Child Health and Wellbeing Network
North East and North Cumbria

Zone Boro Project

Learning and Evaluation Report

ZONE BORO
CONNECTING RESOURCES FOR CHILDREN AND FAMILIES

North East North Cumbria Health & Care Partnership

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Contents

Background

The **Zone Boro** project was a 2-year pilot replicating the successful Zone West children's social prescribing model into Middlesbrough for children aged 7 to 11 years, **with the aim of demonstrating proof of concept and gain financial commitment to become sustainable at place**. This project is part of the Children's Integration Centre bid for NHS England Children and Young People's Transformation Programme funding, by the North East and North Cumbria Integrated Care Board's Child Health and Wellbeing Network.

The aim of the Integration Centre is to connect expertise and relevant organisations and host the NENC Children's Integrated Care Fellowships. As the largest Integrated Care System (ICS) nationally with the highest poverty levels outside London (and the highest growth rate of child poverty in the UK) we need to deliver **multiple integration models at pace to benefit the large number of disadvantaged young people in our region**. One of the integration models that we wanted to spread at pace was the Zone West model of social prescribing, to benefit the young people within Middlesbrough through the creation of Zone Boro.

Zone West is based on the principle of proportionate universalism (Marmot 2010). The model works upstream, taking an early intervention and prevention approach. The programme works with children who are at increased risk of poor academic achievement, poor long-term health outcomes, and higher incidence of social, emotional, and mental health difficulties. Children are identified through integrated health and education pathways and work is delivered in schools, GP (General Practitioners) surgeries and the community.

Purpose

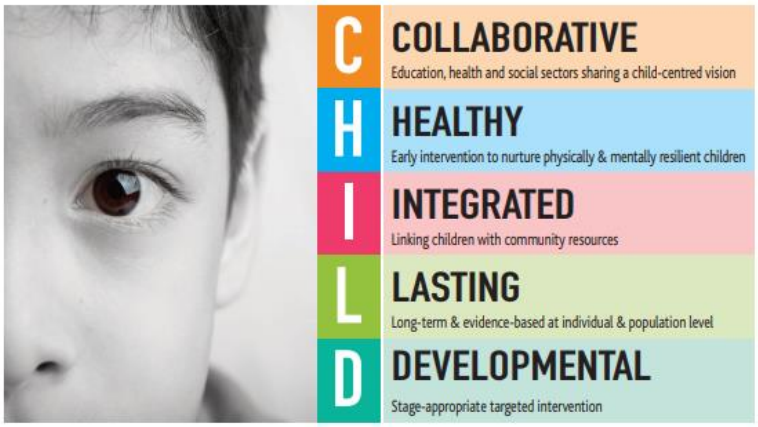
The purpose of this document is to share the learning from the implementation of Zone Boro, for both those interested in **social prescribing models for children** and those interested in the wider learning from replicating a service **into a new area at pace**. The learning from Zone Boro is also available in summary report Zone Boro Key Learning Summary.

The experiences and some of the tips highlighted may resonate with those familiar with transformation and challenges when implementing pilots but are still of value to those wishing to understand our journey to influence future work.

Social Prescribing Model

Zone West takes a child centred approach.

- **C**ollaborative – education, health and social sectors sharing a child centred vision.
- **H**ealthy – early intervention to nurture physically and mentally resilient children.
- **I**ntegrated - linking children with community resources.
- **L**asting – long term & evidence-based at individual and population level.
- **D**evelopmental – stage appropriate targeted intervention.



Zone West impact data demonstrated statistically significant benefits to the approach:

- School-reported data showed a highly significant positive effect on children's emotional difficulties and hyperactivity, a significant positive effect on children's conduct difficulties and a highly significant effect on children's attention in class.

- Self-reported quality of life data showed improvements across all scales, particularly for physical and social functioning.

- Parent-reported data indicated a highly significant effect on children's conduct difficulties and hyperactivity and a significant effect on emotional difficulties.

The Network's previously commissioned Zone West replication document provided a clear understanding of the *What*, in terms of the foundations of Zone West, and the *How* in which this had been implemented. This allowed the new Zone Boro project team to develop a local plan based on the successes and learning from a well-established service. The intention of the partnership approach was to enable other areas to benefit from the learning with a view to implementation and ongoing local multi-agency commissioning of the programme at place. which is one of the main roles of the CHWN, to connect and share good practice to drive improvement for children and young people (CYP) and Families.

Zone Boro Vision

To implement and embed a child-centred and relationship-based social prescribing service in Middlesbrough at pace.

Zone Boro Mission

Combine the expertise of Zone West Advisors, Clinical Lead and the NENC Child Health and Wellbeing Network (CHWN), to achieve the vision through the delivery of five key objectives;

1. Building and establishing local Social Prescribing practice in Middlesbrough
2. Identifying locality anchor organisations in the community to root Zone Boro.
3. Introduce the Zone West approach to key stakeholders and existing partnerships encouraging and embedding sustained collaboration.
4. Recruit, train, implement caseload and quality assure a team of Link Workers.
5. Monitor the impact of the Zone Boro programme.

Implementation of Zone Boro

This section details the five implementation objectives, sharing the key stages of each objective and the learning from this summarised into *Top Tips*.

Objective One: Building and establishing local Social Prescribing practice in Middlesbrough

1.1 Identify a key target area utilising Index of Multiple Deprivation (IMD) and prevalence of risk factors associated with health, education, and social outcomes.

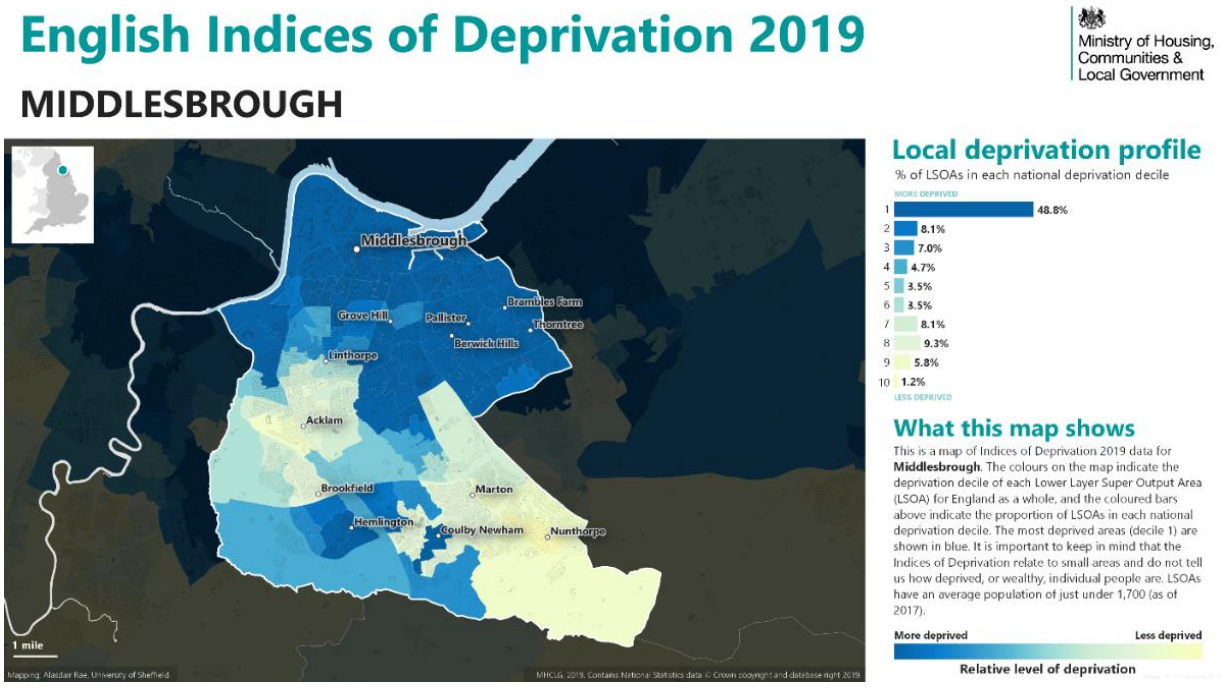
The degree of deprivation of an area can be measured using IMD deciles. Those in group (decile) 1 are in the 10% most deprived areas in the UK. Those in group (decile) 10 are in the 10% least deprived areas in the UK. The divided small localities are of approximately equal population size, allowing for comparison of areas. These areas are known as Lower-layer Super Output Areas (LSOAs). The IMD is based upon seven different domains which can be used as a combined assessment of deprivation but may also be considered individually. They are:

- Income (weighting of 22.5%)
- Employment (weighting of 22.5%)
- Health Deprivation and Disability (weighting of 13.5%)
- Education, Skills, and Training (weighting of 13.5%)
- Barriers to Housing and Services (weighting of 9.3%)

- Crime (weighting of 9.3%)
- Living Environment (weighting of 9.3%)

Middlesbrough has a 'rank of average score' of 5. This means it's the fifth most deprived local authority area in England, and it has become more deprived since 2015. Middlesbrough was identified as the pilot area for replication due to significantly high levels of deprivation, health inequalities and poor health outcomes for children. A third of the North East's Parliamentary constituencies now has a child poverty rate of 40% or above. In Middlesbrough the rate is 50.7%, with the highest rates of child poverty in the North East and North Cumbria region.

Figure 1: LSOAs and Deprivation Profile for Middlesbrough This data was used to identify schools within the most deprived LSOAs (by Income Deprivation Affecting Children Index (IDACI) decile)



1.2 Consider Primary Care Networks (PCN) and Schools within this defined area;

- *Two primary schools recruited and engaged in the programme. The pupil characteristics of these schools are detailed in Table 1.*
- *One PCN with 5 GP practices was recruited and engaged in the programme.*

The LSOA data was used to create a local list of schools to consider involvement in the programme. As part of this process the team considered other early intervention programmes of work that were being delivered to support children within each of the primary schools, for example, the Mental Health Support Teams.

Table 1: Overview of participating school's pupil characteristics (all ages)

School	Total Pupils	SEN* Plan	SEN Support	Boys	ENFL**	FSM*** Eligible	Overall absence	Persistent absence
Ayresome	745	0%	25.8%	51.8%	71.4%	46.5%	9.2%	34.5%
Linthorpe	740	0.4%	14.2%	53%	39.8%	39.4%	3.8%	6%

**Special Educational Needs, **English Not First Language , ***Free School Meals*

Holgate PCN was identified as a primary site for replication. Based in the Tees Valley, this PCN has a combined list population of 44,618 people and is comprised of 5 practices (Teesside, 2021):

• Borough Road & Nunthorpe Medical Practice

• Fulcrum Medical Practice

• Haven Medical Practice

• Linthorpe Surgery

• The Village Medical Centre

The PCN had an established social prescribing service for adults and contained Deep End GP Practices which are those identified as being within areas of highest deprivation. This PCN covered the same LSOA as the identified target schools.

Top Tip 1: Engage future commissioners in the initial planning phase to support identification of priority schools and PCN's, to ensure the service is considered as part of and complementary to local serviced provision at place.

1.3 Convene an advisory Steering Group to develop new partnerships with key partners including, but not limited to, health, education and Voluntary Community and Social Enterprises (VCSE)

The Zone Boro Steering Group (ZBSG) was established at the implementation phase of the project. The aim of the ZBSG was to champion the implementation and embedding of Zone Boro into Middlesbrough and ensure that its delivery

complemented and built on existing work within Middlesbrough to improve outcomes for children and young people.

Membership of the ZBSG included a range of stakeholders and experts (Table 2).

Table 2: Zone Boro Steering Group Membership

Job Title	Organisation
Network Delivery Manager	Child Health and Wellbeing Network
GP	Primary Care Network
Programme Manager	Northeast Wellbeing
Public Health Lead	Middlesbrough Council (Public Health)
Commissioning Delivery Manager MH	ICB (South ICP, formerly Tees Valley CCG)
Chief Executive Officer	Middlesbrough Mind (VCSE)
Chief Executive Officer	The Link CIC (VCSE)
Head of Early Years & Primary Inclusion	Middlesbrough Council (Education)
Programme Officer	You've Got This (VCSE)

Top Tip 2: Establish a steering group in the initial planning stage of the programme prior to Implementation, to ensure early engagement and buy in from key local partners and future commissioners.

Objective Two: Identifying locality anchor organisations in the community to root Zone Boro

2.1 Listening to the community; parents, children, teachers, and healthcare professionals along with current provider of statutory and voluntary child services

Learning from the strengths of Zone West highlighted the importance of embedding Zone Boro into the community adopting a bottom-up approach, to meet the specific needs of the community. The needs of communities may differ between localities, therefore local consultation with key stakeholders and those who would be in receipt

of support prior to commencement is integral to ensuring successful implementation and acceptability from all involved.

A listening exercise for Zone Boro took place in the implementation phase (see appendix 1, pre-programme listening exercise). Two key groups took part: adults (including professional stakeholders and parents) and children. The results were as follows:

Figure 2: Community Listening Exercise

2.2 Local assets will be mapped and logged

Local assets were mapped, and several meetings organised to ensure parallel and cohesive working within the local community, to bolster services for children and young

Top Tip 3: Local asset mapping is a useful approach to support Link Worker induction, understanding of local service provision and engaging key stakeholders.

people and enable collaborative working. This aligned with the vision to respond to local needs, providing a preventative service and avoiding duplication of provision. (See appendix 2, asset mapping example template)

Objective Three: Introduce the Zone West approach to key stakeholders and existing partnerships encouraging and embedding sustained collaboration

3.1 Utilise the learning from the Zone West evaluation to support roll out
3.2 Develop project delivery plan supported by stakeholders
3.3 Establish referral pathways that support and link with local services

In the first three months of the pilot, mentoring, advice and support came from the Zone West Project Lead, particularly around induction of Link Workers, development of processes, documentation and information sessions for health professional to raise awareness of the service and referral criteria. This strengthened programme fidelity while adapting to fit the specific needs of Zone Boro area. This support remained available on an as-needed basis. The Zone West project team developed a project delivery plan to support implementation and delivery which outlined timescales, actions and risks to delivery. This was shaped by the Zone West replication document and the five key priorities articulated in the PID.

Top Tip 4: Include additional support to get the new service up and running and if project resources allow extend this, balancing levels of support with budget available and value for money.

3.4 Ongoing communication with partners to support the roll out of the project and keep them informed of key developments.

Throughout the programme, the ZBSG provided a mechanism for ongoing communication with key partners. Alongside this, the Programme and Clinical Leads continued to meet with multiple statutory and voluntary partners.

The aim of meetings was to continue to understand and develop relationships within the local context, to ensure the programme worked alongside and in collaboration with place-based assets.

PCN teams were kept updated with regular newsletters and case study reports. The team presented at the local GP meetings, along with the Head Teachers Forum. Additionally, during the pilot, the Zone Boro Project Lead became an Ambassador for

Top Tip 5: Communication is vital and using both existing routes and new innovations to communicate across a wide range of stakeholders maximises impact. Utilise steering group as well as operation experts in this.

You've Got This (YGT). YGT is a Sport England South Tees pilot with a vision of 'Active Lives as a Way of Life'. Many children were referred to Zone Boro due to inactivity, poor nutrition and associated poor mental health (see appendix 3, Zone Boro activity and weight management – You Can! findings) .

Objective Four: Recruit, train, implement caseload and quality assure a team of Link Workers

4.1 Recruit two Link Workers

While recruitment started at the project initiation, there were delays with successful recruitment. Following 3 rounds of recruitment, the anticipated October 2021 start date was pushed back and 1 FTE (Full Time Equivalent) link worker started in January 2022, and a second in March 2022, commencing school delivery in May 2022, followed by GP practices in June. The anticipated near full first year delivery in schools was reduced to one half term impacting on operational delivery and subsequent outcomes that could be achieved.

Top Tip 6: Consider local providers to host local services, to utilise existing relationships, asset awareness and provide a place-based approach to recruitment to reduce lead time and maximise impact from outset.

4.2 Link Workers induction and training

Link Workers received a full induction programme that was provided by the Project Lead, with mentoring by the Project Lead of Zone West. The induction covered;

- Policies and procedures
- Meet and greet with key stakeholders and local Link Workers
- Role-specific training including e.g., social prescribing training
- CAMHS (Child and Adolescent Mental Health Services) training modules
- Meeting assets
- PCN Induction
- School induction
- Attendance at Zone West team meetings
- Job shadowing Zone West Link Workers
- Data pack upskilling
- Mental Health First Aid
- Joy case management training

4.3 Implement caseload

- Each link worker had a maximum active caseload of 30 children, with 15 from schools and 15 from health referral pathways.
- Intervention took place within school buildings, community venues, GP practices and on home visits where needed.

Implementation of caseloads

In accordance with the Zone Boro Integrated Research Application System (IRAS) ethical approval, the consent procedure was carried out in two stages for school participants. As a population health approach, the whole population of Y3 and Y4 were informed and consented for screening to take place. Once selected Zone Boro participants were data consented to participate in the programme, allowing data to be used as part of the Zone West research project by Newcastle University

Selection of caseloads

Teachers from the two schools filled out the Strengths and Difficulties Questionnaire (SDQ) about the children in their Y3 and Y4 classes. The SDQ is a standardised, robust screening tool for identifying social, emotional and mental health difficulties in children. This data was used to identify samples of children who fell into raised categories of concern. Children were identified for inclusion into Zone Boro in triangulation meetings with SEND leads in both schools.

In Health contexts, the children were referred by GPs and other members of the healthcare team who, in consultation with parents, gained consent.

Context

The Link Workers aimed to be integrated fully into school life. In addition to building relationships with the child and their family, the Link Worker built strong, trusting relationships with Senior Leaders, the pastoral team and teaching staff, and became part of key meetings and information-sharing sessions. This allowed for cohesive work to take place around the child.

Successful integration depends not only on an openness and willingness within the school to embrace the Link Worker as if an employee, but also on the Link Worker making this a priority, especially early in the project.

In the Healthcare setting the Link Worker worked hard to ensure staff were aware of the service. They did so by attending practice meetings and informal coffee mornings,

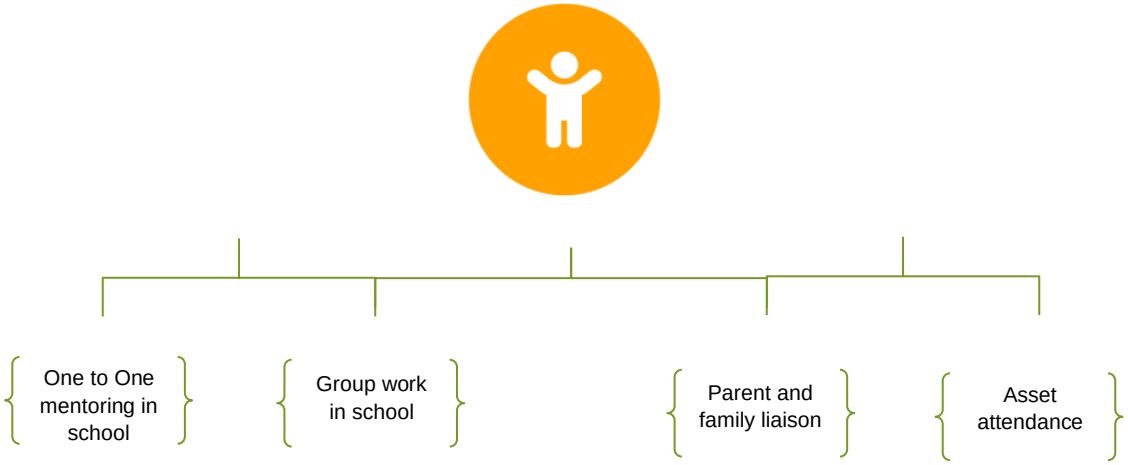
Top Tip 7: Link Worker integration with GP Practices should include non-clinical and administrative staff – knowing names, faces and responsibilities. This will support patient referral to the service and its success.

setting up noticeboards, email introductions to all staff, drop-in sessions in staff rooms, newsletters and leaflet drops.

Work with Children

In schools, Link Workers created formative relationships with children built on trust. They did this in 4 ways:

Figure 3; How the Link Workers engaged with the children and families



Mentoring for health referrals was predominantly one to one; school liaison was also a key factor in ensuring Link Workers were able to support the children effectively.

All interventions were focussed on the needs of the child; these were evidence-based using baseline data assessments and co-created personal development plans. These interventions supported the management of anxiety, sedentary and unhealthy lifestyles, and emotional, social and behavioural regulation. Activities were based around gardening, bush craft, cooking, craft, team building, social and emotional

games, and stories. These sessions also provided space to build a trusting relationship between the Link Worker and child, to give the child a voice, and to allow the Link Worker to advocate for the child.

Alongside these interventions, holistic support was often identified for a child or their family members such as specialist schooling, housing, employment, benefits, financial advice, mental health support, drug and alcohol support or bereavement counselling. Link Workers signposted to external organisation/charities and supported access where needed.

When ready, children were supported to attend local assets specific to their personal development plans such as music and dance groups, family football sessions and youth groups.

Examples of how these sessions support children include:

- Gardening: social skills, sedentary lifestyle, self-esteem, anxiety
- Board games: social skills, emotional regulation, rule following, listening.
- Ball/ active games: sedentary lifestyle, social skills, friendship building
- Cooking: good nutrition, life skills, self-esteem, listening, friendship building

Holiday Activities and Food Programme

Holiday playschemes were run in addition to the above to ensure continuity of contact and delivery. Funding for this came via the Holiday Activities and Food Programme, funded by the Department for Education, and other funders such as Greggs and the Tees Valley Community Foundation. They led trips to, for example, the seaside to build sandcastles and have a splash in the sea, to the woods for a day of bushcraft and shelter building, a trip to a farm and a visit from Santa. The scheme provided day sessions in conjunction with other local charities giving opportunities for therapeutic gardening, nature journalling and crafts.

4.4 Quality Assurance

Link workers were provided with regular supervision provided by the Project Lead and Clinical Lead. This took the form of case supervision monthly, clinical supervision 6 weekly, mental health supervision via CAMHS on an as-needed basis, and provision for daily urgent/safeguarding queries within school and health settings.

- Case supervision took the form of an informal, open discussion around common themes, specific groups of children, or children of particular concern who were perhaps not making expected progress, and celebration of progress made. It was an opportunity for the Link Worker and Project Lead to have an open discussion and work together to create a bespoke action plan.

Top Tip 8: Maximise opportunities to access other funding streams to enhance reach of existing work and opportunities to your target population.

- Performance management reviews of targets, caseload and data collection took place every 3 months with the Project Lead.
- Clinical Supervision occurred every six weeks face to face, providing a focused discussion around case load, specific challenges within the health setting or health related queries.
- Mental Health Supervision, provided by CAMHS, was offered as a trial on an ad hoc basis to support work with children requiring mental health support, often who were waiting to be seen by CAMHS. This replicated an approach trialled in the Zone West service which provided more specialised mental health support.

Top Tip 9: Consider the allocation of funding to a clinical leadership role with paid dedicated time as a valuable part of a programme team to support, develop and influence the implementation of the programme within the local PCN.

Information sharing agreements

As part of the 'How' of the replication document, there was the need to create place-based information sharing and quality assurance pathways.

Within induction, each member of the team completed a PCN-based induction with the relevant data sharing, consent and quality assurance information completed.

An IRAS application was completed on behalf of Holgate PCN, as an adjunct to the Zone West Newcastle IRAS, which enabled ethical cover for research purposes, when considering access to health records and data relevant to the pilot.

Case management programme

As part of quality assurance and data processing, the Zone Boro team reviewed the options available for case referrals and management.

Penelope is the Social Prescribing Case Management System used by Zone West. With replication into Middlesbrough, the team moved to the Joy system. This system was already in place for adult Link Worker services across Middlesbrough, and knowledge and understanding of this was known within Holgate PCN. This was an inbuilt efficiency to the programme and enabled flexibility for referrals as well as strength to future bids for local commissioning for the service within the area by integrating into preformed systems.

Penelope is a stand-alone system that is mainly used in the corporate setting. It was chosen as the preferred system for Zone West as it was cost effective at the time and had the basic functionality required.

From a Link Worker perspective, Joy was intuitive to navigate, and bespoke elements increased functionality specific to the service needs. The customer service team was highly responsive, supporting this bespoke development element. As a cloud-based system, the only drawbacks faced were during connection timeouts, during which recently input data failed to save (see appendix 4, comparison of data systems).

Top Tip 10: Consider adopting local data collection systems to record outcomes, to reduce costs, ensure ease of local data sharing, and quality assurance. This can be extended to other agreed processes such as data sharing agreements.

Top Tip 11: Consider access to a data analysis role within your project team to ensure data collection and data management is effectively delivered to support the demonstration of project impact.

Objective Five: Monitoring impact of the Zone Boro programme

5.1 Anticipated Outputs

5.1.1 30 children from 2 primary schools will be engaged in weekly Zone Boro activities & signposting

A total of 38 children engaged in Zone Boro via the two identified schools. 27 children from 2 schools had matched pre and post programme data that could be analysed as part of the evaluation.

In March 2022, children were identified via a screening programme using the Teacher's SDQ scores. These data were analysed by North East Wellbeing with supervision by Newcastle University. Children were referred to the Zone Boro programme using a combination of these data, school-specific data, and qualitative feedback from school staff working closely with these children.

5.1.2 30 children from 2 GP Practices will be on a Zone Boro referral and treatment pathway

A total of 37 health referrals were received into Zone Boro from GP practices within Holgate PCN. 32 of the children referred engaged in the programme. The main reason for opportunistic referral included behaviour, caring responsibilities, poverty and housing, eating challenges, loneliness and isolation, health condition, mental health, sedentary lifestyle and/or high body weight. The service received referrals from a wide range of healthcare staff across the PCN including Care Navigator, GPs, Adult Link Worker, Receptionist, Nurse Practitioner, Safeguarding Lead, and a Medical Student.

All children in the PCN < 18 years with Type 1 diabetes were proactively contacted to offer the service. This cohort was chosen as managing Type 1 diabetes can impact significantly on children's social and emotional development, affecting friendships, schooling and social integration. The overarching aim was to provide support to children, or their parents or carers, to build resilience and understanding in dealing

with a chronic condition. There are well documented associations between poor school attendance, lower academic achievement, higher levels of drug and alcohol use, and mental health difficulties in teenage children with poorly controlled diabetes. Of the 37 health referrals, nine of these were identified through the population health management approach focusing on managing Type 1 diabetes; four families accepted support. Each of the Link Workers received support and training from the NENC Diabetes Network, providing an opportunity to integrate with other ICB services.

5.2 Anticipated Benefits

At the outset of the project these were holistic anticipated benefits, however, it was recognised that some of these are difficult to measure or evidence impact over the lifetime of the pilot. These include:

- **Contribute positively to future local employment rates** – this would be a longer-term outcome and would need to consider individual confidence levels and ongoing support and tracking.
- **Reduce unnecessary GP and ED attendances -** this would be a longer-term outcome measure; consideration would need to be given to the capacity to collect baseline measures at individual and locality level when scaling a programme from pilot phase.
- **Reduce demand on SEND provision in education settings -** there is some anecdotal evidence to suggest that the service supported capacity within the school setting through supporting individual children.
- **Early intervention in emotional and mental health reduces demand on clinical mental health services –** although this was not measured as part of the project, this is anticipated benefit as there is a wealth of evidence that supports that early intervention can substantially reduce the burden on clinical services.

Outcome Measures

Assessments were completed at two time points by the Link Workers: before interventions started and at a 9-month follow-up. An assessment pack was used with parents, teachers, and children themselves. Qualitative data was also collected in the form of case studies and following focus groups held with children and school staff.

The assessment pack contained and measured:

- Social-emotional mental health (SEMH): measured by the Strengths and Difficulties Questionnaire (SDQ) - Completed by teacher, parent, and child
- Quality of life: measured by the Paediatric Quality of Life Inventory (PedsQL) - Completed by parent and child
- Pragmatic Language: measured by the pragmatic language subscale of the Children's Communication Checklist-2 (CCC)-, completed by parents
- Expressive and receptive vocabulary: measured by a vocabulary list designed by the research team- completed by parents.

Data sets were analysed by North East Wellbeing with supervision by Newcastle University. Data analysis was funded as part of the integration bid.

Outcomes

Data analysis demonstrated a statistically significant positive effect of Zone Boro on children's social and emotional mental health (improved conduct and hyperactivity difficulties), and quality of life (improved physical, emotional and social functioning) as reported by parents (Figures 3 and 4 below).

Figure 4. Mean (SD) pre and post parent report SDQ score

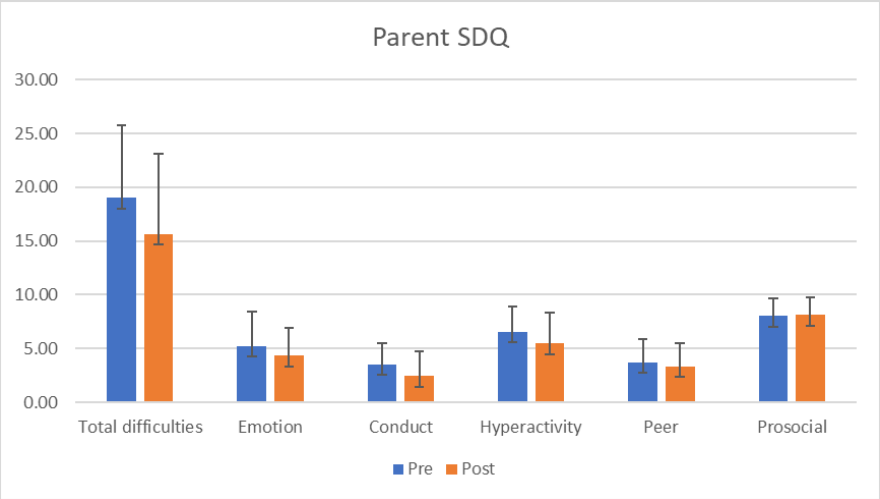
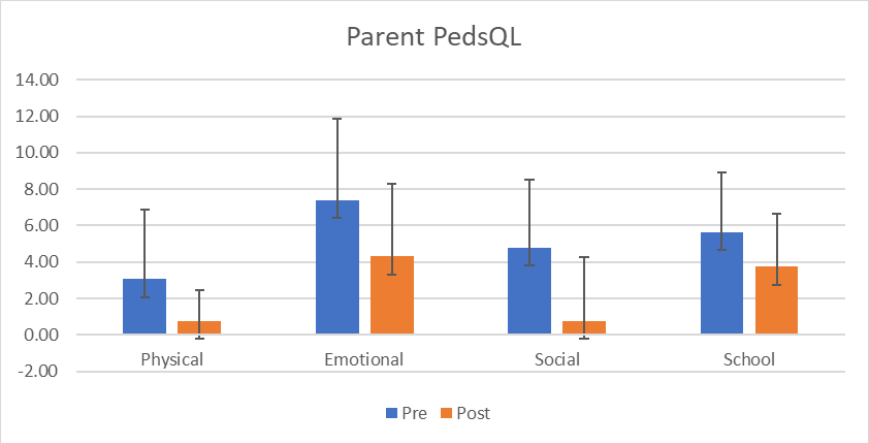


Figure 5. Mean (SD) pre and post parent report PedsQL scores



Teacher-reported data also indicated improvement in children's SEMH although these trends did not reach statistical significance. This statistical level is likely due to very low scores at baseline in teacher data (i.e., a floor effect indicating no SEMH difficulties at the start of the programme) and a small sample size due to the first phase of the pilot in two schools. Child-reported SEMH and quality of life remained stable over time, however there was improvement (non-significant) in children's self-reported expressive and receptive vocabulary (see appendix 5 and 6, case study examples and Zone Boro outcome summary).

Qualitative Data

Case Study One:

- **Age 7; significant parental illness**
- **School refuser**
- 1:1 outdoor therapeutic work focussed on resilience
- Child-managed reward system established
- Family liaison
- Attends school daily.
- Self-confidence high

Case Study Two:

- **Age 6; large family with two ASD siblings**
- **Anxiety and low self-esteem; no friendships; tearful**
- 1:1 therapeutic work focussed on self-appreciation and giving child a voice
- Group mentoring focussed on friendships.
- Friendship groups established.
- Bubbly and talkative
- Took part in school sports day.

Child

“My favourite thing about working with the Link Worker is that she helps me be confident, be proud of myself.”

“I was really shy...she’s helped me to be not as shy. I’m really happy that my Link Worker here for me. I used to not be able to answer any questions at all.”

“We work on my mental health, and that’s really helped me a lot.”

“She’s helped me make more friends.”

“I used to run out of school and not come back.”

“I used to not be as happy. My health has got better physically and mentally."

School

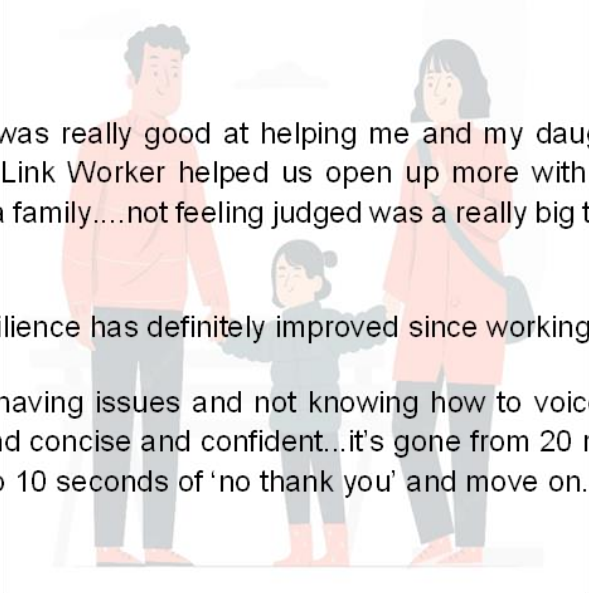
“One child who springs to mind is a little girl who has emotional-based school avoidance...she’d had previous work in school...The Link Worker has worked with this child, worked with the mum, supported her mum to get her into school. Now mum is getting her into school every morning. This is the impact of the Link Worker, working with the family, not just the children.”

“The role of the Link Worker has enhanced our school offer... through the holiday club which has support them during the summer, during that long period away from school...(it) has reduced the anxiety in children coming back after the holidays...return to school...has been successful.”

“We have three quite tricky girls who have positively engaged...they were children who didn’t want to be involved in groups...being outside (therapeutically) has had a positive impact on them being back in the classroom.”

“Parents are a lot more willing to come and speak to me about things. (Things they) find slightly awkward to talk about...(they) are more willing to speak about it because the children are.”

Parent



"The Link Worker was really good at helping me and my daughter communicate about issues...the Link Worker helped us open up more with each other and to become closer as a family....not feeling judged was a really big thing for me and my family."

"Her emotional resilience has definitely improved since working with Zone Boro."

"She's gone from having issues and not knowing how to voice them correctly to being very clear and concise and confident...it's gone from 20 minutes of crying to get her to speak, to 10 seconds of 'no thank you' and move on."

B) Qualitative Health Data

Case Study Three:

- **Age 11; family circumstances mean he is home-based.**
- **Inactivity, overweight, asthmatic, poor nutrition**
- Family cooking sessions, including child choices.
- Exercise programme developed based on child interest.
- Gardening
- Growing own fruit and vegetables
- Actively cooking with parent and eating self-prepared meals

Case Study Four:

- **Age 10; ASD**
- **School refuser with declining mental health**
- 1:1 therapeutic work focussed on giving the child a voice
- Link Worker - advocate for child with external agencies
- Family liaison
- Attends specialist school.
- Attends school daily.

Learning and challenges faced

The Zone West replication document provided a very clear understanding of the 'What', in terms of the foundations of Zone West and the way in which this had been implemented, with a proposed set of actions and ways of working. Yet the replication of a programme into another area requires dynamic response to the differing commissioning structures, relational maturity, and community-based nuances in the replication geography.

A key challenge for the Zone Boro programme was the later development of collaborative cross-sectional working and lack of local financial commitment to enable continued work. In addition to this, the Zone Boro programme was introduced at a time of change. The local CCG was being disbanded, with transition to the ICB. There was significant uncertainty across local statutory bodies in relation to job roles, areas of responsibility and funding commitments moving forward.

This uncertainty was not limited to the health sector. With reducing budgets and changing portfolios also in local authority and educational settings, again there was challenge in engaging parties to provide funding commitments or consider integration of Zone Boro into established and commissioned services.

This context creates an even greater need to demonstrate value for money. It was anticipated that the initial pilot costs would be higher before wider operational implementation would achieve economy of scale. Zone Boro costs from the core funded elements and children involved equated to circa £3000 per child. The strong fidelity of the Zone Boro approach within Middlesbrough created less focus on how we might benefit a larger number of disadvantaged young people to secure value for money within the timelines available.

Top Tip 12: Maximise your project's impact at scale by considering value for money in your project plan, so opportunities are not lost, and you can increase reach within your target population. This may help attract commissioners to support subsequent stages of your work and ideally an operational service.

The programme as yet has been unable to secure ongoing funding commitment at Place. There are several learning points gained during the implementation of the programme which can inform future works in relation to these funding decisions:

1. The Zone Boro programme was a two-year pilot programme with the aim of demonstrating proof of concept and sustainability at place. A full two years of learning was not achieved; due to delays in the recruitment of Link Workers (due to begin in September 2021), the Link Workers did not commence working with children until May 2022. There is some reflection that the initial job adverts were advertised as a Newcastle-based post, with the host organisation being in Newcastle potentially deterring Middlesbrough based applicants.

Top Tip 13: When piloting a project at pace, ensure operational delivery starts at the earliest point and outcomes are achievable within the project timeline.

2. When replicating a project requiring it to move into a new local system (in our case 45 miles away with different Council and health commissioners), it is important to quickly establish local knowledge and early trusted relationships, which if not already in place can disadvantage implementations with providers working in a new geography as they take time to establish. The learning that can be shared from the Zone Boro programme includes highlighting the importance of local knowledge and influence recommending that opportunities to work in partnership with local providers early in the programme to promote sustainability are maximised. This was particularly important to the Integration Centre ethos of spread to maximum benefit across the region.

Top Tip 14: Prevent unwavering loyalty to a defined model when introducing a service to a new area by agreeing a few overriding principles, from which operational detail can adapt to local processes and needs.

3. As the project developed it became clear that initial proposals regarding budget outlines did not provide enough granularity around requirements such as travel, physical resources, room hire and ongoing project management. This required an in-project review of required budgets, and an alteration in project structure and staffing. While it is important to have a learning mindset to ensure the dynamic development of a pilot, there needs to be a clear understanding of requirements when working within a defined financial envelope to avoid any detrimental impact on service delivery.

Top Tip 15: When developing bid proposals at pace try to include larger contingency allocations for gaps that may emerge.

4. Where service and Link Worker integration is not prioritised within school, it can alter the perceived impact of the service and subsequently ongoing buy-in from schools. The Link Worker role, their fit with the school ethos and the efforts made early in the project are critical to success. It is important to recognise the multiple conflicting priorities across the education system and that any proposed new model of delivery does not exacerbate existing challenges. Though data was positive for the cohorts of children from both schools, the perceived success of the programme was greater from the school where integration was prioritised.

Top Tip 16: Involve Head Teachers and/or key staff within the school setting in the steering group to ensure they understand the importance of integration.

5. Integration was shown to be equally important in the healthcare setting. This became a challenge when accessing electronic systems, and subsequently impacted the speed at which link workers were able to integrate and communicate with the healthcare team. Ensuring Link Workers are integrated fully into the PCN, as if an employee, is essential to prevent delays with delivering interventions and ensure clean administrative processes.

6. In line with replicating the approach of Zone West, mental health supervision from CAMHS was trialled to support Link Workers with challenging cases. Many children were referred due to poor mental health and/or were awaiting diagnoses of autism spectrum disorder and other neurodevelopmental disorders. Supervision can support accelerated progress for the child. This service was not an ongoing offer and provided an example of altered commissioning between areas impacting on the exact replication of one service into another area.

Top Tip 17: Consider how mental health supervision will be provided in a new locality to ensure this is delivered from the outset of the service.

Conclusion

The purpose of this document is to share the learning from the implementation of Zone Boro, for both those interested in social prescribing models for children and those interested in the wider learning from replicating a service into a new area at pace. The Zone West model was successfully replicated to create the Zone Boro social

prescribing model in Holgate PCN and two schools within Middlesbrough. There were challenges to implementing the service at pace and Zone Boro was unable secure local funding in the anticipated timeline. Both the children and parents supported by the programme experienced significant personal impacts.

A great deal of learning came out of the development of the service and provided some key questions to consider when replicating a successful service from one area into another. The top tips outlined throughout the document provide considerations and solutions to address the questions.

Key questions to ask when replicating a service into a new area are:

- What are the key components of the service that must be replicated to ensure its success? What it is i.e., where does the flexibility lie within the initial structure/ethos of a service?
- Is there opportunity to utilise established relationships and structures within the local area?
- How can you establish a steering group to engage at concept and into operational delivery?
- What is the allocated budget and realistic costs of service delivery with adequate contingency?
- What are the assurance and outcome requirements of all parties involved?
- How will the service record data and manage impact analysis?
- How will you work with local commissioners to ensure ongoing sustainability and become a business-as-usual service?

Top Tips

1. Engage future commissioners in the initial planning phase to support identification of priority schools and PCN's, to ensure the service is considered as part of and complementary to local service provision at place.
2. Establish a steering group in the initial planning stage of the programme prior to Implementation, to ensure early engagement and buy from key local partners and future commissioners.
3. Local asset mapping is a useful approach to support Link Worker induction, understanding of local service provision and engaging key stakeholders.
4. Include additional support to get the new service up and running and if project resources allows extend this, balancing levels of support with budget available and value for money.
5. Communication is vital and using both existing routes and new innovations to communicate across a wide range of stakeholders maximises impact. Utilise steering group as well as operation experts in this.
6. Consider local providers to host local services, to utilise existing relationships, asset awareness and provide a place-based approach to recruitment to reduce lead time and maximise impact from outset.

7. Link Worker integration with GP Practices should include non-clinical and administrative staff – knowing names, faces and responsibilities. This will support patient referral to the service and ensure its success.
8. Maximise opportunities to access other funding streams to enhance reach of existing work and opportunities to your target population.
9. Consider the allocation of funding to a clinical leadership role with paid dedicated time as a valuable part of a programme team to support, develop and influence the implementation of the programme within the local PCN.
10. Consider adopting local data collection systems to record outcomes, to reduce costs, and ensure ease of local data sharing and quality assurance. This can be extended to other agreed processes such as data sharing agreements.
11. Consider access to a data analysis role within your project team to ensure data collection and data management is effectively delivered to support the demonstration of project impact.
12. Maximise your project's impact at scale by considering value for money in your project plan, so opportunities are not lost, and you can increase reach within your target population. This may help attract commissioners to support subsequent stages of your work and ideally an operational service.
13. When piloting a project at pace, ensure operational delivery starts at the earliest point and outcomes are achievable within the project timeline.
14. Prevent unwavering loyalty to a defined model when introducing a service to a new area by agreeing on a few overriding principles, from which operational detail can adapt to local processes and needs.
15. When developing bid proposals at pace try to include larger contingency allocations for gaps that may emerge.
16. Involve Head Teachers and/or key staff within the school setting in the steering group to ensure they understand the importance of integration.
17. Consider how mental health supervision will be provided in a new locality to ensure this is delivered from the outset of the service.

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