**Mental Health and Health Inequalities in Lancashire and Cumbria**

**9-11am Friday 12th of November 2021**

**Key points for each question:**

**1. What are the key local issues linking mental health and health inequalities in Lancashire and Cumbria?**

* **Key points from the nearpod:**
	+ Deprivation generally but also specifically within rural and coastal regions
	+ Increased isolation due to the pandemic resulting in increased risks of hidden mental health and crisis
	+ Problems around suitable housing
	+ Types of employment available (e.g. seasonal work)
	+ Financial insecurity
	+ Lack of opportunities for young people, and as a result, reduced aspiration
	+ Lack of strategic/integrated approach to commissioning services and short-term funding for voluntary sector
	+ Need more fine-grained data that gets down to ward level and improves understanding of differences within/between groups
	+ Workforce issues leading to fragile services across public and voluntary ector; recruitment to low income areas a challenge
	+ Childhood adversity and trauma
	+ Lack of inclusion of service-users in planning and service design
	+ Stigma++
* **Key points from discussions:**
	+ Demand for mental health community services ~50% higher than the English average
	+ Transformation Programme around Community Mental Health equates to about £3M investment to respond locally for improving mental health (30% to voluntary sector)
	+ Working towards a procurement framework that ensures fairness in how contracts for provision are awarded and which meets the needs of local communities
		- Feedback from recent event highlighting how commissioning practices and cycles could be improved and how funding can be allocated to support prevention
	+ Need to keep in mind prison populations
	+ Need to keep in mind DWP for any initiatives/training around mental health – significant workforce and already delivering a range of activities designed to support people/businesses around mental health and disability
	+ Some aspects of mental health services have become too transactional or online/app based - the importance of face-to-face and having actual people who can provide support where needed can’t be understated
	+ Need greater alignment in terms of place-based commissioning and delivery across different levels in the system
	+ Fragility in statutory services cause severe knock-on effects, and need greater creativity in roles to address persistent gaps in workforces in different parts of the region (i.e. don’t always have to be clinical/statutory posts)
	+ Stigma around mental health and past experience of engaging with services is hugely problematic – grassroots/community organisations well-placed to help with breaking this down
* **Some links:**
	+ Lancashire Violence Reduction Network: <https://www.lancsvrn.co.uk/>
	+ Changing Futures Programme: <https://www.gov.uk/government/publications/changing-futures-changing-systems-for-adults-experiencing-multiple-disadvantage/changing-futures-changing-systems-to-support-adults-experiencing-multiple-disadvantage>
	+ RECONNECT Care After Custody: <https://www.england.nhs.uk/ltphimenu/wider-social-impact/reconnect-care-after-custody/>

**2. What actions are working and what actions should be taken to improve mental health for better health equality? Who should be responsible/leading this?**

* **Examples from the nearpod:**
	+ Mental health support in schools+++
	+ Hyperlocal joined-up community teams
	+ Community hubs/drop-ins/single point of access – Sure Start worked well
	+ IAPT services
	+ The excellent partnerships already in place (e.g. mental health partnership in West Cumbria)
	+ Asset-based approaches/community development (e.g. Wigan)
	+ Mental health first aid training/improving mental health literacy
	+ Recovery Colleges
	+ Social Prescribers/Health and Wellbeing Coaches/Health Visitors (e.g. Social prescribers based in local government are linked into the community and a wide range of partners and have had beneficial outcomes)
	+ Changing workforce models which involve people with lived experience/peer-support workers
* **Key points from discussion:**
	+ Don’t reinvent the wheel – identify and build upon what’s already there in terms of partnerships and activities for asset building within communities
	+ Homeless Health Hub in Blackpool has been successful, funding secured for mental health service dedicated to supporting homeless communities, now wanting to link up health hub and changing futures work to provide a system/wrap around approach and to reduce ***stigma*** experienced by this group
	+ Local government has an important role in pump primping local voluntary providers and enabling them to make connections [takes time++], examples in West Lancs: sleep support service for children and young people – significant impact on wider families (e.g. parents being able to get back to work); internships for people with learning disabilities and autism – **very difficult to ensure sustainability of successful services due to uncertain funding**

**3. What are the barriers that prevent you from making a step change in health inequalities?**

* **Key points from nearpod:**
	+ Demonstrating cause and effect to direct funding into prevention
	+ Long-term timeframes for impact
	+ Stigma
	+ Many pathways not suitable for people with ASC
	+ Lack of integration between mental and physical health services
	+ Large scale organisational reform
	+ Lack of understanding between NHS and third sector in terms of what each can contribute not just re: service delivery but wider impacts
	+ Need better data to understand outcomes across groups
* **Key points from discussion:**
	+ Transition planning for people is an ongoing challenge (e.g. for people leaving prison)
	+ Need to develop skills as a system around collaborative leadership and for the statutory sector to really understand the value of the leadership that the third sector brings (e.g. innovation, flexibility) – need **equal** recognition in system leadership
	+ From voluntary sector perspective there was a clear lack of prior engagement of the voluntary sector in the development of the procurement framework described earlier – should be involved in design and planning from the outset
	+ There is also a lack of understanding of the importance of infrastructure bodies (e.g. CVS) which means that they are not recognised as having a role in providing co-ordination and support in achieving the objectives of transformation programme (and consequently this work is not funded)

**4. Where are the greatest opportunities for improvement?**

* **Key points from nearpod:**
	+ Early intervention
	+ Greater integration
	+ Long-term investment (e.g. Big Local); targeted investment
	+ Taking a holistic approach; trauma-informed care
	+ Building upon what’s already out there
	+ Value the workforce – make person-centred (doesn’t always require clinically trained intervention)
	+ Greater involvement of wider partners e.g. housing, built environment
	+ Role of anchor institutions
	+ Co-production with local communities – (e.g. ? some services may be designed in a way that does more harm than good for some people (e.g. neurodiverse) but need better data to understand this further)
	+ Go beyond services to address social determinants and grow the social movements needed for change

**Appendix:**

**Contributions from nearpod**

**1. What are the key local issues linking mental health and health inequalities in Lancashire and Cumbria?**

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| * Deprivation
* High levels of poverty
* Prevalence of MH common disorder correlates with Index of Multiple Deprivation. It would be interesting to have the same data on Wards rather than LAs
* Coastal deprivation
* Moving to post industrial society has stripped some people of a sense of identity (and maybe purpose), especially older generations
* Our design of 'Place' is critically important not just for MH but for sustainable communities. Are we designing inclusive Place or are we guilty of being passive and allowing things to slide unchecked?
* The size of the geography some areas of very isolated and deprived e.g. Barrow
* Geographical diversity of rural, urban and distance to services
* Communities in last 2 years but even before then a general trend of becoming insular leading to more social isolation with higher risks of hidden MH, downward spiral of decline leading to crisis, self neglect. suicidal thoughts.
* Something about people feeling happy, content, having self worth and esteem. A lot of the upstream quality of life measures that are preventative and help mitigate risk of MH/depression/anxiety
* Post industrial and coastal communities which are evidenced to have an impact on health equity
* We have lost a lot of infrastructure around 'purpose ' for people living with MH, LD, Autism around quality of life such as FE/HE education, training and employment. Real relationship with SEND and transitions.
* 'Brain drain' of cities such as Manchester and Liverpool has seen many socially mobile young people move out of Lancashire
* Type of employment available
* Better data analysis and presentation from local services using IMD, age, sex, ethnicity. We need to focus on the differences in outcomes by different groups.
* The Blackpool 'Pull'- Historic view of Blackpool, B&Bs becoming HMOs and services stretched
* Poor environment - Housing
* Disparity of reasons for mh issues - rurality, alcohol misuse, hidden dv - need a bespoke response to all of these
* challenges around suitable housing
* Hope, aspiration and opportunity
* We forget about rural deprivation
* Aspirations and opportunities for YP can be limited
* Short term funding is a MASSIVE issue for third sector providers, constantly losing talent
* deprived parents, leading to deprived children and young people - with low aspirations and multi generational poorer outcomes
* Proper co-ordination and focus for funding so that it isn't scatter gun but properly invested and achieving outcomes.
* Childhood adversity and trauma
* Limited opportunities for people
* Housing, training and jobs linked programmes.
* More focus and resource on promoting good mental health. The absence of mental illness/problems does not equal good mental health by default
* West Cumbria has really fragile MH services due to recruitment issues. This means lack of access to services making things more difficult. We need to think very differently about new roles and cross system roles so that we can get support to people in the most deprived areas.
* More focus and resource on promoting good mental health. The absence of mental illness/problems does not equal good mental health by default
* recent reliance on the provision of services rather than genuine down stream work in communities
* We complicate our statutory responses to these issues and have too many initiatives
* Rurality can hide need within data because it is smaller numbers but can be more acute issues
* complicate our statutory responses to these issues and have too many initiatives
* Seasonal work in Blackpool and other coastal communities
* The 'Well-being Works for Better Mental Health' have excellent evidence based interventions and survey data, focusing on causes of low mental wellbeing.
* Historically Planning for, and not with stakeholders
* a lot of children MH issues relate to family circumstances and parents MH which obv links to inequalities, esp around financial security within the home
* Intergenerational issues with parenting and disorganised attachments in early childhood leading to mental health issues throughout the life-course
* Economic regeneration for Lancashire and South Cumbria depends on the three aspects of social determinants of mental health to improve - business and innovation partners should be involved
* underestimating the link with economics - are our economic partnerships as engaged in the health equalities agenda as we need?
* We need sustainable funding to support real integration. we still have separate strategies with separate funding profiles...and duplicate in places. Therefore we don't provide the required breadth of provision.
* Generations of families reliant on benefits as income
* established long community investment
* Let's stop using 'medical' as a pejorative term for problems and use science positively (as set out in the NHS Constitution) to guide better thinking - too many negative themes emerge when analysing complex issues
* Building on an evidence based and data driven service offers for local communities - one size not fitting all.
* Churn of people due to Govt policies that have allowed LAs and others to move people on rather than take responsibility. e.g. homelessness and rough sleeping, allocating to HMOs
* Stigma attached to mental health
* Intergenerational transmission of complexities
* Stigma attached to multiple disadvantage / co-occurring Mental Health and physical health co- morbidities
* Mental health workforce on the Fylde Coast - it's difficult to attract psychiatrists and psychologists to work at the end of the M55. They also have a tendency to settle and work in their university town.
* Poor and expensive transport infrastructure making it difficult to get to employment opportunities, medical and social care services, education etc
* Very fragile statutory sector services due to issues relating to recruitment in disadvantaged areas this puts more pressure on services further down the system
* Multiple comorbidities & needs evaluated ought to be based on 'impact' Where services are led by diagnosis a person or family may have 5 moderate issues that collectively makes up severe need. Though if not a single one is severe, access help denied.
* Services alone will not improve outcomes and inequalities. Policy interventions and close and ongoing engagement and involvement of our communities. We need listen & involve residents in decision making about planning, policy & resource allocation.
* ACE core questionnaire emphasis on psychosocial experience - only one question Ron poverty, nothing on parents lack of work, chronic illness homelessness/housing insecurity etc. Risks making material drivers of health inequalities less visible
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**2. What actions are working and what actions should be taken to improve mental health for better health equality? Who should be responsible/leading this?**

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| * https://www.lancswt.org.uk/our-work/projects/myplace
* Really welcome the new Transformation Programme approach and integration and working with third sector we need to build on this
* Emotional Health commissions in Schools - Lancashire VCFSE Consortium - LCC
* More Mental Health Support Teams in Schools and Colleges for early intervention and prevention
* Implementation of Mental Health Support Teams in Schools
* Mental Health Support teams in schools should be across all schools. Where we have them the schools are so positive about it
* we need to be working at the most local level and having joined up community teams - community development approaches
* Today is a good example of other agencies coming together- more of this
* An increased awareness of workforce crises - although the impact is felt right now critically
* Investment in local community hubs where people can access mh support - as a walk in -without stigmatisation
* Community drop ins for YP - delivered jointly between health, LA and VCFS
* introduction of Initial Response Service providing a single point of access
* There are localised community collaboratives working well, they work best when led by those who have the lived experience...whether employed in the scheme (peer support) or part of the true coproduction of the design.
* Build on small examples of best practice for colleagues with Autism
* really good partnerships already exists between local authorities and health we need to protect this in all the re-organisation of CCGs and LA (Cumbria)
* We have developed Cumbria wide Partnerships ( 1 Bereavement Support and 1 Unpaid Carers) the groups have an inclusive, cross sector membership and are becoming a good safe space to tackle complex issues
* Assets based approach needed. Good outcomes in BwD when we used a Healthy Communities Collaborative approach to make improvement in relation to for example falls, healthy eating, adult abuse
* Transforming West Cumbria Mental Health Partnership - funded and non funded partners working together
* Education, education, education
* Early days, but PHE funded Better Mental Health Projects in BwD and Blackpool (in progress) will offer evidence from evaluation reports. All BwD projects are being delivered by CVFS
* we need to be much better at understanding data and put more resources into people and communities living in the most deprived areas and experiencing the worst outcomes
* Its early stages but we are developing a Recovery College model in North Cumbria
* Community Development - Wigan good example of really embedding this in their villages, towns - local groups
* Youth Mental Health First Aid training for the children and young people's workforce - delivered by our Primary Mental Health Workers
* also lots of progress in Lancs and south cumbria with recovery college but much more to do
* Blackpool have developed an integrated Health and Social care pre and post needs let pathway, also have a rough sleeper/homeless team which has been coproduced and co-delivered.
* Fantastic mental health partnership project in West Cumbria led by Community Foundation and funded by Sellafield. Significant and sustained investment
* We employ a team of Social Prescribers who deliver Health Coaching. We want to extend this in Chorley and South Ribble.
* Cumbria Community Foundation work is to address disadvantage in Cumbria and would want to help. We have seen success in bringing partners together and can attract funding from other sources also
* Lets include people with lived experience it is vital - we need to hear about their experiences and what would have helped earlier for them
* More of a focus on Parent Infant Mental Health and the importance of promoting positive relationship between the parent/caregiver and infant. First 1001 days...
* Good model in Cumbria of Health & Wellbeing Coaches - working in Public Health Teams and connecting with 3rd sector, GPs, ASC and newer Social Prescribers
* Increased focus and recognition on CYP and trauma.
* Evidence based training, increase capability and capacity in mental health literacy in communities, councilors, residents, front line workers, etc. Helps combat stigma. Eg, ASIST, SafeTalk, MHFA, YMHFA, Connect 5
* It should be a partnership approach with a true sense of coproduction
* NE & NC ICS funded maternal mental health project in North Cumbria developing Hub/Navigator role to connect people experiencing maternal mental health with third sector orgs
* Frontline early years practitioners being trained in Institute for Health Visiting training in perinatal and infant mental health. Greater awareness is helping parents get the support they need.
* We need to challenge the 'self- fulfilling prophecy' message that some YP constantly hear about the place they live and the opportunities that they may/or may not get
* we should proactively recruit from the most deprived communities and do proactive work to enable people to be able to be successful in getting roles
* We need long term funding to evaluate programmes and projects. Sadly, evaluations do not get funded as resources are scarce. Essential if we want to inform the evidence base. More collaborations with the academics/ universities needed, ie. NW ARC
* Sure Start Children's Centre's worked really well for many families - often at that walking alongside people level Sayyed was advocating - huge reductions in funding have impacted their reach and impact in Early Years
* Dedication of full days spent with an independent panel to review the health and support for those with mental health issues for those with Learning Disabilities & Autism. A rich & person centred process that focuses on actions on health inequalities
* MyPlace programme is well established and expanding into the Bay through Postcode Lottery funding building on the National Lottery funding over last few years - lots of organisations are good at bringing funding into the region - how make sustainable
* Promotion of Improving Access to Psychological Therapies (IAPT) for supporting people with Long Term Conditions such as diabetes, COPD, MSK, pain, stroke etc. Importance of link between mental and physical health and having a more holistic approach.
* The national Building Better Opportunities (support for people with complex needs including SMI to work towards employment) has been really successful particularly in disadvantaged areas but funding will end September 2022
* growing workforce models that include peer support workers / advocates
* BwD suicide rates have been reduced by concerted partnership efforts and focus over last 10+ years. We need sustainable ongoing efforts, close partnership working and leadership
* Peer support workers/experts with experience employment. Value true partners, inclusivity & reciprocity

**From chat:** * There is a wonderful model of bringing in significant local employer investing in mental health in West Cumbria. The project is managed by Cumbria Community Foundation
* Community Foundations can manage funding programmes that can attract business support
* good examples across the country of models of peer support to enable the integration into meaningful employment for those with complex MH needs
* Maybe we also need to consider the workforce strategies of the NHS / stat providers and VCFS within the ICS footprint to ensure we provide access to jobs within the care sector for people who come through our services and volunteer and give back, this works well for us.
* in North we are looking at a volunteering and work project as part of the Transformation Programme working across our whole system but led by third sector
* Lancashire BME have a men's group for south Asian men which helps fight the stigma related to mental health issues.
* Digital Technologies play a key role, Togetherall is commissioned across the Fylde Coast but interestingly 63% of users are accessing out of hours so we need to be mindful that we need more services offering 24/7 support.
* Just been reading about Innovation Agency NWC - Boost for mental health support at GP practices in Lancashire and South Cumbria from the Innovation Agency at <https://www.innovationagencynwc.nhs.uk/>...
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**3. What are the barriers that prevent you from making a step change in health inequalities?**

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| * Its harder to measure & direct funding towards what 'might have happened' if you hadn't invested
* This may be seen as long term and preventative so has to wait until we have helped those with acute needs in health.
* Stigma around mental health conditions
* Genuine down stream activity takes time to show outcomes that translate into our National Targets for Mental Health and Learning Disability - strategic leads to be brave with investment to turn the curve
* there are still a lack of pathways within MH that are suitable and designed for people with ASC, our treatments sometimes are not suitable for them and cause more harm
* Own capacity and those of others we need to work with
* Lack of integration between mental and physical health services
* Large scale organisational changes at a time when demand is at its highest and workforce is at its lowest.
* Competition for scarce funding. Harms partnership working, relationships and trust
* We need positive cultural change within statutory sector to improve collaborative leadership (including third sector), skills and investment in co-production etc
* Emphasis on "criteria" preventing access to services
* organisational structure Barriers
* Has to be about whole communities, statutory, VCSE but also schools, businesses etc
* The third sector need to work more effectively with NHS systems to ensure that leaders and local staff fully understand what we are able to offer not just in terms of service provision but system change and innovation skills
* What we are all talking about makes sense to us but we need to consider how we ensure the whole workforce are aware of the aims and objectives and not just senior leaders
* IT systems and data collection systems are not well developed enough to provide useful data to highlight difference in outcomes by different groups. More use of outcome based measurement tools, population surveys, eg. life satisfaction, WEMBWS
* Exploring barriers in access - to suggest audit or secret shopping on convenience/helpfulness on every referral pathway against the most vulnerable persons opportunities (learning disabilities, homeless etc) will tell us if they are truly accessible
* Mental health needs vs mental health illness vs behaviour that challenges vs periods of emotional dysregulation - any, or all of these, accompanied by self-harm and/or suicidal ideation - what's our response locally/nationally?
* Often there is not recognition of services fulfilling their legal requirement for making reasonable adjustments to make changes to their approach/provision for those with learning disabilities/ASD/MH
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**4. Where are the greatest opportunities for improvement?**

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| * Gaining full partner agreement (& evidence of their involvement) to 3 separate (but connected) All Age Strategies for Mental Health, Learning Disability & Autism. These should clearly define the vision, priorities and held accountable for achieving.
* More models like Big Local (10 year Lottery investment in disadvantaged communities) providing long term investment
* Early intervention in the first 1001 days, breaking any negative intergenerational cycles and promoting positive parenting. Supporting perinatal and parent infant mental health.
* Support integration as expected in new ICS without dividing partners
* Agreement to take holistic approach to individuals, promote personalisation, person centred support, choice and control
* Equity in priority of funding to early support
* Deliberate health investment in the areas most impacted by health inequalities
* Lets build on what we have that's strong across the footprint. We need to know what's out there, much of it is visible to see on social media - list to the people in our communities they are willing to speak up
* Value the workforce who are working hard, doing good things with compassion in the community.
* For those with learning disabilities utilise intelligence coming from LeDeR reviews and facilitate rapid response and spread
* Greater involvement of Housing and Built Environment
* Genuine Anchor Institutions - local buying, employment- Joyful places to work
* we share the same vision. we have good relationships. so we use this to jointly deliver change and we don't look at the money until we agree what we are agreeing to do.
* Co-production it is so important to work with local communities to design their own health services and for those services to make sense to those communities
* Evaluate with each person accessing MH services over a week, ask each person how many occasions they have made help seeking attempts prior to getting it? A short term evidence based evaluation of experience.
* Stope creating health services that make sense to strategists and planners (middle class professionals with access to money and transport) rather than the people who really need them
* Early intervention and prevention work in schools. Mental Health Support Teams in more schools. Most long term mental health issues start before adolescence.
* Measure the duration of time untreated/unsupported
* Emphasis on trauma informed care in the locations of highest social determinants
* Person centred workforce planning -over 70% of people's needs whatever the cohort can be met by people without professional registration
* Trust each others assessments.
* Good food and built environment (Green Space)
* Consider what people are doing for themselves in our communities, like you say it's not just about services it's also about growing social movements and promoting how people recognise how they can help themselves and each other
* Place emphasis on assessments of peoples resilience and assets in every interaction we have, given poor mental health is both a contributor to, and consequence of, wider health inequalities
* Need to engage Occupational Therapists much more as they have a key role to play in building individual, community health and well being and engagement in meaningful occupations and health outcomes, working across the lifespan and organisational boundaries, health, local authority, education ,Prisons, third sector etc. They have proactive person centred approach. Link very closely with social prescribers
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