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Lancashire and South Cumbria ICS

Suicide Prevention Training Specification

Contents

Introduction

Context

This specification outlines the requirements of all age suicide prevention training (including mental health awareness and self-harm) across the Lancashire and South Cumbria Integrated Care System (L&SC ICS). Commissioners view this as a key element of place based prevention in the mental health agenda.

Suicide prevention, mental health awareness and well-being is a priority for L&SC ICS, with recognition that there is no health without mental health.

Suicide Prevention, is one of the cross cutting work streams within the L&SC ICS. The vision for the Lancashire and South Cumbria Suicide Prevention is:

"*Lancashire and South Cumbria residents are emotionally resilient and have positive mental health*".

L&SC ICS has developed an action plan based on national guidance and local information as a vehicle to deliver the Governments national target of a 10% reduction in suicides by 2021. The L&SC ICS Suicide Prevention Logic Model (see appendix 1) which was endorsed and agreed in November 2017, has 5 pillars:

- Leadership
- Prevention
- Intervention
- Post Vention
- Intelligence

L&SC ICS has been successful in securing nation investment from NHS England who are investing in 8 ICSs (STPs) of 44 nationally to support suicide prevention.

The funding provided by NHS England must prioritise:

a) Prevention beyond secondary services: place-based community prevention work targeting; middle-aged men and/or primary care support

AND/OR

b) Reduction within services via quality improvement: self-harm care within acute hospitals and/or generally within mental health services. This should account for people with diagnoses of personality disorder.

L&SC ICS requires potential providers to work beyond this requirement, providing an all age focus on mental health and suicide prevention.

National Strategic Background

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men. Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own

lives. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death.

More than a quarter (28 per cent) of suicides were amongst people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013. However, suicides amongst inpatients in mental hospitals have significantly declined over the same period, as a result of better safety precautions.

Suicide is the second leading cause of maternal death, after cardiovascular disease.

The Mental Health Five Year Forward View (FVFV) https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf Recommendation 3: The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, reviewed annually thereafter and supported by new investment.

Lancashire & South Cumbria Integrated Care System

Designed to bring together the NHS, Local Government, Communities and Community Organisations; the key strategic partners are:

- NHS England- North West Coast Strategic Clinical Network
- Clinical Commissioning Groups (CCGs) - Greater Preston, Chorley and South Ribble, East Lancashire, West Lancashire, Blackpool, Fylde and Wyre, Morecambe Bay, Blackburn with Darwen
- Local Government - Lancashire County Council, Cumbria County Council, Blackpool Council, Blackburn with Darwen Council
- NHS Acute and Community Trusts - Lancashire Teaching Hospitals NHS Foundation Trust, University Hospitals of Morecambe Bay NHS Foundation Trust, East Lancashire Hospitals Trust, Blackpool Teaching Hospitals NHS Foundation Trust, Lancashire Care NHS Foundation Trust, Cumbria Partnership Foundation Trust
- VCFS sector
- Prisons
- Lancashire Constabulary
- Cumbria Constabulary
- North West Ambulance Trust

The L&SC ICS is made up of 5 Integrated Care Partnerships (ICPs) Localised Health & Care Economies who form and facilitate partnerships with local communities and community organisations. The five local Integrated Care Partnerships and their respective populations are as follows:

ICP and population

ICP	Population
Central Lancashire	**392, 809**
Fylde Coast	**350,646**
Morecambe Bay	**345,853**
Pennine Lancashire	**556,769**
West Lancashire	**113,697**
Total	**1,759,774**

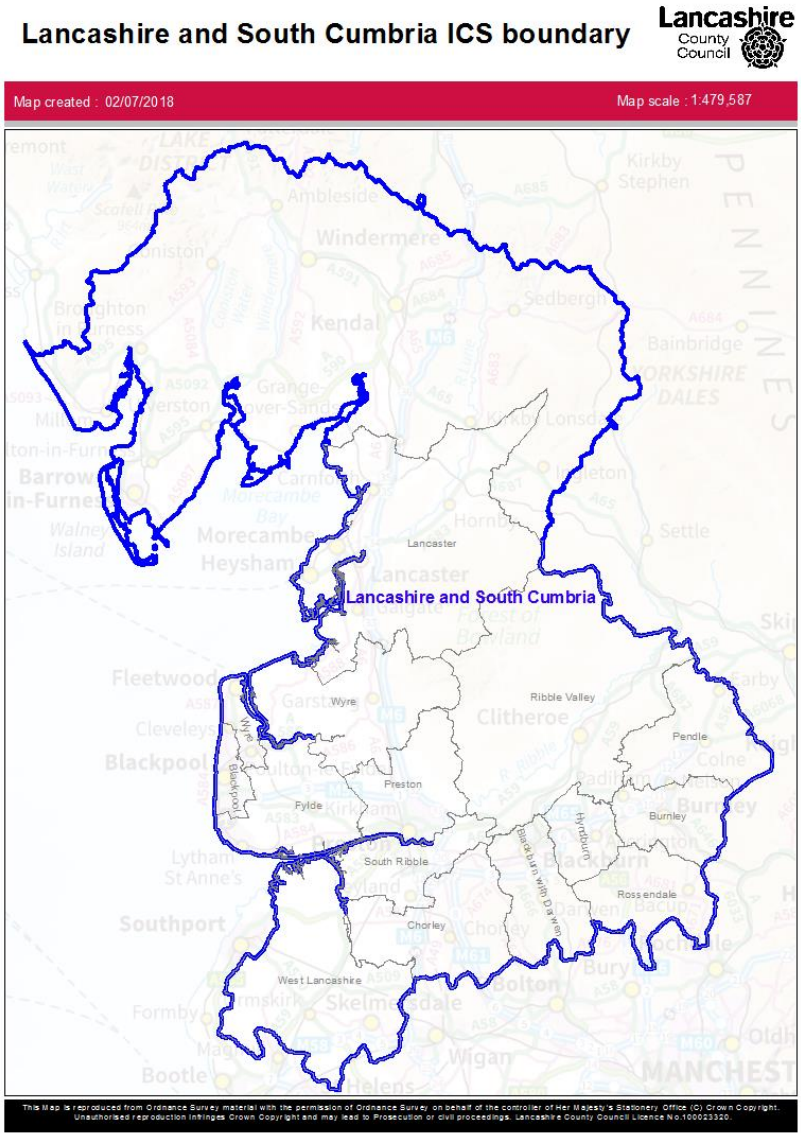
Table SAPE19DT5: Mid-2016 Population Estimates for Clinical Commissioning Groups in England by Single Year of Age, Persons – Office for National Statistics

See table below for populations of the eight Clinical Commissioning Groups within the ICS:

Source NHS Digital

CCG	Registered patient by area
BLACKBURN WITH DARWEN CCG	174,986
BLACKPOOL CCG	173,268
CHORLEY AND SOUTH RIBBLE CCG	183,432
EAST LANCASHIRE CCG	381,783
GREATER PRESTON CCG	209,377
MORECAMBE BAY CCG	345,853
WEST LANCASHIRE CCG	113,697
FYLDE & WYRE CCG	177,378
Lancashire & South Cumbria STP	1,759,774

See diagram 1 below for a geographical map of the L&SC ICS:


Lancashire and South Cumbria ICS boundary
Lancashire County Council
Map created : 02/07/2018
Map scale : 1:479,587
Lancaster
Lancashire and South Cumbria
Wyre
Ribble Valley
Pendle
Preston
Fylde
Burnley
South Ribble
Rossendale
Chorley
West Lancashire
Windermere
Kendal
Morecambe
Heysham
Fleetwood
Blackpool
Clitheroe
Southport
Bootle
Wigan
Bolton
Skelmersdale
MANCHESTER
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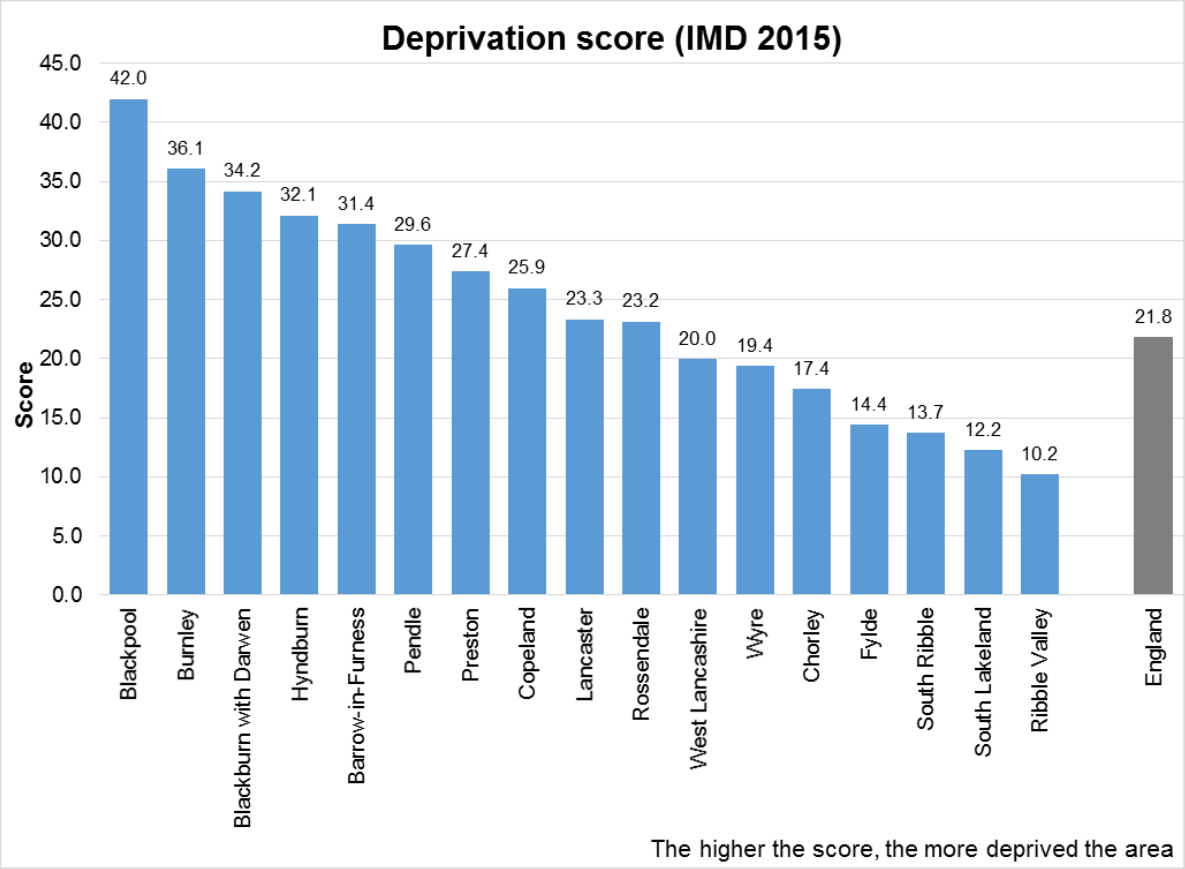
The table below shows the geographical area of L&SC ICS includes the following districts:

ICP	Central Lancashire	Fylde Coast	Morecambe Bay	Pennine Lancashire	West Lancashire
Districts	Chorley	Blackpool	Barrow-in Furness	Blackburn with Darwen	West Lancashire
	Preston	Fylde	Lancaster	Burnley	
	South Ribble	Wyre	Millom & Environs	Hyndburn	
			South Lakeland	Pendle	
				Ribble Valley	
				Rossendale	

The geographical area of L&SC ICS includes the following districts **Local authority**	**Part of ICS**
Barrow-in-Furness	Whole
Blackburn with Darwen	Whole
Blackpool	Whole
Burnley	Whole
Chorley	Whole
Copeland	6 LSOAs
Craven	3 LSOAs
Fylde	Whole
Hyndburn	Whole
Lancaster	Whole
Pendle	Whole
Preston	Whole
Ribble Valley	Whole
Rossendale	Whole
South Lakeland	Whole
South Ribble	Whole

West Lancashire	Whole
Wyre	Whole

The Graph below shows the Deprivation Score (IMD 2015)



Lancashire and South Cumbria ICS Current Suicide Profile

The L&SC ICS has established a Suicide Prevention Oversight Group which will work across the ICS to achieve the national target of a 10% reduction in suicides by 2020.

The data presented below focusses on Suicide rates in and across the L&SC ICS and the main findings of Local Authority level suicide audits across the ICS footprint.

L&SC ICS is ranked 4th nationally for the rate of suicide (age standardised per 100,000 population, 2013-15) with a rate of 12.2. This compares to a range between 15 and 7 across England.

On the same basis the ICS is ranked 5th for male suicides with a rate of 18.6 and 8th for female suicides with a rate of 5.9.

Male deaths are highest in the 30-44 and 45-59 age groups with rates of 27 and 24.5 per 100,000 population. Female deaths also peak in these same age ranges with rates of 7.4 and 7.9 respectively.

Table (3): The L&SC ICS ranks as follows across the age ranges compared to other ICS's:

Age range	National STP ranking
10-29	11th
30-44	5th
45-59	8th
60-74	9th
75 and over	18th

Within the ICS footprint Blackpool (16.0), Hyndburn (15.3) and Preston's (13.7) suicide rates are significantly higher than England. Blackpool and Preston share 21% of all suicide deaths across the ICS local authorities. The local authorities of Barrow-in-Furness, Blackburn with Darwen, Chorley, Copeland, Fylde, Hyndburn, Lancaster and Ribble Valley appear to be showing an increasing rate; the England rate is showing signs of stabilisation.

Self-harm is known to be a significant risk factor in suicides. Within the ICS nine local authorities have rates of emergency hospital admissions for intentional self-harm that are significantly worse than England. Blackpool (578.9per 100,000) and Barrow in Furness (342.9) are the two local authorities with clearly higher rates than the rest of the ICS; the England rate is 185.3.

Each of the local authorities within the ICS has conducted suicide audits over recent years. Whilst not identical in methodology, the audits have raised a number of emerging themes that are common across each. The stand out common themes are as follows:

- Depression/mental illness
- Alcohol and substance misuse
- Self-harm
- Relationship breakdown
- Financial difficulty

The suicide rate amongst men in Lancashire & South Cumbria is higher than in other age groups and females, as follows:

Table 4: Lancashire and South Cumbria STP Suicide Rates 2013-2015 per 100,000 population

2013-2015 suicide rate Lancashire & South Cumbria STP

Age	Male	Female	All persons
10-29	8.9	4.5	6.7
30–44	27	7.4	17.1
45–59	24.5	7.9	16.2
60–74	16.7	4.0	10.2
75 and over	14.9	5.1	9.2

Risk factors for suicide

Training should also reflect local evidence on the wider determinants as determined by both national data and local suicide audits. Examples include:

Risk factors for suicide	Protective factors for suicide
Contextual factors	
Area deprivation (adverse economic and labour market conditions: poverty and inequality, unemployment) Neighbourhood violence, crime and fear of crime Lack of affordable housing, homelessness Poor access to high quality public services (health, education, criminal justice, social care) Social or cultural discrimination (negative attitudes to mental illness and suicidal behaviour, gender stereotyping, homophobia, racism) Lack of opportunities to participate in community life,	High area socio-economic development Financial security and stable economic conditions (high stable employment, low inequalities) Safe and secure living environment Safe and affordable housing Access to high quality public services (health, education, criminal justice, social care) Fair and tolerant community

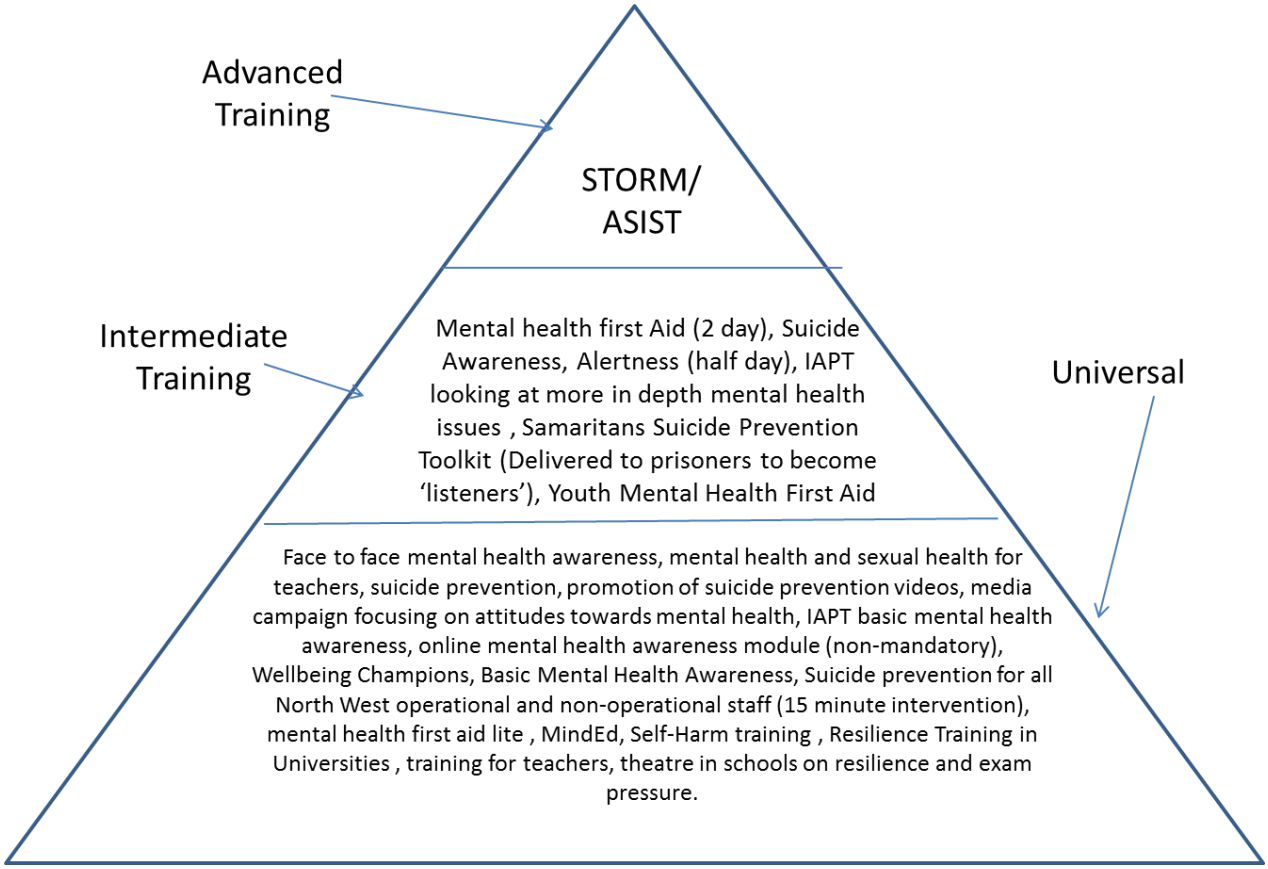
low social cohesion, little control over community resources, rural isolation Irresponsible media reporting and representation of mental ill-health, suicide and suicidal behaviour Availability of, ease of access to, and lethality of method	Opportunities to participate in community life, high social cohesion, high control over community resources, supportive rural communities Responsible media reporting and representation of mental ill-health, suicide and suicidal behaviour Restricted access to methods of suicide
Individual factors	
Socio-demographic characteristics: gender (male), age (young-middle aged), low socio-economic status, 'high risk' occupation, unemployment Mental illness or disorder or history of self harm, with inadequate care, treatment and support towards recovery Chronic pain or illness and inadequate access to high quality health and social care Alcohol and other drug problems Personal history of abuse, violence, or bullying Family dispute and dysfunction, separation, divorce, single person households, bereavement Family history of suicide or mental illness School failure, low educational achievement Low self-esteem, lack of confidence, poor coping and problem solving skills Lack of meaning and purpose in life, little sense of control over life circumstances Inability to handle life stressors, hopelessness, rumination, impulsivity Peer rejection and social isolation, imprisonment	Socio-demographic characteristics: gender (female), age, higher socio-economic status, low occupational exposure to risk Mental health and wellbeing Good physical health and access to high quality health and social care when necessary No alcohol or other drug problems Physical and emotional security Family harmony, supportive and caring parents/family, stable marriage No family history of suicide or mental illness Positive educational experience Positive sense of self, self-confidence, good coping and problem solving skills Sense of meaning and purpose in life, sense of control over life's circumstances Ability to handle life stressors, positive outlook and attitude to life Supportive social relationships, sense of self-determination

One element of this work-plan is to increase the skills and capacity of the wider public health workforce within partner organisations and communities, particularly the children and young people's workforce, and to support an assets approach to improving well-being.

Current Provision across the L&SC ICS

Current provision across the L&S ICS is by locally commissioned providers delivering a range of local and international programs, often utilising freelance trainers. The diagram below highlights what is currently available/commissioned across the L&S ICS.

NOTE: That the Universal offer of Zero Suicide Alliance and Mind Ed are not included in the scope of this commission.



Targeted population for training programme:

Commissioners expect provider(s) to explicitly target:

- children and young people and young adults as key risk groups for self-harm:
- Middle aged men and
- Women in the perinatal period as key risk groups for suicide.

Commissioners expect provider(s) to target work place, educational and community settings to ensure we raise awareness of mental health, self-harm and suicide and build resilience across communities.

Provider(s) will also deliver tailored, place based community focused workforce development interventions, targeting:

- Those in contact with vulnerable/potentially high risk adults, in particular middle aged men experiencing deprivation
- Those in contact with CYP at risk of self-harm and suicide as this is ultimately the way to reduce acute self-harm presentations
- Primary care support (e.g. in Integrated Care Communities (ICCs) or equivalent neighbourhood)

Provider(s) must work in close conjunction with the ICS suicide prevention team, local public health teams, and statutory, commissioned, and VFS providers of existing suicide prevention interventions, in order to avoid duplication and maximise added value.

Provider(s) should consider targeting the following settings and/or organisations as a minimum requirement:

- Building and Trade contractors
- NHS – hospital and integrated care communities, primary care (optometrists; pharmacists; dentists; GPs), Maternity and Peri-Natal Team
- Blue light services
- Local Authorities
- DWP, job centres, citizens advice and equivalent
- Telecoms industry
- Prisons and Youth and adult criminal Justice Settings
- Probation service and Community Rehabilitation Company
- Workers in major local industries (e.g. Nuclear, and Aerospace, pharmaceutical industries
- Rural and agricultural workers
- Early Years and Nurseries
- Schools
- University campuses and Colleges
- Sports clubs and venues

- Voluntary, Community and Faith sector, including organisations supporting Veterans

There needs to be a particular emphasis for the first 6 months of the plan targeting those areas that have the highest suicides e.g. Preston, Blackpool and Hyndburn. The training provider will liaise with local public health teams and providers of existing interventions to avoid duplication and maximise added value.

Suicide Prevention Training Service requirements

Aims and objectives

The L&SC ICS wish to implement a training programme to increase capacity to support people to address the psycho-social determinants of their mental health within a whole system approach to mental health for all ages. The programme will increase community capacity for well-being by:

- To establish a consistent, evidence informed approach to training that delivers consistency and best practice within each ICP area or ICC/ Neighbourhood across L&SC .
- To co-produce in collaboration with those with lived experience, communities, work places and aligned professionals to ensure meaningful and targeted training is delivered.
- Improve the engagement of individuals, communities and health professionals in public mental health initiatives.
- Increase resilience in communities and workplace settings in relation to mental health, suicide awareness and self harm.
- Raise awareness of risk factors and high risk groups across the age spectrum.
- Raise awareness of specialist interventions e.g. Cluster management
- Reduce inequalities in accessing information and increasing awareness of mental health and well-being and the Five Ways to well-being.

Specific programme objectives include:

- A life course approach with specific focus on
    - Young people
    - Women in the Perinatal period (during pregnancy and 12 months after birth) and
    - Middle aged men, especially those experiencing deprivation
- To develop, promote and co-ordinate training programmes to equip individuals and professionals working in multiple settings to recognise emotional distress and develop well-being promoting skills and increase knowledge of mental health and suicide prevention.
- To develop and deliver Universal, Intermediate and Specialist levels of training.

- A training programme to be delivered based on the weightings detailed on page 16 using evidence-informed training packages wherever possible e.g. existing packages such as ASIST or new training programmes developed by providers, supported by a clear theory of change which responds to local data and community voice.
- Targeting of specific work places and or organisations known to employ target groups i.e. Building Trade, Prisons, major local employers
- General workforce development across the ICS including those that are currently being trained e.g. student engineers, health and care professionals in training, student teachers
- Training in local communities to improve community resilience, this must include VCFS, community groups and community members.
- To co-ordinate the bookings and delegate information as appropriate for the course.
- Within the resource allocated to each ICP area seek to innovate/ test and learn evidence based approaches that complement the universal/ already commissioned services to avoid duplication (*please liaise with local Public Health teams regarding other commissions)*
- To evaluate the impact of the training programme on attendees' confidence to deliver support and information, and increased capacity.
- To support the evaluation of the training programme in partnership with Liverpool John Moores University.

Expectations of the Provider:

- The Provider(s) shall ensure that information, materials and resource packs provided to Service Users reinforce consistent, evidence-informed messages around suicide prevention, resilience and emotional health and wellbeing.
- The Provider(s) shall encourage ongoing and continued learning and improvement in this area of work.
- The Provider(s) will collect a comprehensive range of short and medium term monitoring and evaluation information about the effectiveness of the training and its practical implementation i.e. DNA's, target groups, practice development. This should include follow up of Service Users after 3 months. It should also include evidence of iterative reflection and learning , by the Provider(s), on what is working well, not so well, any 'hidden gems' and any modifications to delivery as a consequence.
- The Provider(s) shall use a range of technology platforms such as websites and apps. to support the promotion and delivery of the training programme.
- The Provider(s) shall ensure training materials are available in a range of accessible formats and mediums to meet the language and literacy needs of Service Users and their clients.
- The Provider(s) shall collaboratively work with providers of other training programmes (e.g. statutory mental health providers, other NHS Trusts) to

avoid duplication and to ensure synergy, and alignment of suicide prevention training opportunities across the ICS/ ICP/ ICC footprints

- The Provider(s) is expected to tailor sessions to organisations' individual needs and client focus as required. For example, when delivering training to prevent suicide and self-harm in young people, he Provider(s) will target the following : schools staff/ college/university staff, Council children's services, public health/ school nurses, child protection and early help workers, , police, NHS including Primary Care and Acute settings, and third sector organisations working with young people e.g. Young Carers Organisations.

Supporting joined up action to prevent suicides across the L&S ICS

The Provider(s) shall be an active member of the L&SC Suicide Prevention Oversight Board attending quarterly meetings convened by the Commissioner and supporting the ongoing development of the L&SC Suicide Prevention Logic Model Action Plan by:

- disseminating and sharing good practice locally
- supporting the development and implementation of local, regional and national policy.
- contributing to local/ national consultations and strategic planning e.g. local STP's
- contributing to local research/audit
- contributing to the ongoing development of suicide prevention care pathways for adults and young people
- contributing to the co-production of suicide prevention conferences/learning/media events
- contributing to ensuring positive media engagement in reporting suicide and suicide prevention messages
- supporting third sector involvement in delivering the L&S ICS Suicide Prevention Logic Model Action Plan including awareness raising campaigns that target high-risk groups, for example World Suicide Prevention Day.
- The Provider shall respond efficiently to requests from CCGs/ Stakeholders for information on local populations to help inform needs assessments and other reports e.g. JSNA.

Service Delivery Days and Times

The Service shall be provided Monday to Friday (excluding public holidays) during the hours of 9am to 5pm but with flexibility to operate 'out of hours' to meet the needs of Service Users.

Service Delivery Premises

Services shall be delivered to Service Users from premises that support the provision of an effective and efficient service that meets the needs of Service Users and may include:

- Council premises including Sure Start Children's Centres
- School/Further Education/University settings
- Integrated Care Community hubs such as General Practices and/or Community Clinics
- NHS premises: Community hospitals, Integrated Care Community hubs such as General Practices and/or Community Clinics
- Third sector organisational settings
- Other suitable premises

Where use of external venues is necessary, the Service Provider will ensure that they are fully accessible, can be reached by public transport and provide the privacy and confidentiality necessary for suicide awareness or intervention skills training.

Service Delivery Equipment

The Provider is responsible for purchasing within the contract price resources to support the delivery of the Service.

Service Delivery Staffing

All Staff shall have an Enhanced Disclosure and Barring Service check (DBS).

The Provider(s) shall ensure that Staff participates in appropriate safeguarding training.

All Staff will receive annual training on confidentiality and information governance.

Staff shall have appropriate skills, experience and qualifications and should have relevant training e.g. ASIST/ STORM

Staffing and management structures will be streamlined and efficient with all Staff having clear areas of responsibility and remits. The Provider(s) shall have effective performance management measures in place for Staff performance, to include those related to Staff competency and capability, professional development and appraisal procedures. This shall also include evidence of professional updates (where appropriate) and regular supervision.

Staff employed by the Provider(s) shall be able to use technology, input into information management systems and record interventions effectively to ensure that the monitoring reports required for the management of the Contract are accurate.

Quality Assurance

Governance

The Provider is required to demonstrate the principle of 'best value' through continuous service improvement taking into account a combination of effectiveness (successful outcomes), efficiency (high productivity) and economy (costs).

The Provider shall ensure that robust Governance systems are in place to include, but not limited to:

- Service User safety (incident, risk management, alerting system, safe environment, safeguarding).
- Clinical effectiveness considerations (cost effectiveness, evidence-based practice, compliance with NICE guidance, participation in audit and policy development).
- Staff management (continuing professional development (CPD), supervision, equality and diversity, social networking /digital media).
- Service User experience (complaints management, consent, patient/public information, patient/public involvement).
- Information governance (Service User records, data protection, confidentiality).
- The Provider shall have clear policies in place that manage risk/safe working practices and procedures to remedy poor performance.
- The Provider shall report Serious Incidents occurring within the Service in line with process agreed in line with the Council Procedures.
- The provider will have a current written Equality policy that clearly demonstrates: their service delivery practice; Equality employment practice; and provide an accessible and flexible service that is able to target underrepresented groups with protected characteristics.

National Standards, Evidence and Guidance

The Provider shall comply with all applicable legislation, regulations, guidelines and statutory circulars incorporating relevant best-practice including but not limited to:

- Five Year Forward View for Mental Health NHS England, 2016[1]
- Healthy Lives, Healthy People: Our strategy for public health in England, 2010[2]
- Local suicide prevention planning : A practice resource, NPAS 2016[3]
- NICE guidelines e.g. Community engagement: improving health and wellbeing and reducing health inequalities (2016) NG44, NICE guideline CG123 Self-harm (NICE CG16 & NICE CG133)
- No Health Without Mental Health: A Cross-Government Outcomes Strategy for People of all Ages, 2011[4]
- No Health Without Mental Health Implementation Framework, July 2012[5].
- Preventing Suicide in England: a cross government outcomes strategy to save lives, 2012[6]
- Preventing Suicide: A toolkit for mental health National Patient Safety Agency, 2011[7].
- Public Health England Suicide Prevention Planning Guidance- October 2016
- 3rd Progress report of the Preventing Suicide Government Strategy- January 2017
- Health Select Committee Recommendations- January 2017
- National Suicide Prevention Alliance- NSPA Strategic Framework 2016-19
- FYFV for MH

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf
[3] http://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf
[4] www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf
[5] Department of Health, NHS Confederation Mental health Network, Rethink Mental Illness, Turning Point, Centre for Mental Health et al (July 2012) www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf
[6] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england
[7] www.nhsconfed.org/Documents/Preventing-suicide-toolkit-for-community-mental-health.pdf

Contract management

Information Collection and Sharing

It is required that Service Users consent that the Provider collect, store and share all data related to the provision of the Service with the Council and other relevant partners.

The Provider is responsible for ensuring that Service Users records generated during Service Delivery are collated, stored, retrieved and destroyed in accordance with Data Protection legislation.

The Provider and the Council shall ensure that all the necessary permissions and agreed data sharing protocols are in place for sharing information and data with all relevant parties including Service Users.

When confidential data is transferred to the Council, it shall be submitted through an agreed secure portal or via another pre-agreed method which meets the Data Protection guidance.

All ICT hardware including, but not limited to: servers, memory storage devices, routers, computers and mobile devices that are used for the communication and/or recording of data related to the administration, provision and monitoring of the service are to be protected with adequate encryption, antispyware and antivirus software as defined by the Council.

Access to all ICT hardware is to be controlled by physical and remote log-in security measures that prevent unrestricted access to the device and/or its operating system.

When personal data is lost, destroyed and/or damaged by unauthorised and/or unlawful processing of such data, the Provider is required to implement a breach management plan that is to include immediately notifying the Council of the breach.

Service Lead reviews

Service Lead(s) ("Authorised Representative") for the Contract shall in an on-going manner review the Services delivered by the Provider such reviews may include:

- Discussions with Service Users;
- Observing Service Delivery;
- Ensuring the Provider has adequately addressed complaints about the Service received from either: Service Users; Council staff; stakeholder bodies; other interested parties and/or partner agencies.

When the Commissioner (s) determines that service delivery is not fit for purpose and/or putting Service Users at risk the CCG may, alongside other remedial action, increase the frequency and/or number of its quality reviews.

The quality reviews carried out by the Service Lead will, as appropriate, be recorded in the Contract Monitoring Report and as appropriate will be reflected in actions included in the Action Plan.

Contract Monitoring Report and Meetings

The Provider shall submit complete and accurate Contract Monitoring Reports 30 working days after the end of each reporting period in a format agreed by the CCG to the Suicide Prevention Programme Manager.

Quarter	Service Delivery Reporting Period	Contract monitoring Report deadline
3rd	1 October to 31 December 2018	30 calendar days after the last day of the Service delivery reporting period
4th	1 January to 31 March 2019	

The Suicide Prevention Programme Manager and the Provider(s) shall determine if a contract management meeting is required. The decision will be based on:

- the stage of the Contract
- the amount of risk the Contract is exposed to
- the probability of the Contract under achieving its KPIs
- the degree of concern about the quality of Service Delivery

When a contract management meeting is regarded as necessary it shall be held as soon as possible but within 60 working days from the end of each reporting period.

4 Signs of Success

Outputs/Outcomes

No.	Description
1.	Number of training sessions by training type /date/location e.g. male dominated employers e.g. BT, BAE, building and trade companies
2.	Numbers of Service Users who attended training (location/training category/workforce sector) and to include Did Not Attend (DNA) information
3.	Number of staff delivering training.
4.	Number of People trained in the impact/risk of Self Harm
5.	Number trained in mental health awareness
6.	Percentage of those who are trained who report improved knowledge, skills and confidence in identifying individuals at risk and in responding appropriately immediately post training
7.	The percentage of Service Users at 3 months post training session, reporting confidence in disseminating key messages, which help to prevent suicide across their organisation, community, client group. This shall include qualitative impact examples.
8.	Number of Service Users making formal complaints about the service (verbal or written) and evidence of improvements made to the Service as a result of a compliant.
9.	Evidence of improvements made to Service as a result of feedback from Service Users and /or delivery staff.
10.	Number of events co-produced during Suicide Prevention Day
11.	Range of activity supporting the L&S ICS Suicide Prevention Oversight Board

Pathway development

The training providers will be expected to bring added value to their delivery by working with the ICS Suicide Prevention Training Co-ordinator to deliver training across the ICS in line with best practice, data, local expressed need, and targeted requirements.

The providers will need to work with partners including ICS Suicide Prevention Training Co-ordinator and local public health teams to ensure that training outcomes are sustainable and that organisations develop pathways for access to relevant information and onward referral when appropriate.

Allocation of resources

The bidding process and finances will be split into five ICP footprints as detailed below

Bidders can bid for a whole footprint, or for e.g. YP in any number of footprints.

Funding has been split into the five ICP 'lots' on the following basis:

- ICP population 50% (£0·074 per capita)
- Suicide rate 40%

	Suicide Rate per 100,000	Per capita allocation
Central Lancashire ICP	12.343	£0.058
Fylde Coast ICP	13.628	£0.078
Morecambe Bay ICP	13.077	£0.074
Pennine Lancashire ICP	11.958	£0.039
West Lancashire ICP	7.900	£0.006

- Deprivation 10%

	Deprivation Index	Per capita allocation
Central Lancashire ICP	20.1	£0.144
Fylde Coast ICP	27.8	£0.169
Morecambe Bay ICP	21.5	£0.160
Pennine Lancashire ICP	29.3	£0.130
West Lancashire ICP	20.0	£0.146

The ICP allocations are as follows:

ICP	**Funding**
Central Lancashire	£56,547
Fylde Coast	£59,150
Morecambe Bay	£55,432
Pennine Lancashire	£72,283

West Lancashire	£16,588
Total	**£260,000**

Appendix 1 L&SC ICS Logic Model

Lancs SC SP Logic model draft version 2

Appendix 2 Key Documents

https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2016registrations#main-points

https://sites.manchester.ac.uk/ncish/reports/annual-report-2017-england-northern-ireland-scotland-and-wales/

https://www.hqip.org.uk/resource/report-suicide-by-children-and-young-people-2017/#.W1dwNWeovdc

https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

http://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf

www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf

Department of Health, NHS Confederation Mental health Network, Rethink Mental Illness, Turning Point, Centre for Mental Health et al (July 2012)

www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

www.nhsconfed.org/Documents/Preventing-suicide-toolkit-for-community-mental-health.pdf