

# Learning from VCFSE involvement in neighbourhood working - children and young people. Webinar



Children and Young People's  
Transformation Programme



**Sefton CVS**  
Supporting Local Communities



**KOALA**  
North West

Sefton Council 



Cheshire and Merseyside

# Learning from VCFSE involvement in neighbourhood working – children and young people.

## House keeping.



### Microphones

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### Chat Function

Feel free to use the chat throughout the session. We will monitor it and respond where possible.

### Recording

Any recordings will be shared in line with the purpose of this session. Please respect the confidentiality of others when participating.



### Cameras

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### Use of AI

We may use AI notetaking, recording, or transcription tools. By joining, you acknowledge and consent to this.

Please do not use your own AI notetaking tools or automated recording bots during this session.



### Respectful Participation

Please be respectful in the chat and during discussions. We aim to create a safe, inclusive space for all.

### Slides & Materials

Any slides or resources used today will be shared following the webinar.

### Timing

We will begin and end promptly. Please stay for the full session if you can.

# Learning from VCFSE involvement in neighbourhood working – children and young people.

## Agenda.

- |        |  |
|--------|--|
| 1pm    | <b>Welcome, introductions, and session aims:</b> Dave Packwood, VSNW   |
| 1.10pm | <b>Learning from Beyond Programme:</b> Liz Crabtree – Programme Director, Beyond Programme, Cheshire & Merseyside  |
| 1.25pm | <b>VCSE &amp; NHS Partnership in Cheshire West:</b> Bev Morgan – CEO, Koala North West, and Heather Cattrell – NHS Programme Lead, Cheshire West                                 |
| 1.45pm | <b>Children and Families Transformation in Sefton:</b> Sharon Cotterall – Strategic Lead for Children and Families, Sefton CVS<br>Jacquie Finlay – Programme Manager, Sefton MBC |
| 2.05pm | <b>Q&amp;A, summary, and close:</b> Dave Packwood, VSNW  |



# CYP Neighbourhood MDTs Cheshire and Merseyside

May 2026

Dr Elizabeth Crabtree, Programme Director  
[liz.crabtree@alderhey.nhs.uk](mailto:liz.crabtree@alderhey.nhs.uk)

# National Direction so far



## Foundations of NBH - initial 6 core components:

- A. Population health management
- B. Modernise general practice
- C. **Neighbourhood multidisciplinary teams**
- D. Integrated intermediate care
- E. Urgent neighbourhood services

## Provides examples of effective CYP NBH models:

- Focus on CYP with complex needs
- Primary-care led, multi-agency teamwork
- Early intervention and prevention
- Local flexibility in design
- Phased implementation and scaling

## Describes 3 radical shifts:

**From hospital to community;** delivering more care closer to people's homes and in local neighbourhoods, reducing reliance on hospitals.

**From analogue to digital;** leveraging technology (AI, genomics, wearables) to free up staff from admin and empower people.

**From sickness to prevention;** proactive intervention to help people make healthy choices.

## In implementing NBH, immediate focus to be on:

- Improving and tackling unwanted variation in GP access for the whole population.
- Reducing unnecessary non-elective admissions and bed days from high priority cohorts
- Enabling patients requiring planned care to receive specialised support closer to home.

## Primarily focus on priorities for systems over next three years to 2029:

Improvement in health outcomes, access to general practice, patient experience of planned care, urgent and emergency care performance, and patient and staff satisfaction. As well as reform of outpatient services.

States 'fundamental reimagining' of current workforce to deliver NBH health.

250 Neighbourhood health centres by 2035

Further info on SNP, MNP and IHO contracting



## System Approaches to Addressing Health Inequalities



### Population Health Intelligence

Using CIPHA, Johns Hopkins risk stratification, and linked LA-ICB datasets to proactively identify CYP most at risk of poor outcomes



### Targeting Deprivation / Vulnerable Cohorts

Based on deprivation, child poverty, persistent school absence, repeat urgent care use, and unmet need



### Focus on Core20PLUS5 and SEND

Prioritise Core20PLUS5, CYP with SEND, neurodiversity, MH needs, and long-term conditions such as lung health



### Improving Access and Reducing System Barriers

Reduce the burden on families least able to navigate complex systems, addressing inequalities linked to access and fragmentation.



### Prevention and Early Help

Early intervention to narrow outcome gaps – improving school attendance, reducing crisis care, and strengthening family resilience



# NHS England Children and Young People



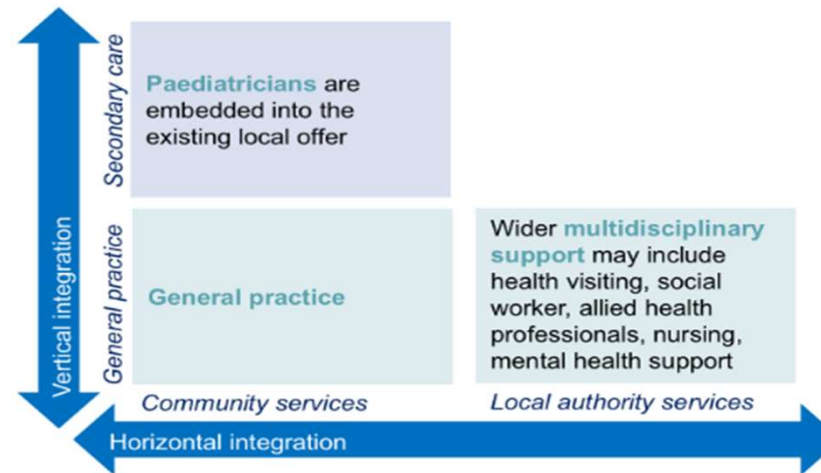
## Hospital to Community

<b>Key Statistics</b>	<ul style="list-style-type: none"> <li>Children have the <b>highest rate of unnecessary emergency department (ED) attendance</b> of any age group, and these <b>numbers are rising</b>.</li> <li>Around <b>5 million children attend ED</b> annually - <b>75% are discharged</b> home to self-care</li> </ul>
<b>Engagement Themes</b>	<ul style="list-style-type: none"> <li>Parents <b>feel overwhelmed</b> with a lack of trusted advice sources</li> <li>Need to improve <b>timely access</b> to specialist advice</li> <li>Healthcare settings feel <b>siloes and difficult to navigate</b></li> <li>Familiar settings <b>close to home</b></li> <li>Information is <b>not joined-up</b> and connected</li> <li><b>Proactive</b> approach to identifying concerns</li> </ul>

### Interventions

## Neighbourhood Multidisciplinary Teams for CYP

*Strengthening primary care for children through Neighbourhood Teams*



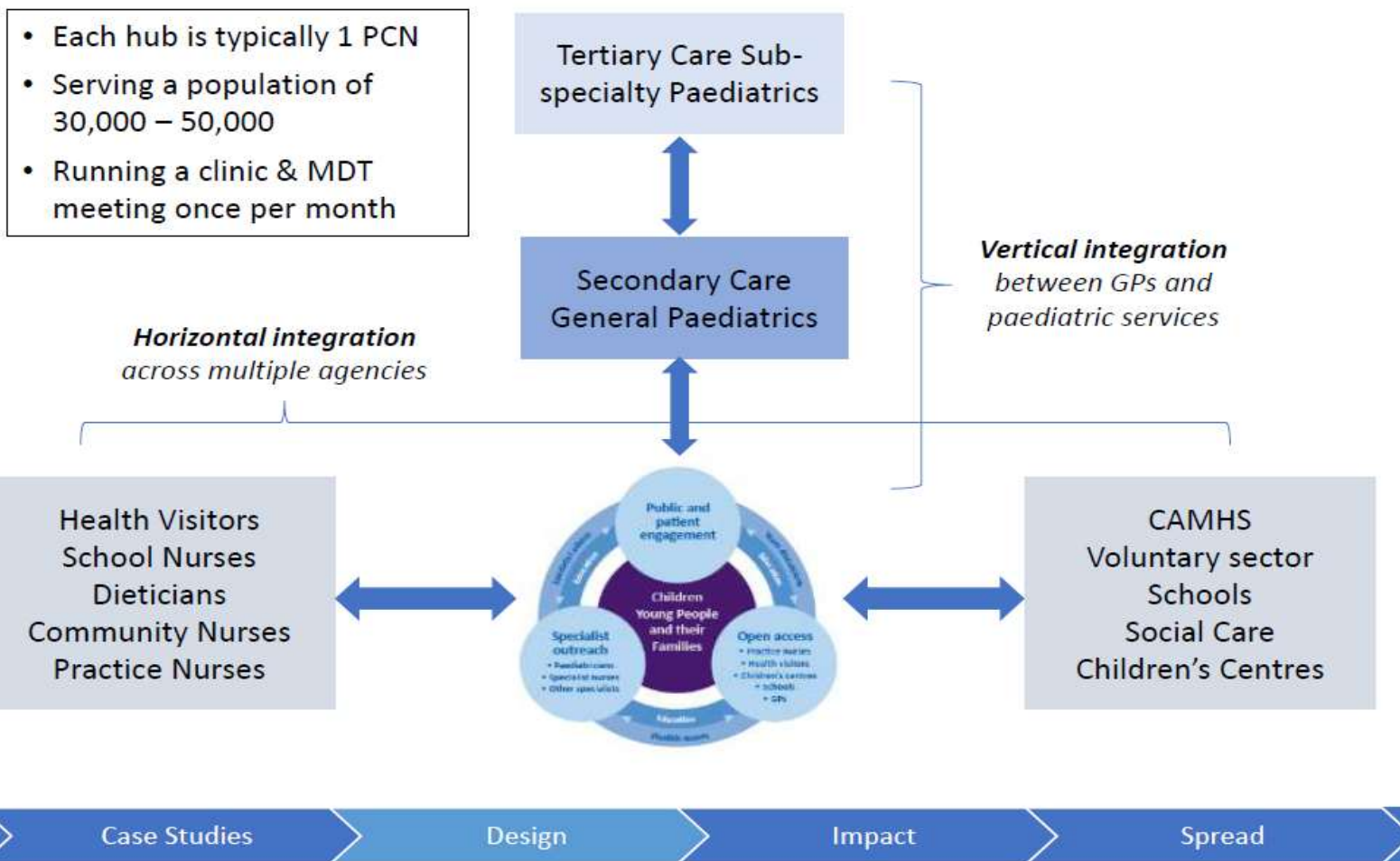
E.g. Connecting Care for Children (NW London)

- **22% fewer A&E attendances**
- **39% decrease in new patient hospital appointments.**
- **42% of further appointments shifted from hospital to community**
- **19% reduction in subspecialty new appointments.**
- **17% drop in paediatric hospital admissions.**

<b>Digital Tools</b>	<b>Healthier Together – a trusted authoritative support for parents/carers/families</b>
	<b>Digital Child Health Record via NHS App</b>
	<b>111 Online for &lt;5-year-olds</b>

# CHILD HEALTH GP HUBS

## Integrated child health model of care



## CC4C Impact Summary

### Service Impact (12 months)

- **MDTs & Clinics: 24 sessions, 154 cases discussed, 126 patients seen**

### Hospital Utilisation Improvements:

- 39% of new hospital appts avoided
- 42% shift to GP settings
- 19% fewer subspecialty referrals
- 17% reduction in admissions
- 10% drop in A&E attendances

### Patient Experience

- Preferred GP-based care; reported higher confidence in GPs
- 100% would recommend the service

### Professional Development

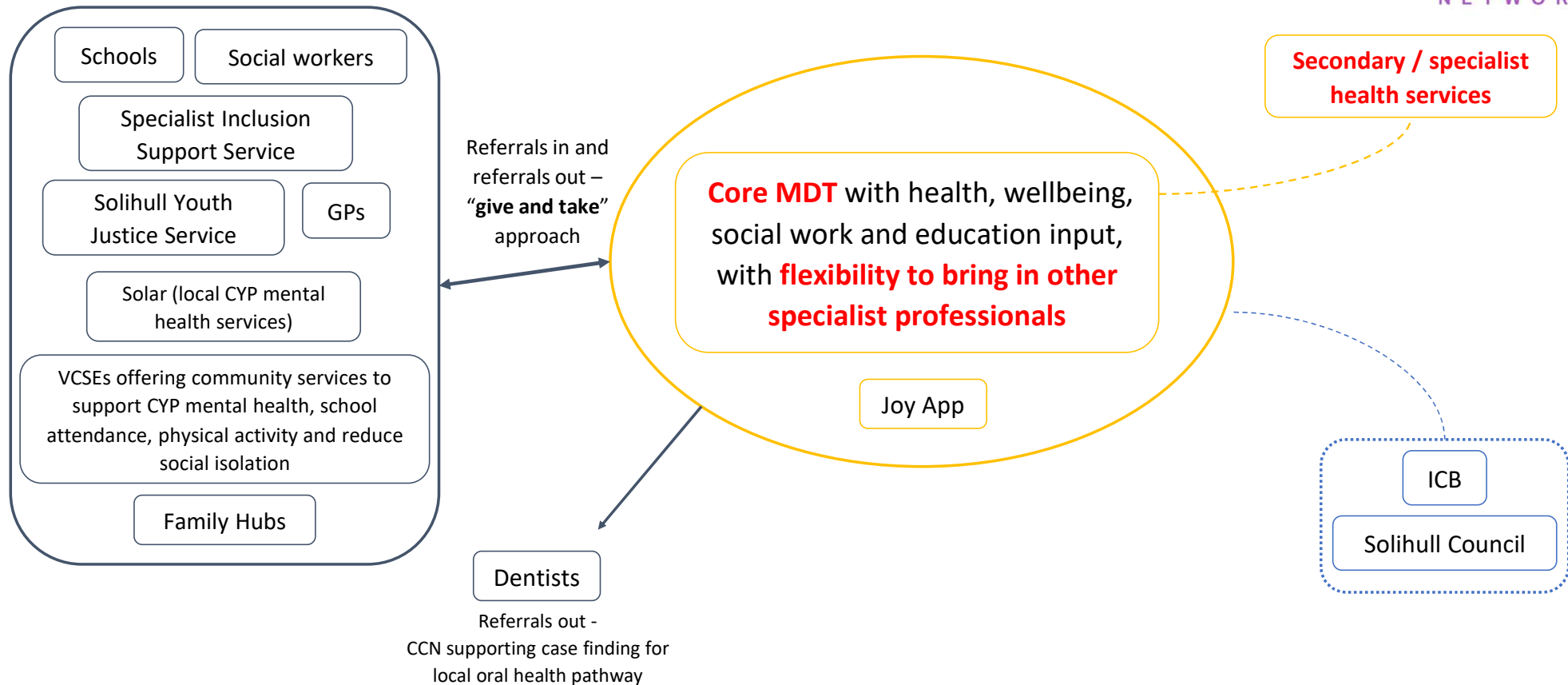
- Majority of 50 surveyed professionals reported:
- Improved knowledge of local services
- Stronger collaboration and capability
- 82% strongly agreed hubs built trust and social capital

**The CC4C model reduces secondary care use, boosts patient satisfaction, and strengthens professional networks - supporting integrated community-based paediatric care.**

# North Solihull example model (Rizwan Rafi)



## The Flexible MDT





## WHAT WE ARE ACHIEVING?



**25%**

Reduction in CAMHS referrals

**27%**

Reduction in referral to Community Paediatrics



**40%**

Reduction in referrals to Autism /ADHD assessment services

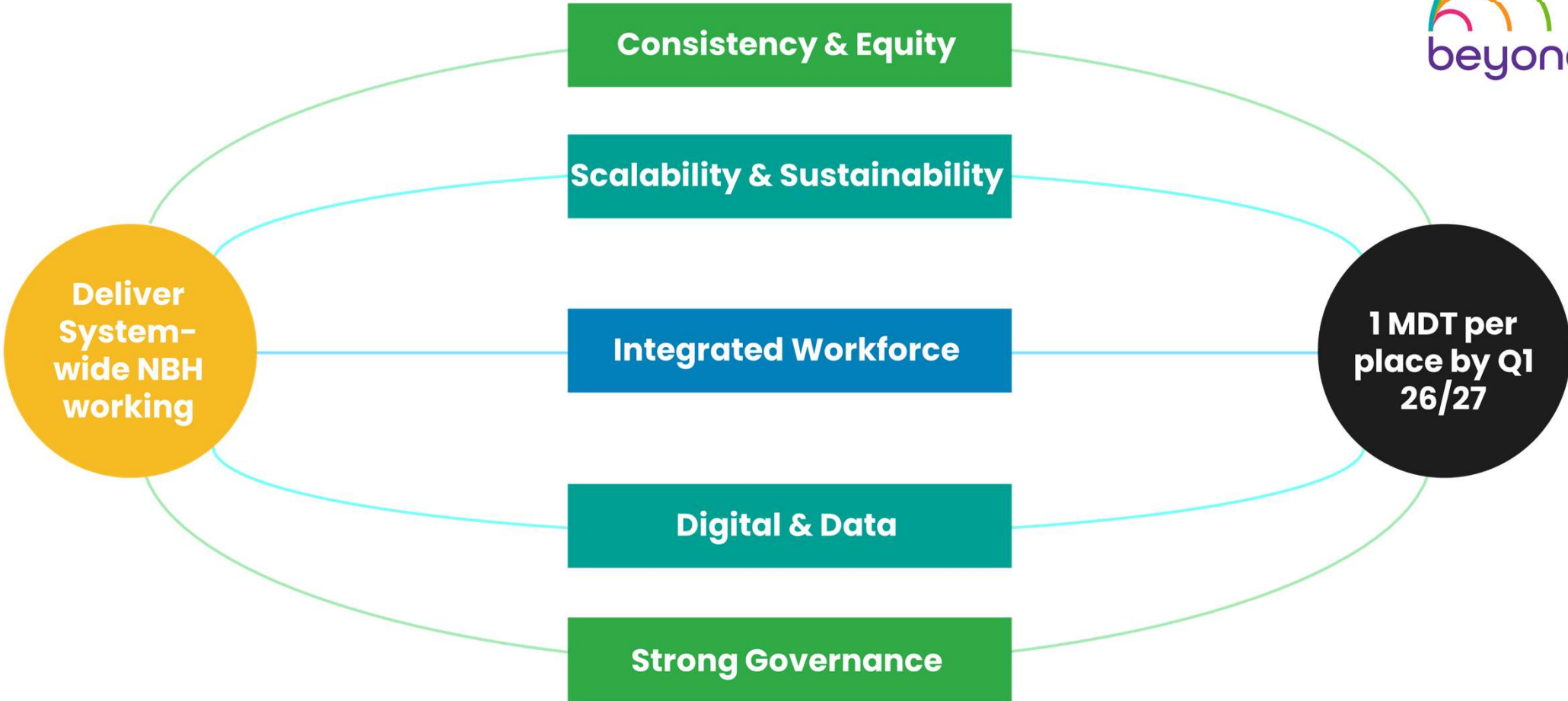
**>1000**

Referrals into VSCE sector organisations

**>1000**

Signposts into self-help, advice and guidance

# Approach



Led through MDT NBH Focus Group

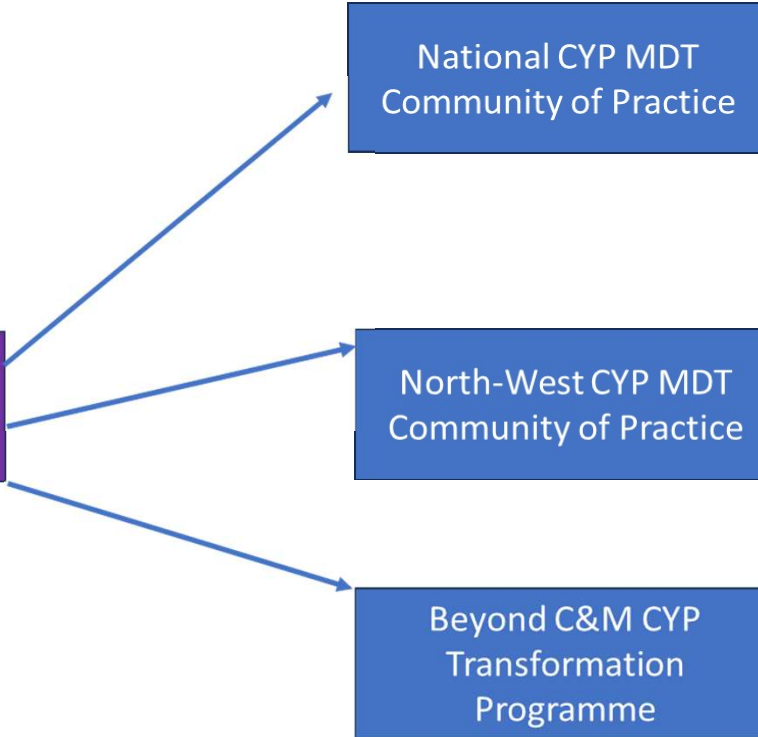
Drive standardisation with local flexibility

Align with key strategies: Families First, Family Hubs, Best Start in Life

C&M All Age  
Neighbourhood Group



CYP Neighbourhood MDT Focus  
Group



National CYP MDT  
Community of Practice

North-West CYP MDT  
Community of Practice

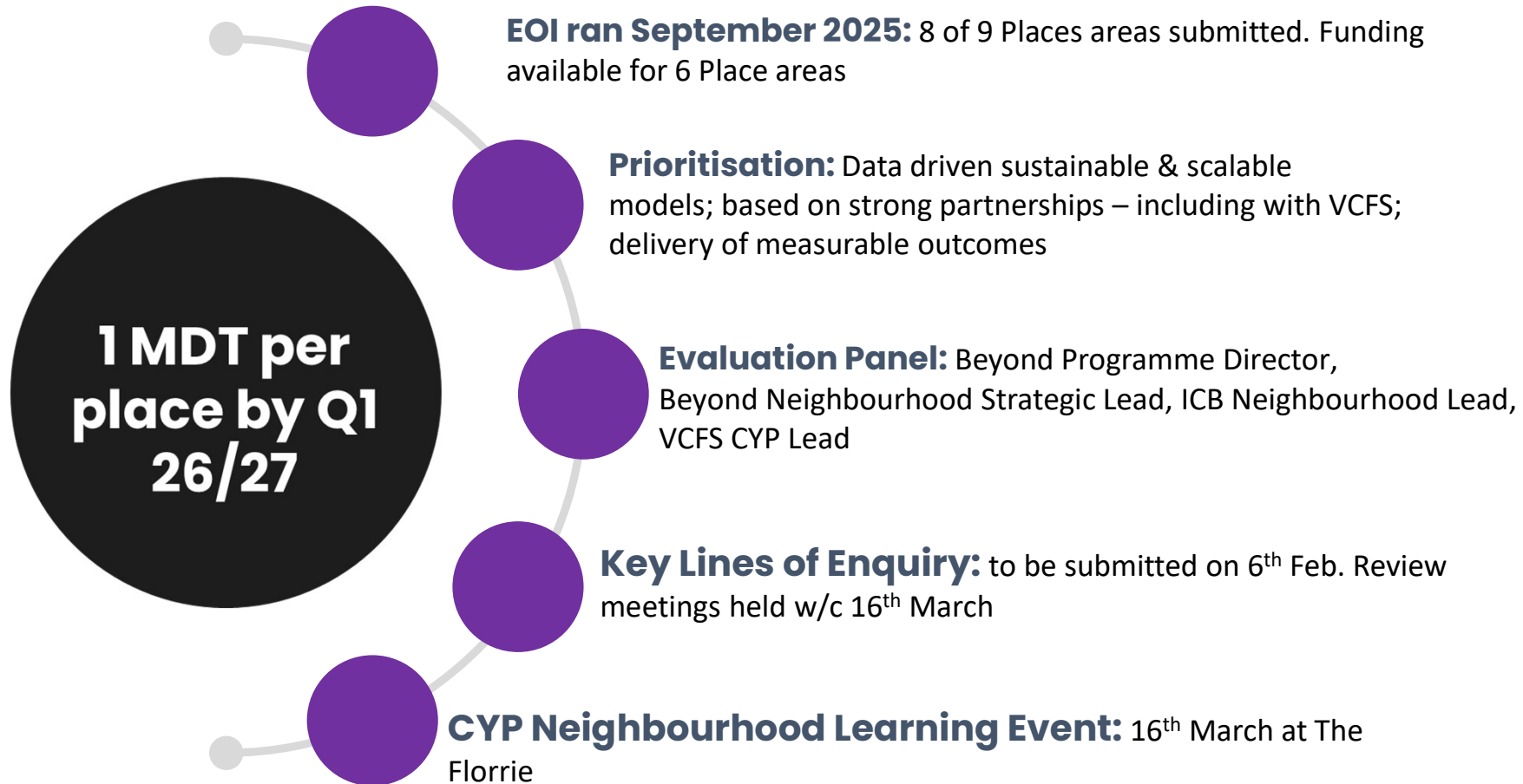
Beyond C&M CYP  
Transformation  
Programme

**Bi-monthly Focus Groups**

Next Steps: Create bi-monthly newsletter/toolkit of practice from across England to support partners in implementation



# Development of Delivery



# Development of Delivery – Next steps...



• **Audit:** Mapping exercise from audit data on Neighbourhood activity

• **Key Lines of Enquiry (6 months):** Key Line of Enquiry review meetings held with representatives from all funded Places

• **MDTs:** At least 1 MDT set up in each Place by Q1

• **Data Sharing and Information Governance:** Approach to be developed and communicated

### Sefton\*

Bootle CYP MDT pilot focusing on complex families and respiratory health

### Knowsley

Redesigning existing CDT model to "This is Me" focussed MDTs. Focus on early years children with additional needs

### St Helens\*

GP led MDTs for CYP with **complex, multi-sector** needs who might be lost / bounced between services

### Liverpool\*

Respiratory-focused MDT with LCC Test & Learn approach and Alder Hey. Embeds diagnostics, GP champions, training, and family engagement

### Warrington

Alignment of PCNs with Family Hubs to provide an accessible Early Help offer.

### Wirral\*

Neurodiversity and mental health drop-ins at Family Hubs, with training, parent sessions, and enhanced ND Virtual Hub

### Halton

Borough Wide MDT- cohort is CYP who are "bounced" around the system due to fragmented services

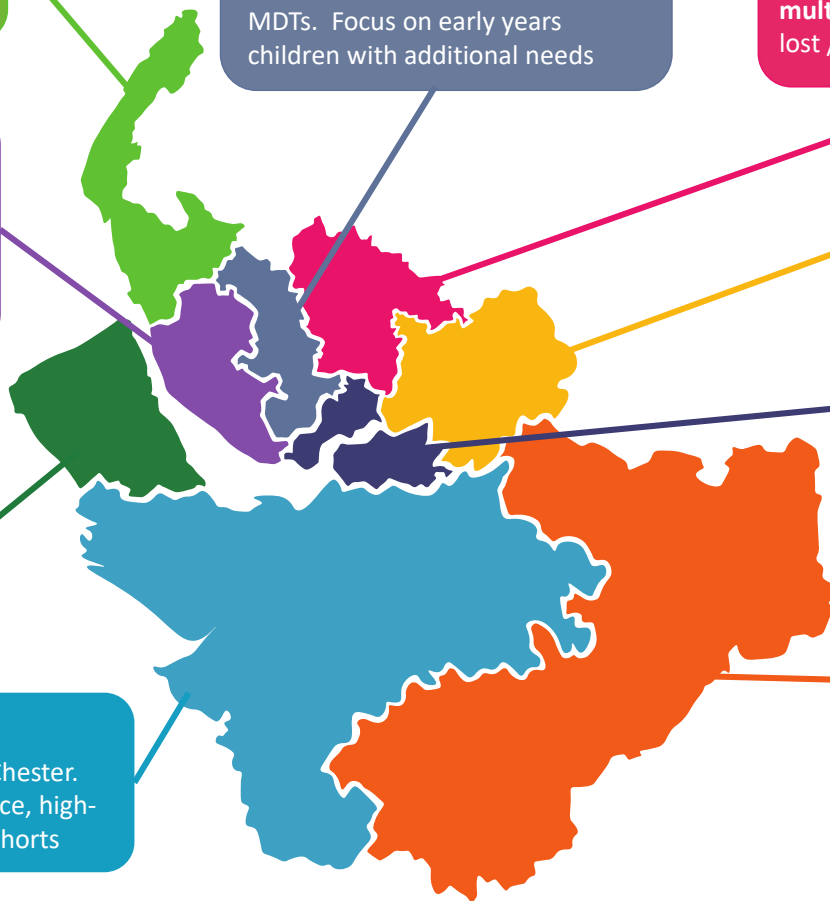
### Cheshire West\*

CYP Health & Wellbeing MDT model in Chester. The plan targets persistent school absence, high-intensity urgent care users, and SEND cohorts

### Cheshire East\*

Macclesfield Child Health MDT targeting respiratory and MH inequalities. Outcomes include reduced A&E use and improved Family Hub integration

## Emerging Models Across C&M



# CYP Neighborhood Learning Event: 19th March at The Florrie



80+ attendees

5 Key-note speakers

Afternoon workshops



“Really good and meaningful session. We need to continue to connect the adult and children work on neighbourhoods now we are at this juncture.”

“The input and discussions made the day a good use of my time.”

“I found the event to be interesting and informative, and it was a great opportunity to share information regarding the pilots and network.”

# Key Lines of Enquiry (KLoE) Summary February 2026



1. Action plan in place with clear metrics, milestones and governance
2. Evidence of effective partnership working across health, LA, Housing, VCSE, education etc
3. Evidence of co-production with children, young people and their families
4. Use of data to identify, target and track at-risk cohorts with a focus on underserved communities
5. Clearly identified MDT roles / responsibilities / processes
6. Clear baseline identified and evidenced
7. Early indicators of improved outcomes
8. Productivity e.g. number of MDTs
9. Lessons learned in last quarter to support sustainability and scalability
10. Issues for escalation / learning

- ✓ All Funded and non-funded Places were asked to submit their KLoE by 06/02/26 (3 months post bid outcomes)
- ✓ The Beyond NB Team had KLoE meetings with all Places during the last week of February and first week of March
- ✓ All Places were RAG rated by the Beyond NB Team in line with their current progress
- ✓ Programme management recommendations were made to each Place
- ✓ A summary document was submitted to the Beyond Programme Director
- ✓ KLoE to be submitted 08/05/26 (6 months post bid outcomes)

\*Unfunded Places

# Identified Opportunities & Challenges Ahead

## Data & Training

### Access to Population Health Data.

Use of different systems - The need for a unified digital solution that supports multi-agency information sharing, avoids duplication across system, promotes equity and allows for better triangulation of data.

VCSE IG compliance varies- some smaller organisations struggle with requirements.

Inconsistent training and access for PCN on data tools.

## Engagement & partnership

### Interest already well established.

### Specialism and expertise exist.

### Already working multi-agency.

Secondary care capacity/workforce concerns.

Need for long term commitment to Family Hubs and neighbourhood working to avoid cycles of reinvention.

## Planning & Funding

### Historic Knowledge to inform priorities.

Limited capacity of providers (lack of funding).

Overlap with Family First: Models clarity to avoid perceived duplication.

Fragmented Funding vs. sustainability.

## Macrostructure

Too many reforms at once

Organisational challenges linked to restructuring/voluntary redundancy processes.

Current system pressures pose risks to stability

## Learning & Evaluation

Need for cross-place learning

Lack of national KPIs for best practice demonstration



Opportunities



Further information on Place delivery

## CYP MDTs Progress by Place: Funded Places

### Liverpool

#### What are they doing?

-Developing a CYP NBH MDT with an explicit focus on lung and respiratory health as part of the integrated respiratory care pathway.

-Multi-agency MDT, not limited to health, but explicitly considering:

- Housing conditions
- Air quality
- Fuel poverty
- School attendance and education
- Wider family and social factors

Intended to act as a ‘test and learn’ approach for a NBH model that can later be scaled or adapted for other cohorts

#### Why are they doing it?

Rooted in population health evidence

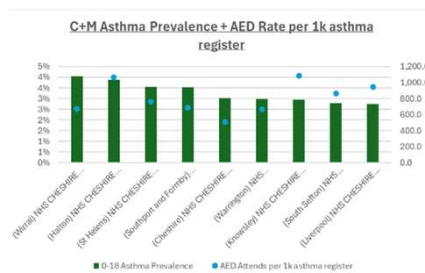
Lowest Asthma prevalence (0-18 years), second highest volume of asthma patients

Asthma patients report third highest rate of AED attends per 1k across C&M

#### Who is involved in the partnership approach?

Health forms the core delivery spine:

- 2 PCN’s (Anfield & Everton, iGPC)
- Alder Hey
- Mersey care
- VCSE



### Wirral

#### What are they doing?

- NBH model focusing on support CP with neurodiversity and mental health needs. Delivered through a drop-in model at Family Hubs

- Initial pilot focused in Rock Ferry area with potential to scale following evaluation

- Focusing on things such as continence, sleep , AFRID, etc.

- Triangulating with Community Paeds data to identify cohort for support within model

#### Why are they doing it?

Local Evidence shows 47% of children presenting with mental health difficulties into ‘Branch’ Wirral’s single point of access identify as neurodiverse.

Linking in with support groups in Wirral to ensure support being offered is congruent with feedback from families

#### Who is involved in the partnership approach?

Reporting positive impacts on partnership working, sharing of ideas and joint planning already. MDT expected to be mobilised in May.

Paediatrics, health visiting, school nursing, family hub teams, education, early help, social care

## Sefton

### What are they doing?

- Developing a co-located respiratory-focused MDT in Bootle for primary school aged (4-11years) children.
- 50 CYP identified through triangulation of CIPHA, Local Authority and education attendance data.
- Initial focus on 'reactive' referral element with 2 schools involved in the pilot, with plans for 'proactive' referral route into MDT once mobilised.

### Why are they doing it?

Bootle experiences high levels of deprivation, with the borough's highest rates of childhood obesity, low birth weight, poor mental health, fuel poverty and demand for children's services. Families often face multiple vulnerabilities, making it an appropriate starting point for an integrated model.

In Bootle, asthma prevalence appears low at 3.8% (257 diagnosed CYP). Of these 40% have an asthma plan, though 70% were invited for a review last year.

### Who is involved in the partnership approach?

Local Authority Lead for the project- with project management and delivery through South Sefton PCN team

Working Group: education (2 primary school teachers), Alder Hey, Merseycare, voluntary and community sector (Sefton CVS, Parenting 2000)

## St Helens

### What are they doing?

St Helen's care communities are multi-agency meetings between health, education, local authority, housing and VCSE sector.  
Focus on Ward of Parr within Central PCN

### Pro-active referrals:

patients identified using John Hopkins risk stratification and CIPHA, cross-references with CYP open to children's services to prioritise;

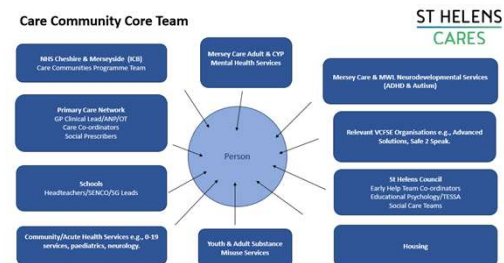
### Reactive referrals:

From anyone professional within care community partnership  
Direct care element of clinic appointment with GP and paediatrician, with potential follow up, professional knowledge sharing

### Why are they doing it?

Building on established care communities' work. Three routes into care community: complex patients (reactive approach), high intensity issuers (semi-reactive), proactive CIPHA searches based on local population health/CIPHA searches.

### Who is involved in the partnership approach?



## Cheshire East

### What are they doing?

Macclesfield Care Community is a partnership across health, care, local authority, and voluntary sectors. It is aiming to deliver a child health neighbourhood model. Using John Hopkins Patient Needs Group segmentation, they have identified a cohort with higher levels of low complexity, medium complexity and mental health needs (PNGs 4, 5, and 8) compared to the regional average. The project will target health inequalities, particularly asthma/respiratory conditions and mental health.

### Why are they doing it?

Adult-focused High Intensity User project, which includes expanded primary care clinics and MDTs, has shown promising results- 13% fewer A+E visits + estimated 9% cost reduction over 6 months. Looking to replicate the model for young people

Macclesfield's has a mix of urban and rural wards. Around 20% of the population is aged 0–19, accounting for ~30,000 GP appointments annually and on average 22% of monthly A&E attendances (300–400 visits).

### Who is involved in the partnership approach?

The project group includes:

- Cheshire East Care Community Development Group
- Macclesfield Primary Care Network
- East Cheshire NHS Trust and Mid Cheshire NHS Trust
- 0–19 Health Visiting Team
- Cheshire East Council\* (Family Hubs, Early Years, Family Help & Prevention, Public Health)
- Community & Voluntary Services

The Macclesfield Joint Strategic Needs Assessment, supported by multi-sector partners, has also informed project development.

## Cheshire West

### What are they doing?

Initially targeting Chester South, Chester East, and Chester Central PCNs to provide a coordinated, family-centred response to complex needs.

The pilot will prioritise CYP experiencing the greatest inequality and unmet need, including:

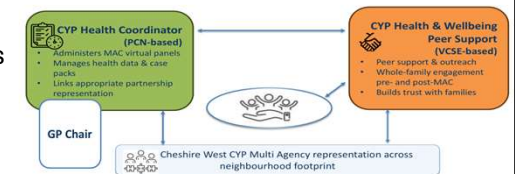
Children in deprived neighbourhoods (Chester PCNs)

CYP with SEND, supporting rollout of the Neurodiversity This Is Me profile tool

CYP with persistent school absence or exclusion risk

Families with repeat urgent care use

Families facing perinatal and early years risks



### Why are they doing it?

The Chester Neighbourhood footprint was selected based on:

- High rates of persistent school absence
- Elevated child poverty (notably in Blacon and Lache)
- Repeat urgent care use and perinatal/early years risks Insights from Data into Action and Population Health analysis highlight the need for coordinated whole-family support.

The two integrated roles will be co-located within PCNs and VCSE settings, linked to statutory services, and co-produced with families to ensure cultural competence and trust.

### Who is involved in the partnership approach?

Delivered through Community Partnership model.

Primary Care Networks (PCNs)

Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector

Local Authority

Schools and Education

Acute Paediatric Services

Community Health Services

Children and Young People (CYP) and Families

## CYP MDTs Progress by Place: Unfunded Places

Knowsley	Warrington	Halton
<p><b><u>Progress</u></b></p> <ul style="list-style-type: none"> <li>• Supportive discussions held with Public Health Colleagues linking in with NBH leads within ICS and LA.</li> <li>• Discussion on 21/04 with plans to take forward next stages of scoping.</li> </ul>	<p><b><u>Progress</u></b></p> <ul style="list-style-type: none"> <li>• Facilitative discussions held with Local Authority.</li> <li>• DCS agreement to move forward with plans and initial data scoping underway.</li> <li>• Beyond providing some data capacity to support identification of target cohort.</li> </ul>	<p><b><u>Progress</u></b></p> <p>ILACs and SEND reports outline that there is fragmented delivery of care pathways across Halton.</p> <p>Focusing on CYP who are reported as being ‘bounced’ around the system.</p> <p>CYP:</p> <ul style="list-style-type: none"> <li>• With complex needs that would benefit from integrated, collaborative and co-ordinated support.</li> <li>• Whose needs span more than one professional cohort and may sit outside commissioned service acceptance threshold/criteria for specialist support – resulting in them being “bounced” around the system.</li> <li>• With physical health and/or social challenges for them/their family.</li> <li>• May have suspected neurodiversity and/or emotional wellbeing concerns.</li> </ul> <p>Partners involved:</p> <p>Bridgewater Community Paediatrics, GP clinical lead, Mersey Care, Halton Borough Council Family Hub lead, Primary Care. Mental Health services, general paediatrics, social prescribers, social care, schools SEND PCF.</p> <p>Plans to move forward with plans without funding, currently testing anonymised cases.</p>

*Learning from VCSE Involvement in  
Neighbourhood working – Children and  
Young People (VSNW Webinar)*



# Cheshire West's Children and Young People's Neighbourhood Health & Wellbeing

## Multi-Agency Coordination (MAC) Pilot

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Cheshire West Place | Presented to VSNW Webinar | 11<sup>th</sup> May 2026

# What is the Neighbourhood Health Framework?



A national shift in how the NHS delivers care – closer to where people live.

## National Policy Drivers

NHS England CYP Neighbourhood Health Guidelines 2025/26 set out a requirement for integrated, neighbourhood-level care focused on children and families with complex needs.

This builds on the NHS 10 Year Plan, Planning Guidance, Better Care Fund, Family Hubs and Families First Partnership.

## What is a Neighbourhood?

A neighbourhood is a geographically defined community, typically aligned to a Primary Care Network (PCN) (*population size 30,000 to 50,000*) — the group of GP practices working together locally.

In Cheshire West, the Pilot focuses on two Chester PCNs and their surrounding communities.

## Why Neighbourhood-Based?

By coordinating services at neighbourhood level, families get support that fits around their lives — not fragmented across different systems.

Prevention and early help happen before needs escalate, reducing pressure on hospitals and statutory services.

*Key term: PCN = Primary Care Network — the local group of GP practices that anchors this model.*

# Led by Primary Care: The PCN Anchor



## Why Primary Care?

- 1 GPs and Primary Care Networks have the longest-standing relationships with local families — they are often the first point of contact for both physical and mental health concerns.
- 2 PCNs hold population health data that can proactively identify families with complex or unmet needs — not just those who present in crisis.
- 3 Neighbourhood Health Guidelines specifically place Primary Care as the natural anchor for local multi-agency coordination.
- 4 A GP Chairs each MAC meeting, ensuring clinical oversight and safeguarding awareness throughout.

## PCN Roles in the MAC

### GP Chair

Chairs the MAC, facilitates multi-agency discussion, ensures safeguarding is addressed.

### PCN Admin / Manager

Manages referrals, quality-checks cases, prepares agendas, logs decisions on the tracker.

### Population Health Data

Identifies High Intensity Users and complex households using primary care data — bringing evidence into coordination.

### Clinical Insight

Contributes medical perspective and ensures the GP record reflects agreed plans.

# The Voluntary Sector: A Core Partner — Not an Add-On



The VCSE sector is central to how this model works — not peripheral. A dedicated role sits at the heart of the MAC.

## VCSE Families Link

- ▶ Makes warm, non-clinical first contact with the family to explain the MAC process. Providing system navigation and outreach to families in the community.
- ▶ Engages with the whole family before and after the MAC meeting. To enable representation of the family's voice and lived priorities within the MAC meeting itself.
- ▶ Follows up after the MAC to explain what was agreed and what happens next. Builds trust with children, young people and families who are hardest to reach.
- ▶ Collects lived experience feedback to inform continuous improvement. Captures soft intelligence and community signals that data alone cannot show.
- ▶ Ensures families feel heard, informed and empowered — not 'done to'.

 *Families must not feel the MAC 'happens to them'. The VCSE role ensures they are at the centre of every decision.*



# Supporting Families for 26 years

- Place-based voluntary organisation rooted in early help and family support
- Long-standing trusted presence with families experiencing complexity
- Working across health, local authority and community boundaries
- Specialising in engagement with families who find systems hard to navigate
- Experienced partner in multi-agency and integrated working



**KOALA**  
North West

## Koala NWs role in the pilot

### **Our role within MAC focuses on:**

- Bringing the family's lived reality into decision-making
- Translating professional plans into understandable, doable actions
- Supporting families to stay engaged between meetings
- Reducing disengagement, missed appointments and drift
- Feeding learning back into the partnership



**KOALA**  
North West

# Koala NWs role in the pilot

- Recruited and embedded a dedicated part time experienced Family Support Co-ordinator
- Coordinator acts as the named VCSE link for families involved in MAC
- Attends all monthly MAC meetings as part of the core process
- Provides pre- and post-MAC contact with families to:
  - explain the MAC process
  - gather consent
  - support understanding of agreed actions
- Focus on navigation and signposting, not duplicating existing services
- Feeds learning, gaps and outcomes back into MAC monitoring and review

# Key Principles: How We Work Together



## Family at the Centre

Every decision must reflect the family's own priorities and goals. They are involved at every stage — not just notified of decisions made about them.

## Information Sharing with Consent

Information is only shared with valid, explicit consent in place. All partners follow their organisation's information governance protocols.

## Named Ownership

Every action agreed at the MAC has a named professional and a clear deadline. No action is 'everyone's responsibility'.

## Early Escalation

If partners encounter a barrier or risk, will raise it immediately. Timely communication protects outcomes for families.

## Safeguarding First

If a safeguarding concern arises at any point, all partners follow their statutory duty and escalate through the appropriate pathway immediately.

## Continuous Improvement

Learning is captured from every MAC. Family feedback and partner reflections drive better practice for future cases.

# What This Pilot Is – and What It Isn't



## ✓ This pilot IS...

- ▶ A small, focused prototype in two Chester PCN areas.
- ▶ A foundational step in reshaping how the system supports CYP and families.
- ▶ An opportunity for VCSE to be an equal, embedded partner in NHS-led coordination.
- ▶ A model for gathering evidence to grow and influence future commissioning.
- ▶ A space to build trust and demonstrate what voluntary sector intelligence adds.
- ▶ An opportunity to learn together — continuous improvement is built in.

## ✗ This pilot is NOT...

- ✗ Funding for new or additional service delivery right now.
- ✗ A large-scale immediate expansion of existing services.
- ✗ New statutory pathways or a replacement for existing structures.
- ✗ Another meeting for partners to attend without purpose.
- ✗ A one-way flow of information from statutory to voluntary sector.
- ✗ A tick-box exercise — outcomes for families are the only measure of success.

# Next Steps for the Pilot



1

## Information Sharing Agreements

Partners confirm information-sharing protocols are in place ahead of Go-Live.

2

## Internal Communications

Each partner organisation communicates the MAC process to their teams so referrals can flow.

3

## Go-Live MAC Meeting

First operational MAC meeting, chaired by GP, with VCSE Families Link and full partner representation.

4

## Review & Learn

After initial MAC meetings, partners reflect on barriers, lived experience feedback, and refine the model through quarterly partnership strategic meetings.

5

## Evidence Building

Data and stories gathered through the pilot will inform the case for wider adoption and future commissioning.



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# Thank You

Cheshire West Place CYP Neighbourhood Health & Wellbeing MAC Pilot

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Bev Morgan, CEO, Koala NW

# Learning from VCSE Involvement in Neighbourhood working Children and Young People

May 2026

Sharon Cotterall & Jacque Finlay





# Neighbourhood Health – Bootle MDT - EOI

## Aim

Test a neighbourhood multidisciplinary team (MDT) model for children, young people and families in Bootle – integrating health, care, and community support around families with complex needs. £35k seed funding from Beyond.

## Scope

CYP MDT to enable earlier identification and personalised family support, focusing first on children open to social care, complex needs, and poorly controlled respiratory conditions. Fully supported by Families First Partnership and Family Hubs.

## Deliverables

- Fully operational, Bootle MDT
- At least 50 families identified and supported through integrated MDT discussions
- Evidence of improved coordination and reduced duplication across services
- A scalable model for replication across Sefton



## Key Partners

- Schools
- Voluntary Sector
- Children's Services
- PCN
- MerseyCare
- Alder Hey
- Right to Succeed



# Expected Benefits and Outcomes

Earlier identification & Prevention

More co-ordinated joined up care

Reduced pressure on hospitals and GP services

Improved asthma control & respiratory health

Better school outcomes

Stronger family engagement & empowerment

Tackling inequalities

Improved quality of life for children & Families

System level benefits



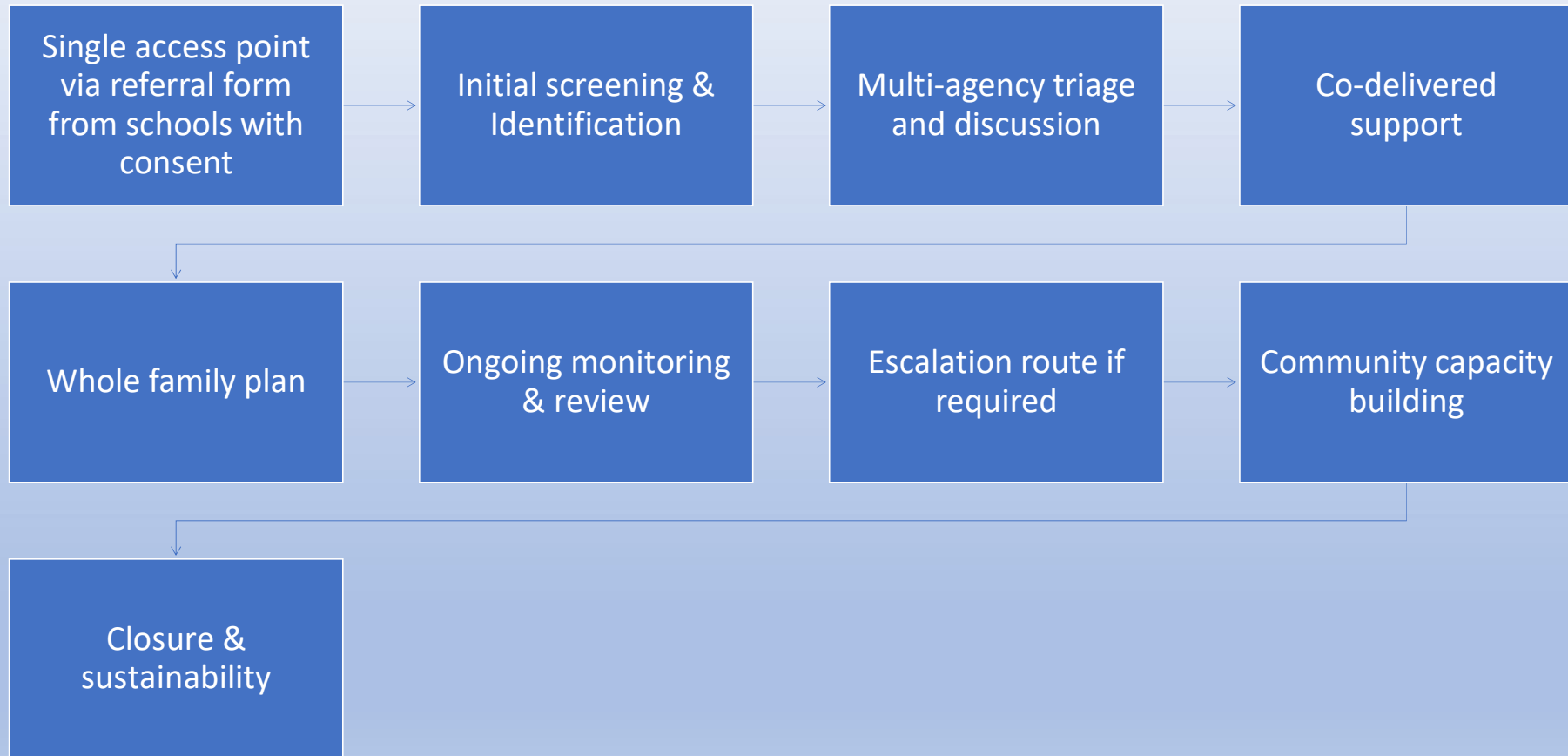
# Aligning Neighbourhood Health with Families First Partnership (FFP)

Neighbourhood Health Principles	Families First Principles
Place-based working	Locality teams, Family Hubs, and Team Around the School
Joined-up care	Integrated Early Help, Social Care, Education, VCFS & Health
Early intervention & prevention	Support before crisis, step-up/down pathways
Person-centred and relational	Co-produced, trauma-informed and strengths-based support
Tackling inequalities	Simpler access to help for families with complex needs

## Why This Matters

- Shared goals create strong foundations for partnership working
- Enables truly joined-up support across health, social care, education, and community
- Helps build a system where families feel known, supported and empowered

# Delivery Model



# Healthy Homes and Healthy Lungs – Parenting 2000

## Programme Overview

This programme aims to improve respiratory health and reduce school absences linked to asthma and other breathing difficulties among children in two Bootle primary schools.

The programme will be introduced and delivered within the school settings. Parents will have the opportunity to attend informal coffee-mornings hosted by the schools and then can engage in sessions that have been developed to support their needs.

Delivery will be led by the Respiratory Parent Champion (RPC) from Parenting 2000 in close collaboration with a wide range of expert partners e.g. Team Around the School and Primary Care Network Asthma Clinic to ensure evidence-based, integrated support.

# Healthy Homes and Healthy Lungs – Parenting 2000

## Aims

- Improve children’s respiratory health and reduce preventable school absences
- Equip parents with knowledge, tools and confidence to manage respiratory health
- Address environmental factors (cold homes, damp, allergens) affecting health
- Strengthen school knowledge through asthma-friendly accreditation
- Build sustainable peer-to-peer parent support

## Delivery

### Parent Engagement & Education

Workshops, drop-ins and 1:1 support for parents

Guidance on respiratory symptoms, asthma management and healthcare navigation

Asthma basics, inhaler awareness guidance, early warning signs, when to seek help

### Healthy Homes: Reducing Environmental Triggers

Identifying environmental triggers and managing them

Joint workshops with partners such as Energy Project Plus / Green Doctor , Groundwork and Fuel

poverty support with energy advice partners

Damp and mold advice using safe, non-toxic methods

Ventilation, heating and indoor air quality guidance

# Delivery

## Healthy Lifestyles Support

In partnership with Living Well Sefton, Active Sefton and Social Prescribers  
Promoting exercise and outdoor activity  
Encouraging use of natural environments (Green Sefton)

## Healthy Eating & Wellbeing Education

Supporting immune system health through good nutrition  
Promoting good sleep, rest and stress control  
Smoking/vaping reduction with Smoke Free Sefton



## Delivery

### Peer Support & Community Capacity

Identify and train parent Peer Mentors

Facilitate regular peer-support meetups and informal parent networks

### School Support & Accreditation

Progress toward Asthma Friendly School Accreditation

Training for staff and education and awareness materials for families

## Expected Outcomes



Improved respiratory health and fewer flare-ups



Reduced school absence related to respiratory health



Parents better equipped to manage home environments



Sustainable parent-led peer support



Increased signposting into other support services



Thank You

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Learning from VCFSE involvement in  
neighbourhood working – children  
and young people.

Q&A.