HSC Public Health Agency

STRATEGIC OUTLINE BUSINESS CASE FOR THE PROVISION OF THE 'LIFELINE' CRISIS INTERVENTION SERVICE FOR NORTHERN IRELAND

Date of publication 27 August 2015

CONTENTS

Section	Title	Page
1	Introduction	3
2	Strategic Context	4
3	Assessment of Need	14
4	Objectives and Constraints	44
5	Identification of Options	56
6	Assessment of Monetary Costs and Benefits	63
7	Assessment of Risks	67
8	Assessment of Non-Monetary Costs and Benefits	77
9	Affordability, Management, Procurement and Post Project Evaluation	86
10	Conclusions on Evaluation of Options	90

APPENDICES:

Appendix 1	Table 14: Suicide Rates
Appendix 2	Pre Consultation Engagement Summary
Appendix 3	Definitions
Appendix 4	NPC Calculations
Appendix 5	Equality Screening

1. 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 overall aim of the service is to provide 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 suicide prevention strategy 'Protect Life'.

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.

The aim of this Strategic Outline Business Case (SOBC) is to identify a Lifeline service model beyond 2015 that best meets the needs of those at immediate risk of suicide or self-, preparing the way for the next re-tender of the service. In doing this it will take account of the monitoring and evaluation from the existing service, evidence in relation to service models elsewhere, Departmental policy direction and, importantly, stakeholder engagement. The SOBC will review and refresh the service objectives for Lifeline. Following an assessment of monetary and non-monetary costs and benefits, a preferred option will be identified. Consideration will also be given to the mechanisms available to the PHA, such as commissioning and procurement, to secure the service objectives and preferred option. Public consultation on the preferred option and the Equality Impact Assessment (EQIA) will follow. Once the consultation has closed, a Final Business Case will be prepared, taking account of the responses to the consultation, before the new service is commissioned.

2. STRATEGIC CONTEXT

2.1 Introduction

According to the World Health Organisation (WHO) more than 800,000 people die from suicide every year, or approximately one death every 40 seconds. Suicide worldwide was estimated to represent 1.4% of the total global burden of disease between 2000 and 2010[1].

There have also been significant increases in suicide rates in Northern Ireland in the period 2001-14. Since 2001 the three year rate of registered has increased from 9.5 per 100,000 in 2001/03 to 15.95 deaths per 100,000 population in 2012/14p. The rate has remained over 15 deaths per 100,000 since 2008/10. [2] In 2014 there were 268 deaths recorded as suicide in Northern Ireland, three quarters of whom were male and during 2013/14 there were 12,076 presentations at emergency departments for self-harm and suicidal ideation.

2.2 Protect Life

It was in this context that the Northern Ireland Suicide Prevention Strategy "Protect Life" was published by DHSSPS in October 2006. The strategy initially covered the period 2006 – 2011. In 2010, the Northern Ireland Suicide Strategy Implementation Body (SSIB) proposed that the strategy be refreshed and extended for a two further years. The result was the publication of the refreshed NI Suicide Prevention Strategy "Protect Life – A Shared Vision" in 2012. While maintaining a long-term goal of reducing suicide rates in Northern Ireland, the refreshed Strategy sets a new aim "to reduce the differential in the suicide rate between deprived and non-deprived areas". [3] A new regional strategy combining suicide and mental health is currently under development by the DHSSPS.

[1] http://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html (accessed 5/2/15)

[2] Public Health Agency Health Intelligence Briefing – Suicide in Northern Ireland – June 2014, based on figures from NISRA – http://www.nisra.gov.uk/demography/default.asp31.htm

[3] Protect Life A Shared Vision: The Northern Ireland Suicide Prevention Strategy 2012 – March 2014 (refreshed June 2012)

2.3 Other Strategic Drivers

There are numerous regional and local strategies, frameworks, policy, guidance and action plans that are relevant to the development of services to help reduce suicide in Northern Ireland. While those included below do not provide an exhaustive list, they do set out the key drivers for the future of the Lifeline service and represent the primary policies in respect of promoting positive mental health and addressing self-harm and suicide prevention.

'Making Life Better: A Whole System Strategic Framework for Public Health 2013 – 2023' – The vision and aim of the framework is "through strengthened co-ordination and partnership working in a whole system approach … to create the conditions for individuals and communities to take control of their own lives and move towards a vision for Northern Ireland where All people are enabled and supported in achieving their full health and wellbeing potential. The aims are to achieve better health and wellbeing for everyone and reduce inequalities in health." A central theme in the framework is "empowering healthy living", including the long term outcome of "improved mental health and wellbeing and reduction in self-harm and suicide."[4]

Transforming Your Care – The high incidence of suicide in Northern Ireland, particularly among young men is recognised, with the resulting proposal for a "continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men."[5]

Bamford Regional Action Plan 2012 – 2015[6] – Promoting positive community and personal health and wellbeing was central to the Bamford Review's vision. The Action plan 2012 – 2015, with its cross-government endorsement, continues to drive the implementation, and reiterates the importance of taking forward the actions in the Protect Life Strategy on Suicide Prevention as well as the development of the new Regional Mental Health and Wellbeing Strategy.

[4] Making Life Better: A Whole System Strategic Framework for Public Health 2013 – 2023. (June 2014)
[5] Transforming Your Care: A Review of Health and Social Care in Northern Ireland (December 2011)
[6] Delivering the Bamford Vision: The response of the NI Executive to the Bamford review of Mental Health and Learning Disability Action Plan 2012 - 2015

Public Health Agency Corporate Strategy 2011 – 2015 – The second core goal identified in the PHA Corporate Strategy is "to improve the health and social wellbeing of our population" with emphasis on a number of key areas, including "making healthier choices easier through better information and influencing population health behaviours" and "implementing actions to improve the mental health of the population and reduce levels of suicide and self-harm."[7]

2.4 Preventing Suicide – the evidence

As the World Health Organisation (WHO) 'Preventing Suicide – A global imperative'[8] report states 'suicides are preventable'. However, it recognises that this is not simple, rather it requires a range of measures and interventions with multi-sectoral inputs and actions.

The WHO report describes crisis helplines as 'public call centres which people can turn to when other social support or professional care is unavailable or not preferred'. It cites studies from the USA[9] and Belgium[10],indicating that helplines have been shown to be effective in engaging with suicidal individuals and reducing suicide risk during the call and in subsequent weeks, and also that helplines may be a cost effective strategy for suicide prevention. Overall the WHO report states that 'helplines have proved to be a useful and widely implemented best practice.', however the WHO report also adds 'despite reducing suicide risk, the lack of evaluation means that there is no conclusive association with reducing suicide rates.'

[7] Public Health Agency Corporate Strategy 2011 - 2015
[8] Preventing Suicide: A Global Imperative, World Health Organisation (2014)

[9] Gould, MS., Kalafat, J., Harrismunfakh, J. L. & Kleinman, M. 2007, *An evaluation of crisis hotline outcomes. Part 2: suicidal callers. Suicide and Life Threatening Behaviour*. The American Association of Suicidology. 37(3):338-352.

[10] Pil, L., Pauwels, K.., Muijzers, E., Portzky, G., & Annemans, L. 2013. *Cost-effectiveness of a helpline for suicide prevention*. J Telemed Telecare. 19(5):273-81.

While some long term risk factors for suicide have been established, accurate identification of individuals at imminent risk of suicide is difficult[11]. It is recommended that suicide prevention strategies at the individual level should include a comprehensive assessment of everyone presenting with suicidal behaviours[12]. The term 'risk of suicide' covers a very broad array of behaviours and is dependent on the accuracy of the assessment[13] which includes an assessment of risk[14].

The WHO 'Preventing Suicide' report highlights the multi-factorial nature of the risk factors requiring adoption of a multicomponent evidence based approach to intervention. The National Institute for Health & Care Excellence (NICE) guidance states that this should be culturally appropriate to each individual's needs[15].

There is limited evidence regarding the efficacy of helplines and associated support. As commissioners of these services the PHA would expect any provider to contribute to the evidence and learning from the evidence, and that any service commissioned could be modified in light of any new evidence, in agreement with the commissioner. As the WHO 'Preventing Suicide' report states, improving the quality of clinical care and evidence based clinical interventions as well as improved research and evaluation of effectiveness of interventions is an important strategic objective.

There is a growing body of evidence that a recovery approach is the most appropriate in terms of emotional health and wellbeing. Recovery is described as

---

[11] Chesin, M., & Stanley, B. 2013. *Risk assessment and psychological interventions for suicidal patients*. Department of Psychiatry, Columbia University. Bipolar Disorder. NY: John Wiley & Sons. 15(5):584-93. doi: 10.1111/bdi.12092.

[12] Scott, A. & Guo, B. 2012. *For which strategies of suicide prevention is there evidence of effectiveness?* Health Evidence Network. Denmark: WHO.

[13] HSR&D. 2009. *Strategies for Suicide Prevention in Veterans*. Veteran Affairs. Los Angeles: Healthcare.

[14] NICE CG16. 2012. *Self Harm: The short term physical and psychological management and secondary prevention of self harm in primary and secondary care.* Available at: http://guidance.nice.org.uk/CG16 [Accessed 13 March 2014]

[15] NICE CG136. 2011. *Service user experience in adult mental health: Improving the experience of care for people using adult NHS mental health services*. Available at: http://www.nice.org.uk/guidance/CG136. [Accessed 30 July 2014]

something that individual's experience, that services promote, and that systems facilitate. It is in line with the direction of travel for mental health services in NI[16], Implementing Recovery through Organisational Change[17] and the Centre for Mental Health[18] .

The findings from the Providing Meaningful Care[19] report have indicated that some vulnerable people will not access the normal services such as primary care, mental health services and crisis support lines. Many of those who have survived a suicide attempt have referred to the impromptu nature of their acts and how often calling into a support service was the critical key to saving their lives. This has also been the feedback from service providers who have referred to a vulnerable individual arriving at their premises in need of immediate assistance.

2.5 Public Health Agency Approach

The Public Health Agency (PHA) work in respect of mental and emotional wellbeing and suicide prevention is part of wider Northern Ireland multi-sectoral work and takes a public health approach across the continuum from prevention through to bereavement support, as illustrated over page.

International evidence would suggest that there is no one single intervention that can reduce the rates of suicide and self-harm[20], therefore the PHA's approach is to support and commission a range of services, which when taken together, can be effective in helping to contribute to reducing the rates of suicide and self-harm. This acknowledges that it can be difficult to evaluate the effectiveness of any single intervention and therefore it can be challenging to assess issues such as risk and

[16] DHSSPS. 2011. Transforming Your Care: A Review of Health and Social Care in NI.

[17] Implementing Recovery through Organisational Change. Available at: http://www.imroc.org

[18] Centre for Mental Health. Available at: http://www.centreformentalhealth.org.uk/recovery/Recovery_Colleges.aspx

[19] Providing meaningful care: using the experiences of young suicidal men to inform mental health care services Short Report. Authors: Dr Joanne Jordan, Professor Hugh McKenna, Dr Sinead Keeney, Professor John Cutcliffe

[20] Platt S, Hawton K. Suicidal Behaviour and the Labour Market. In: Hawton K, Van Heeringen K, eds. The International Handbook of Suicide and Attempted Suicide. New York: Wiley, 2000: 310-84

benefits, nonetheless, it is important that that perceived impact is taken into account in any needs assessment.

Continuum Model (Multi-faceted Approach)

1	2	3	4	5	6
Building capacity & resilience: Awareness & education	Early recognition of signs & symptoms; Awareness of interventions available & how to access	Appropriate & accessible services & support	Crisis Response & Postvention (bereavement support)	Using & building the evidence & test new ways if evidence doesn't exist	Leadership & co-ordination; Sharing of good practice
					

The Lifeline helpline and associated support sits within this continuum (columns 3 and 4 above). These services aim to provide short term help at the point of crisis; they do not provide all the support required for all people at risk of suicide. Other services at each end of the continuum include building capacity, resilience and raising awareness of mental health and wellbeing at a population level, and targeted interventions for specific communities. Many of these services are commissioned by the PHA, but others are funded and provided by other organisations. Additionally a range of statutory services are also commissioned by the HSCB at primary care, community and acute levels.

Evidence has shown the strong correlation between self-harm and risk of suicide; reviews such as Owens et al[21] and Muehlenkamp and Gutierrez [22] being just two of the academic reviews that have reported on the relationship between the two. As

[21] Owens D, Horrocks, J, House A – Fatal and non-fatal repetition of self-harm: Systematic Review. British Journal of Psychiatry, 2002, 181: 193-199

[22] Muehlenkamp J and Gutierrez PM- An Investigation of Differences Between Self-Injurious Behavior and Suicide Attempts in a Sample of Adolescents. 2004 The American Association for Suicidology 2004 DOI: 10.1521/suli.34.1.12.27769

part of the wider commissioning response to addressing suicide prevention the PHA is investing £0.719m in a new Self-harm Intervention programme (SHIP). SHIP will be delivered by community based organisations in each of the Local Commissioning Group areas, and will accept low to medium risk referrals from Trust mental health services (individuals assessed at high risk remaining with Trust mental health services). SHIP clients will be offered up to five 'one to one' psychological therapy sessions and potentially one further session for family/carer support. The service, which was piloted in the Western Health and Social Care Trust, will now be available across Northern Ireland to over 2,700 individuals per annum. The SHIP model is complementary to the proposed Lifeline Services.

In addition to the new Self-harm Intervention Programme, the PHA is also in the process of commissioning specific services for targeted vulnerable groups such as Travellers, Black Minority Ethnic groups and the Lesbian, Gay, Bisexual and Transgender community. An additional £0.150m will be invested in specific mental health and emotional well-being projects to improve resilience within these communities and reduce the risk of them needing crisis interventions such as the Lifeline Helpline or hospital emergency care.

2.6 Lifeline: service history

A suicide prevention helpline was first established as a pilot in North and West Belfast, under the 'Protect Life' Strategy, in October 2006. The primary focus of this service was young people aged 11-25 years in North and West Belfast. In May 2008, a regional service, now branded as 'Lifeline' was launched[23]. The service was extended to include all age groups and was to be strengthened by the provision of additional face-to-face support services for people in crisis. Since that date the service has continued to develop. The overall aim of the current helpline is to provide 24/7 support to all people at immediate risk of suicide or self-harm across Northern Ireland, thereby helping to reduce the levels of suicide and self-harm incidents.

[23] This decision was taken at Departmental level prior to evaluation of service demands or outcomes

The regional Lifeline service has been provided by an independent contractor, awarded through public tender. The service was retendered in 2011, with the current contract running from March 2012 to March 2015, with the possibility of 18 months extension (to September 2016).

The PHA took over commissioning and management of the Lifeline service in April 2010 working with the service provider, the Health and Social Care Board (HSCB), Health and Social Care (HSC) Trusts, other community and voluntary organisations and service users. Management of the contract has included how to deliver a demand led service within budget, maintaining satisfactory levels of performance, the level and type of support that should be available, ensuring clarity of purpose of the service and appropriate use as well as links with other community based services and with statutory services. These will be further explored in the following chapters.

2.7 Services elsewhere

In developing this SOBC, the PHA has looked at other statutory and voluntary helplines and associated services. International evidence would suggest that the indication of the effectiveness of helplines is somewhat inconclusive, primarily due to the lack of quality of studies and robust evidence of outcomes. There are challenges in comparing universal services such as the Lifeline service in NI and services targeting vulnerable groups such as war veterans, Lesbian, Gay, Bisexual and Transgender (LGBT) services etc.

These conclusions are reflected in the 2014 WHO report on suicide prevention[24] which concluded that crisis helplines can be in place for the wider population or may target certain vulnerable groups. The latter can be advantageous if peer support is likely to be helpful. Helplines in the USA have been shown to be effective in engaging seriously suicidal individuals and in reducing suicide risk among callers during the call session and subsequent weeks. While a study of telephone and chat helpline services in Belgium suggests that these strategies might also be cost-effective for suicide prevention. Helplines have proved to be a useful and widely

[24] Preventing Suicide – "A global imperative". WHO ISNB 978 92 4 156477 9 September 2014

implemented best practice; however, despite reducing suicide risk, the lack of evaluation means that there is no conclusive association with reducing suicide rates.

The International Association of Suicide Prevention (IASP) has established a Special Interest Group to review best practice in terms of crisis helplines and they have concluded that helplines are increasingly being recognised as vital components of a suicide prevention strategy. Their effectiveness lies in the offer of accessible (by phone), convenient (often 24/7 delivery) and confidential (no names) support to people who are in crisis. In their view, helplines can attract suicidal persons to reach out for help at a critical time, thereby enabling a compassionate response to be provided and the potential for life saving intervention towards safety and continuing support.

In terms of the development of helplines attention is being drawn towards framing principles and techniques for good practice including a shift towards 'evidence based' practice and definitions of intended consumer outcomes. The group have framed crisis theory and principles on consumer empowerment. It reports that many helplines world-wide use volunteers and non-professional workforces in their delivery. This level of engagement demonstrates the ability of the helplines to harness community resources and collaboration towards suicide prevention.

The Special Interest group have pointed to recent research on help seeking behaviours and suicide risk assessment has informed the practice of helplines towards clearer understandings of effective response to callers in crisis. Attention to safety planning with suicidal callers and the interplay between helplines and emergency services is reinforcing the lifesaving value of crisis outreach. An emphasis on creating pathways for callers towards accessing ongoing mental health services is also framing the role of helplines as gateway services thereby playing a key role in a national primary health care system.

Within the context of the findings of the IASP group the PHA have examined other models that work both within a National Health Care setting and externally including the Scottish ‘Breathing Space’ service, the only other regional service in the UK available to the general population, which is commissioned by a statutory Health Service. Breathing Space, is part of NHS24 (Scotland), but has its own separate branding. The service therefore maximises the opportunities for direct ‘handover’ of

clients in immediate danger of suicide or self-harm to emergency services, as well as benefitting from the efficiencies of shared services (HR, finance, accommodation etc). Breathing Space provides a 'listening ear' service and is provided by appropriately trained individuals, who do not require a specific counselling qualification for the role. It is based on an empowerment and enabling model, and does not make referrals, rather it signposts callers to relevant services.

Enablement and empowerment are defined as a corrective approach to addressing the lack of control, sense of helplessness, and dependency that many service users have developed after long-term interactions with the mental health system. A sense of empowerment emerges from inside one's self and it has three core components:

- Autonomy or the ability to act as an independent agent. This includes knowledge, self-confidence, and the availability of meaningful choices.
- Courage - a willingness to take risks, to speak in one's own voice, and to step outside of safe routines.
- Responsibility, a concept that speaks to the individuals obligations.

The learning from this has been fed into the model outline in section 4.

2.8 Conclusion

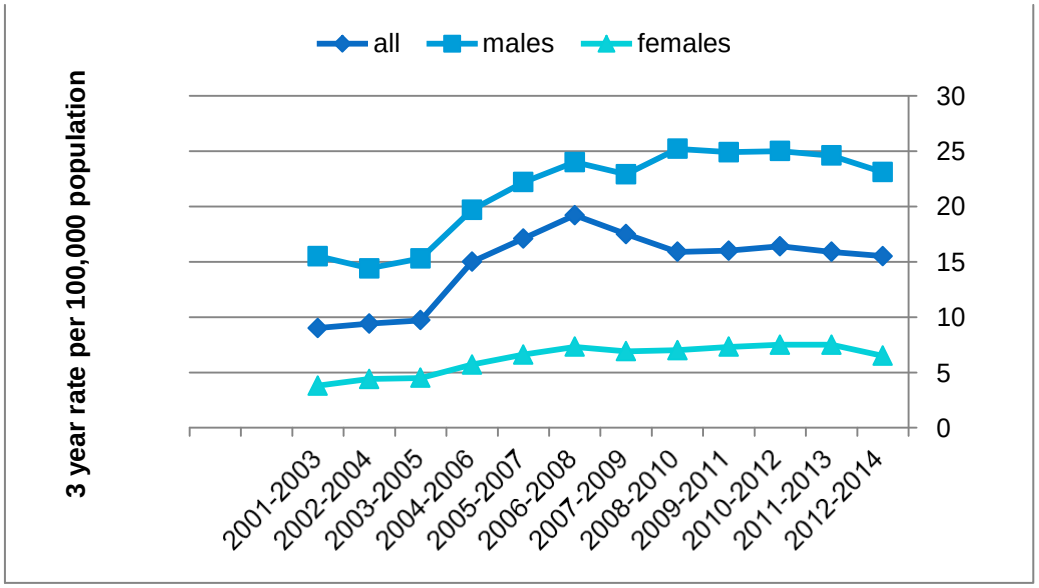
The case for the existence of a suicide and self-harm prevention helpline is already established through the existing regional strategies, primarily 'Protect Life'. This SOBC seeks to identify the best model and delivery mechanism for the Lifeline for the future and particularly for the next five years. It will also consider the mechanisms available to secure the service objectives and preferred option. It is important that these services do not duplicate existing services; rather Lifeline should complement them, maximising the use of resources, and be an integral part of the continuum of services aimed at preventing suicide, working closely with other services and service providers. The identification of objectives and sifting of options to arrive at the preferred option, will take account of the direction set out in the key documents referenced in this section, especially the need to provide an accessible service for those most at risk as well as one that is based on empowerment.

3. ASSESSMENT OF NEED

3.1 Incidence of suicide in Northern Ireland

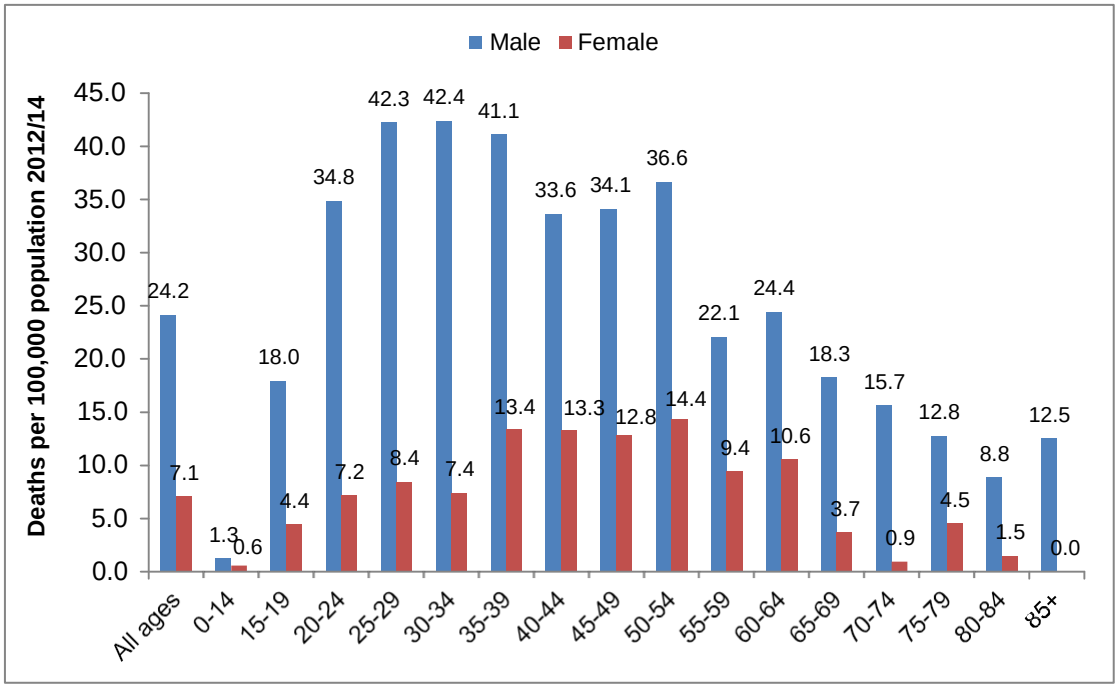
Approximately 2% of all deaths registered in Northern Ireland each year are recorded as suicide. In 2014 there were 268 deaths in Northern Ireland provisionally recorded as suicide, over three quarters of whom were male (207 males and 61 females). As in other countries, the annual rate of suicide for 2014 in Northern Ireland is higher for males (23.1 per 100,000) than females (6.5 per 100,000. Over the last 10 years the 3 year rolling rate of registered suicide in Northern Ireland has increased from 9.5 per 100,000 in 2001/03 to 15.5 2012/2014p. (Appendix 1, Table 14)

Figure A: 3 year suicide rate per 100,000 from 2001/2003 – 2012/2014



The latest data on suicide by age, 2012-2014 (see figure B below), shows that the highest rates of suicide for males was among those aged 30-34 years (42.4 per 100,000), followed by 25-29 years (42.3 per 100,000). For females, the highest rates were among those aged 50 - 54 years (14.4 per 100,000), followed by 35 - 39 years (13.4 per 100,000).

Figure B: Crude rate of suicide (3 year) in Northern Ireland by age and gender: 2012-2014



Changing rates by age and gender

The greatest increases in male suicide rates (between 2001/2003 and 2012/14) have been observed in age groups 35-39 (from 20.7 to 41.1 per 100,000), 50-54 years (from 21.3 to 36.6 per 100,000). (Appendix 1, Table 14). The greatest increases in female suicide rates, (between 2001/2003 and 2012/14) have been observed in age groups 50-54 years (from 4 to 14.4 per 100,000), and 35-39 (4.5 to 13.4 per 100,000).

In the youngest age group, aged 15 to 19 the overall rate has increased from 7.3 per 100,000 to 11.4 per 100,000 between 2001/2003 and 2012/14.

The latest three year rate for Northern Ireland is 15.5 deaths per 100,000 for 2012-2014. Belfast has the highest suicide rate at 20.2 deaths per 100,000, followed by the Western area at 16.1 per 100,000. The South Eastern area has the lowest rate at 13.8 per 100.000. Figure C below shows the trends in overall registered suicide rates by LCG/HSCT area since 2001/03.

Figure C: Crude suicide rates (3 year) by LCG/HSCT from 2000/02 to 2012/14

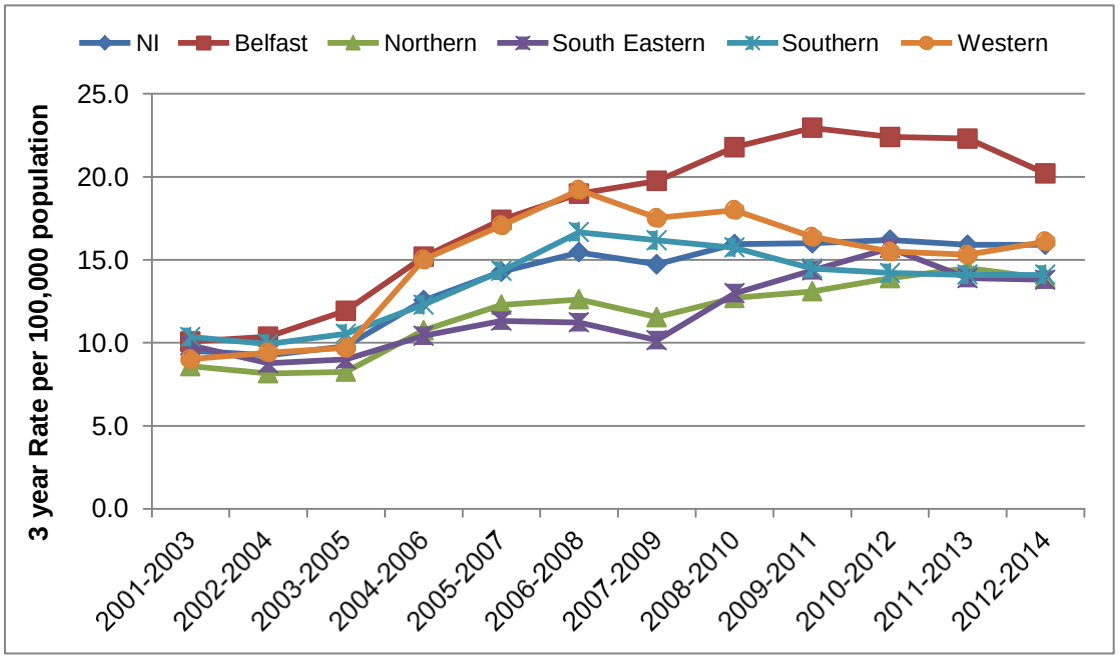
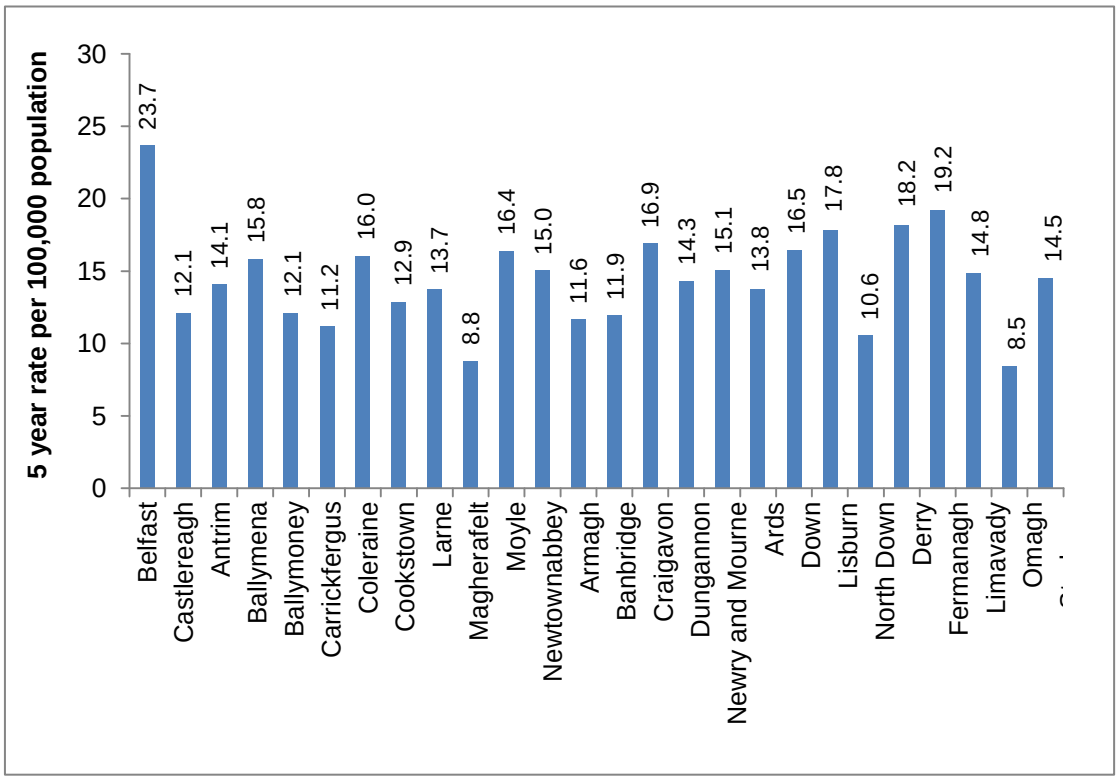


Figure D below shows the variation in registered suicide rates by Local Government District (LGD)[25] using a five year rate to increase robustness (2010 – 2014). The highest rate was recorded for Belfast (23.7 per 100,000), followed by Fermanagh (19.2 per 100,000) and Derry/Londonderry (18.2 per 100,000).

[25] Figures 2009/2013 therefore categorised by pre RPA Local Government Districts

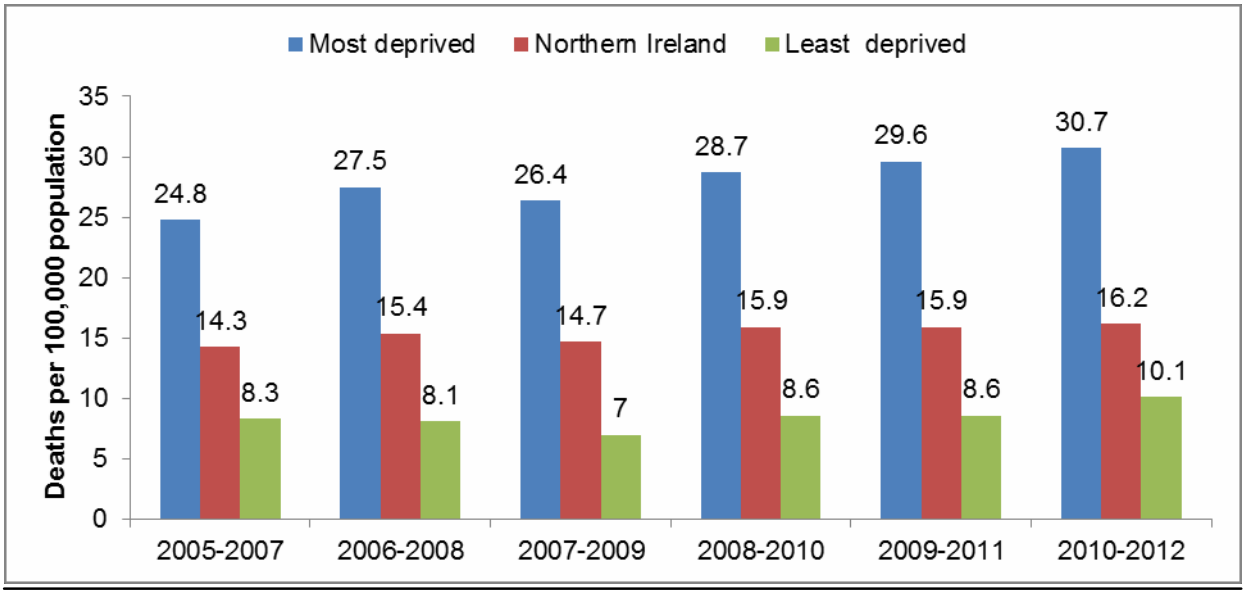
Figure D: Rate of suicide by Local Government District (5 year average), 2010 - 2014



The Health and Social Care Inequalities Monitoring System (HSCIMS) comprises a number of indicators, including suicide rates, which are monitored over time to assess area differences. Inequalities between the 20% most deprived areas (defined using the Northern Ireland Multiple Deprivation Measure (NISRA) and Northern Ireland as a whole are measured. The NI crude suicide rate was 16.2 deaths per 100,000 population in 2010-2012[26]. The rate in the most deprived areas was 30.7 suicides per 100,000, 3 times higher than in the least deprived areas (10.1 deaths per 100,000 population). Figure E below shows the suicide rate by deprivation since 2005/07.

[26] At time of preparation 2010-12 most up to date deprivation figures available

Figure E: Crude suicide rate by deprivation (3 year rolling) 2005/07 to 2010/12



Whereas deaths by homicide/suicide are relatively rare in Northern Ireland, there is a growing body of evidence to indicate that the prevalence is increasing, in particular where there are factors such as long-term conditions. A series of reviews have been done by organisations such as the American Centre for Disease Control, the Violent Policy Centre (through support from groups such as the Herb Block Foundation, The David Bohnett Foundation, The Joyce Foundation, and The John D. and Catherine T.MacArthur Foundation) to examine key factors related to homicide/suicide events and they conclude that the issue is becoming a an increasing Public Health challenge which services need to respond to. Work has also commenced in Ireland through the National Suicide Research Foundation to examine the issue and the extent of the problem in Ireland given a number of high profile deaths in recent years. Whereas this needs analysis does not report on such deaths the issue is acknowledged as a service challenge that needs to be managed within the context for the future Lifeline service.

3.2 Incidence of Self Harm in Northern Ireland[27]

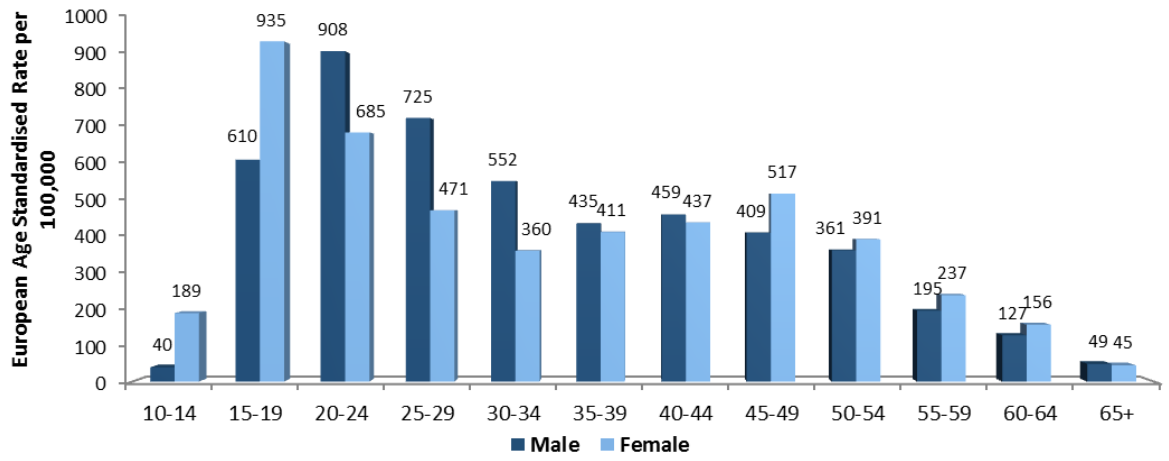
The following figures are taken from the NI Registry of Deliberate Self Harm Annual Report 2013/14:

- 5,983 people presented to Northern Ireland Emergency Departments as a result of self-harm in 2013/14, with a total of 8,453 presentations.
- 19.7% of people presented on more than one occasion during the period.
- Overall the gender balance was even, however in the Belfast Trust males accounted for 53% and in the Southern Trust they accounted for 52%, while in the Northern area females accounted for 55.6% and in the west they accounted for 55.2%.
- The 15-29 year age bracket accounted for 44.4% of all self-harm presentations see figure F below).
- In addition to 8,453 presentations of self-harm, there were 3,623 ideation cases[28] recorded during 2013/14 accounting for 30% of all combined episodes of deliberate self-harm and ideation (n=12,076). Almost two thirds (65.4%) of ideation cases were male in contrast to the even gender balance among deliberate self-harm cases

[27] Deliberate Self Harm definition used: "An act of non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage and which is aimed at realising changes that the person desires via the actual or expected physical consequences."

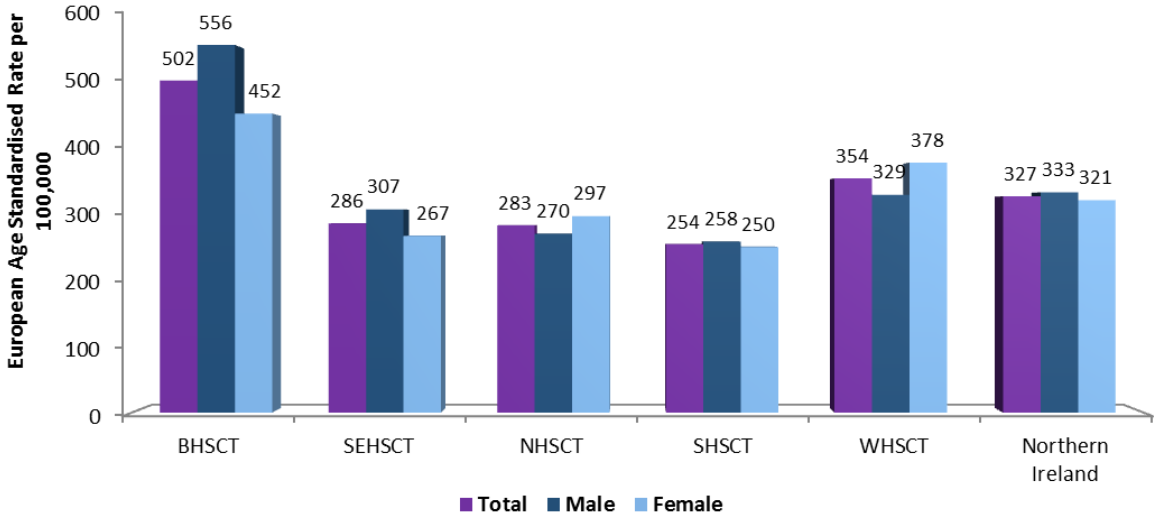
[28] Ideation *includes presentations to ED due to thoughts of self-harm and / or suicide, where no act has taken place*

Figure F: EASR[29] per 100,000 of deliberate self-harm in Northern Ireland by age and gender, 2013/14



- The Belfast Trust accounted for almost 30% of presentations, South Eastern and Northern Trust 18% each and the Western and Southern Trusts with 17% each (figure G below).

Figures G: Incidence rates of deliberate self-harm, all ages per 100,000 by gender and HSCT area, 2013/14



3.3 Current Lifeline service data

The following is based on an analysis of the 2012/13 – 2014/15 (current contract period) raw data downloaded from the current provider's Lifeline client information management system (CIMS).

[29] EASR – European Age Standardised Rate

During the first two years of the contract period the Lifeline helpline and follow on support activity levels rose significantly, exceeding resources available. Following a review of the data to understand the nature of the activity, the PHA worked with the service provider to ensure that measures, compatible with the stated role of the Lifeline service, should be taken to manage demand, ensuring that those most in need of the service, and for whom the service had been developed, were prioritised and received appropriate and timely support. Additional measures were also taken to ensure appropriate management of frequent callers.

The following analysis of data illustrates the levels of activity before and after the introduction of the demand management measures.

Calls to the Lifeline Helpline

Figure H below shows a comparison of the inbound call volume to the Lifeline helpline during the last year of the previous contract (2011/12) with the current contract. While there was a reduction in volume at the beginning of the new contract, this increased, peaking in July 2014 (with the number of missed calls also increasing during this period). However, the call demand has decreased significantly during the second half of 2014/15, with the level of missed calls becoming negligible during the last quarter.

Figure H: Calls into Lifeline, April 2011 to March 2015.
(Call demand – all calls made to the service answered or not – from KPI data. All calls answered: all calls answered by the service from raw data)

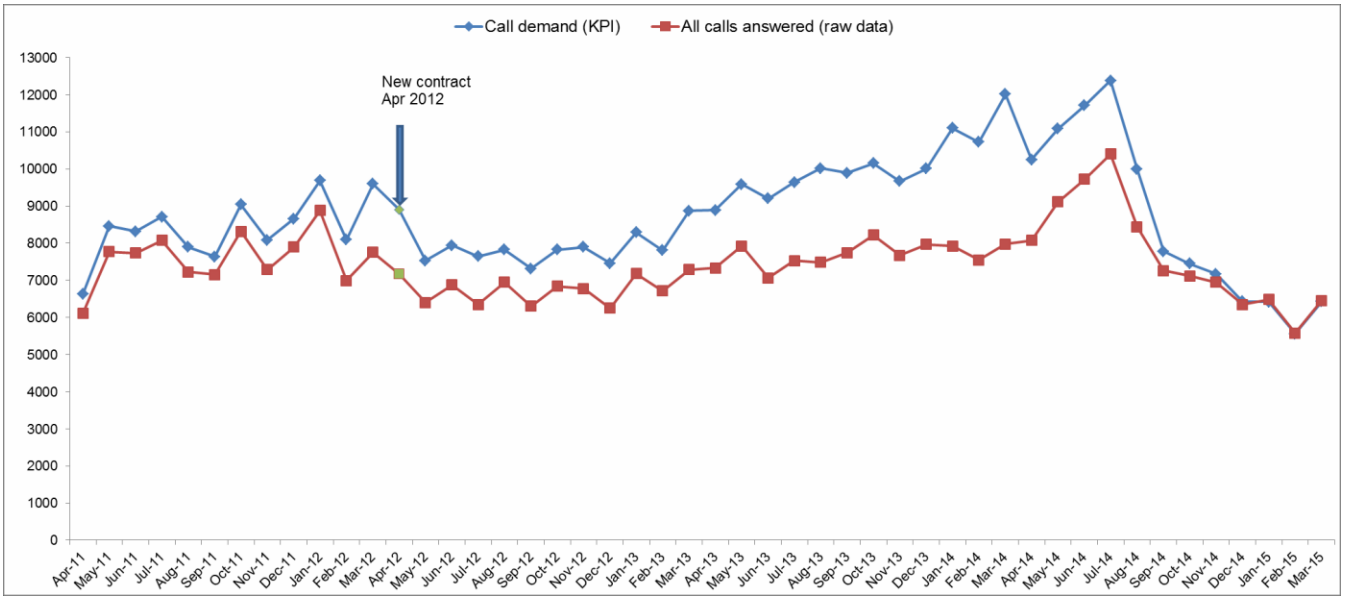


Table 1 below shows the total number of inbound calls received during each of the last three years. With the introduction of the new contract, the number of calls increased by 14% between 2012/13 and 2013/14; however this levelled to an increase of only 1.2% from the previous contract figures (2011/12) by 2013/14 and a slight fall between 2011/2012 and 2014/15.

While most of the calls received by the Lifeline helpline result in an interaction with the call operator ('active' calls), a number require no interaction and are classified by the provider as 'inactive' calls (including hang-up, silent and abusive calls). The main change in demand on the service came in 2012/13 not from a significant increase in the number of calls received since 2011/12, but from the number of calls classified as 'active' calls (from 56% in 2011/12 to 75% in 2014/15).

Table 1 – Lifeline Inbound Calls 2011/12 – 2014/15

Contract year	**Total calls in***	**Average per month**	**Average 'active' per day**	**% active**	**% inactive**
11/12	91174	7598	139.2	56	44
12/13	80896	6741	145.2	66	34
13/14	92266	7689	185.6	74	26
14/15	91826	7652	189.2	75	25

Figures I(i) and I(ii) below show the caller frequency in 2013/14 and 2014/15. The majority of callers (72% in 2013/14 and 70% in 2014/15) make only 1 or 2 calls. As in previous years there is a very small proportion of clients (2.6% in 2013/14 and 3.2% in 2014/15) making more than 30 calls each, with 0.9% in 2013/14 and 1% in 2014/15 making over 100 calls each. It is evident however that a very small number of callers make the highest demand on the service. In 2013/14, 80 clients made just under half (46%) of all active calls (24,484 calls). In 2014/15 however, there have been signs that this pattern appears to have been managed to some extent. The last half of 2014/15 saw considerable change in the frequent caller activity, coinciding with the introduction of the additional measures to ensure appropriate management of frequent callers.

Figure I(i): Percentage of clients and the number of calls they made(2013/2014)

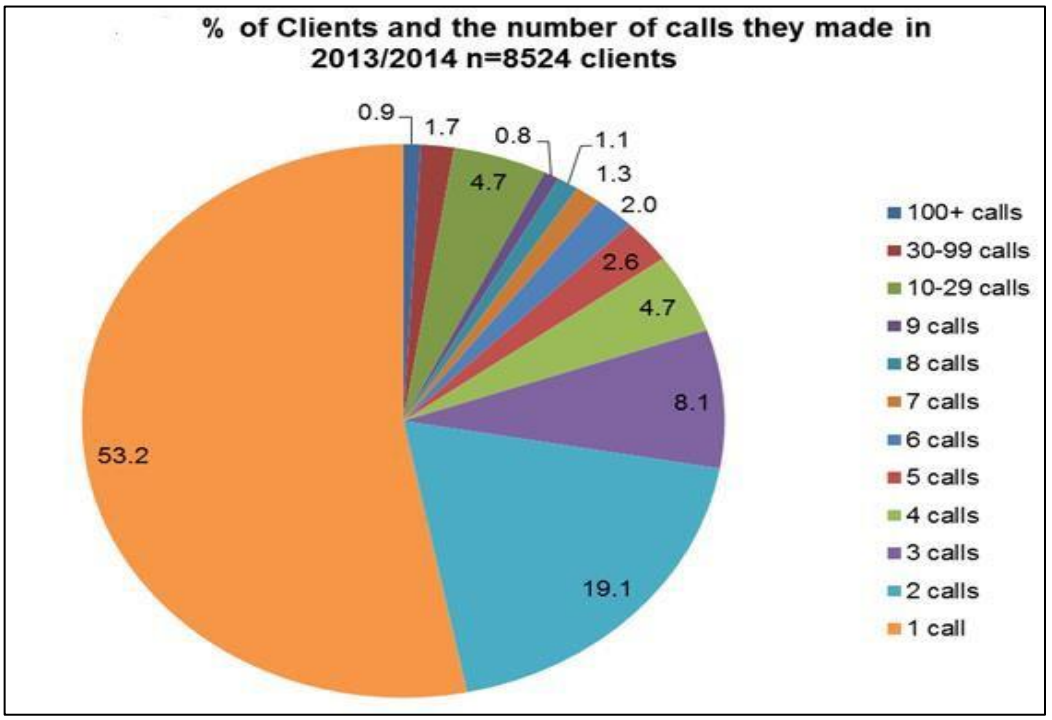
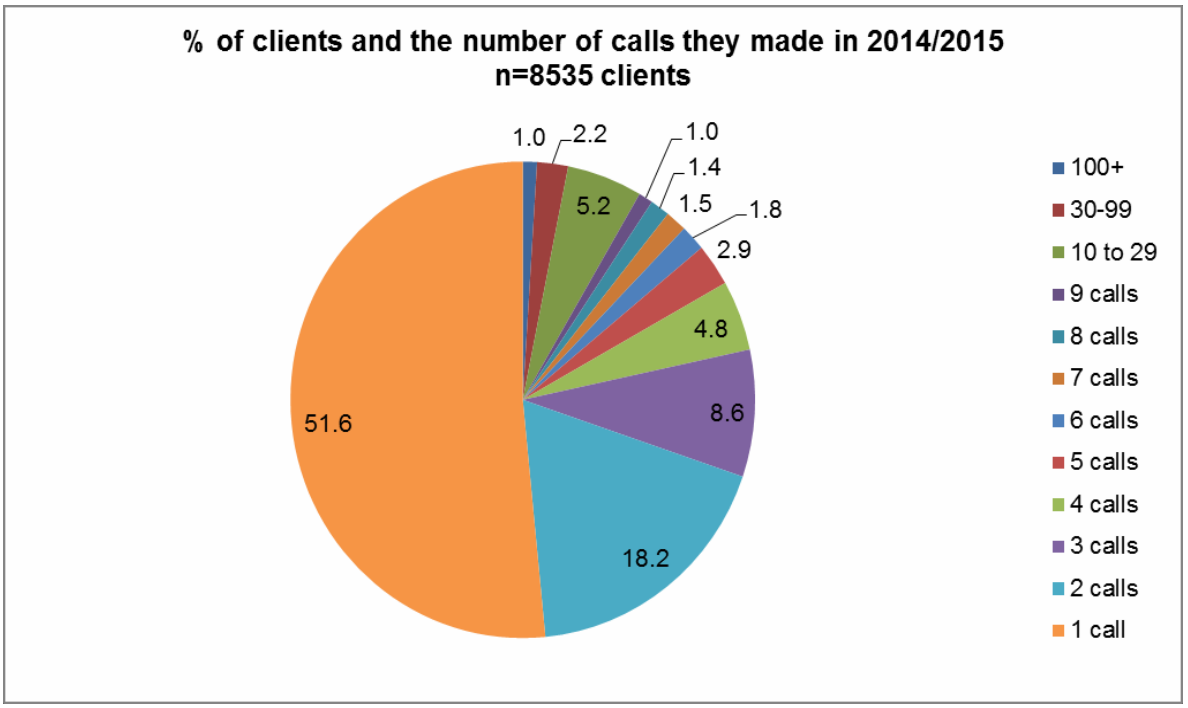


Figure I(ii): Percentage of clients and the number of calls they made(2014/2015)



The pattern for average number of calls received and answered (excluding missed or abandoned calls) by day of the week and by hour has remained fairly constant over the last two years. The average number of calls remained approximately equivalent between Monday and Friday, with a slight decrease on Saturday (Figure J below). In addition looking at activity by hour of the day (Figure K) answered inbound calls are at their lowest between 5 - 8am and highest between 3 – 5pm.

Figure J: Average number of calls by day of the week (April 14- March 15)

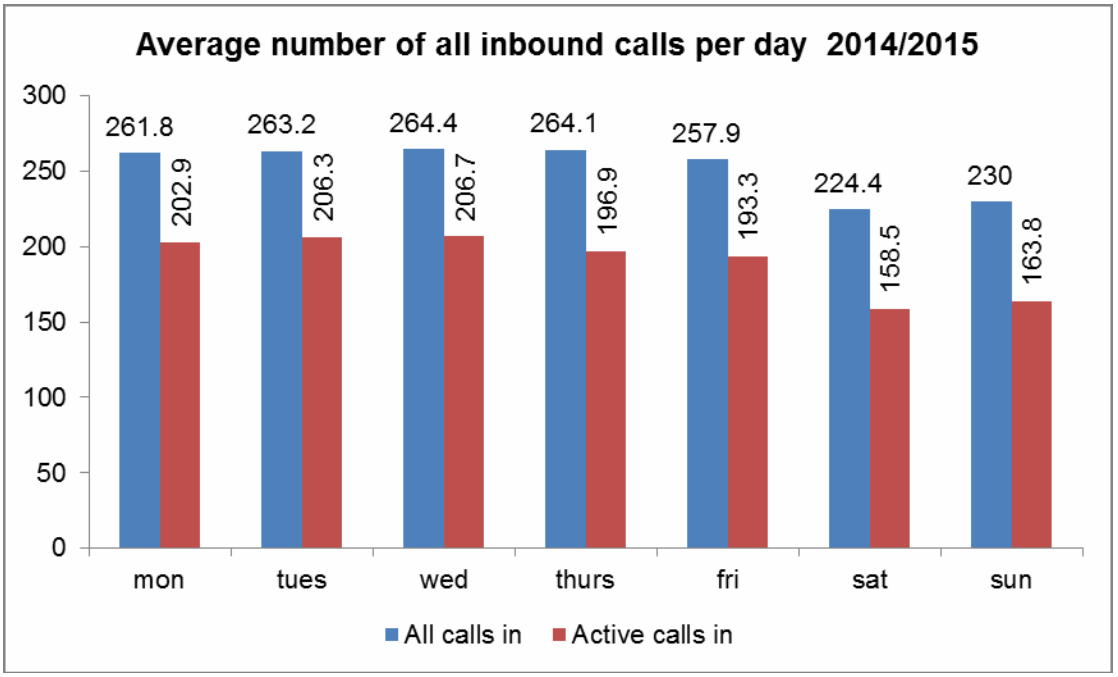
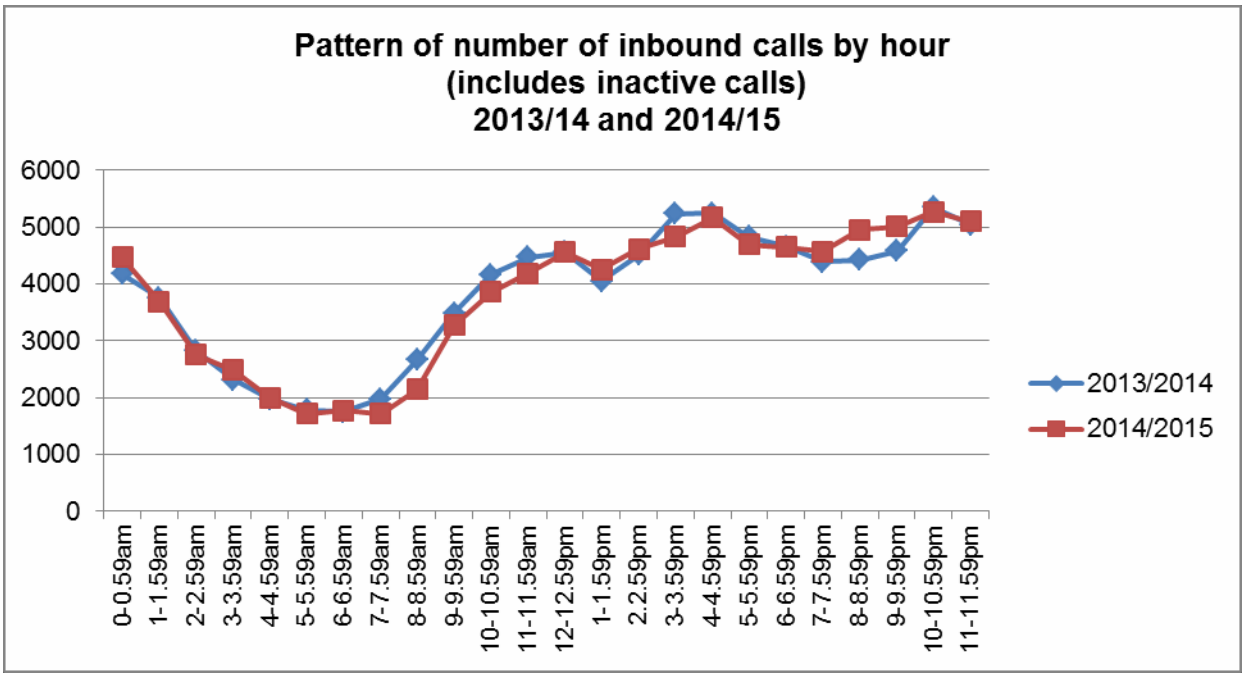


Figure K: Pattern of all inbound calls by hour 2013/14 and 2014/15.



The pattern of demand illustrates the need for a 24/7 helpline.

A further indicator of when individuals are vulnerable and at risk of self-harm and/or suicide is the patterns of presentations for self-harm to the Emergency departments as reported in the NI Self Harm Registry. Demand actually increases late night/early morning and at weekends rather than declines (see figures L(i) and L(ii) below).

Figure L(i): Number of self-harm presentations to emergency departments by day 2012/13 and 2013/14 (NI Self Harm Registry)

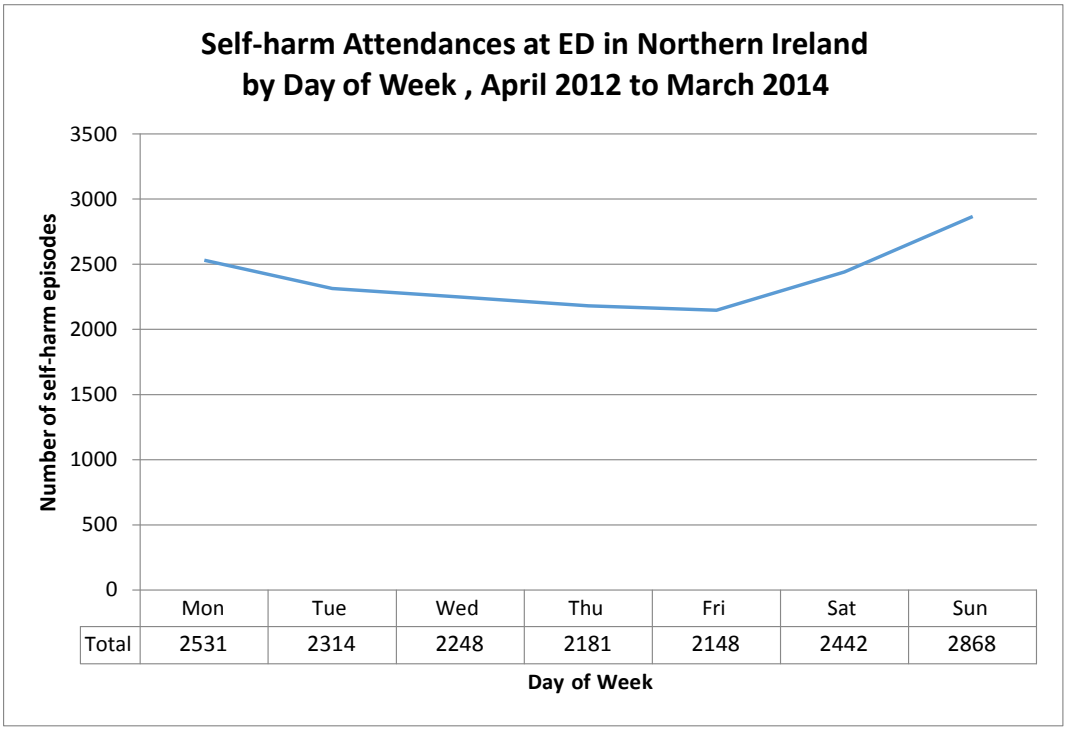
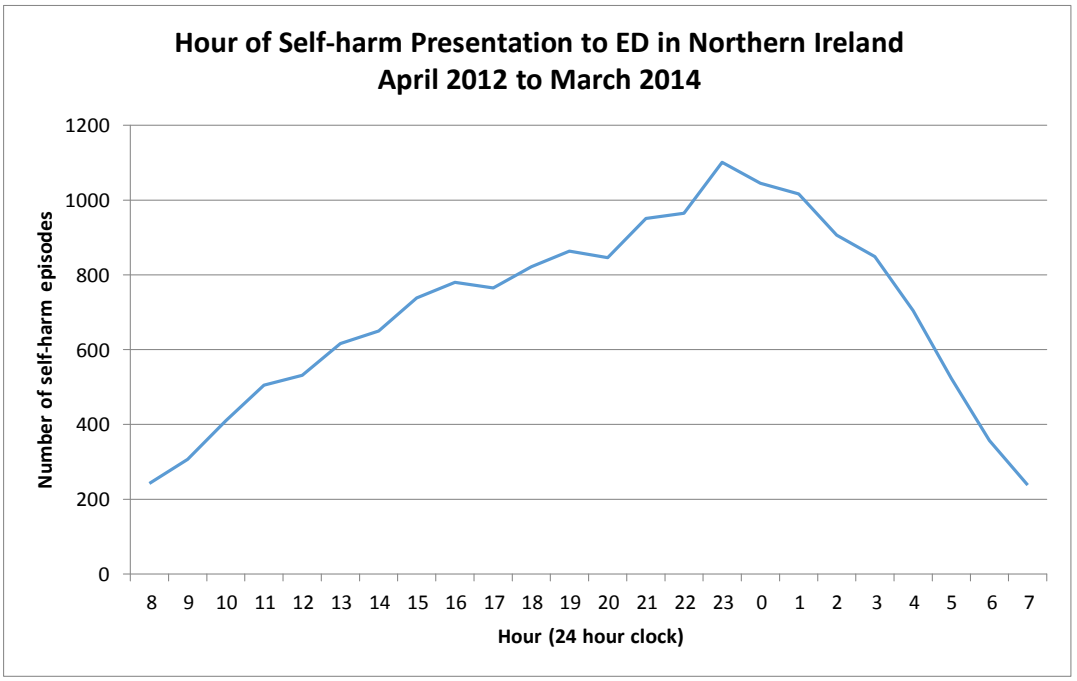


Figure L(ii): Self-harm presentations to emergency departments by time of attendance, NI, 2012/13 and 2013/14 (NI Self Harm Registry)



Of the 75% 'active' calls to the Lifeline service received during 2014/15, the majority (64%) were classified by the service provider as 'follow on Lifeline support' (i.e. referred back into the Lifeline telephone service). Emergency calls comprised less than 1%.(figure M(i) and M(ii) below show the figures for 2013/14 and 2014/15)

Figure M(i): 'Nature of active calls into Lifeline % April 2013 to March 2014.

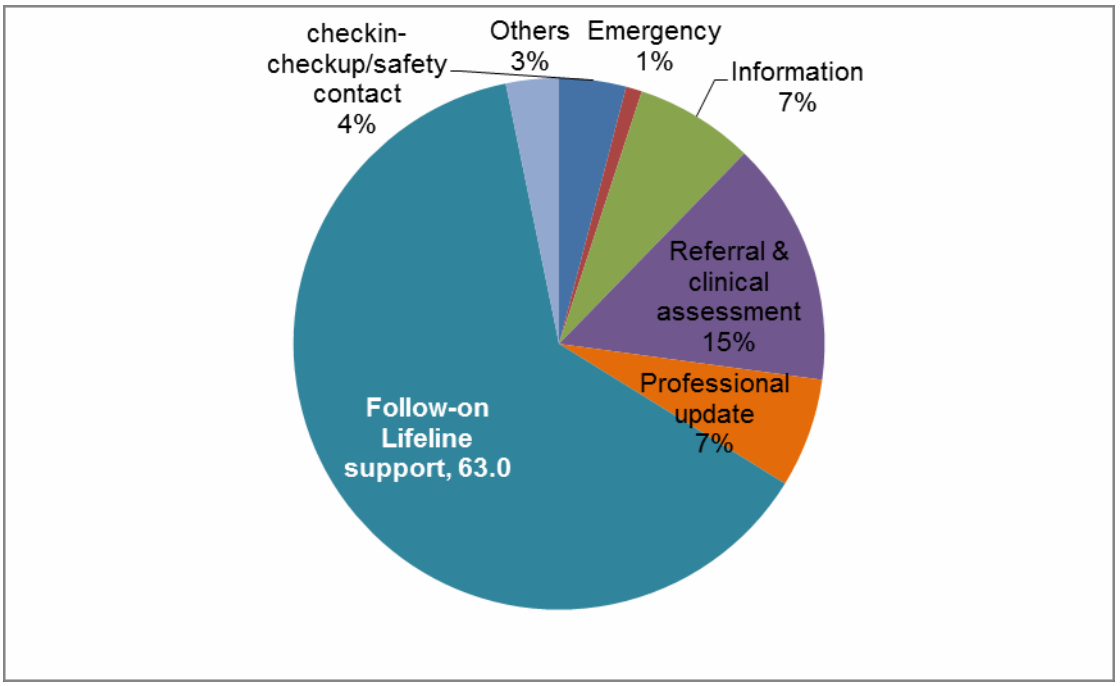
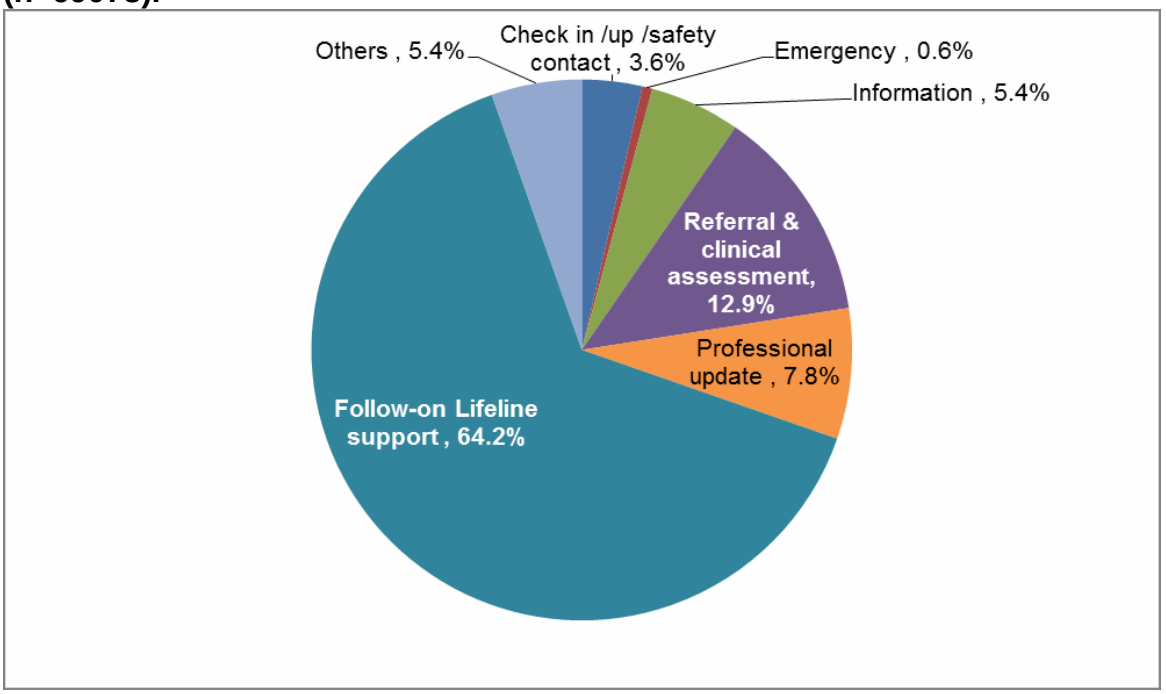


Figure M(ii): 'Nature of active calls into Lifeline % April 2014 to March 2015 (n=69078).



It should be noted however that 'follow on support' decreased in the last quarter of 2014/15 to 42%.

The majority of calls from clients in both years were risk rated by the counsellor as 'medium':

Figure N: Percentage of calls at each risk level for 2013/14 and 2014/15

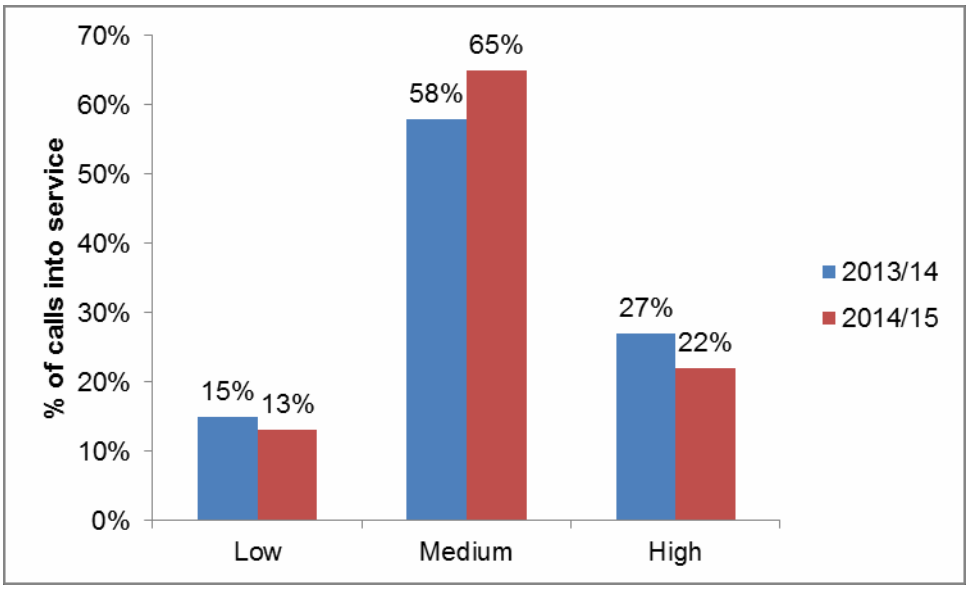


Table 2 below shows that the majority of calls are made directly by clients, (75% in 2012/13, 78.8% in 2013/14 and 79.6% in 2014/15), however a number of calls are received from a 'third party' caller (14.7% of total calls in 2012/13, 13.6% in 2013/14 and 13.3% in 2014/15)

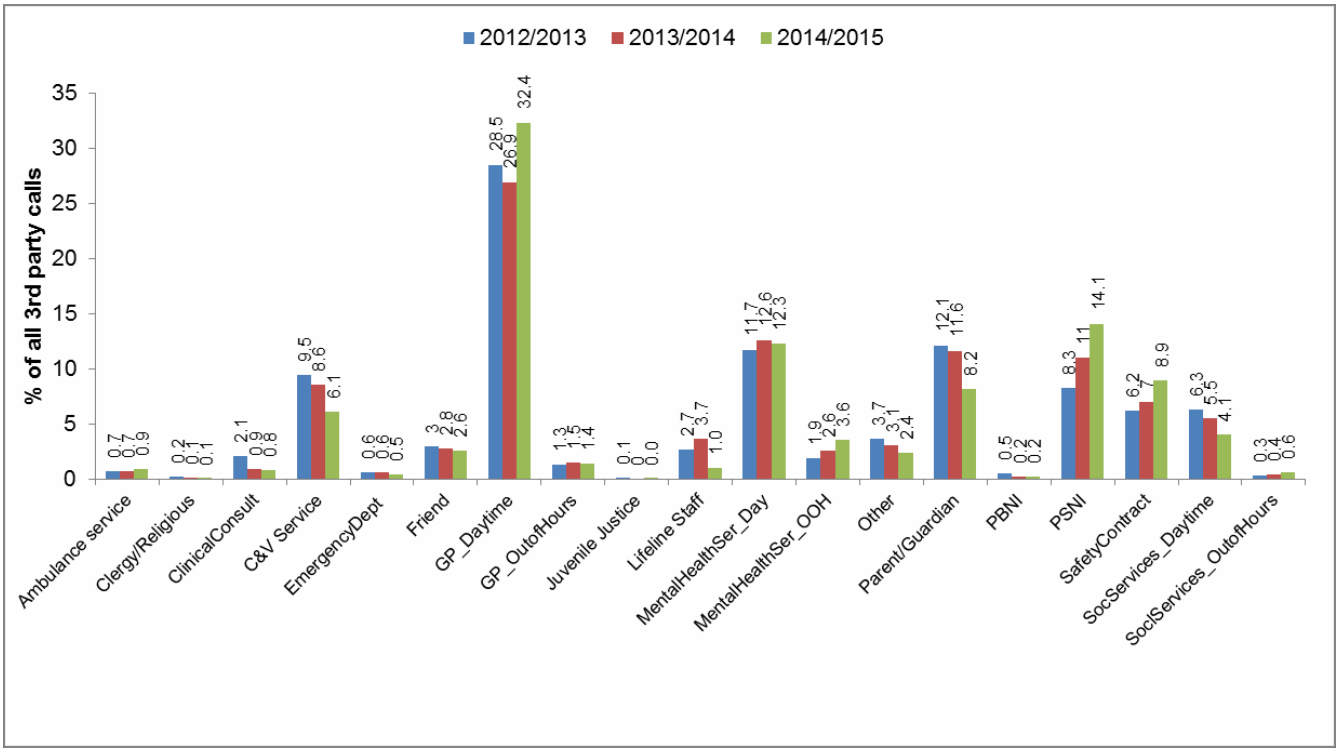
Table 2: Number of callers by source 2012/13 – 2014/15

Table 2	2012/2013 (n=53013)			2013/2014 (n=67754)			2014/2015 (n=69078)		
	No of callers	No of calls	% of total calls	No of callers	No of calls	% of total calls	No of callers	No of calls	% of total calls
Clients	6818	39728	75	8524	53344	78.8	8535	54915	79.6
3rd party	3698	7769	14.7	4601	9228	13.6	4151	9223	13.3
'other'	Unknown*	5516	10.3	Unknown	5182	7.6	Unknown	4940	7.1

*Unknown – we know the number of calls where the caller is categoriesed as 'other but as these calls are not allocated to an individual we cannot count how many people actually made the calls (5.g. 5516 not necessarily 5516 individuals as there may be repeat callers).

Figure O shows that the majority of third party callers each year, were from GP (daytime), followed by daytime mental health services, parent/guardian, the PSNI and the community and voluntary sector.

Figure O: % of types of third party callers per year.



The majority of calls from third party health service callers were from the Belfast and South Eastern Trust areas (see figure P).

Figure P: Third party HSC call rate per 100,000 population by Trust area.

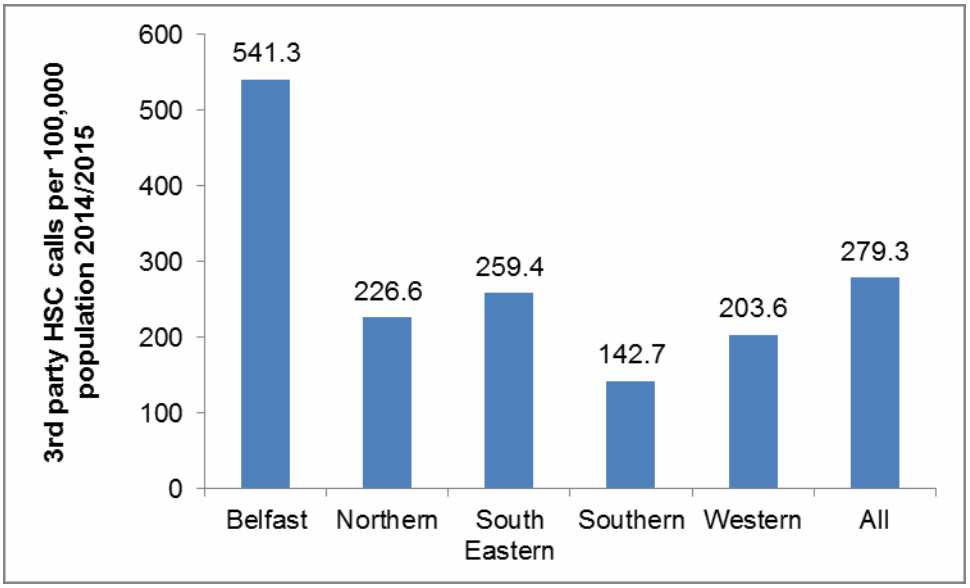
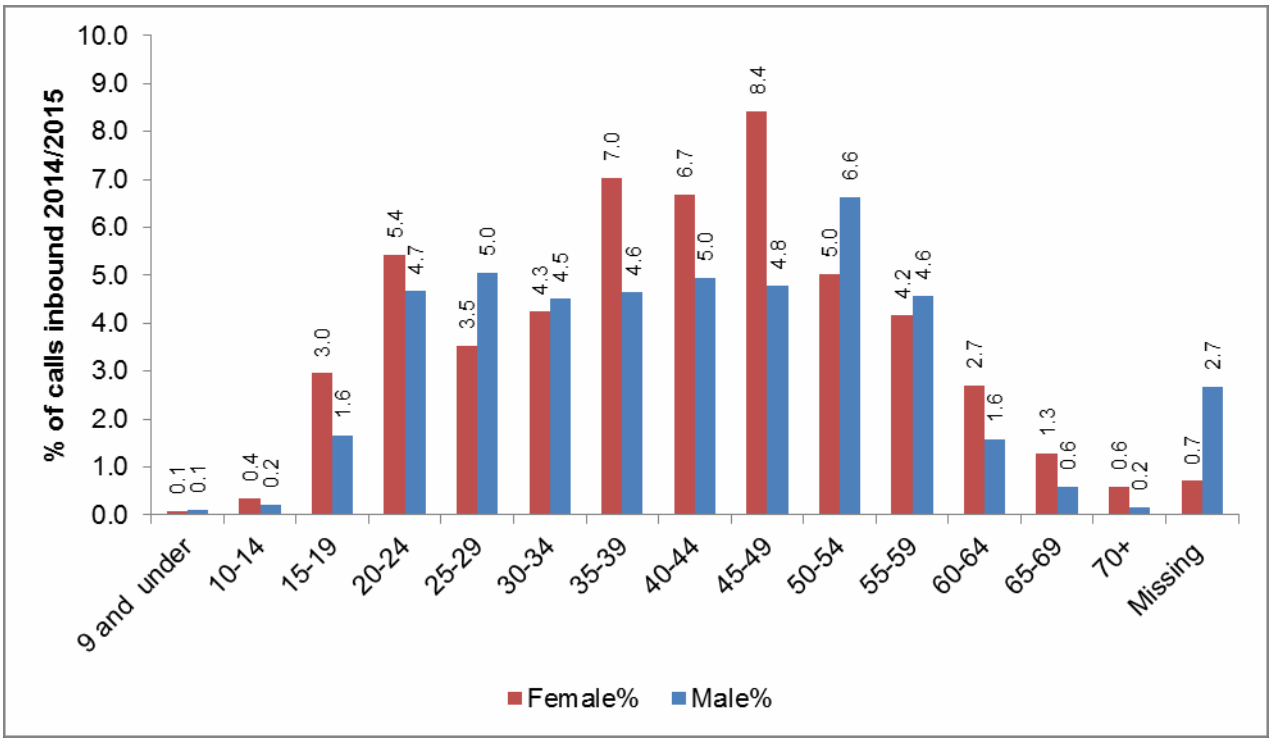


Figure Q below shows the distribution by age and gender of all callers into the service in 2014/15. A higher proportion of calls are received from females than

males. Females aged 45-49 are the highest frequency caller group (8.4% of all calls are from this group).

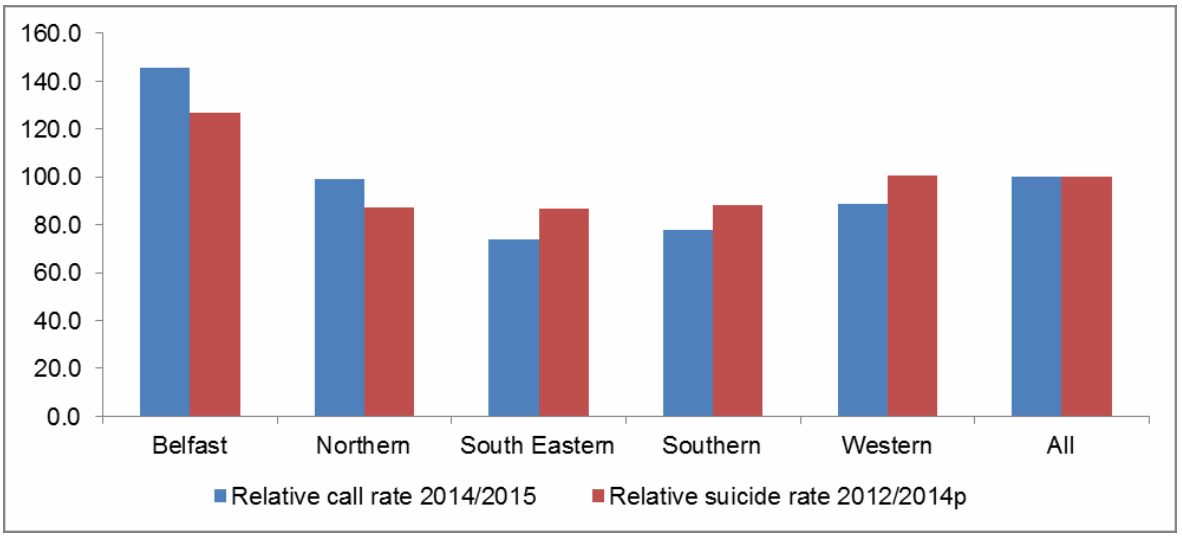
Figure Q: Gender & Age distribution (%) of all calls from 'clients' and 'Third party' callers 2014/2015 *(calls where gender was recorded n=63307)*



When compared to suicide rates (figure B page 13), it is apparent that those most at risk (i.e. males, and particularly males between 25 and 34 years) are less likely to access the current service.

A comparison of relative call rates and relative suicide rates showing how each Trust area compares with the NI average shows that Belfast has the highest call rate reflecting the higher level of suicide in this area. While Belfast and Northern Trust areas have call rates higher relative to their suicide rates, South Eastern, Southern and Western areas have call rates lower that their level of need.

Figure R: relative call rate and relative suicide rate by Trust area (calls 2014/15)

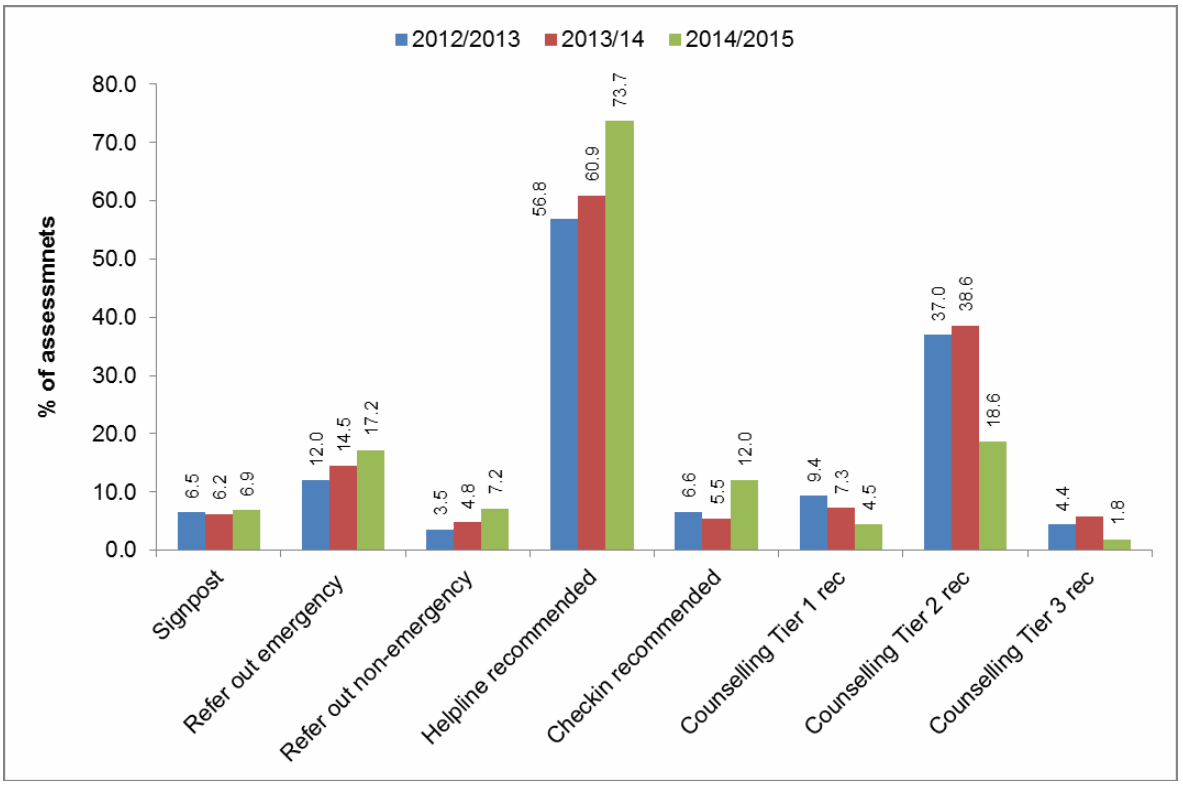


Lifeline Follow on activity

Data downloads from the service provider show that during 2012/13, 9,673 assessments were conducted on 7,251 clients; rising to 13,445 assessments for 10,192 clients during 2013/14, with a further rise to 13,658 assessments carried out on 9,657 clients during 2014/15.

During the three years 2012/13 to 2014/15 “helpline recommended” was the most frequent counsellor assessment outcome recommended. Emergency referral was recommended in 12-17% of the assessments (mostly to PSNI and ambulance service). “Signposting” was recommended in less than 7% of the assessments.

Figure S: Recommended actions for clients assessed each year of contract 2012/13 – 2014/15



During 2012/13, 21,554 counselling sessions were attended by 4,434 clients, increasing to 30,742 sessions by 6,364 clients in 2013/14 (table 3). The average number of sessions attended per client each year was 4.8, with 15% exceeding the standard package of 6 sessions[30]. The number of clients receiving Lifeline wraparound counselling has reduced significantly during 2014/15, with the average number of sessions and number of clients exceeding 6 sessions also falling, as set out in table 3 below.

Table 3: Number of Clients and Counselling sessions 2012/13 and 2013/14

	No of sessions attended	No of clients	No of session per client - range	Average number of sessions	No of clients (%) exceeding 6 sessions
2012/2013	**21554**	**4434**	**1-29 sessions**	**4.8**	**600 (14%)**
2013/2014	**30742**	**6364**	**1-63 sessions**	**4.8**	**936 (15%)**
2014/2015	**15474**	**3681**	**1-54 sessions**	**4.2**	**196 (5%)**

[30] The contract KPI for packages exceeding 6 sessions is <5%

Table 4: Counselling (number of sessions and clients) by Trust area

Trust		2012/13	2013/14	2014/2015
Belfast	No of clients	1,376	1,850	1149
	No of sessions	6,515	8,765	4770
Northern	No of clients	1,204	1,904	979
	No of sessions	6,000	9,523	4100
South Eastern	No of clients	858	1,222	848
	No of sessions	4,335	5,702	3538
Southern	No of clients	440	526	329
	No of sessions	2,078	2,633	1328
Western	No of clients	461	722	403
	No of sessions	2,146	3,474	1602
Unknown/other	No of clients	95	140	33
	No of sessions	480	645	136

Figure T(i) Number of clients attending counselling by Trust area 2012/13 – 2014/15

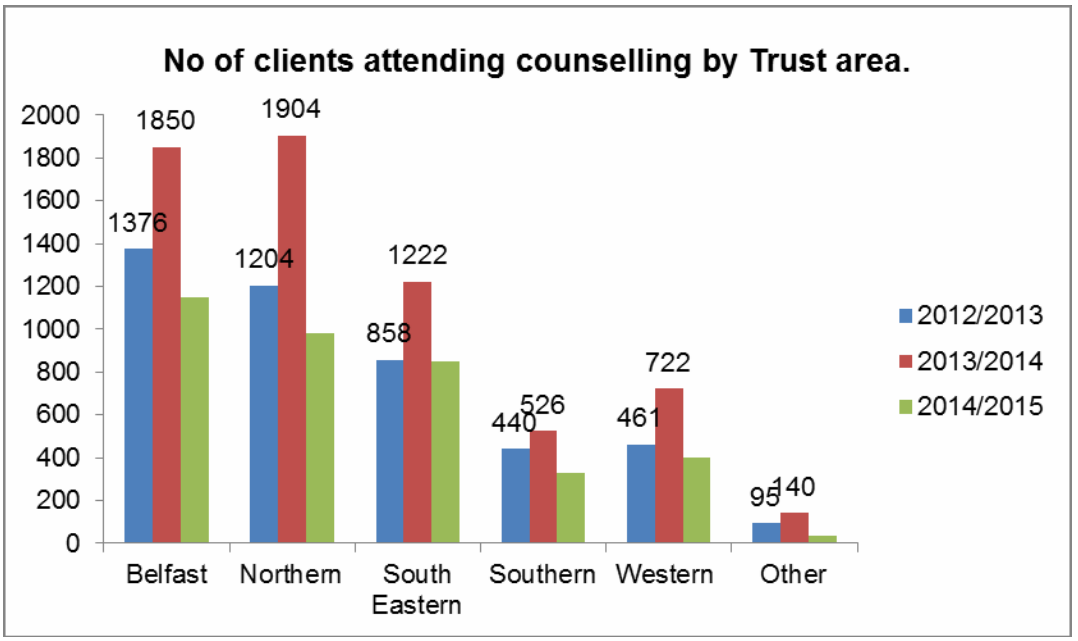
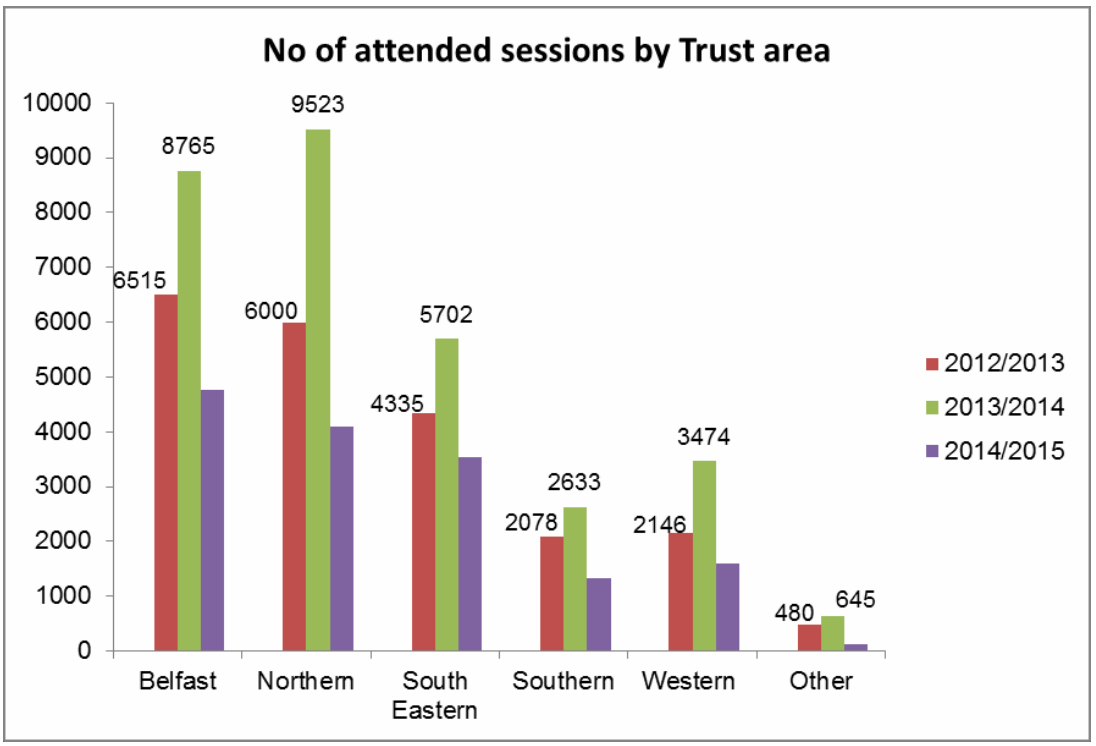


Figure T(ii) Number of sessions attended by Trust area 2012/13 – 2014/15



Children and young people using Lifeline

In the year April 2013 to March 2014 calls from under 17's or in relation to under 17's (i.e. made by third party callers) accounted for 3.4% of all clients and third party calls into the service or 3.1% of all calls into the service. This number decreased in the year April 2014 to March 2015, with calls from under 17's or in relation to under 17's accounting for 2.3% of all client and third party calls into the service, or 1.6% of all calls into the service. Tables 5(a) and 5(b) below show the number of calls in at each age (age 3 to 17) by third party and clients during the two years.

Table 5(a) – Number of Calls to Lifeline (2013/2014) in respect of children aged 17 or less

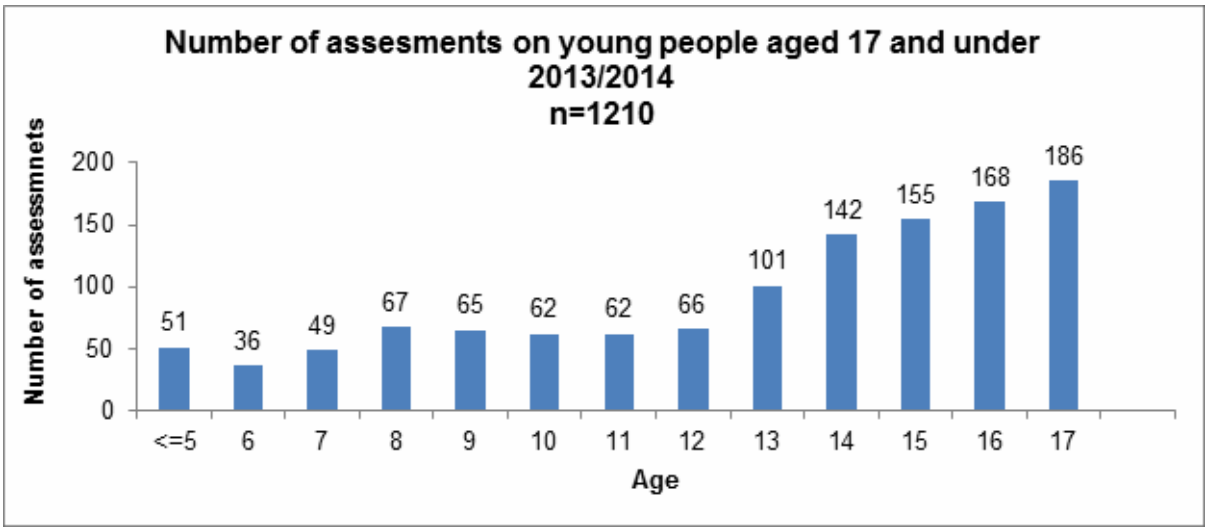
Number of calls in **(April 2013/March 2014) by AGE (years)**									
	≤10	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**Total**
3rd Party calls	430	80	109	109	200	219	232	206	1585
Client calls	22	5	9	21	69	113	142	192	573
Total calls	**452**	**85**	**118**	**130**	**269**	**332**	**374**	**398**	**2,158**

Table 5(b) – Number of Calls to Lifeline (2014/2015) in respect of children aged 17 or less

Number of calls in **(April 2014/March 2015) by AGE (years)**									
	≤10	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**Total**
3rd Party calls	147	28	57	73	80	134	135	149	803
Client calls	20	10	12	39	63	111	118	336	709
Total calls	**167**	**38**	**69**	**112**	**143**	**245**	**253**	**485**	**1,512**

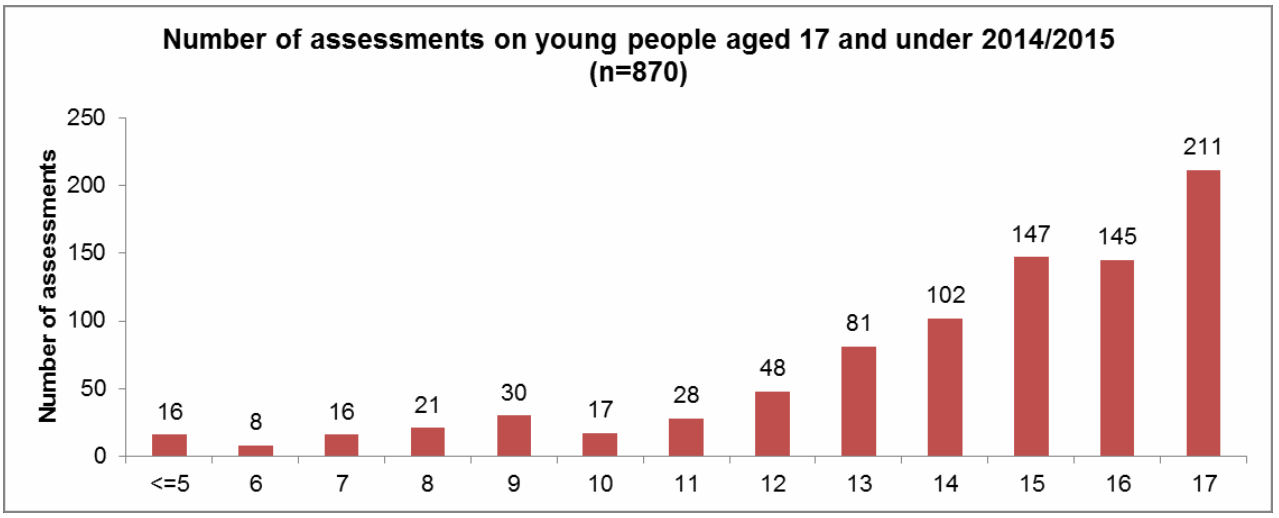
Between April 2013 and March 2014, 1,210 clients aged 17 and under were assessed, while 870 clients aged 17 and under were assessed during 2014/15. It should be noted that in respect of children under 15 the overwhelming majority accessed the service through their parent/guardian being the initial service user and the assessment of the child was linked to family support interventions provided by Contact.

Figure U(i): Number of assessments on clients 17 and under assessed in 2013/2014 (n=1210)*



*Please note DOB not available for all clients. Also only run for clients who have completed comprehensive risk assessment date filled.

Figure U(ii): Number of assessments on clients 17 and under assessed in 2014/2015 (n=870)*



*Please note DOB not available for all clients. Also only run for clients who have completed comprehensive risk assessment date filled.

Following assessment, just under 71% were recommended for face to face counselling (including creative and play therapy) during 2013/14. (It should be noted that creative and play therapy were not part of the original contract specification and only permitted on a pilot basis to try to create an evidence base for their effectiveness.) Following assessment in 2014/15, 30% were recommended counselling, 8% signposted and 80% helpline recommended.

A wide range of main presenting issues are identified, including anger, anxiety, family breakdown and depression. The numbers by age range with the main presenting issue being self-harm, suicidal ideation or suicide intention is as follows:

Table 6(a): Number of clients assessed in 2013/14 aged 17 and under where suicide/self-harm was identified as a main issue.

Age band	Suicidal bereavement	Suicidal ideation	Suicidal intention	Self-harm	Other issues	Total no of clients assessed*
4 & under	0	0	0	0	24	24
5 – 11	<5	20	<5	16	326	368
12 – 15	<5	61	<10	92	302	464
16 & 17	<5	63	<5	47	240	354
TOTAL	<10	144	12	155	892	1210

*clients where comprehensive risk assessment date was filled

Table 6(b): Number of clients assessed in 2014/15 aged 17 and under where suicide/self-harm was identified as a main issue.

Age band	Suicidal bereavement	Suicidal ideation	Suicidal intention	Self-harm	Other issues	Total no of clients assessed*
4 & under	0	0	0	0	9	9
5 – 11	<5	17	0	<10	101	127
12 – 15	<5	83	<5	106	184	378
16 & 17	<5	107	<10	60	178	356
TOTAL	<10	207	11	174	472	870

*clients where comprehensive risk assessment date was filled

In both 2012/2013 and 2013/2014 around 17% of all those who attended counselling were young people aged 17 and under, compared to only 3.4% of incoming client and third party calls relating to those aged 17 and under. The proportion of children attending counselling has however fallen significantly in 2014/15 to 9.4%.

Table 7: Children in counselling 2012/13 and 2013/14

	Total number of clients who attended counselling	Total number of young people age<= 17 who attended counselling	% Counselling clients aged 17 and under
2012/2013	4,434	765	17.3%
2013/2014	6,364	1,053	16.5%
2014/2015	3,741	352	9.4%

3.4 Pre Consultation Engagement

The PHA issued a public consultation to inform the future procurement of the Lifeline crisis response service on 1 April 2014 which closed on 24 June 2014. A copy of the full report is available on the PHA website (www.publichealth.hscni.net)[31].

The main findings from the consultation responses are summarised below:

A total of 154 responses were received by the PHA during the consultation period. Eight of the responses were received from respondents outside of Northern Ireland which were reported on separately and the Department of Justice sought a separate meeting on the issue of a crisis helpline rather than completing the standard questionnaire.

Of the 146 responses received from within Northern Ireland; 57 were from individuals, 66 from Community and Voluntary organisations, 13 from Health & Social Care organisations, six from another statutory body and four 'other'. Two thirds (n=97) of the respondents had direct experience of Lifeline.

Almost three quarters of respondents (73%) felt that the service had a beneficial effect with 17% of respondents indicating that they were unsure as there was no clear evidence base with which to make an informed decision. The benefits cited by respondents included; 24/7, accessible, responsive, free, confidential, signposting and de-escalation. Some respondents noted the benefit of long term support and a check-in service while others cited the importance of promoting empowerment and enabling recovery.

Over half of respondents (n=86) stated the service should be retained as a telephone helpline service with short term counselling support (in terms of those who had experience of the service, just over half (n=55) indicated that the service should be retained in this way.) There was however general agreement that continuous change was necessary to ensure the service provided was efficient and responsive. There were a number of suggestions for change; these have been considered as part of the SOBC development process, and where feasible incorporated into the proposed future service model.

[31] Public Consultation report available at: http://www.publichealth.hscni.net/publications/lifeline-consultation-report-%E2%80%93-summary-feedback-public-health-agency%E2%80%99s-public-consultat

The suggestions included:

- Lifeline interventions should be evidence based;
- The Helpline should also utilise emerging technologies;
- Separate the Helpline and counselling elements of the Lifeline service
- Lifeline service should be responsive to and link with other future emerging developments;
- Evaluation of clinical impact important;
- The Lifeline service should be informed by community and voluntary sector and service user representatives;
- There should be working protocols with emergency services.

A number of suggestions were considered to be outside the scope of the Lifeline service, including:

- Creation of a separate standalone service for the prison population;
- Provision of physical safe places under Lifeline;
- Lifeline to be a referral pathway into HSC mental health services;
- Operate the helpline only outside 9 – 5 office hours;
- Further develop and extend the Lifeline service to cover the Republic of Ireland and all of the UK;
- To provide family assessment and/or therapy;
- To provide a check-in and outreach service

Further detail is provided in Appendix 2.

It was noted that respondents considered that interventions provided through the Lifeline service should be evidence based and provide immediate de-escalation (n=133) and comprehensive risk assessment (n=125) within the context of a short term rapid response and not duplicate existing provision. While it was acknowledged that a number of other interventions were beneficial these were for the longer term and were not appropriate within the context of a short term rapid response service.

Some respondents indicated that the existing Lifeline service had expanded beyond the original objectives, with insufficient partnership working arrangements particularly with more locally based services. It was suggested that there should be a refocus on crisis intervention with Lifeline prioritising those in greatest need. There was concern regarding the answered call rate, limited access to counselling in rural communities and lack of mechanisms with which to monitor clinical impact.

Effective interpersonal skills of the call operators and counsellors were noted as vital. There were differing opinions as to whether the call handers should be care professionals; however there was general agreement that call operators should be appropriately trained and that all counsellors delivering Lifeline counselling should be qualified to diploma level and working towards accreditation.

3.5 Conclusion

It is clear that there is a continuing need for crisis support services to help reduce the rate of self-harm and suicide in Northern Ireland. The pre-engagement consultation results highlight the consensus of opinion that a helpline and support services should be continued.

There are aspects of the current model that work well and should be maintained as the foundation for any future model, in particular the existence of a regional, 24/7 suicide and self-harm prevention helpline. The level of empathy, compassion and support call operators provide, including the process of immediate referral to emergency services when necessary, ability to undertake a risk assessment, skills in de-escalation and signposting of callers on to existing services and the provision of support services to address the immediate crisis of individuals at risk of self-harm and/or suicide are also recognised as important features to maintain.

In shaping the Lifeline service for the future, the PHA wants to ensure that the service represents high quality care that:

- is centred on the individual and their needs
- ensures clients are in control of managing their own condition
- ensures clients will always be treated with compassion, dignity and respect

- gives clients the best possible intervention in the most appropriate setting, and fully supports recovery
- reflects clients' preferences and where the feedback provided is acted upon

Another key aspect is that the Lifeline brand should be protected and continue with a separate marketing budget to promote public awareness across NI.

The primary focus of the service needs to be clear, as a short term intervention service for people in crisis and at risk of self-harm and/or suicide and which provides support which the individual cannot or will not access elsewhere. In line with the evidence supporting a recovery approach (see section 2), the Lifeline service ethos should be an enablement and empowerment approach, with a service model that will not foster dependency.

While the Lifeline helpline should remain available to all the population the service should be enhanced to reduce barriers to engagement for those identified at highest risk, especially those higher risk groups, such as young males, as identified in this section.

Suicide and self-harm prevention is a shared responsibility between statutory, voluntary, community groups, communities and individuals[32] which requires a coordinated comprehensive range of appropriate initiatives to address their needs. The data analysis has shown that currently only a small number of children have received follow on support from the current service. Given the specialist nature of children's services, and the existing specialist Child and Adolescent Mental Health Services (CAMHs) the proposed future Lifeline service should not duplicate existing care pathways and services. This is also assessed in the equality screening (see appendix 5).

The PHA is tasked with commissioning services which build community capacity, promote choice and support the development of sustainable communities [33] [34]. Sustainability includes introducing measures such as restricted "lotting" to promote

[32] DHSSPS. Mental Health Service Framework. Available at: http://www.dhsspsni.gov.uk/sqsd_service_frameworks_mental_health

[33] DHSSPS. Making Life Better. Available at: http://www.dhsspsni.gov.uk/making-life-better

[34] World Health Organisation. Health 2020. Available at: http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being

competition in the market place. The enhancement and broadening of the range of support services will build capacity and accessible within local communities.

Using the term 'evidence based [35] and evidence informed' to describe Lifeline support services will ensure that these services can adapt to emerging research on what works. Research is the foundation of evidence based practice and is given precedence in policy documents.[36] The PHA recognises the importance of robust Lifeline data which can be used to provide evidence to inform practice, see section 4.

While the difficulties of predicting future levels of activity for a demand led helpline are recognised, it is not expected that the call demand to the helpline should increase over the next 3 years, given that the 3 year suicide rate is steadying (at just over 15 per 100,000 in the last 8 years). Although it is recognised that the rates of attendance at Emergency Departments for self-harm and suicide ideation has increased by about 6% over the last 3 years, these clients would be directly referred into existing Mental Health Services or the community based SHIP initiative. Therefore the current (2014/15) 'active call' demand will be used for planning purposes. Likewise, the number of Lifeline follow on support sessions in 2014/15 will be used for comparative costing purposes.

Overall the focus for the new service will be to strive to improve outcomes for service users and provide the commissioners with the necessary assurances that the service is focused on its primary aims and provides value for money. The following sections set out the specific objectives for the proposed future model, and options to meet these.

[35] Sackett, D. L., Rosenberg, W. M. C., Muir Gray, J. A., Haynes, R. B. and Richardson, W. S. 1996. *Evidence based medicine: what it is and what it isn't*. British Medical Journal, 312, 71-2.

[36] DHSSPS.2012. Improving outcomes through research and development.

4. OBJECTIVES AND CONSTRAINTS

The previous sections show the continuing need and particular requirements for a suicide prevention helpline for those at immediate risk of suicide, self-harm or homicide/suicide, (see appendix 3) with access to appropriate services.

The proposal set out in this business case seeks to address these issues, by commissioning a Lifeline Helpline along with a range of appropriate follow on support services which are evidence based/informed, building on the learning and evidence from existing services in Northern Ireland and experience and best practice from elsewhere.

4.1 Aim

The overarching aim of the Lifeline crisis intervention service, as an integral element of the Protect Life strategy, is to help reduce the number of deaths as a result of suicide and the number of incidents of self-harm in Northern Ireland, through enabling access to appropriate services for those at immediate risk of suicide, self-harm, or homicide/suicide.

4.2 Objectives

The objectives of the Lifeline service are as follows:

	Objective/description	Description and Measures
1	The Lifeline crisis helpline service will provide, through a single point of access, an accessible, effective and timely response for all callers in Northern Ireland at immediate risk of suicide or self-harm, or homicide/suicide.	• 24/7, 365 days/year operation of the Lifeline telephone number; • 100% calls to be answered within 30 seconds (no missed calls); • Use of new technologies (eg texts, apps, social media etc) to reach key groups (eg young adults, disabled etc) as agreed with the commissioner; • Helpline Service to be accessible to ALL people in NI irrespective of, age, geography, and including access for prison population
2	The Lifeline crisis intervention service will provide a virtual safe place for those at immediate risk of suicide, self-harm, or homicide/suicide in NI.	• Access to triage and, where appropriate, assessment, de-escalation, referral to emergency services and or signposting, at the point of immediate risk of suicide, self-harm, or homicide/suicide);

3	The helpline will immediately triage and assess individual clients to de-escalate, refer to emergency services and provide advice and signpost to appropriate evidence based and evidence informed services	◊ All clients to be triaged at point of *first* call; ◊ All appropriate callers to be risk assessed at point of first call; ◊ All clients at immediate risk of suicide, self-harm or homicide/suicide, to be de-escalated, with immediate referral to appropriate emergency services, where appropriate; ◊ All clients not at immediate risk of suicide, self-harm or homicide/suicide, to be provided with advice and signposted to other appropriate services; ◊ Clients under 18 years of age not suitable for the service to be referred to GP/Trust Gateway Service (Family and Child Care) ◊ Facility whereby in exceptional circumstances vulnerable clients (see service model) may be connected with the appropriate service (applicable to maximum 5% total callers)
4	The Lifeline crisis intervention service will encourage empowerment and enablement for those who contact them.	◊ Provision of signposting information for those not at immediate risk, to empower and enable them to take control of their own actions; ◊ System/protocols in place to manage frequent callers
5	Provision of a range of appropriate evidence based and evidence informed interventions, which promote empowerment and self-management, to which callers to the Lifeline helpline can be signposted	◊ Availability of range of appropriate evidence based/informed interventions, through 'Lifeline' , i.e. Community Based Psychological Therapies (primarily counselling with limited non-invasive complementary therapies where appropriate); ◊ These interventions will be available for clients under the age of 18 years of age where risk assessment indicates that this service is appropriate. ◊ Services available and accessible across all NI; ◊ Signposting to other appropriate services not funded through 'Lifeline' budget.
6	Provision, by exception, should be made to enable those individuals at immediate risk of suicide or self-harm who may find it difficult to make the initial	◊ suitable provision for face to face de-escalation by exception; ◊ Service available and accessible in each LCG/Trust area.

	contact with the helpline service by telephone, to make initial face to face contact with appropriate services.	
7	The Lifeline crisis intervention service will develop close links, and will work in partnership, with relevant HSC organisations (including primary care), other statutory organisations and voluntary and community groups.	◊ Appropriate agreed referral protocols to the emergency services (primarily NIAS, PSNI and Prison Service); ◊ Evidence of signposting to appropriate services from voluntary & community or statutory organisations across NI, including appropriate access for people living in rural areas ◊ Establishment and maintenance of up to date database of relevant organisations and services to which callers can be signposted.
8	The Lifeline crisis intervention service will ensure effective corporate, clinical and social care governance arrangements are in place and maintained	◊ Lifeline providers to use recognised assessment standards as agreed with the HSC and compatible with standards used elsewhere in HSC. ◊ Staff appropriately qualified and trained, commensurate with the nature of the service (helpline and evidence based/informed interventions), with sound supervision and management arrangements; ◊ The service will have documented arrangements for dealing with Serious Adverse Incidents (SAIs) and complaints, in line with HSC requirements and guidance; ◊ The provider will have robust documented information governance arrangements to ensure data protection (including policies and procedures for data protection and records management); ◊ Arrangements for agreed data sharing between helpline and evidence based/informed service providers, in line with information governance requirements; ◊ The provider will have robust financial controls; ◊ The provider will have robust performance management and governance arrangements; ◊ Establishment and implementation of Memorandums of Understanding with the Emergency Services [NIAS, PSNI and NI Prison Service]

		◊ Provision of robust, accurate and timely data (including activity reports, KPIs, and data extract download) to the commissioner as specified and agreed with the commissioner.
9	The Lifeline service will demonstrate value for money within the budget available	◊ Manage the level of demand within the budget available for the service; ◊ Minimum duplication with other services (statutory or voluntary & community); ◊ Provision of robust, accurate and timely data (including activity reports, KPIs, and data extract download) to the commissioner; ◊ Supports a sustainable market.
10	Timely introduction of new service at the end of the current contract period, with a smooth transfer	◊ The service should be developed, procured and in place no later than 1 October 2016 ◊ Timely and appropriate transition arrangements between the old and new service as appropriate.
11	Provision of an effective marketing and communication programme, which is responsive to suicide and self-harm trends in NI, and continues to raise awareness of the Lifeline service year on year.	◊ Annual marketing and communications plan agreed with PHA; ◊ Unprompted awareness of the Lifeline service to increase year on year and reach a minimum 40% level among the general public by 2018. (ref PHA Annual tracking of public awareness of Lifeline); ◊ Prompted awareness of the Lifeline service to reach 80% by 2018; ◊ Provision of targeted communications with key groups (agreed with PHA), eg young men, prisoners, people living in rural areas/more deprived areas etc; ◊ Strategic mix of a range of communications channels (including the use of new technologies) to communicate effectively with target audiences;

4.3 Service model and values

The core element of the Lifeline service is the Lifeline Helpline. This will be supported by a range of interventions, that may be recommended to callers, and which will be commissioned and procured at the same time as the helpline.

Helpline

- The Lifeline helpline is for those at immediate risk of suicide, self-harm or homicide/suicide;
- At first point of contact the helpline will provide a 'listening' service, rather than a formal counselling service;
- The helpline will risk assess and de-escalate clients at immediate risk of suicide or self-harm, referring on to emergency services (NI Ambulance Service, PSNI or where appropriate to NI Prison Service) if appropriate;
- The helpline will enable and empower service users to access the services they require through signposting, rather than acting as an intermediary;
- The helpline will however include the facility whereby in circumstances callers, for whom signposting only is not sufficient, may be assisted to connect to relevant services ('enhanced signposting'). This service will be predominantly directed towards, but not exclusively limited to a specific group of callers, eg. those with a learning disability, those where English is not their first language and people with a sensory impairment. It is anticipated that this would only be a small number of callers, estimated at no more than 5%.
- The enhanced signposting should also enable and empower those service users who, because of their vulnerability and/or disability, feel unable to directly access services. Although, in these limited circumstances, the helpline may directly contact services on the caller's behalf, this will only occur with the explicit consent of the caller, except where there is a safeguarding responsibility. It will be important that in those instances where callers are 'connected' to the relevant service/s that all steps are taken to give the callers the ability and confidence to directly access services themselves.
- Where appropriate, callers will be signposted to other relevant voluntary, community or statutory services;
- The helpline will be person centred, aiming to provide a positive client experience;

- The helpline will respond and, where appropriate, adapt to, service user feedback accessed where possible through direct service user involvement, with Commissioner agreement and direction as appropriate;
- The helpline will offer a service that is based on the best current evidence from research and practice.
- The Lifeline helpline is a free to call telephone helpline, however, it is recognised that there are new and emerging technologies, which will be more accessible and acceptable for some people (electronic forms of communication, eg apps, SMS, on-line chat rooms etc). The service provider will be expected to explore and utilise appropriate technologies, alongside the more traditional telephone helpline, in partnership with and seeking the approval of the Commissioner before introduction.
- The helpline will be accessible to ALL people in Northern Ireland irrespective of geography or age;
- Children and young people who phone the Lifeline helpline will be assessed. If deemed to be at minimal risk the caller will be signposted to other services. If deemed to be at low risk, suitably mature and it is clinically necessary, they will be offered Lifeline community support services. If deemed to be at high risk they will be referred to Gateway services. If deemed to be at immediate risk they will be referred to emergency services. All assessments will entail follow up with General Practice services.
- The helpline will operate 24/7, 365 days/year.
- The Lifeline helpline provider will be required to develop and maintain a database of relevant existing regional and local support services suitable for callers at risk of suicide, self-harm or homicide/suicide, and call operators will be able to signpost callers to these services (this would be directly linked to http://www.mindingyourhead.info);
- Once the primary care talking therapy hubs (see definition, Appendix 3) are operational the helpline should signpost through the hubs where appropriate.
- The provider should have active strategies in place to manage demand.

Provision should also be made for a face to face de-escalation and support service. It will provide an alternative access route in those exceptional circumstances where those at immediate risk of suicide, self-harm or

homicide/suicide, can make initial face to face contact with the service in the community. This element of the service would only be available to a small number of people who are unable to call the helpline and would therefore be a relatively small cost out of the overall budget, estimated at less than 5%.

In this model an individual may arrive at an appointed provider, who will:

- Provide immediate de-escalation and support the individual who is in crisis.
- If it is considered that the individual requires counselling from the Lifeline Community Based Psychological Therapies (LCBPT) service then they will be signposted to the Telephone Helpline for an appropriate assessment. The provider can also ring the Lifeline service on behalf of the individual if necessary
- If the individual is in immediate risk the provider can ring NIAS, PSNI or Crisis response team via the GP.

In order for this to be effective the service will need to have sufficient geographical coverage, across each of the five HSC Trust areas.

An element of protect life funding will also be used to commission additional specific follow on support services which are evidence based/informed, across all of Northern Ireland, to which callers may also be signposted to. These specific additional support services are covered within the scope of this SOBC, and are outlined below.

<u>Follow on support services which are evidence based / informed</u>

- Services commissioned should be based on and informed by the best evidence currently available.
- The evidence based/informed interventions will be in the form of Community Based Psychological Therapies (CBPT). (see definition in Appendix 3)
- In a small number of cases, the individual many not be ready to engage with CBPT. In these circumstances, the CBPT provider will also be able to offer up to a maximum of two sessions of non-invasive complementary therapies to support the individual deal with their current state of crisis and anxiety, and enable them to commence CBPT. Whereas the Royal College of Psychiatrist

highlight the lack of robust evidence on the effectiveness of complementary therapies they do acknowledge that many patients report they find them helpful in managing anxiety and depression.[37]

- These services will only be available to callers signposted from the Lifeline helpline following assessment (appropriate information sharing protocols will be put in place to facilitate and monitor this);
- Clients will be assessed to determine appropriateness for the service regardless of the outcome of the risk assessment by the helpline;
- Assessments and access criteria will be in accordance with HSC standards, and agreed by the commissioner;
- Potential service users considered not appropriate for this service will be signposted on to other more appropriate service(s);
- The Lifeline support services must be clinically safe, promote future sustainability and maintain client choice;
- They must be flexible enough to address the evolving needs in terms of any emerging new mental health promotion and suicide prevention strategy and commissioning priorities (eg the proposed primary care talking therapy hubs);
- The support services should be reserved for those at immediate risk of suicide, self-harm or homicide/suicide, and are subsequently deemed through risk assessment to be likely to benefit from the support services in terms of reducing their likelihood to complete suicide, self-harm or homicide/suicide;
- The support services will be specific to the needs of the client group and will not duplicate any other service commissioned through HSC in Northern Ireland;
- The support services will not offer counselling to clients currently in receipt of counselling from any other statutory or voluntary/community agencies or on a waiting list for such services;
- The support services providers will offer services that are based on the best current evidence from research and practice;
- The support services will enable and empower service users rather than fostering dependency on the service;

[37] Royal College of Psychiatrists' Public Education Editorial Board. – Improving the lives of people with mental illness. •Author: Dr Ursula Werneke. Editor: Dr Philip Timms. January 2014

- The support services will be person centred, aiming to provide a positive client experience;
- The support services will respond and, where appropriate adapt, to service user feedback accessed where possible through direct service user involvement;
- The support services will be accessible to people across Northern Ireland;
- While prisoners will have access to the Lifeline Helpline, they must only be referred to/signposted to appropriate services provided by, and agreed in advance with, the prison service and prison health service provider;
- It is recognised that children and young people need specialist services, however if a child or young people rings the Lifeline helpline and has been assessed to be at low risk, suitably mature and it is clinically necessary, they will be offered Lifeline community support services. It is expected that any provider would be able to access suitably qualified staff to work with these young people. All assessments will entail follow up with General Practice services

Marketing and promotion

- The Lifeline branding applies to the helpline, and the follow on support services which are evidence based/informed;
- The provider will be required to work closely with the PHA Communications team to ensure consistency and appropriateness of messaging is maintained at all times.

4.4 Constraints

The key constraints impacting on the provision of the Lifeline service are:

Interactions with other Agencies

The success of the Lifeline service is reliant on good networks with HSC bodies, primary care and other statutory organisations as well as voluntary and community organisations working in this field. The Lifeline service provider/s will need a good

knowledge and understanding of the services provided; likewise other organisations need to be clear about what the Lifeline service provides. It is essential that there is good communication, sharing of information and joined up partnership working, to ensure that clients move seamlessly between services, ensuring that they are in the most appropriate service, and that there is no duplication. This is relevant to both referrals and signposting.

The development and agreement of clear referral pathways to emergency services and protocols for signposting to the follow on support services which are evidence based/informed will be fundamental.

Public Expectations

The whole area of mental health and suicide in particular is very emotive, and also generates considerable political interest. Public awareness surveys have shown that 96% of those surveyed year on year feel that there is a need for this type of service[38]. While we have to work within the confines of available budget, strategic fit, and the evidence base, it is essential that consideration is taken of public and political views in respect of these services. In developing this Strategic Outline Business Case therefore, a public consultation has been held; the findings from this have informed the proposed future model, alongside other relevant information (see section 3 assessment of need). We are also liaising closely with the DHSSPS, ensuring that they are kept informed. Issues of equality have also been taken into account in the development of the strategic outline business case, and an equality screening carried out.

A public consultation will follow the completion of this Strategic Outline Business Case, the findings of which will inform the Final Business Case.

It is further recognised that as the service is established it will be important that the service provider/s also continue to engage with the public.

[38] Annual PHA tracking survey 2014-Millard Brown Ulster Omnibus

Finance

It is recognised that all HSC budgets are under pressure, and it is imperative that public monies are well managed and utilised in the most effective and efficient manner to achieve the best outcomes. It is therefore vital that the structure of the new Lifeline service is one that will maximise the use of the available resources, ensuring that those most at risk are targeted, with the ability to keep costs under control.

The Lifeline service is demand led, and thus it is not possible to control the volume of activity; with a cost-per-call volume this poses the risk of the costs of the service escalating beyond the budget available.

While we must ensure that necessary steps are taken to control the costs of this service, this must be done within the context of safety, quality and effectiveness of the service. However, it is deemed that a number of factors, if built into the new service will assist in controlling the costs within the budget available at the same time as ensuring that the most effective and appropriate service is available for those who need it, and also assuring the sustainability of the service:

- Clarification of, and ensuring that the service remains within, its core function, i.e. for those at immediate risk of suicide, self-harm or homicide/suicide. The Lifeline service is not aimed at those with lower levels of distress;
- Clear messaging regarding the core purpose of the service;
- Ensuring no duplication with other services (through clarity of purpose and criteria, good communication with other services, and appropriate pathways and protocols);
- Good demand management processes;
- Clear agreement on how third party professional calls should be dealt with; and
- Moving away from a cost per call contract, to a ‘block’ arrangement for the Helpline.

Timescales

Commissioning of the future Lifeline service will be consistent with the requirements of EU social care procurement. The timelines for implementation will need to take account of the procurement regulations and processes.

The Lifeline service is already included in the PHA Procurement Plan for 2015/16; BSO Procurement and Logistics Service (PALS) have been alerted and will be engaged at an early stage when the likely timescales have been confirmed, along with early development and agreement of tender strategy and specification.

Achieving long term outcomes

The overarching aim of the Lifeline service is to help to reduce the levels of suicide and self-harm in Northern Ireland. It is recognised however that the Lifeline service is only one element of the Protect Life Strategy; one service out of the many that are working together to reduce the levels of suicide and self-harm in our society.

It is also recognised that the long term outcomes will also be impacted by external factors, including economic factors that are outside of the control of this project or indeed of any one organisation.

Evaluation will continue to be important, and will need to be carried out after a meaningful period of operation. The anticipated cost of evaluation is therefore included in the monetary analysis. Additionally, it will be important that service providers collect, and report on, agreed data sets, that will inform future evaluation. It is noted however that the lack of an appropriate common IT system/systems that integrate, will limit the ability to gather information for evaluation in a consistent manner.

Providers may also be required, in agreement with the commissioner, to adapt and further develop their services, in line with the results of evaluation and of emerging evidence.

5. IDENTIFICATION OF OPTIONS

This section sets out the options identified to meet the objectives as set out in section 4.

5.1 Long-list of options

The following long-list of options was identified:

Option	Title	Description
1.	Status Quo (Do nothing)	Under this option the existing service model, i.e. the provision of the telephone helpline and support counselling services through one regional contract with a single provider, would be continued and retendered.
2.	Do minimum (Cease Lifeline helpline and wraparound services completely)	Under this option the existing Lifeline service (telephone helpline and wraparound services) would be terminated at the end of the current Lifeline contract. There would therefore be no dedicated Lifeline helpline for those at immediate risk of suicide or self-harm in Northern Ireland, nor any associated support services. The existing 'Lifeline' budget would be reallocated across a range of other existing PHA priorities within the suicide prevention strategy.
3.	Single regional Lifeline helpline with signposting only to other existing services	Under this option a regional Lifeline helpline service would continue to be commissioned, however the helpline would be 'stand-alone'. Call-operators would 'de-escalate' callers. They would not refer callers into any other relevant services (i.e. no referrals on to emergency services). The helpline service would only signpost callers to other appropriate existing services. Once the helpline service has been costed, the balance of the existing 'Lifeline' budget would be reallocated across a range of other existing PHA priorities within the suicide prevention strategy.
4.	Single regional Lifeline helpline with NO referrals or signposting	Under this option a regional Lifeline helpline service would continue to be commissioned, however the helpline would be 'stand-alone'. Call-operators would listen and 'de-escalate' callers. Callers would neither be referred to any services (including no referrals to emergency services) nor would they be

		signposted to other appropriate services. Once the helpline service has been costed, the balance of the existing 'Lifeline' budget would be reallocated across a range of other existing PHA priorities within the suicide prevention strategy.
5.	Single regional Lifeline helpline with agreed referral pathways to emergency services and signposting to other existing services	Under this option a regional Lifeline helpline service would continue to be commissioned, however the helpline would be 'stand-alone'. Call-operators would listen and 'de-escalate' callers. Callers could be referred to emergency services, or signposted to other appropriate existing services. Once the helpline service has been costed, the balance of the existing 'Lifeline' budget would be reallocated across a range of other existing PHA priorities within the suicide prevention strategy.
6.	Single regional Lifeline helpline with referral to an associated regional follow on support service which is evidence based/informed, as separate but integrated services, through two distinct regional contracts	This option would provide a regional Lifeline helpline as a single service under a distinct contract. However, alongside it a separate single regional contract would be put in place for a Lifeline follow on support service which is evidence based/informed. The helpline would triage, assess and de-escalate callers as above. Callers at immediate risk of suicide, self-harm or homicide/suicide would be referred to emergency services. Clients, not at immediate risk, but meeting the agreed criteria would be referred to the Lifeline evidence based/informed service provider or to other statutory or voluntary/community services (in line with agreed pathways and protocols). As above, callers not meeting the criteria for referral would be signposted to other relevant services.
7.	Single regional Lifeline helpline with referral to associated local follow on support services which are evidence based/informed, as separate but integrated services, through at least six distinct contracts	This option would be the same as option 6 above, however while there would be one single regional helpline, rather than having one single regional provider for Lifeline follow on support service which is evidence based/informed, the provision of these services would be separated into at least five lots, according to the five Trust areas.
8.	Single regional Lifeline	This option would provide for a single

	helpline and a range of associated services, including a physical safe place and assertive outreach	regional helpline (as a separate contract), with associated, but separate distinct contracts for a physical safe place, assertive outreach and counselling under 'Lifeline'. Callers would be triaged, assessed through the helpline, where possible they would be de-escalated through the helpline, or where appropriate referred for immediate access to the Lifeline 'safe place' or to Lifeline assertive outreach or to emergency services, if appropriate. Callers not meeting the criteria for these would be signposted to appropriate services.
9.	Single regional Lifeline helpline, referral to emergency services and signposting to associated follow on support services which are evidence based/informed (regional contract) with provision for locality based incidental de-escalation in exceptional circumstances.	This option would provide for a single regional helpline (as a separate contract), with an associated, but separate distinct single regional contract for relevant follow on support services which are evidence based and/or informed. Callers to the helpline would be triaged, assessed and where appropriate de-escalated and if appropriate referred to emergency services. Callers at immediate risk of suicide or self-harm but not meeting the criteria for emergency services would be signposted to the appropriate evidence based/informed interventions, (to the services funded through the Lifeline budget, or to other existing services as appropriate). The helpline would also, by exception, be able to connect a specified group of clients with appropriate services. Provision would be available, by exception, for face-to-face de-escalation (for those unable to directly access the service through the helpline), on a locality basis across each Trust area.
10.	Single regional Lifeline helpline, referral to emergency services and signposting to associated follow on support services which are evidence based/informed (at least 5 contracts in line with Local Commissioning Group/Trust areas) and provision for locality based incidental de-escalation in exceptional	This option would be the same as option 10 above, however rather than one single regional contract for follow on support services which are evidence based/informed, the provision of these services would be separated into at least 5 lots covering the 5 Local Commissioning Group/Trust areas. The helpline would also, by exception, be able to connect a specified group of clients with appropriate services. Provision would be available, by exception, for face-to-face de-escalation (for those

	circumstances.	unable to directly access the service through the helpline), on a locality basis across each Trust area.

It is recognised that there are also different means of securing the options above; that is commissioning directly from a HSC organisation or public procurement (from a community, voluntary, private or statutory organisation). Depending on the nature of the option above, the mechanism for securing the service could be a combination of commissioning and procurement. The options for securing the service are set out below:

Option	Title	Description
A	Procurement of the Lifeline helpline service	Under this option the regional Lifeline helpline service would be taken forward through a procurement process, seeking tenders from non HSC organisations, with adjudication and the award of contract in line with procurement regulations.
B	Directly commissioning the Lifeline helpline from an existing HSC Trust	Under this option the regional Lifeline helpline would be directly commissioned from one HSC Trust, to facilitate referral and immediate 'hand over' in those instances where a caller is actively suicidal and where immediate intervention is required to prevent death or serious physical harm. The NI Ambulance Service (NIAS) is the only Trust to be considered as it is a regional Trust and has existing crisis telephony infrastructure and expertise.
c	Procurement of support services	Under this option the follow on support services which are evidence based/informed would be taken forward through a procurement process, seeking tenders from non HSC organisations, with adjudication and the award of contract in line with procurement regulations.
D	Directly commissioning support services directly from HSC Trusts	Under this option the support services would be directly commissioned from HSC Trusts.

Assumptions:

- An element of the Lifeline budget will be ringfenced for communication/awareness raising and evaluation under each of the above options.

5.2 Sifting of Long-List of Options

Each of the above options was considered by the project team to determine if they met the objectives as set out in section four. In particular it was considered fundamental that that the short listed options should provide a 24/7 helpline, with referral to emergency services and link to accessible follow on support services which are evidence based/informed. This initial sifting also included a high level assessment of what is feasible within the available funding and timescales of this business case.

Options 2, 3, 4, 6, 7, 8 and D were discounted at this stage based on the following rationale:

Option	Title	Reason for not shortlisting
2	Cease service	By ceasing the Lifeline helpline, and not reinvesting the money in a replacement helpline for those at immediate risk of suicide, self-harm or homicide/suicide, it would meet none of the objectives. It would also potentially result in individuals self-harming and/or taking their own lives by suicide.
3.	Regional helpline only + signposting	While this option would meet the objective of providing a helpline for those at immediate risk of suicide, self-harm or homicide/suicide, and would allow for signposting to existing services, it would not provide an adequate service to those in immediate crisis, as it would be unable to refer the caller to emergency services.
4	Regional helpline only	While this option would meet the objective of providing a helpline for those at immediate risk of suicide or self-harm, it would not meet the objective of referring those at immediate risk out to emergency services, nor of signposting to relevant follow on support services which are evidence based/informed.
6.	Regional helpline & referral to separate regional follow on support services which are evidence based/informed (two contracts)	While this option would meet the objective of providing a helpline for those at immediate risk of suicide, self-harm or homicide/suicide, and would enable referral to emergency services, it would ~~be~~ undermine the enablement and empowerment objective, as it would refer callers into other services, rather than signposting them.

7.	Regional helpline & referral to several separate follow on support services, which are evidence based/informed, contracts	While this option would meet the objective of providing a helpline for those at immediate risk of suicide, self-harm or homicide/suicide, and would enable referral to emergency services, it would be unlikely to meet the enablement and empowerment objective, as, like option 6 above, it would refer callers into other services, rather than signposting them.
8.	Regional contract for helpline + separate contract for a physical safe place and assertive outreach	This option would meet the objectives of providing a helpline for those at immediate risk of suicide, self-harm or homicide/suicide; however as the objective for the Lifeline service, is to provide a virtual safe place for de-escalation, with provision for referral to emergency services and signposting to appropriate follow on support services which are evidence based/informed, the provision of a physical safe-place and assertive outreach is out with the remit, timescales and available budget of the Lifeline service.
D	Directly commissioning support services from HSC Trusts	While a single regional helpline provides for access for any caller from anywhere in NI, research findings support the value in providing locally community based and relatively informal services. In particular, it is recognised that some[39] people may not be willing to go to statutory services, while they would find it easier to avail of a service provided by an independent private or community provider. It is therefore considered that only commissioning the support services from HSC Trusts would be too restrictive, and that service provision would benefit from a mixed economy with a variety of different providers across different locations in Northern Ireland. It is however noted that under the procurement route, HSC Trusts would also be able to bid. Option D has therefore not been shortlisted.

Note, although Option 1 – the status quo, does not necessarily meet all the criteria as used to perform the initial sift, it has been retained as the baseline option.

[39] Providing Meaningful care: using the experiences of young suicidal men to inform mental health care services. Dr J Jordan, Prof H McKenna, Dr S Keeney, Prof J Cutliffe.

5.3 Shortlisted Options

The following four 'model' options, along with the three helpline 'delivery' options have been shortlisted for further evaluation:

'Model' Options

Option 1 Status Quo

Option 5 Single regional Lifeline helpline with agreed referral pathways to emergency services and signposting to other existing services

Option 9 Single regional Lifeline helpline, referral to emergency services and signposting to associated follow on support services which are evidence based/informed (regional contract)

Option 10 Single regional Lifeline helpline, referral to emergency services and signposting to associated follow on support services which are evidence based/informed (at least 5 contracts in line with Trust areas)

Options for securing the service

Option A Procurement of the Lifeline helpline service

Option B Directly commissioning the Lifeline helpline from the NI Ambulance Service

Option C Procurement of support services

Note, Option C will not be evaluated again as a separate option in the following sections, as it will be an integral part of options 1, 5, 9 and 10.

6 ASSESSMENT OF MONETARY COSTS AND BENEFITS

This section considers the monetary costs and benefits associated with each of the shortlisted options which have been summarised below.

Option	Description
1	Status Quo
5	Single regional Lifeline helpline with agreed referral pathways to emergency services and signposting to other existing services
9	Single regional Lifeline helpline, referral to emergency services and signposting to associated follow on support services which are evidence based/informed (regional contract)
10	Single regional Lifeline helpline, referral to emergency services and signposting to associated follow on support services which are evidence based/informed (at least 5 contracts in line with Trust areas)
A	Procurement of the Lifeline helpline service
B	Directly commissioning the Lifeline helpline from the NI Ambulance Service

The financial appraisal of each option estimates annual operating costs and revenues alongside capital costs and net present costs (NPCs) over a period of three years. These are summarised in table 8 below.

Table 8: Operating, capital and net present Costs for shortlisted options[40]

Option	Description	Annual Cost Revenue	Capital cost	TOTAL COST	3 year contract NPC
		£000	£000	£000	£000
1	Status Quo	3364	0	3364	9425
5a	Single regional Lifeline helpline with agreed referral pathways to emergency services and signposting to other existing services	1694	0	1694	4746
5b	Single regional Lifeline helpline with agreed referral pathways to emergency services and signposting to other existing services	1694	0	1694	4746
9a	Single regional Lifeline helpline, referral to emergency services and signposting to associated evidence based/informed services (regional contract)	2698	0	2698	7558
9b	Single regional Lifeline helpline, referral to emergency services and signposting to associated evidence based/informed services (regional contract)	2698	0	2698	7558
10a	Single regional Lifeline helpline, referral to emergency services and signposting to associated evidence based/informed services (at least 5 contracts in line with Trust areas)	2698	0	2698	7558
10b	Single regional Lifeline helpline, referral to emergency services and signposting to associated evidence based/informed services (at least 5 contracts in line with Trust areas)	2698	0	2698	7558
A	Procurement of the Lifeline helpline service				
B	Commissioning of the Lifeline helpline from the NI Ambulance Service				

6.1 Operating Costs and Revenues

In order to calculate the annual costs for each option and a Net Present Cost to the Northern Ireland economy the following principles were applied:

- **for the helpline**:

  In the status quo option, the Lifeline helpline costs are a replication of the activity and costs of the existing service in 2014/15.

[40] A – procurement of the Lifeline helpline; B – directly commissioning the Lifeline helpline from NIAS Capital costs disclosed as depreciation within the annual cost revenue.

A/B: To enable comparison, the estimated costs for both procurement and commissioning of the Lifeline helpline service (options 5, 9 and 10) are calculated using pay and non-pay costs relating to the provision of a 24hour helpline service. These assumptions and costs will be refined at Final Business Case stage.

- **for the follow on support:**

  The costs of the 'Lifeline follow on support' under the status quo (option 1) are a replication of the activity and revenue expenditure under the existing Lifeline follow on support service. 2014/15 costs and activity were used as a reflection of the most up to date information available.

- **for the Evidence Based Informed Services (EBIS)**:

  For options 9 and 10 the expected revenue expenditure is based on the procurement of EBIS sessions which have been calculated using the market assessed cost of £50 per counselling session. For comparative purposes the cost per session has been applied to the same number of sessions as the existing Lifeline follow on support (i.e. 15,474 sessions for the 2014/15 financial year). It is not anticipated that the cost for several contracts for EBIS would materially differ to one regional contract. These assumptions and costs will be refined at Final Business Case stage.

- **for the face to face de-escalation/ complementary services**:

  An additional £230K has been identified which would cover face to face de-escalation and complimentary therapies (options 9 and 10). It is estimated that the cost per session would be in the region of £35.

- **Public Relations (PR):**

  For options 1, 5, 9 and 10 PR costs are based on the existing 2014/15 PR costs. It is not anticipated that this will change across the options.

- **Evaluation:**

  For options 5, 9 and 10 contract evaluation has been estimated at £40k.

Table 9 shows comparative costs of each option applying the above principles

Table 9: Comparative revenue costs

.

Comparative Revenue Costs

Cost element	STATUS QUO £000	OPTION 5a £000	OPTION 5b £000	OPTION 9a £000	OPTION 9b £000	OPTION 10a £000	OPTION 10b £000
recurring revenue							
helpline costs (activity 68,086 calls)	2,245	1,504	1,504	1,504	1,504	1,504	1,504
Follow on support (activity 15,474 sessions)	969						
EBIS (activity 15,474 sessions)				774	774	774	774
face to face de-escalation/ complimentary therapy	-			230	230	230	230
PR	150	150	150	150	150	150	150
Evaluation		40	40	40	40	40	40
total revenue	3,364	1,694	1,694	2,698	2,698	2,698	2,698

6.2 Capital Costs

For the directly commissioning of the Lifeline helpline from the NI Ambulance Service option a Capital Cost of £500k has been included. This is a preliminary figure and if this option is approved an accurate cost based on fit for purpose building costs and equipment required will be provided as part of the full Business Case. The capital funds would be requested by NIAS from the DHSSPS through the normal Capital Resource Limited (CRL) process.

For the procurement of the Lifeline helpline service.it is assumed that depreciation will be charged on existing equipment owned by the provider. In the absence of costs at this initial stage the charge of depreciation for the estimated £500k costs has been used for consistency.

6.3 Net Present Costs

The standard discount rate of 3.5% per annum in real terms has been applied to account for the time value of money.

The NPC calculations are set out in Appendix 4.

7 ASSESSMENT OF RISKS

In any appraisal there is always likely to be some difference between what is expected and what eventually happens. It is therefore essential to identify and analyse the potential risks and uncertainties, and to show how they compare under each option.

7.1 Identification and analysis of risk

The following risks have been identified, and their impact and likelihood assessed against each of the shortlisted options.

Key Risk	Risk Description
Inability to commission/procure within the timescales	The contract for the current Lifeline service was due to cease 31 March 2015, with the option of 18 months extension (to 30 September 2016). However there is a risk that the new service may not be in place within any extended timescale (including the potential for issues such as TUPE to lead to the transition period having to be extended beyond the period planned) or that the commissioner could not extend the contract, or that the provider may not agree to an extension. The impact of this risk is rated as major, as it could potentially mean a period without any service.
Public/political implications re future service model	The Lifeline service is very high profile, and the future of the service is likely to be of interest to voluntary, community, statutory and private organisations delivering suicide prevention services, the general public, especially those who have been affected by suicide, as well as local politicians. Any public/political concerns regarding the future service model and perceived potential impact on future suicide and self-harm rates, has the potential to cause reputational damage to both the PHA and to the Lifeline service/brand. The impact is rated as moderate.
Management of existing Lifeline services users (particularly 'frequent callers')	There is a potential risk that existing service users (whether those who are frequent callers to the helpline, or are availing of a programme of support sessions at the time of contract retender) may be 'lost' in any transition. Failure to manage these people appropriately could be detrimental to both the service user and their family, and therefore the impact has been rated as moderate.
Demand outstripping budget availability	Given that any helpline service is demand led, there is always the potential that the demand for the service will outstrip the available budget. Given the potential impact in the current climate of financial constraints, the impact of this has been rated as major.
Data protection	While direct referrals will be minimal under the proposed

	model, information will still be required to be shared between the helpline and support provider, with the potential for personal information to be lost or misused. Should this happen it could have a negative impact on the individual/s concerned and to the reputation of the PHA, the provider/s and the Lifeline service. The impact of this risk has been rated as moderate.
Technology and data collection	There are two aspects of this risk. Risk of technology failure (hardware/software) and the inability of the information system to track clients across structural boundaries leading to difficulties in monitoring client outcomes and subsequent evaluation. The impact of this risk has been rated as moderate

The risk scores were assessed using the HSC Risk matrix, as follows:

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

7.2 Risk Assessment of Shortlisted Options

MODEL OPTIONS:

Risk	Impact	Option 1		Option 5		Option 9		Option 10	
		Likelihood	Risk score	Likelihood	Risk score	Likelihood	Risk score	Likelihood	Risk score
Inability to commission/procure within timescales/lack of service	4	2	8	3	12	3	12	3	12
Public/political implications re future model	3	4	12	5	15	4	12	2	6
Management of existing Lifeline service users	3	3	9	4	12	3	9	4	12
Demand outstripping budget availability	4	4	16	2	8	3	12	3	12
Data protection	3	2	6	2	6	3	9	3	9
Technology	3	3	9	2	6	3	9	4	12
TOTAL			60		59		63		63

HELPLINE DELIVERY OPTIONS:

Risk	Impact	Option A		Option B	
		Likelihood	Risk score	Likelihood	Risk score
Inability to procure within timescales	4	3	12	2	8
Public/political implications re future model	3	2	6	3	9
Management of existing Lifeline service users	3	3	9	3	9
Demand outstripping budget availability	4	3	12	3	12
Data protection	3	3	9	2	6
Technology	3	2	6	1	3
TOTAL			54		47

7.3 Risk management and mitigation commentary

Option 1	
Key Risk	**Risk management/mitigation**
Inability to commission/procure within the timescales	Under this option the existing specification would be used, therefore procurement could commence soon after the final business case was approved, and the risk minimised. Learning from previous tenders, and prudent assumptions regarding timelines for transition, will be applied.
Public/political implications re future service model	Given the responses to the pre-consultation and some of the issues identified in the needs assessment analysis, it is likely that there would be some negative response to maintaining the status quo. While this risk would be mitigated to some degree through a further public consultation prior to procurement, a robust procurement process and associated communication plan, as the model itself would not be changed it is not anticipated that it would be possible to reduce the risk by much. As the service model would be unchanged it is not anticipated that the impact on suicide and self-harm rates would differ from now.
Management of existing Lifeline services users (particularly 'frequent callers')	As the service would be unchanged the impact on existing service users should be minimal; however as there is always a potential that a new provider may be awarded the contract through the procurement process, the likelihood is 'possible'. The management and transfer of existing service users would be a key element of the procurement process.
Demand outstripping budget availability	Demand management is a major issue with the existing service, and it would be anticipated that this would continue with the status quo. Robust performance management arrangements would be put in place to mitigate this risk.
Data protection	Data protection is a risk for any service; however the provider will be expected to have robust information governance policies and procedures in place with active compliance. It will also be essential to have robust data sharing agreements in place between providers. However the Lifeline service being a single contract would also help mitigate this risk.
Technology	Risk of technology failure (hardware/software) is a risk for any model. As the service will have to be re-procured, there is potential that the new provider may either have to implement a new system or undertake substantial adjustments to an existing system, to meet the needs of

	the service. This may be more prone to technical glitches in the early stages which may impact on collection of monitoring data. Any IT system faces the possibility of failure, and providers will be required to have robust business continuity plans. However under this model the helpline and support services system are likely to be combined, there is a greater risk that if one system fails the total system for all services fails. There will however be no need to track clients across structural IT boundaries which will allow easier monitoring of clients and evaluation.

Option 5	
Key Risk	**Risk management/mitigation**
Inability to commission/procure within the timescales	Following final business case approval a new specification for helpline only would need to be developed. However, as the specification would be for a 'helpline' only (one specification and one 'lot'), this should simplify the process and minimise any delays in procurement. Learning from previous tenders, and prudent assumptions regarding timelines for transition, will be applied.
Public/political implications re future service model	If it were perceived that a lesser service was being put in place, there is likely to be a very negative response. This would be mitigated through the implementation of a communication plan to explain the decision. As there would be no dedicated support services, there is however a risk that the suicide and self-harm rates could increase, due to lack of appropriate services
Management of existing Lifeline services users (particularly 'frequent callers')	While existing callers to the Lifeline helpline would be managed and transferred through the procurement process, it is likely that additional negotiations would be required with other existing services to manage those using current Lifeline 'support' services.
Demand outstripping budget availability	While the helpline service is demand led, with the potential for service pressures, this would be mitigated through clear costing in the tender documentation and clarity in the specification regarding call classification.
Data protection	Data protection is a risk for any service; however the provider will be expected to have robust information governance policies and procedures in place with active compliance. It will also be essential to have robust data sharing agreements in place between providers.
Technology	Risk of technology failure (hardware/software) is a risk for any model. As the service will have to be procured, there is

	potential that the provider may either have to implement a new system or undertake substantial adjustments to an existing system, to meet the needs of the service. This may be more prone to technical glitches in the early stages which may impact on collection of monitoring data. However with no support service provision, there will be no need to track clients across structural IT boundaries

Option 9	
Key Risk	**Risk management/mitigation**
Inability to commission/ procure within the timescales	Following final business case approval a new specification for helpline and interventions would be required. The risk would be mitigated by doing the preparatory work in parallel with the preparation of the final business case, following the public consultation, minimising delays in procurement. Learning from previous tenders, and prudent assumptions regarding timelines for transition, will be applied.
Public/political implications re future service model	While there may be some negative response to the change in the service, it is anticipated that this would be limited, as a 24/7 helpline and support services would be provided. Additionally, the availability of some enhanced services ('incidental de-escalation') would be positive. However a single regional contract for the interventions may cause adverse publicity. This would be mitigated through the specification setting out geographical coverage for the interventions, along with a communications plan. The final service model would also take account of feedback from public consultation. While it is recognised that with splitting the helpline and support service elements some people may fail to connect with the appropriate support services, this is mitigated by the provision of enhanced signposting for the most vulnerable, face to face de-escalation for those who would not phone as well as greater availability and access to local support services. This should also address concerns about the risk to suicide and self-harm rates.
Management of existing Lifeline services users (particularly 'frequent callers')	As the nature of the helpline and interventions would be changed there will need to be robust arrangements for the transfer of existing users, included in the tender documentation and with communication and negotiation with the existing service provider and other service providers.
Demand outstripping budget availability	While the helpline service is demand led, with the potential for service pressures, this would be mitigated through clear costing in the tender documentation and clarity in the specification regarding call classification. Robust protocols for entry into the interventions would be agreed and closely

	monitored.
Data protection	Data protection is a risk for any service; however the provider will be expected to have robust information governance policies and procedures in place with active compliance. It will also be essential to have robust data sharing agreements in place between providers.
Technology	Risk of technology failure (hardware/software) is a risk for any model. There is potential that the provider may either have to implement a new system or undertake substantial adjustments to an existing system, to meet the needs of the service. This may be more prone to technical glitches in the early stages which may impact on collection of monitoring data. In addition there will be a requirement to track clients across the structural IT boundary between helpline provider and a regional provider of local support service. This will increase complexity of the technological linkages which may impact on collection of monitoring data.

Option 10	
Key Risk	**Risk management/mitigation**
Inability to commission/ procure within the timescales	Following final business case approval a new specification for helpline and interventions would be required. The risk would be mitigated by doing the preparatory work in parallel with the preparation of the final business case, following public consultation, minimising delays in procurement. Learning from previous tenders, and prudent assumptions regarding timelines for transition, will be applied.
Public/political implications re future service model	While it is expected that there will be some negative response to the change in the service, it is anticipated that this would be limited and short term as a 24/7 helpline would still be available and several geographically based contracts for interventions would ensure better local access to services. Additionally the availability of some enhanced services (especially incidental de-escalation) would be positive. It is anticipated that any negative response would be balanced by the improved local access and enhanced services. The risk would also be mitigated through a robust communications plan. The final business case would also take account of feedback from the public consultation. While it is recognised that with splitting the helpline and support service elements some people may fail to connect with the appropriate support services, this is mitigated by the provision of enhanced signposting for the most vulnerable, face to face de-escalation for those who would not phone as well as greater availability and access to local support services. This

	should also address concerns about the risk to suicide and self-harm rates.
Management of existing Lifeline services users (particularly 'frequent callers')	As the nature of the helpline and interventions would be changed there will need to be robust arrangements for the transfer of existing users, included in the tender documentation and with communication and negotiation with the existing service provider and other service providers.
Demand outstripping budget availability	While the helpline service is demand led, with the potential for service pressures, this would be mitigated through clear costing in the tender documentation and clarity in the specification regarding call classification. Robust protocols for entry into the interventions would be agreed and closely monitored. Additionally as this option is more closely linked to local services, it is anticipated that they could assist in managing demand locally.
Data protection	While data protection is a risk for any service, if there are multiple service providers the potential for data to be sent to the wrong place is increased. However all providers will be expected to have robust information governance policies and procedures in place with active compliance. It will also be essential to have robust data sharing agreements in place between providers. In addition the number of contracts for EB/I services will be limited to one per Trust area to help mitigate this.
Technology	Risk of technology failure (hardware/software) is a risk for any model. There is potential that the provider may either have to implement a new system or undertake substantial adjustments to an existing system, to meet the needs of the service. This may be more prone to technical glitches in the early stages which may impact on collection of monitoring data. Any IT system faces the possibility of failure, and providers will be required to have robust business continuity plans. However as the helpline and support services systems will be separate, technology failure in any one part of the system, will not affect the other parts of the system. There will however, be a requirement to track clients across structural IT boundaries between the helpline provider and a network of local support services. This increases the complexity of the technological linkages which increases risk for monitoring and may make evaluation of outcomes more difficult.

Risk assessment of the two options for acquiring the regional helpline (NB risk assessment of options A and B relates to the provision of the helpline only):

Option A	
Key Risk	**Risk management/mitigation**
Inability to commission/ procure within the timescales	Following final business case approval a new specification for the helpline would need to be developed. The risk would be mitigated by doing the preparatory work in parallel with the preparation of the final business case, following public consultation, minimising delays in procurement. Learning from previous tenders, and prudent assumptions regarding timelines for transition, will be applied.
Public/political implications re future service model	As there would be open competition for the award of contract, it is anticipated that any adverse response would be minimal, and would be dealt with through normal communication channels. As the distinct Lifeline brand will be retained irrespective of provider, it is not considered that this will influence perceived impact on suicide and self-harm rates.
Management of existing Lifeline services users (particularly 'frequent callers')	There will need to be robust arrangements for the transfer of existing users, included in the tender documentation and with communication and negotiation with the existing service provider and other service providers.
Demand outstripping budget availability	While the helpline service is demand led, with the potential for service pressures, this would be mitigated through clear costing in the tender documentation and clarity in the specification regarding call classification.
Data protection	Data protection is a risk for any service; however the provider will be expected to have robust information governance policies and procedures in place with active compliance. It will also be essential to have robust data sharing agreements in place between providers.
Technology	Risk of technology failure (hardware/software) is a risk for any model. There is potential that the provider may either have to implement a new system or undertake substantial adjustments to an existing system, to meet the needs of the service. This may be more prone to technical glitches in the early stages which may impact on collection of monitoring data.

Option B	
Key Risk	**Risk management/mitigation**
Inability to commission/ procure within the timescales	This option would eliminate the need for building in the required procurement timescales (for the helpline), while time would still be required to negotiate with NIAS and for NIAS to plan and make arrangements for the transfer of the helpline, this would commence at an earlier stage (i.e. one the final business case approved) as no procurement required. Learning from previous tenders where applicable, and prudent assumptions regarding timelines for transition, will be applied.
Public/political implications re future service model	As this would see the transfer of a helpline currently provided by a non HSC body into statutory services, it is anticipated that there could be an adverse response. This would be mitigated by initial conversations with DHSSPS, and proactive implementation of a robust communication plan. It is anticipated however that the benefits of closer alignment to emergency services and that 'Lifeline' would remain as a distinct brand would be welcomed. The final service model would also take account of feedback from the public consultation. As the distinct Lifeline brand will be retained irrespective of provider, it is not considered that this will influence perceived impact on suicide and self-harm rates.
Management of existing Lifeline services users (particularly 'frequent callers')	There will need to be robust arrangements for the transfer of existing users, with communication and negotiation with the existing service provider and other service providers.
Demand outstripping budget availability	While the helpline service is demand led, with the potential for service pressures, this would be mitigated through clear costing and agreement with NIAS, along with a robust SBA and associated controls.
Data protection	While data protection is a risk for any service, all HSC organisations have strict information governance controls and risk management processes in place as part of Accountability arrangements, which will reduce the risk. It will also be essential to have robust data sharing agreements in place between providers. While data would be shared with the external EB/I service providers, any risk relating to sharing with emergency services would be significantly reduced.
Technology	The risk of technology failure (hardware/software) is a risk for any model, as outlined for each of the models above. However as the NIAS system is part of the HSC network, risk around technological breakdown and transfer of data and security is likely to be less. It would also benefit from the robust emergency services resilience arrangements.

8 ASSESSMENT OF NON MONETARY COSTS AND BENEFITS

While costs and benefits must be assessed in monetary terms, this does not provide a full picture, and it is important to also assess the non-monetary impacts to ensure that a balanced decision is made. A suitable method of evaluating these non-monetary impacts must be applied. This section sets out the non-monetary costs and benefits associated with each of the short-listed options.

The term used to describe the assessment of non-monetary costs and benefits is Multi-Criteria Analysis (MCA). There are two common forms of MCA:

- Impact Assessment – tabulates the impact of each option upon each non-monetary factor in an impact assessment or performance matrix; or
- The Weighted Scoring Method – involves assigning numerical weights to each factor to reflect its comparative importance; scoring the performance of each option against each factor on a numerical scale and calculating a 'weighted' score for each option.

This business case uses the weighted scoring method.

8.1 Non-Monetary Benefit Criteria and Weighting

Non-monetary benefit criteria should align with the objectives of the business case. The following criteria have been selected, and weighted according to their comparative importance, for the purposes of assessing the various options:

Criteria	Factors include:	Weighting
Accessibility	• The Lifeline helpline service should be available to all NI residents irrespective of location; • It should also be innovative and make efficient use of new technologies (eg texting, virtual chat rooms, Apps etc) to reach particular client groups (eg young males, the deaf community etc); • Accessible within each Trust area.	20
Timeliness	• The helpline should be available at the times when people need it (24/7, 365 days/year); • Callers who are actively suicidal and where there is immediate risk of death or serious harm, should be referred immediately to emergency services (where the caller is willing to give sufficient details); • Callers assessed as requiring follow on support services which are evidence based/informed should	20

	be able to access these within a timely manner.	
Quality	• The Lifeline service provides an appropriate service for callers (triage, assessment, de-escalation, incidental de-escalation, referral to emergency services and sign-posting) as set out in the service model; • An appropriate range of follow on support services which are evidence based/informed are available within the Lifeline crisis intervention service.	20
Flexibility	• The service is capable of adapting to manage fluctuating levels of demand, within budget; • The service is capable of adapting to work with changes and developments in other associated services (whether statutory or voluntary & community); • The service is capable of adapting to new technologies.	15
Sustainability	• The service is based on an empowerment and enabling philosophy • Mechanisms are in place to appropriately manage repeat service users; • The service works in partnership with other services (community, voluntary, statutory) with active co-operation, communication and mutual support, working to ensure all service users mental health needs are appropriately met and to eliminate duplication.	15
Ease of implementation	• The preferred option should be capable of being introduced with minimal disruption and within the required timescale (i.e. by 1 October 2016)	10
TOTAL		100

The non-monetary benefit criteria link to the objectives, as follows:

Criteria	**Link to Objective/s**
Accessibility	1,5,6
Timeliness	1,3,5
Quality	2,3,5,6,8,11
Flexibility	9,1,7
Sustainability	4,7
Ease of Implementation	10

8.2 Non-monetary costs and benefits scoring criteria

Each option was assessed against the non-monetary costs and benefits criteria, and scored using the following scale:

Score	Meets the criteria:
5	Completely
4	Highly
3	Moderately
2	Limited
1	Does not meet the criteria

8.3 Non-monetary costs and benefits assessment

Table 10: Model Options (1, 5, 9 and 10)

Benefit criteria	%	Score out of 5 x weighting							
	weight	Option 1		Option 5		Option 9		Option 10	
Accessibility	20	3	60	2	40	3	60	4	80
Timeliness	20	3	60	1	20	3	60	4	80
Quality	20	3	60	1	20	4	80	4	80
Flexibility	15	4	60	3	45	4	60	4	60
Sustainability	15	2	30	2	30	3	45	4	60
Ease of Implementation	10	4	40	4	40	3	30	3	30
TOTAL	100		310		195		335		390

Table 11: Options for Securing the Helpline Service (A and B)

Benefit criteria	%	Score out of 5 x weighting			
	weight	Option A		Option B	
Accessibility	20	4	80	4	80
Timeliness	20	4	80	5	100
Quality	20	4	80	4	80
Flexibility	15	4	60	4	60
Sustainability	15	3	45	4	60
Ease of Implementation	10	3	30	4	40
TOTAL	100		375		420

Nb as analysis of Options A and B relates to the delivery of the helpline only, they should not be compared to the benefit analysis of Options 1, 5, 10 and 11.

8.4 Summary of Assessment

Each of the options was assessed against the weighted criteria, as set out above. The four shortlisted options for the full service are analysed and compared first ('model options'). Options A and B, as subsets of the above, looking at how the helpline could be procured or commissioned ('helpline delivery options'), are analysed and compared separately.

The results showed that:

Model Options

Option 1 scored the second lowest at 310. While the current service model is a regional service, it is based on direct referral into services (counselling as well as emergency services) with limited signposting. The single current regional contract model provides limited local rural access to Lifeline support services, compared to other models. The model does not include provision for individuals, in those exceptional circumstances where they are unable to make initial contact via the telephone, to make initial face to face contact with the service ("incidental de-escalation"). Critically, the current service model is not designed to empower and enable callers as it is based on a direct referral model. The single regional contract for both helpline and support services would limit opportunities for partnership and shared working compared to other models. This option would however be relatively easy to implement as procurement would be based on the existing specification.

Option 5 scored the lowest at 195. With only a regional helpline and no funding for 'Lifeline' follow on support services which are evidence based/informed, there is no guarantee that consistent services would be available from existing services across all geographical locations. Additionally, as no funding would be put into 'Lifeline' follow on support services which are evidence based/informed, the existing services may not include all the appropriate interventions and potentially there could be insufficient services, resulting in long waiting lists and delays. Nor does it include provision for initial face to face contact in exceptional circumstances ("face-to-face de-escalation"). It is also possible that with no specific 'Lifeline' follow on support services which are evidence based/informed, call operators may be less

knowledgeable about existing service provision and the specific criteria for each of these. Without any specific Lifeline evidence based/informed interventions the service is likely to be less flexible to manage fluctuating demand, and to adapt to work with changes in other associated services. While this option would facilitate empowerment and enablement, a single helpline contract without any associated follow on support services which are evidence based/informed may lead to limited partnership and shared working; and without these links the service may be more vulnerable. While it should be possible to implement the helpline in a timely way, there would likely be disruption for clients as effectively availability of support services would be reduced, with a negative impact on quality.

Option 9 scored the second highest at 335. While this option includes a regional helpline and associated follow on support services which are evidence based/informed, the single regional contract for the latter may result in more limited local access across the geographic spread of Northern Ireland. Two large regional contracts (one for the helpline and one for the follow on support services which are evidence based/informed), may be less flexible; in particular the regional interventions contract may be perceived to be at a greater distance from and hence potentially less responsive to local needs with limited flexibility to adapt to work with changes and developments in other associated services, especially those in the community and voluntary sector, at a local level. While this option would be sustainable in respect of being based on an enabling and empowerment philosophy, it scores less well, as with two large regional contracts there is less scope for access, partnership and shared working at local levels. With only two contracts, it should however be relatively straightforward to implement.

Option 10 scored the highest at 390. This option scores high against the majority of the criteria, reflecting that it provides for both a regional helpline as well as provision for initial face to face contact in exceptional circumstances (“face-to-face de-escalation”) and dedicated evidence based/informed interventions that would be provided through a number of local contracts reflecting the geographical spread of Northern Ireland. Having several geographically based contracts for follow on support services which are evidence based/informed will facilitate greater flexibility,

maximise local access, with services more sensitive and responsive to local client and community needs.

Option 10 scores less than options 1 and 5 for ease of implementation, as with several contracts for evidence based/informed interventions, greater co-ordination and management will be required to ensure minimal disruption within the timescales. However based on experience from other services this is considered achievable within timescales.

Options for securing the Helpline service

NB The scoring of options A and B is solely related to the delivery of the helpline and does not refer to availability of follow on support services which are evidence based/informed. The scoring of options A and B can therefore not be compared to the scoring of Options 1,5, 9 and 10 above, rather it is purely to differentiate between the two alternatives for acquiring the helpline.

Option A scored 375. While option A would meet all the benefit criteria for the helpline, it scored less well than option B in respect of timeliness, as although it would be able to refer callers to emergency services, it would not have the same direct access as NIAS. In respect of implementation, this would have to go through full procurement before a new provider could begin to implement and thus may take longer to establish the helpline and especially put the necessary referral arrangements with emergency services in place.

Option B scored the highest (for helpline delivery) at 420. This option scored highly as it would enable immediate handover to ambulance services for those clients who are actively suicidal; the existing close working between NIAS and other HSC services as well as with other emergency services should also enable seamless referral of these callers. This should therefore ensure quicker, more appropriate and safer access to emergency services when needed. NIAS have established arrangements to provide strong clinical, information and corporate governance as part of the comprehensive HSC controls, assurance and accountability arrangements within the HSC. These will be applicable to the helpline, assisting with

and strengthening quality, safety and management of the service. Under this option the helpline would be a core element of HSC services, with the associated benefits from the existing interfaces between NIAS, HSC Trust services (including emergency departments and mental health services) and primary care, as well as interpreting services. As the evidence based/informed interventions would be procured separately by public procurement, this would ensure a balance between statutory and non-statutory services for the whole Lifeline service with key local support services and choice maintained, at the same time as providing the benefits from the greater integration with statutory services NIAS would bring. The model would also utilise the existing NIAS call centre infrastructure, benefiting from the existing strong resilience and business continuity arrangements for the emergency services (including back up arrangements with NHS Scotland), but maintain the distinct Lifeline number and separate identity. As NIAS already has a well-established telephone control centre with key links in place, it is anticipated that it could be implemented relatively quickly.

The non-monetary costs and benefits will be factored into the overall analysis and findings together with the monetary costs and benefits.

8.5 Equality of Opportunity

Section 75 and Schedule 9 of the Northern Ireland Act 1998 require public authorities to assess the likely impact of plans and policies on equality of opportunity between the range of social categories:

- Between people of different religious belief, political opinion, racial group, age, marital status or sexual orientation
- Between men and women generally
- Between people with a disability and people without
- Between people with dependents and people without

This Strategic Outline Business Case was screened for equality implications as required by the Act. Using the Equality Commission for Northern Ireland's screening criteria it was considered that there are major implications for equality of opportunity. The Strategic Outline Business Case will therefore be subject to an equality impact assessment.

It was also considered under the terms of the Human rights Act, 1998, and was deemed to be compatible with the European convention Rights contained in the Act. (The full equality screening template is attached at appendix 5).

8.6 Sustainability

Sustainable Development can be defined as "development which meets the needs of the present without compromising the ability of future generations to meet their own needs"[41]. Sustainability is not just about protecting the environment, it is about ensuring stable social and economic growth for all, encompassing social, environmental and economic aspects.

The objectives of this strategic outline business case reflect the need to ensure that the future development of the Lifeline service is sustainable. This is embedded in the non-monetary benefit analysis of the options.

8.6 Lifetime Opportunities

The 2006 Anti- Poverty and Social Inclusion Strategy for Northern Ireland (Lifetime Opportunities) tackles poverty and social exclusion by targeting efforts and available resources at those most in need. The strategy is structured around four key life stages; early years (0-4), children and young people (5-16), working age adults and older citizens.

The priorities outlined in the strategy are:

- Eliminating poverty
- Eliminating social exclusion
- Tackling area based deprivation
- Eliminating poverty from rural areas
- Tackling inequality in the labour market
- Tackling health inequalities
- Tackling cycles of deprivation.

As a policy, Lifetime Opportunities means changing the way all government departments and agencies target the resources they have, so that more of these can

[41] The Brundtland Report: "Our Common Future" – the Report of the 1987 World Commission on Environment and Development

be used to benefit those who are most disadvantaged. The options considered in this business case are wholly consistent with Lifetime Opportunities in its aim to tackle deprivation and inequalities through helping to reduce the number of deaths as a result of suicide and the number of incidents of self-harm in Northern Ireland.

9. AFFORDABILITY, MANAGEMENT, PROCUREMENT AND POST PROJECT EVALUATION

9.1 Affordability

The Lifeline service has a recurring budget of £3,500,000 per annum within the PHA recurring baseline. Additionally the PHA has identified an additional £230,000 per annum from within its recurring baseline to enhance the available budget for the Lifeline service, giving a total available budget of £3,730,000 per annum. This additional investment, on top of the £719,000 (per annum) budget for the recently commissioned new self-harm intervention programme and £150,000 for targeted interventions for vulnerable groups will enable better service provision to help reduce the number of suicides and incidents of self-harm in Northern Ireland.

In developing this Strategic Outline Business Case, the PHA has sought to ensure value for money, maximising the level and scope of service that can be obtained from the available budget.

Tables 12 and 13 at the end of this section (page 88) set out the affordability and budget.

It should be noted, that the various options have been assessed using the same activity levels for the 'follow on support' (status quo) and follow on support services which are evidence based/informed (options 9 and 10), for comparative purposes. However, as the tables show that options 9 and 10 are lower cost than the status quo, the balance of the budget would be used to purchase additional activity (over and above the proposed new face to face de-escalation and complementary therapies), or for other appropriate services under 'Protect Life', ensuring better use of the existing money to provide additional and enhanced services for those in need.

The proposals within this strategic outline business case are affordable and deliverable within the budget available.

9.2 Commissioning

The service model and delivery mechanism recommended in this Strategic Outline Business Case will be subject to public consultation. Once the public consultation has closed, a Final Business Case will be prepared for PHA board approval,

enabling the Lifeline service to be commissioned (including procurement). The Final Business Case will be prepared, taking account of the findings from the public consultation.

Commissioning of the Lifeline service will include procurement, in line with Public Contracts Regulations 2015, and may also include direct commissioning from a HSC Trust.

The procurement will be taken forward through the HSC COPE[42], (the Business Services Organisation Procurement and Logistics Service – BSO PALS). Given the procurement regulations and BSO PALS advice, it is anticipated that this exercise will take a minimum of 6 months.

Direct commissioning, if appropriate, will be taken forward through the normal HSC arrangements for commissioning services from HSC Trusts.

The Public Health Agency will work towards a managed transition with all key stakeholders to ensure there is a smooth transition and patient safety and service quality are not put at risk.

9.3 Management

Once the service has been commissioned, the service provider/s will be responsible for the day to day management, in line with the tender specification and associated contract. The provider/s will also be required to put robust systems in place to gather and monitor information, as set out in the specification, and to submit regular, agreed, performance monitoring returns to the PHA as service commissioner.

The contract will be managed by the PHA. This will include general oversight and contract management (monitoring performance and payment against the agreed specification and contract). The PHA will consult and involve other relevant partners as appropriate.

9.4 Post Project Evaluation

It is important that the Lifeline Service is robustly evaluated, to assess the impact, effectiveness, efficiency and value for money of the proposed approach, and will

[42] COPE – Centre of Procurement Excellence

seek to measure the success of the service in meeting the objectives set out in section 4 of the strategic outline business case. This evaluation will be undertaken through:

- regular performance monitoring, as set out above, and
- additional specific evaluation

The costs of the specific evaluation have been factored into the monetary evaluation of this case. The evaluation will reflect the availability of robust data at any given point. It will be essential to prepare for this evaluation as the service is commissioned, to ensure that appropriate data is recorded from the beginning.

Table 12: Cash flow statement (capital and revenue)

Cost element	OPTION 5a £000	OPTION 5b £000	OPTION 9a £000	OPTION 9b £000	OPTION 10a £000	OPTION 10b £000	OPTION 1 DO NOTHING £000	OPTION 10b PREFERRED £000	DIFFERENCE BETWEEN OPT 1 & 10b £000
capital costs	-	500	-	500	-	500	-	500	500
funding from CRL	-	- 500	-	- 500	-	- 500		500	500
recurring revenue									
helpline costs	1,404	1,404	1,404	1,404	1,404	1,404	2,245	1,404	- 841
Follow on support or CBPT			774	774	774	774	969	774	- 195
Face to face de-escalation/ complimentary therapy			230	230	230	230	-	230	230
PR & evaluation	190	190	190	190	190	190	150	190	40
Depreciation on commissioned service (non-cash)		100		100	-	100		100	100
Depreciation of existing assets in procured services	100		100		100				
total revenue	1,694	1,694	2,698	2,698	2,698	2,698	3,364	2,698	- 666

Table 13: Budget statement (capital and revenue)

Cost element	OPTION 5a £000	OPTION 5b £000	OPTION 9a £000	OPTION 9b £000	OPTION 10a £000	OPTION 10b £000	OPTION 1 DO NOTHING £000	OPTION 10b PREFERRED £000	DIFFERENCE BETWEEN OPT 1 & 10b £000
Non-cash received for commissioned service		100		100		100	-	100	100
Recurring revenue budget	1,694	1,694	3,730	3,730	3,730	3,730	3,500	3,730	- 230
total	1,694	1,794	3,730	3,830	3,730	3,830	3,500	3,830	- 130

FUNDING AVAILABLE FOR PURPOSE OF ADDITIONAL CBPT/COMPIMENTARY THERAPY SESSIONS	-	100	1,032	1,132	1,032	1,132	136	1,132	536

10. CONCLUSIONS ON EVALUATION OF OPTIONS

This section sets out the conclusions and recommendation of the preferred option resulting from the review of the short listed options.

10.1 Conclusions

The strategic outline business case considered a range of issues and information in relation to the overarching aim of commissioning a Lifeline Helpline along with a range of appropriate follow on support services which are evidence based/informed, building on the learning and evidence from existing services in Northern Ireland and experience and best practice from elsewhere. The Lifeline service, as an integral element of the Protect Life strategy, aims to help reduce the number of deaths as a result of suicide and the number of incidents of self-harm in Northern Ireland, through enabling access to appropriate services for those at immediate risk of suicide and self-harm, or homicide/suicide.

The following objectives were identified:

1. The Lifeline crisis helpline service will provide, through a single point of access, an accessible, effective and timely response for all callers in Northern Ireland at immediate risk of suicide or self-harm, or homicide/suicide;
2. The Lifeline crisis service will provide a virtual safe place for those at immediate risk of suicide, self-harm, or homicide/suicide in Northern Ireland;
3. The helpline will immediately triage and assess individual clients to de-escalate, refer to emergency services and provide advice and signpost to appropriate evidence based and evidence informed services;
4. The Lifeline crisis service will encourage empowerment and enablement for those who contact them;
5. Provision of a range of appropriate evidence based and evidence informed interventions, which promote empowerment and self-management, to which callers to the Lifeline helpline can be signposted;
6. Provision, by exception, should be made to enable those individuals at immediate risk of suicide or self-harm who may find it difficult to make the

initial contact with the helpline service by telephone, to make initial face to face contact with appropriate services;

7. The Lifeline service will develop close links, and will work in partnership, with relevant HSC organisations (including primary care), other statutory organisations and voluntary and community groups;
8. The Lifeline services will ensure effective corporate, clinical and social care governance arrangements are in place and maintained;
9. The Lifeline service will demonstrate value for money within the budget available;
10. Timely introduction of new service at the end of the current contract period, with a smooth transfer;
11. Provision of an effective marketing and communication programme, which is responsive to suicide and self-harm trends in Northern Ireland, and continues to raise awareness of the Lifeline service year on year.

The options were divided into 'model' options and options for 'securing the service'. Four 'model' options were shortlisted, as follows:

- Option 1 - Status Quo
- Option 5 - Single regional Lifeline helpline with agreed referral pathways to emergency services and signposting to other existing services
- Option 9 - Single regional Lifeline helpline, referral to emergency services and signposting to associated follow on support services which are evidence based/informed (regional contract)
- Option 10 - Single regional Lifeline helpline, referral to emergency services and signposting to associated follow on support services which are evidence based/informed (at least 5 contracts in line with LCG/Trust areas)

A further two options for securing the service were shortlisted, as follows:

- Option A - Procurement of the Lifeline helpline services
- Option B - Commissioning of the Lifeline helpline from the NI Ambulance Service

(The option to procure support services, rather than commission directly from HSC Trusts, was also shortlisted. However, as it is integral to the four shortlisted 'model' options, it was not evaluated again as a separate option.)

Monetary and non-monetary costs and benefits of each of the above options were assessed. This can be summarised as follows:

Table 13(a): Non-Monetary Costs and Benefits

	Model Options				Delivery Options	
	Option 1	Option 5	Option 9	Option 10	Option A	Option B
Non-monetary score	310	195	335	390	375	420

Table 13 (b): Monetary Costs

	Options/ £000						
	1	5a	5b	9a	9b	10a	10b
NPC	9,425	4,746	4,746	7,558	7,558	7,558	7,558
Annual Operating Costs & revenue	3,364	1,694	1,694	2,698	2,698	2,698	2,698

As can be seen from the tables above, options 10 and B score the highest in terms of non-monetary costs and benefits. While option 5b has the lowest monetary cost, it is deemed that this option would not be acceptable as it scores the lowest in respect of non-monetary costs and benefits (given that it only includes a helpline, and no associated support services). Options 9 and 10 are both lower cost than the status quo. (It should be noted that for both of these options, while the running costs of the proposed service are lower, the full budget would be utilised, to enable more activity to be purchased, or used for other appropriate services under 'Protect Life', hence better value for money, combined with enhanced service provision). Capital costs are disclosed through depreciation included in the operating costs.

10.2 Recommendation

Based on both the assessment of the monetary costs and non-monetary costs and benefits option 10b (Single regional Lifeline helpline, commissioned directly from

NIAS, referral to emergency services and signposting to associated follow on support services which are evidence based/informed (at least 5 contracts in line with LCG/Trust areas), is recommended as the preferred option.

While it is noted that option 10 had the highest risk score, it is also recognised that there was relatively small variation between all the options. It is believed that the risks are manageable, and the perceived benefits outweigh the risks. Robust risk management will be built into the continuation of this project.

It is recommended that PHA now conducts a comprehensive public consultation and equality impact assessment on the future model of the Lifeline service, seeking views and inputs on the proposed new model. Once the public consultation closes, the results will be used to inform a final business case, before moving to commission (including procure) the Lifeline service.

APPENDICES

APPENDIX 1

Table 14: Crude rates per 100,000 population) of registered suicides in Northern Ireland by age and gender, 3 yr moving average.

	Reg Year	All ages	15-19	20-24	25-29	30-44	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	≥75
All	2011/2013	15.9	13.2	22.1	27	25.7	25.1	24.1	20.8	21.6	20.1	16.7	12.5	7.6	6.6
	2010-2012	16.2	15.0	28.3	28.3	25.8	21.6	24.0	21.1	20.8	18.0	14.6	12.9	7.8	7.8
	2009-2011	16.0	14.9	27.8	26.2	26.5	21.7	25.8	24.4	19.4	17.3	13.2	12.2	7.4	8.3
	2008-2010	15.9	16.8	23.6	27.4	21.2	23.7	29.4	26.8	20.5	14.4	13.0	11.3	8.0	7.8
	2007-2009	14.7	14.7	16.9	25.8	19.9	22.8	26.5	24.4	19.5	17.6	11.0	14.4	5.4	7.4
	2006-2008	15.4	16.9	18.9	25.4	20.0	24.8	25.8	25.0	22.9	17.6	14.2	13.0	5.5	6.9
	2005-2007	14.3	13.6	19.5	19.9	21.4	21.8	21.1	22.5	23.8	18.7	14.9	11.9	6.1	6.4
	2004-2006	12.6	12.4	17.8	17.4	19.6	20.6	17.5	20.2	21.6	13.5	15.5	8.6	6.2	4.9
	2003-2005	9.8	7.8	14.0	13.6	16.7	15.4	14.1	17.1	15.2	10.2	11.9	8.3	5.7	4.7
	2002-2004	9.3	6.5	13.2	18.7	17.2	13.8	13.0	18.5	13.2	6.4	7.7	7.4	3.4	5.1
	2001-2003	9.5	7.3	15.6	19.5	18.7	12.5	14.4	17.7	12.6	5.4	5.3	7.5	6.9	5.2
MALE	2011/2013	24.6	20.5	36.1	45.5	43.3	36.8	34.1	29.0	36.4	29.8	23.1	19.4	15.2	12.6
	2010-2012	25.1	22.6	45.3	46.4	42.4	33.2	37.0	30.5	34.6	26.6	18.2	19.3	15.7	15.9
	2009-2011	24.9	21.4	44	43.1	44.9	34.6	36.9	34.9	29.2	26.5	18.4	20.1	13.7	16.4
	2008-2010	25.2	25.1	38.2	44.1	36.7	38.6	43.2	40.2	30.5	23.4	17.1	20.9	12.7	16.0
	2007-2009	22.9	22.6	28	40.7	33.7	38.1	37.4	36.1	27.4	27.1	15.1	22.7	7.1	15.6
	2006-2008	24	26.3	29.9	40.6	33.5	38.2	39.6	39.8	30.5	27.3	20.0	18.6	8.5	14.4
	2005-2007	22.2	21.4	31.3	32.7	34.2	34.8	34.7	35.5	32.5	24.6	22.9	16.0	8.7	12.3
	2004-2006	19.7	19.2	29.5	28.2	31.8	32.0	29.9	33.3	29.8	17.7	22.9	12.2	8.8	8.4
	2003-2005	15.3	12.7	22.9	23.0	23.4	25.5	23.4	26.7	21.5	12.2	17.8	12.4	7.7	9.4
	2002-2004	14.4	10.3	22	31.6	22.3	21.8	20.5	27.8	19.8	9.4	11.5	11.6	5.2	10.5
	2001-2003	15.5	12.4	27.8	34.4	27.3	20.7	23.3	24.6	21.3	7.4	9.1	13.9	10.5	10.8
FEMALE	2011/2013	7.5	5.5	7.7	8.9	9.1	13.8	14.6	12.9	12.6	10.4	10.5	6.0	1.0	2.7
	2010-2012	7.5	7.1	10.7	10..5	9.8	10.4	11.5	12.0	12.9	9.3	11.2	7.0	1.0	2.7
	2009-2011	7.3	8.2	11.0	9.5	8.4	9.1	15.0	14.3	9.9	8.2	8.4	4.8	2.0	3.2
	2008-2010	7	8.2	8.3	10.7	5.8	9.1	16.0	14.0	10.7	5.5	9.1	2.5	3.9	2.8
	2007-2009	6.9	6.5	5.2	11.0	6.4	7.8	16.0	13.2	11.7	8.2	7.1	6.9	4.0	2.4
	2006-2008	7.3	6.9	7.3	10.3	6.9	11.8	12.5	10.8	15.3	8.2	8.7	8.0	3.0	2.4
	2005-2007	6.6	5.3	7.0	7.1	9.0	9.2	8.1	10.0	15.1	12.9	7.4	8.1	4.1	2.9
	2004-2006	5.7	5.2	5.6	6.7	7.7	9.6	5.6	7.5	13.4	9.5	8.5	5.5	4.1	2.9
	2003-2005	4.5	2.6	4.7	4.3	10.2	5.5	5.2	7.7	8.8	8.2	6.4	4.6	4.1	2.0
	2002-2004	4.4	2.6	4.2	6.1	12.1	6.0	5.8	9.2	6.8	3.5	4.1	3.7	2.0	2.0
	2001-2003	3.8	2.1	3.0	4.7	10.4	4.5	6.0	10.8	4.0	3.5	1.7	1.9	4.1	2.0

APPENDIX 2

Summary from Lifeline Pre Consultation Engagement, 1 April 2014 – 24 June 2014.

No	Suggested Action	Included in Business Case	Rationale for Public Health Agency decision
1	Maintain Lifeline as a crisis response service for people at immediate risk of self-harm and suicide	Yes	With limited funding, prioritising those in greatest need will be the focus of any future business case
2	Expand the Lifeline service to provide longer term interventions	No	The funded is not available for expansion within the current budget. The initiative is for a short term crisis response service and signposting on to existing providers of specialist and longer term support services.
3	Lifeline interventions which are evidence based, evidence informed as an effective suicide prevention crisis response.	Yes	To meet the service objectives of reducing risk of suicide and self-harm interventions must be evidence based, evidence informed. This is also critical in order to ensure the effective use of public money.
4	Create a standalone separate call line and support service for the prison population.	No	While the prison population have access the Lifeline helpline it is not in the gift of the PHA to commission a separate standalone helpline service for the prison population, nor is there additional funding available within current budget allocation. The Lifeline helpline can only refer / signpost prisoners to appropriate services provided by, and agreed in advance with, the prison service and prison health service provider.
5	Provision of physical safe places under Lifeline	No	The funding is not available in Lifeline budget to provide this service to the standard required to meet governance standards and manage risk. Lifeline aims to provide a virtual safe place.

No	Suggested Action	Included in Business Case	Rationale for Public Health Agency decision
6	The Helpline will be developed to include emerging technologies.	Yes	To meet the needs of a diverse population demographic and in response to particular identified at risk demographic group including young people, socially isolated, etc.
7	Development of Lifeline helpline into a 'call centre' model to manage all mental health, suicide prevention cases and onward referral	No	A diverse population with a diversity of needs requires a range of helpline providers to meet diverse needs. The PHA aim to ensure there is sustainable competition in the market. To provide service user choice.
8	Lifeline to become a referral pathway into HSC Trust mental health services	No	GPs to be maintained as the established referral pathway between community and HSC Mental Health Trust services to provide continuity ensure clarity of roles and responsibilities.
9	Operate helpline only outside 9-5 office hours.	No	Pre engagement public consultation response indicates one of the key benefits of the helpline is the 24/7 facility.
10	Develop Lifeline in Republic of Ireland (RoI) and rest of United Kingdom	No	This is outside the remit of the PHA. RoI has no plans to establish a service similar to Lifeline. Scotland already has Breathing Space a service linked to NHS24. England and Wales will make their own decisions on crisis response.
11	Lobby for additional funding to expand the Lifeline provision	No	The PHA agency as an Arms Length Body is not in a position to lobby.
12	Link Lifeline with future emerging developments such as Primary Care Hubs	Yes	The PHA considers linking Lifeline with emerging develops such as primary care hubs as important to promote effectiveness and efficiency.

No	Suggested Action	Included in Business Case	Rationale for Public Health Agency decision
13	Separate the helpline from the counselling element. Lifeline counselling to be provided by locality providers.	Yes	Promotes competition in the market. Builds community capacity. Improves the link between short and longer term provision within localities. Improve equality of provision across the region including rural areas and access for identified at risk groups. Separation should enable a focus on improving Lifeline Key Performance Indicator targets. Encourage collaborative approaches.
14	Lifeline will develop methods of evaluating clinical impact	Yes	Required to monitor the effective use of public money.
15	Helpline call operators are not required to be professionally qualified but have the relevant experience and receive appropriate training.	Yes	Promotes competition in the market. Cost effective use of resources.
16	Mechanisms to feedback issues relating to Lifeline	Yes	Important to ensure effective governance and with the use of public money
17	Development of MOU / working protocol with emergency services	Yes	It will be important to ensure that there are formal protocols in place to ensure an effective care pathway for individuals at immediate risk which does not necessary need to take the form of a MoU.
18	More than six Lifeline counselling sessions can be offered	Yes	Ensure that there is flexibility in provision the PHA recognise that a small percentage of service users may require more than six sessions.
19	To provide family assessment and / or therapy under Lifeline	No	Duplication of existing provision. No evidence that this is an appropriate intervention in crisis.

No	Suggested Action	Included in Business Case	Rationale for Public Health Agency decision
20	Lifeline counselling only to be delivered by qualified counsellor to diploma level and working towards accreditation	Yes	To ensure governance arrangements. Management of clinical risk. In line with PHA quality standards.
21	Provide a check-in and outreach service	No	In line with Transforming Your Care Lifeline promotes independence and personalisation of care. Follow-up may be provided through 'enhanced signposting' to a small number of vulnerable helpline callers to assist access to evidence based, evidence informed services. The provision of face to face de-escalation, by exception will provide an additional resource for a small number of people at risk who will not or cannot contact the helpline.
22	Adapt the promotion and public awareness message	Yes	Lifeline communication strategy will continue to be responsive and deliver media messages based on what works.
23	Amend Lifeline key performance indicator targets	Yes	Key indicator targets are always be subject to review, remaining focused on the core function of Lifeline - a safe, rapid response intervention.
24	Involve community and voluntary representatives and service user advocate representatives to inform the Lifeline service.	Yes	The PHA are committed to ensuring continued service user / carer involvement to inform the Lifeline service and ensuring mechanisms are in place for engagement with the community and voluntary sector.

APPENDIX 3

Definitions:

Care pathway – a route for the care needed to help a person to move through the different services they may need.

Community Based Psychological Therapies (CBPT) are methods used to facilitate change in an individual based in a community setting. Psychological interventions are specifically activities used to modify an individual or group's behaviour, emotional state, or feelings.

Complementary therapies are services that are complementary to, and run alongside, treatment services and which are non-invasive in nature. They should not be seen as a standalone treatment, rather to facilitate engagement in treatment interventions. These will include reflexology, aromatherapy and body massage. 'Alternative therapies' including acupuncture, herbal remedies, homeopathy etc are not included. Complementary therapies will be available for adults over 18 only.

De-escalation – the caller is verbally engaged and a collaborative relationship is established between the call operator and the caller, enabling the caller to be verbally de-escalated out of their agitated state. Verbal de-escalation is the key to engaging the caller and helping them to become an active partner in the evaluation of their situation and the next course of action. The 3 main objectives are:

- Ensure the safety of the caller and others in the area;
- Help the caller to manage their emotions and distress and maintain or regain control of their behaviour;
- Avoid coercive interventions that escalate agitation.

Referral – request by the call-operator on behalf of the caller, following assessment, for immediate assistance/intervention, for one or more callers (eg where there is a potential cluster) from health care professionals (through NIAS) or police (PSNI). The referral should be sent with basic personal information and assessment information gathered from the caller at point of contact and assessment. Referrals will normally only be made where the caller is actively suicidal and where immediate intervention is required to prevent death or serious physical harm.

Risk assessment – (in medical use) a gathering of information and analysis of the potential outcomes of identified behaviours. Identifying specific risk factors of relevance to an individual, and the context in which they may occur. This process requires linking historical information to current circumstances, to anticipate possible future change.

Signpost – During the conversation the call operator will listen to the caller, feedback, provide advice and support, and guide/enable them to identify the next course of action.

They will provide information about relevant health and care services/sources of support and or information, and how these can be accessed, but leaving the responsibility of following up to access these services/support with the caller.

Primary Care Talking Therapy Hubs – This is a new model currently being commissioned by the HSCB for the treatment of people with common mental health problems. It is a new care pathway for adults who meet the criteria under NICECG: 123 – mental health diagnosis that does not meet the threshold for a statutory mental health referral.

Homicide/suicide - one or more homicides with the subsequent suicide of the perpetrator

Triage – (in medical use) the assignment of degrees of urgency, to decide the order of treatment of a large number of callers / clients.

Appendices 4 and 5 attached in separate documents