proposed that providers of follow-on psychological therapy would undertake a full assessment of each person to determine the appropriate support needed. The service would maintain a clear focus on those at immediate risk of suicide and self-harm and who, following assessment, were deemed likely to benefit from psychological therapy. Appropriate clients would be offered an average of five sessions as part of this service, in line with guidance from the National Institute for Health and Care Excellence (NICE). It was further proposed that such services would avoid duplication of other existing services and use Clinical Outcomes in Routine Evaluation (CORE) measures to assess outcomes with clients.

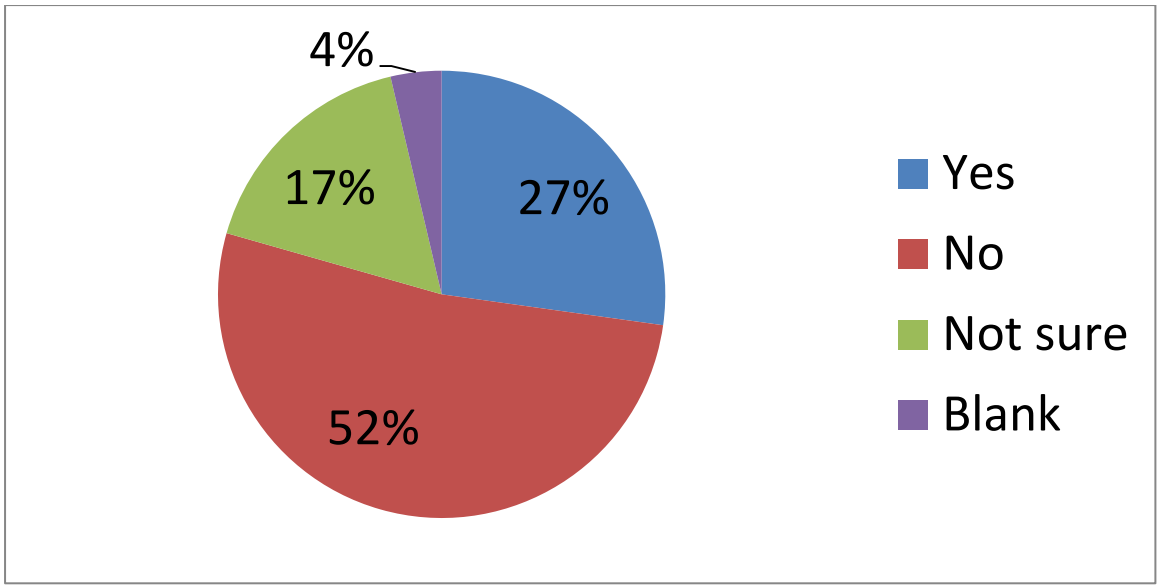
Clients for whom psychological therapy was deemed to not be appropriate would be signposted on to other support services.

Lifeline follow-on psychological services would not be offered to clients already receiving psychological therapy from other providers, or to those on a waiting list for such services unless they were deemed to be in immediate crisis.

What did the consultation responses say?

Of those who submitted responses using the questionnaire format just over half, 52% (n=71) did not agree with the proposed model for psychological therapies, while 27% (n=37) supported the model (see figure 4).

Figure 2: Summary of Responses to the Proposed Psychological Therapy Model



While there was support for the continued provision of psychological therapies as part of the Lifeline crisis response service, many respondents were concerned about a risk of duplication of assessments, and questioned whether five sessions would be adequate. They also highlighted a lack of follow up support and check-ins in the proposed model.

There was concern that a focus on those at immediate risk of suicide and self-harm could risk overlooking those assessed at low or medium risk, but who remained suicidal.

There was also concern that those clients already on a waiting list would not be eligible to access the service.

Many respondents wanted greater clarity about the psychological therapy and they highlighted the need to have effective handover and onward referral arrangements in place. Some wanted support to also be offered to families/carers of clients.

The need for appropriate information systems to monitor services effectively among all providers was also raised by respondents.

Consideration of responses

As proposed, psychological therapy would remain part of the Lifeline crisis support service. There would be an initial assessment through the telephone helpline to support the service user and deal with the immediate suicide or self-harm crisis risk. The professional providing the follow-on psychological service would complete an

assessment of each client to determine how they can best meet the needs and expectations of the service user and achieve the best outcomes with the client.

In response to concerns regarding the number of psychological sessions, we estimate a requirement for an average of five sessions per client (which is slightly more than the current average number of psychological sessions of 4.1/client) with a maximum of twelve sessions in line with guidance from NICE.

In response to feedback during the consultation, we would also propose to enhance the service by including an additional session for family/carer support, if circumstances deemed this beneficial.

Again with regard to comments made through the consultation process, PHA can confirm the importance of protocols to ensure safe handover and referral arrangements. We would also set clear Key Performance Indicators to ensure that follow-on support is provided within a specified time period.

With regard to clients who are on existing waiting lists and who ring the Lifeline crisis service, PHA can confirm there would be an assessment of their immediate needs. Where an increased risk is identified, the relevant service provider would be alerted immediately so that they can effectively manage the person's care pathway. As mentioned earlier, safety check-in calls would be included as part of the future service. Use of Clinical Outcomes in Routine Evaluation (CORE) to monitor services closely would be specified, with appropriate IT support.

Having reviewed the feedback from the consultation, it is considered that the retention of follow-on support in the form of psychological therapies is critical to supporting people at risk of suicide or self-harm. However, a suggestion that Lifeline might become a long-term intervention service has not been recommended as it goes far outside the primary purpose of the crisis service and also the NICE guidelines on counselling provision.

Accordingly, two main options in terms of psychological therapies have been identified:

- **Option 1:** As proposed in the SOBC, a crisis intervention model with an average of 5 sessions per client (maximum 12 in line with NICE guidelines); or

- **Option 2**: A crisis intervention model with an average of 5 sessions (maximum 12 as per NICE guidelines) plus and additional session for family/carer support.

It is recommended that the Lifeline service must remain focused on those at immediate risk of suicide and/or self-harm. The service should not address waiting list pressures in other service areas. Lifeline is a short-term intervention mechanism

to support people through crisis. If clients require longer term support, this should be provided in the most appropriate clinical setting. The current average number of psychological of sessions in the Lifeline service is 4.1 per client. An average of 5 sessions, as set out in the SOBC, would appear reasonable. Furthermore, there is provision for up to 12 sessions for any individual if clinically necessary, however it is proposed that the average for the service model would remain as 5 sessions per client.

The valuable support that families and carers can provide to someone at risk is acknowledged as is the need for families and carers to look after their own wellbeing. Therefore, it may be appropriate on occasions for family/carers to access psychological support. However, it is important to note that family/carer support is not family therapy. Family Therapy should be provided as part of other support services which are commissioned by the Health and Social Care Board in collaboration with the Health and Social Care Trusts.

Recommendation

The recommendation is that the model as proposed in the SOBC should be enhanced and that **Option 2** should represent a first preference, with option 1 as a second preference.

The recommendation would mean that the psychological therapy model:

- is a crisis intervention model including psychological therapy with an average of five sessions (maximum of twelve as per NICE guidance) plus an additional session for family/carer support if required
- has specified handover and referral arrangements to manage a person's care pathway effectively
- is premised on monitoring and management of the performance of the service using CORE and other relevant measures
- is subject to regular (at least annual) independent clinical audits of the quality and appropriateness of the care provided.

3.3 The Inclusion of Complementary Therapies as part of Follow-On Support

What was proposed?

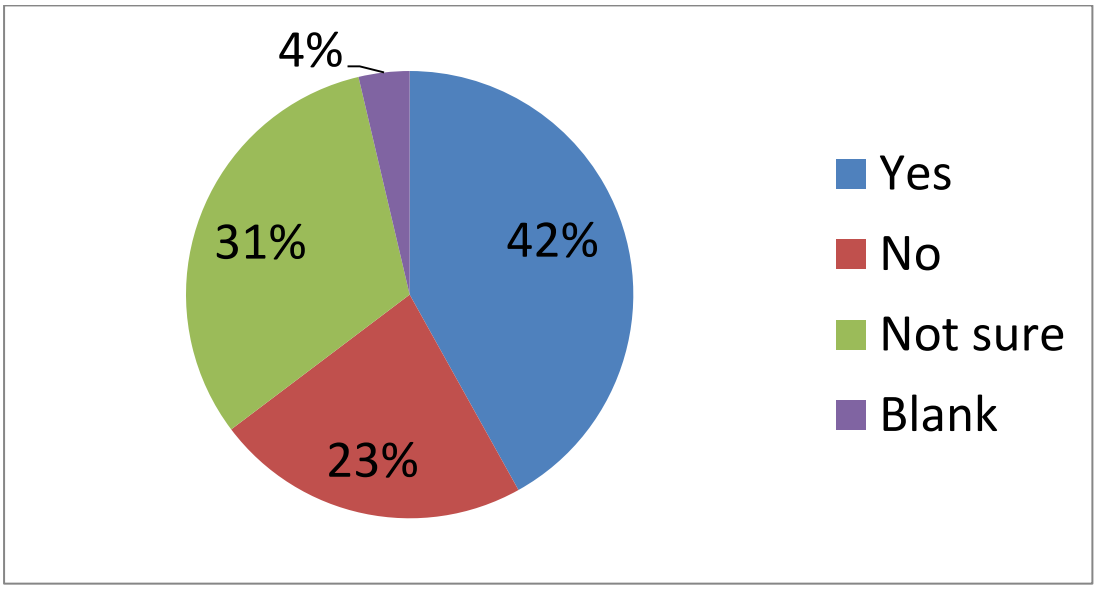
Complementary therapies (in this context body massage, reflexology and aromatherapy) should form part of the follow-on psychological support services. The consultation document proposed a maximum of two sessions, if deemed appropriate, to support an individual in dealing with their distress and anxiety and enabling them to commence psychological therapy.

We also proposed that complementary therapies would be accessed via the psychological therapy provider and that they would be offered in each Local Commissioning Group/Trust area to the agreed PHA quality standards.

What did the consultation responses say?

The majority of completed questionnaires were in favour of the proposed model 42% (n=57) with 23% (n=31) against the inclusion of complementary therapies in the model, however, almost a third 31% (n=43) were unsure (see figure 5).

Figure 3: Summary of Responses to the Inclusion of Complementary Therapies in the Model



Whilst some respondents highlighted the lack of robust evidence for complementary therapies, the feedback from service users, in particular, noted the value of complementary therapies in helping them deal with crisis. Many respondents also supported their value in empowering individuals, and as part of self-care.

There was also significant concern raised about the lack of regulation and the effectiveness of complementary therapies in a crisis situation. Some respondents also questioned whether two sessions were sufficient to bring benefit to service users.

Consideration of responses

The PHA recognises that there were mixed views about the role of complementary therapies in suicide and self-harm prevention. However, service users indicated that they found them helpful in dealing with crisis and in preparing to access other psychological therapy. Whilst we recognise that the evidence base for complementary therapies is limited, we also acknowledge that many patients report that they found them helpful in managing anxiety and depression and that local experience has also highlighted their benefit in helping people engage in other services.

In response to concerns, however, we would require service providers to meet the agreed PHA standards for such services, and manage the interventions as part of an overall care pathway rather than as a standalone service. We acknowledge that a maximum of two sessions may not be sufficient for someone with high anxiety to enable them to access psychological therapy, and to address this issue, we would specify two sessions as an average to allow for some flexibility.

Having regard to the above, two main options arise. These are:

- **Option 1**: A Lifeline service model that includes the provision of service user evidence informed non-invasive complementary therapy services (average of 2 sessions per person) for those with high anxiety to help them access talking therapies; or

- **Option 2**: A model that provided only clinically evidence based interventions such as psychological therapies as part of the Lifeline service and therefore excludes complementary therapies.

Recommendation

It is recommended that the model proposed in the SOBC for the inclusion of complementary therapies as part of the follow-on support service model should be retained. **Option 1** therefore is recommended as a first preference, with option 2 as the second preference.

This recommendation would ensure the new service model has the following:

- The provision of non-invasive complementary therapies (average two sessions) for clients with high anxiety to help them access psychological therapy;
- Specifying adherence to the PHA standards for the provision of complementary therapies;
- Complementary therapies as part of the care pathway rather than a standalone support service;
- Complementary therapies should be targeted at the most vulnerable and that this service should be part of a Lifeline service model where this element can be managed, evaluated and outcomes assessed
- Evaluation of the impact of complementary therapies as part of suicide and self-harm prevention services.

3.4 The Inclusion of Face to Face De-escalation as part of Follow-On Support

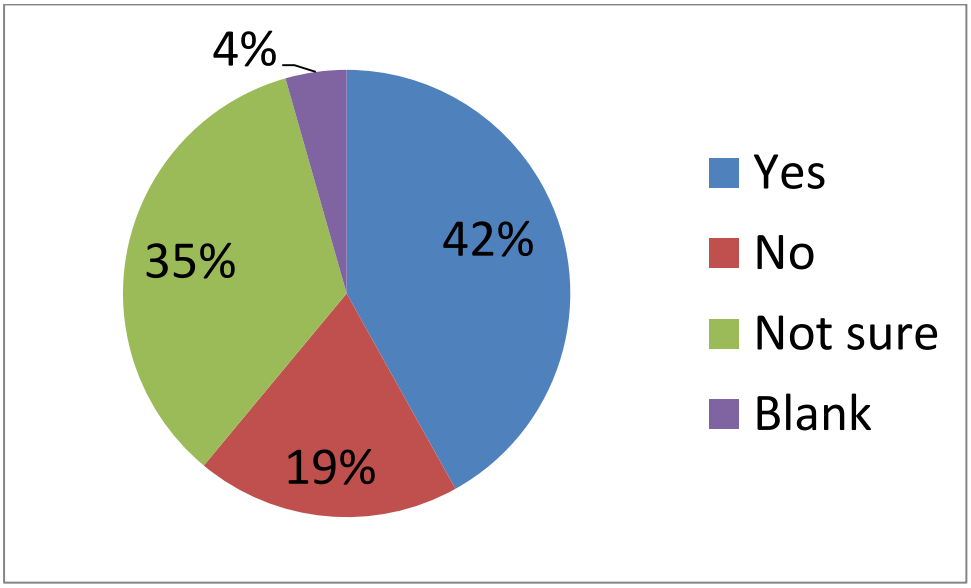
What was proposed?

The consultation paper proposed a face to face walk-in service as part of the Lifeline follow on support service. Some people may have difficulty addressing crisis support telephone and other services. Local experience has also highlighted that service providers occasionally provide face to face de-escalation for those at immediate risk of suicide and self-harm. We proposed that the service would provide a means of making direct contact with the NI Ambulance service or Trust based crisis response team. We also proposed that if the individual needed support from the Lifeline psychological therapy service that they would be signposted or a referral made on behalf of the individual, to the telephone helpline for an appropriate assessment.

What did the consultation responses say?

The majority of respondents, 42% (n=57) were in favour of the proposed introduction of the face-to-face de-escalation element, almost one in five, 19% (n=26) were against the proposal, however, over a third 35% (n=47) were unsure (see figure 6).

Figure 4: Summary of Responses to the Face- to – Face De-escalation Element



The PHA recognises that there were mixed views about the proposal to include face to face de-escalation as part of the service model. Whilst many respondents welcomed the proposal as a further enhancement and as a means of improving

access to existing services, there were also many who questioned the evidence base, clinical governance and regulation of such a service.

There were also concerns about the potential cost of the service and a risk of duplication, since some service providers already provide elements of a de-escalation service. There were significant concerns about the interface between the proposed service and other services, in particular, crisis response teams.

Some respondents also questioned the rationale and how the service could be made accessible, particularly to rural areas, as well as the need to refer through to the Lifeline telephone service for further follow on support which could cause undue stress.

Consideration of responses

The primary challenges identified in terms of this element of the proposal focused on clinical appropriateness, management of demand, care pathway, location and operational hours, affordability and value for money.

The PHA acknowledges the concerns raised about the governance, accessibility, cost and the difficulty of estimating demand for the proposed service. In response to these concerns, we would focus efforts on de-escalation and assessment through the telephone helpline only, and support community based services to recognise and respond using the Lifeline service.

The consultation indicated that the care pathway might be difficult to manage within the proposed model; there is difficulty in reliably ascertaining the level of demand for this type of service or ensuring that a service could be safely provided in a manner that was flexible and had equity of access. It was noted that many groups indicated that they already provided this type of intervention as part of their core business, and

The PHA considers there to be two primary options to consider in respect of this service element. These are:

- **Option 1**: A service model that includes community based walk-in de-escalation, with on-ward signposting to the helpline to access psychological therapies if appropriate; or

- **Option 2**: A model that focused the funding available for de-escalation and assessment by the telephone helpline only and excluded funding for community walk-in de-escalation in Lifeline as this could not demonstrate additional benefit.

Recommendation:

Having considered the consultation responses, it is recommended that the SOBC model should be amended to remove this element from the Lifeline Crisis Intervention service model. The associated funding should be invested in the telephone helpline crisis service to ensure the provision of the proposed safety check-in element. **Option 2** is therefore recommended as a first preference. There is no second preference proposed for this service element.

This recommendation would result in:

- A service model that focuses funding on the de-escalation and assessment by the telephone helpline only;
- Action to support existing community services to recognise and respond appropriately to people who present to them in crisis; this could include contacting crisis mental health teams, calling Lifeline, or other actions appropriate to the person's needs.

4.0 Options for Delivery of the Service

This section describes the options for delivery of the service, a brief description of the main themes from the consultation responses, and recommendations.

4.1 Separation of the Delivery of the Telephone Crisis Helpline from the Delivery of the Follow-on Support Services

What was proposed?

We proposed that the management of the Telephone Crisis service should be separated from the management of the follow on support services.

What did the consultation responses say?

There was a varied response to the proposals. Many respondents suggested that the separation of the management of the telephone helpline from the follow-on support was appropriate as it would remove the potential for a conflict of interest between the provider of the telephone service and follow-on support services, and help to ensure that no one organisation could dominate the sector.

There was also a view that the model would reduce the risk of service failure and promote professional standards and boundaries.

However, there were also many respondents that expressed concerns which centred on a risk to the continuity of care and fragmentation of the service currently in place, as well as concern about having to make a second call if assessed as requiring follow-on support.

Concern was raised about data management and efficient information systems which could cause delays and diminish the quality of service. Other concerns included the potential for an increase in costs.

Consideration of responses

There is a responsibility on the PHA to ensure that we addresses ethical risk through the procurement process and contractors should acknowledge the particular responsibilities they bear when delivering public services, paid for by public money.

The PHA acknowledges the risk that having a single provider for the telephone element and follow-on support services could create a monopoly of provision in the sector, which, over time, could stifle competition, lead to inefficiencies and reduce sustainability of the service.

There are potential economic inefficiencies in a monopoly situation, with for example lack of competition keeping prices artificially high. This is a particular risk where the monopolist provider fails to meet operational standards of the service, KPIs or faces financial difficulties and can no longer operate. There is little or no capacity for the commissioner to activate contingency arrangements in such circumstances.

From the consultation there was no challenge to the idea that the PHA must ensure that delivery of the Lifeline service are within arrangements that are free from the potential for the provider to refer callers to other often costly follow-on support services to increase its income rather than meeting a defined service user need. The service provided currently is a combined telephone and support arrangement, this has some potential for "conflict of interest" of this type.

Consideration has been given to revising the current contract structure to address this potential risk and still allow for the procurement of an integrated service model. However, having regard to extensive governance requirements, clinical monitoring and contract management costs, this was, on balance, was not considered a sufficiently satisfactory approach.

PHA acknowledges the concerns raised about data management. To address these concerns we would include in the service specification a requirement for clinical and information governance standards, including data exchange and the sharing of sensitive information, as well as agreed timescales for access to follow-on support services. Protocols would be put in place to ensure safe handover to follow on psychological therapy.

The PHA consultation had only two options for consideration in respect of this element of the service model, they were:

- **Option 1**: A fully integrated service model which was procured through public tender; or

- **Option 2**: A model with separated service elements which could be either procured or directly commissioned.

Recommendation

The recommendation to the PHA Board is to retain the model as set out in the SOBC and select **Option 2** as the preferred choice. There is no second preference in this instance.

The recommendation would result in:

- A separation of the management of delivery of the Telephone Crisis Helpline from the management of the follow on support services;

4.2 The Commissioning of the Telephone Crisis Helpline from NIAS

What was proposed?

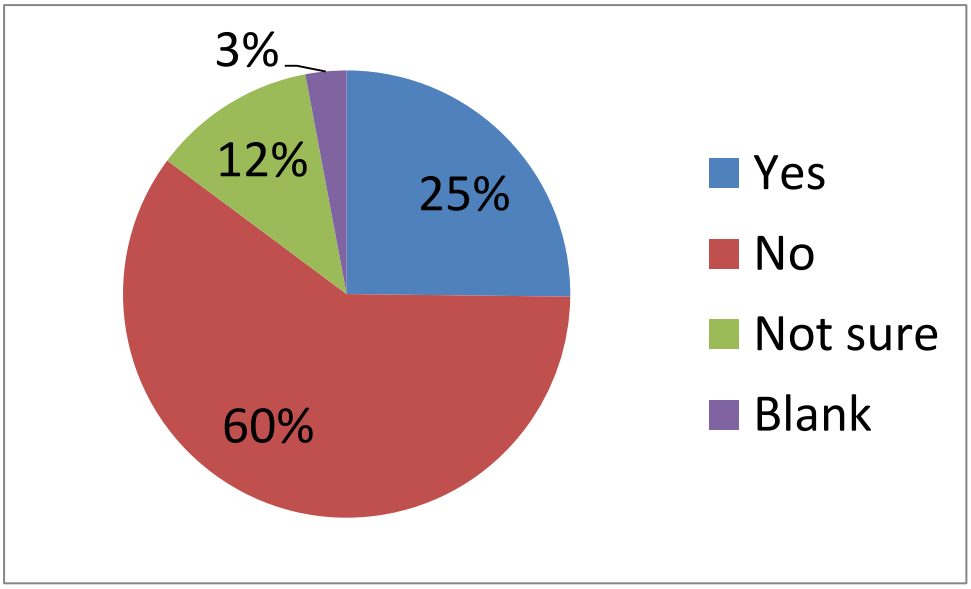
The consultation paper proposed that the Lifeline Crisis Helpline would be directly commissioned from the NI Ambulance Service (NIAS), but separately staffed, operated and branded as Lifeline. Management of the service by NIAS would provide a fully integrated service with other emergency and statutory services, enabling immediate handover and support for those in need of urgent care including mental health crisis teams, emergency departments and primary care.

A further factor was that NIAS, as a statutory provider of health and social care, could also bring robust clinical, information and corporate governance standards and had existing protocols in place with the Police Service for Northern Ireland and HSC Trusts. We proposed that the service within NIAS would be provided by staff with appropriate qualifications and experience, including skills in supporting people in crisis. NIAS also brings considerable strengths in terms of contingency planning and support, being part of a UK National Health Service network.

What did the consultation respondents say?

The majority of respondents, 60% (n=81), were against the proposal to commission the telephone service from NIAS. A quarter (n=34) were in favour of the proposal, while 12% (n=16) were not sure (see figure 7).

Figure 5: Summary of Responses to Proposed Commissioning of Telephone Service from NIAS



Concerns were expressed about the ability of NIAS to undertake management of a service focused on emotional wellbeing. Some service users may also perceive stigma associated with NIAS as a statutory provider which could act as a barrier, rather than a community based service which may be perceived as being more accessible.

There was concern highlighted over potential confusion on which telephone number service users would ring, the loss of confidentiality and loss of expertise, investment and networks created by the current service model.

Some respondents expressed concern about the service moving from the community and voluntary sector to the statutory sector and the attendant risk that this would act as a barrier for those needing to access the service.

There were also concerns about whether NIAS had sufficient experience in suicide prevention to manage the service. Respondents also raised concerns about the future of staff employed with the current service provider.

Consideration of responses

The PHA is satisfied with the capacity of NIAS to deliver a service such as crisis telephone helpline for those at risk of suicide and/or self-harm. NIAS has a regional and national reputation, recognised by the public at large. They have established management and governance support structures which ensure the proposed service model could be delivered if commissioned to do so.

The PHA recognises, however, that overall there was limited support for the proposal to commission the telephone crisis service from NIAS. In particular is the concern that having the telephone service housed within a statutory body could run the risk of reducing public confidence in the service and could also be perceived as a potential barrier for service users.

The options in respect of this element of the service are:

- **Option 1**: Directly commission the telephone service from NIAS as outlined in the SOBC; or

- **Option 2**: Procure the telephone helpline service via public tender

Recommendation

Having regard to the consultation responses, it is on balance recommended that the model proposed in the SOBC should be amended. **Option 2** therefore is recommended as a first preference and Option 1 as a second preference.

This recommendation would mean:

- The procurement of the Telephone Crisis Helpline service through public tender, rather than commissioning of the service from the NI Ambulance Service.

4.3 The Delivery of Follow-on Support Services

What was proposed?

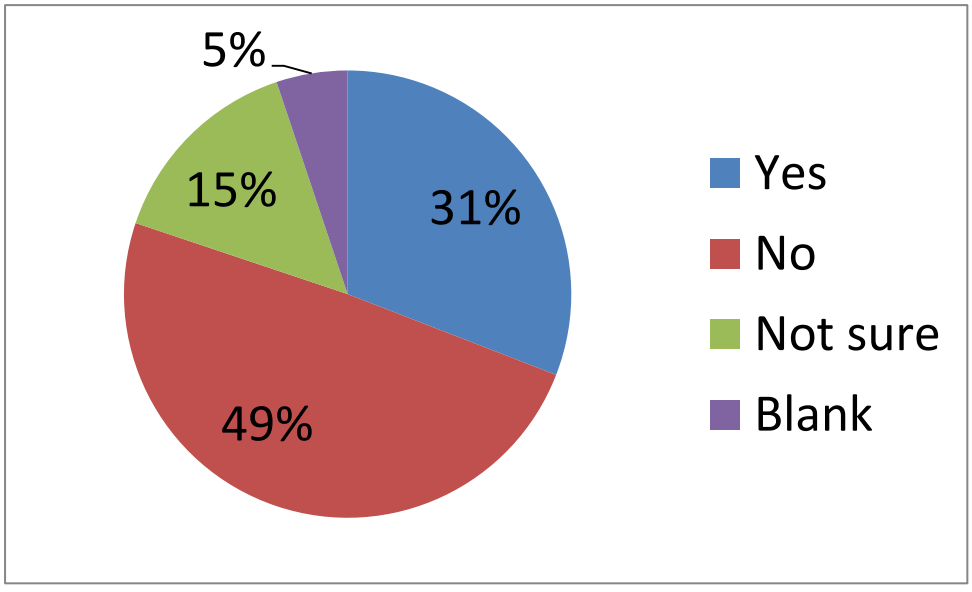
The consultation paper proposed that the follow-on support services would be provided by non-statutory providers procured through a public tendering process.

It was also proposed that support services would be available across Northern Ireland based on the five local Commissioning Group/Trust boundaries. We suggested that developing sustainable, community-based Lifeline support services procured through five separate local contracts would promote choice, competition, build capacity and sustainability within the sector. We proposed that this arrangement would relate closely to local needs, allow for maximum local access to services and build collaboration and integration with other relevant services.

What did the consultation responses say?

Just under half of respondents 49% (n=67) were against the proposal to procure the follow on support services at locality basis. Almost a third, 31% (=42) were in favour of the proposal while 15% (n=20) were unsure, see figure 8.

Figure 6: Summary of Responses to the Procurement of Support Services at Locality Level



Some respondents highlighted the benefit of having a provider who knew the locality, local needs and importantly could build relationships with other service providers to build a more integrated approach to addressing need. Respondents also suggested that access to services would be more equitable and improve local flexibility and responsiveness.

However, many respondents also expressed concerns about the risk of inconsistency of service provision across all five geographic areas, in particular, rural areas. There was also concern about a risk of fragmentation in the care pathway and of the impact that this could have on client outcomes, governance and information management.

It was suggested that evaluation and research would be more difficult through this arrangement. There was concern that the branding of the service would be diluted and that there could be job losses in the current provider.

Consideration of responses

The PHA concludes that whereas a single regional provider for the telephone crisis service demonstrates an effective and efficient means of providing this service, that model would not be necessarily appropriate for follow-on services.

A single provider for follow-on support services might reduce the strength of, and potential for, local integration and interaction with local service providers, health and social care Trusts, GPs, and other local organisations.

Locally available follow-on support services are a key aspect of the Lifeline service. To address concerns about inconsistency, we would develop a common specification for services to PHA-agreed standards across all five geographic areas with key performance indicators which would be monitored closely using the Clinical Outcomes Routine Evaluation (CORE).

PHA would also specify that service providers need to develop close working relationships with other relevant service providers to build a collaborative approach to the care pathway at local level. They would also be required to share learning, skills and experience across the region. There would be clear protocols for information governance and sharing of sensitive data.

In response to concerns about research and evaluation and to provide reassurance, we would specify the contribution to research and evaluation as part of service contracts. In addition, funding has been identified for monitoring and evaluation.

We would also specify that all Lifeline-related services are delivered under the Lifeline brand to consolidate public understanding of the service as a whole. We would require regular independent clinical audit of the service, including the public's perception of the telephone service and follow-on support services.

The options proposed in consultation were to either:

- **Option 1**: Procure the follow-on support services as a single regional contract; or

- **Option 2**: Procure the follow-on support services as five local contracts reflecting the HSC Trust boundaries.

The administration associated with one single contract would be more straightforward for the PHA to undertake and it would also aid data collection in terms of outputs and outcomes. It would also reduce potential risks associated with loss of information sharing and communications breakdown with the provider of the telephone helpline service.

However, ensuring that local people have ease of access to local services is important. Locality based services are also easier to ensure close cooperation with local trusts and other providers in the locality. Having local providers would ensure that the Lifeline branding can be rolled out at a community level and in particular enhance the opportunities to increase access to the service from rural dwellers. This option does pose challenges for the PHA in terms of internal administration but it provides a unique opportunity to benchmark performance across the region, stimulate competition in the local market place and drive forward service improvements.

Recommendation

It is recommended that **Option 2** is seen as first preference and option 1 as second preference.

The recommendation would mean:

- The procurement of the delivery of follow on support services from non HSC organisations based on five local Commissioning Groups/Trust boundaries.

4.4 Lifeline Communications/Marketing and Evaluation

What was proposed?

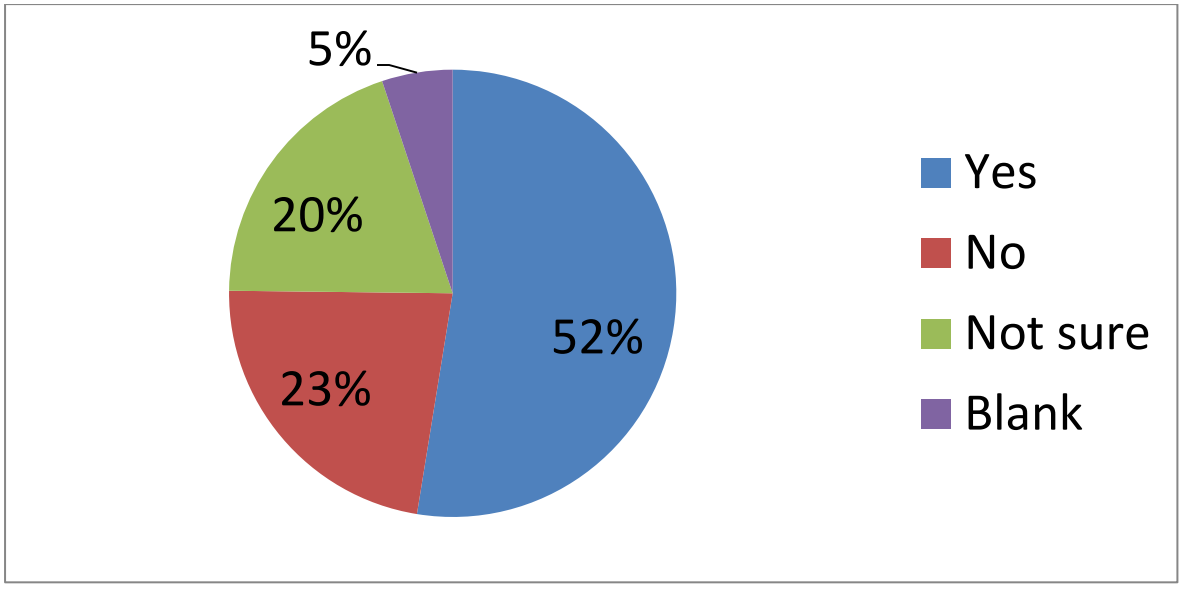
The consultation proposed that the Lifeline brand should continue to apply to all elements of the proposed future service. Key elements would include: distinct public communication/awareness raising and evaluation; providers working closely with PHA communication team to ensure consistency and appropriateness of messaging, linking with other elements of suicide prevention and the implementation of the Protect Life Strategy; and a requirement that the Lifeline brand is used within strict branding guidelines only.

We also proposed that the Lifeline services are evaluated robustly to assess impact, effectiveness, efficiency and value for money of the service which would include regular performance monitoring and specific service evaluation.

What did the consultation responses say?

Just over half, 52% (n=72) agreed with the proposed approach to the marketing/promotion and evaluation elements of the model. Some 23% (n=31) were not supportive of the approach while one in five (n=27) were unsure, see figure 9.

Figure 7: Summary of Responses to Proposed Marketing/Promotion and Evaluation Approach



There was broad support for maintaining the Lifeline branding as it is recognised and well established, and that the branding should be applied to all aspects of the Lifeline

service. There was also support for previous advertising campaigns, website information and suggestions about how these could be strengthened in the future, for example, using social media. There was support for clear and consistent messages and in particular the need to engage more with certain groups.

Many respondents mentioned the importance and need for independent evaluation of the service and of the communications and marketing elements. There was some concerns expressed about the indicative amount (£40,000 per annum) set against this purpose.

Respondents also commented on the 'Protect Lifeline campaign' and expressed concern that misinformation and reputational damage had been caused to the Lifeline brand.

Consideration of responses

The PHA acknowledges the growing recognition of the Lifeline brand and would support the need to continue to raise awareness generally and to engage particular groups. As proposed, the Lifeline brand would apply to all elements of the Lifeline telephone service and follow-on support service.

In response to concerns about the level of funding set aside for evaluation, the PHA does not consider the indicative budget to be excessive (1% of total budget). We would give consideration to the procurement of this element and, irrespective of the mechanism, would focus the evaluation on clear output and outcome measures. In addition, we would encourage academic research wherever possible and appropriate.

In a totally integrated model the inclusion of the Comms/PR element is technically straightforward, as with the current model, a separate funding stream is made available to cover this element of the service provision. However, in the proposed service model the Comms/PR process needs to be more robust and tightly monitored in order to ensure that, even with a revised service model the branding and promotion of Lifeline remains focused and consistent.

Four options have been identified for this element, these are:

- **Option 1:** The provider of the telephone helpline service would be manage the Comms/PR for the whole service

- **Option 2**: The budget would be split between the various providers to work collectively the promotion of the service

- **Option 3**: The Comms/PR element is brought in-house to the PHA and made part of the wider Protect Life Strategy Comms/PR service

- **Option 4**: An independent provider is procured to provide the Comms/PR work

It is critical that the branding remains unchanged and that service users have confidence in the service that they are using and, perhaps more importantly, that those in need should not be aware of any structural changes that have taken place. Given the relatively small amount of £150k pa (4% of the total budget) it is critical that any commissioning of the service needs to ensure additionality and value for money.

There are also a number of challenges in the proposed service model regarding the Monitoring and Evaluation (M&E). The feedback from the consultation was clear about the need for robust and regular monitoring and reporting on the Lifeline service. There are opportunities to promote benchmarking to drive excellence in the service, improve outcomes for clients and impact on the rates of suicide and self-harm. It is also important that the Lifeline service is not seen as standalone and the M&E needs to integrate with other activities which are commissioned under Protect Life, and related strategies such as that for Alcohol and Drugs . There is also the requirement for a separate clinical review process of both the telephone service and the follow-on support service.

Recommendation

On the basis of the above considerations, it is proposed that Comms/PR work should be brought into the PHA as part of the wider Protect Life communications strategy.

Option 3 therefore, is recommended as a first preference, with Option 4 as a second preference, and Option 1 as a third preference.

M&E needs to be accounted for in the full business case with specific resources identified to include the need for regular clinical review during the lifespan of the contract.

The recommendation would mean that:

- Communications, Marketing and Public Relations should remain a core element of the Lifeline service;
- The communication service should be brought into the PHA to integrate it more fully with work on the wider Protect Life Communications Strategy;
- Independent evaluation should be procured as part of the Lifeline service.

Appendix: 1

Summary of Equality Monitoring Returns

Total forms returned 181		
Gender		
Male	59	33%
Female	122	67%
Other (please specify)	0	0
Is your gender identity the same as the gender you were originally assigned at birth?		
Yes	179	99%
No	1	0.5%
Prefer not to say	1	0.5%
Age		
16 - 20	9	5%
21 - 30	17	9%
31 - 40	41	23%
41 - 50	53	29%
51 - 65	49	27%
66+	5	3%
Prefer not to say	7	4%
What is your country of birth		
Northern Ireland	154	85%
England	9	5%
Wales	0	0
Scotland	3	2%
Republic of Ireland	6	3%
Ireland	4	2%
Elsewhere (please state)	5 Nigeria Poland Australia Malta Berlin	3%
Prefer not to say	0	0

What is your ethnic group		
White	177	98%
Black African	1	0.5%
Bangladeshi	0	0
Chinese	0	0
Irish Traveller	1	0.5%
Pakistani	0	0
Indian	0	0
Black Caribbean	0	0
Mixed Ethnic Group	1	0.5%
Black Other	0	0
Roma Traveller	0	0
Prefer not to say	1	0.5%
Any Other Ethnic Group (please specify)	0	0

Disability		
In accordance with the Disability Discrimination Act 1995, a disability is defined as a physical or mental impairment which has a substantial and long-term effect on a person's ability to carry out normal day-to-day activities. Under this definition, do you consider yourself as having a disability?		
Yes	54	30%
No	124	68%
Prefer not to say	3	2%
If yes, please indicate which type of impairment applies to you		
Physical impairment	5	
Sensory impairment	4	
Mental Health condition	42	
Learning disability	9	
Long standing illness	15	
Other (please specify)	Autism Fibromyalgia	
Prefer not to say	3	

Sexual Orientation		
Gay	4	2%
Heterosexual	155	86%
Lesbian	4	2%
Gay Woman	0	0
Bisexual	4	2%
Other (please specify)	2 *Comments* Not orientated really none	1%
Prefer not to say	12	7%
Caring responsibilities		
None	77	43%
Yes	104	57%
Child(ren) under 18	77	
An older person	19	
A person with a disability	19	
Other (please specify)	Mental health illness	
Prefer not to say	5	
Please indicate your religion		
Protestant	60	33%
Catholic	83	46%
Jewish	0	0
Hindu	0	0
Muslim	0	0
Sikh	0	0
Buddhist	1	0.5%
Other (please specify)	19 None 7 Christian 3 Celestian Born Again Christian Aetheist 4 Bahai	10.5%
Prefer not to say	18	10%

Please indicate your marital status		
Single	71	39%
Married/civil Partnership	91	50%
Other (please specify)	11 Widow 4 Separated 4 Divorced 3 Co-habiting	6%
Prefer not to say	8	5%
How would you describe your political opinion?		
Broadly Unionist	27	15%
Broadly Nationalist	55	30%
Other (please specify)	32 *Comments* Liberal / left wing Green Liberal / humanist No favouritism Democratic socialist Past nationalist Not applicable None 8 Neither 3 Holy God is the only position I trust, follow and genuinely always vote for Middle of the road Cross-community Alliance Party Very Alliance Socialist Marxist Republican No preference Neutral British / Irish Equality for all Centrist	18%
Prefer not to say	67	37%