ABS National Evaluation Annual Report

Prepared for: The National Lottery Community Fund
By: The National Centre for Social Research, RSM, University of Sussex, National Children's Bureau, Research in Practice
Publication Date: 9 May 2023

Contents

1 Executive summary

A Better Start (ABS) is the ten-year (2015-2025), £215 million programme set-up by The National Lottery Community Fund (The Fund), the largest funder of community activity in the UK. Five ABS partnerships based in Blackpool, Bradford, Lambeth, Nottingham, and Southend-on-Sea are supporting families to give their babies and very young children the best possible start in life. Working with local parents, ABS partnerships are developing and testing ways to improve their children's diet and nutrition, social and emotional development, and speech, language, and communication. The work of the programme is grounded in scientific evidence and research. ABS is also place-based and working to enable systems change. It aims to improve the way that organisations work together and with families to shift attitudes and spending towards preventing problems that can start in early life. ABS is one of five major programmes set up by The Fund to test and learn from new approaches to designing services which aim to make people's lives healthier and happier. Learning and evidence from ABS enables The Fund to inform local and national policy and practice initiatives addressing early childhood development.

The Fund have commissioned NatCen and partners from the National Children's Bureau (NCB), Research in Practice, RSM and the University of Sussex, to carry out the national evaluation of ABS. The aims of the national evaluation are to:

- Draw upon the evaluation objectives (see below) and provide evidence for primary audiences (ABS grant holders and partnerships) and secondary audiences (commissioners – including local and national government – and local and national audiences).
- Provide evidence to support ABS grant holders to improve delivery outcomes throughout the lifetime of the project.
- Enable The Fund to confidently present evidence to inform policy and practice initiatives addressing early childhood development.
- Work with local ABS evaluation teams to avoid duplication of evidence and enable collation of evidence from local ABS evaluations.

There are four evaluation objectives:

- **Objective 1**: To identify the contribution made by the ABS programme to the life chances of children who have received ABS interventions.
- **Objective 2**: To identify the factors that contribute to improving diet and nutrition, social and emotional skills and language and communication skills through the suite of interventions, both targeted and universal, selected by ABS partnerships.
- **Objective 3**: To evidence, through collective journey mapping, the experiences of families from diverse backgrounds through ABS systems.
- **Objective 4**: To evidence the contribution the ABS programme has made to reducing costs to the public purse relating to primary school aged children.

To address these four objectives, the evaluation includes a range of qualitative and quantitative evaluation activities, to build a mosaic of evidence to help tell the story of the impact of ABS.

About the first annual report

This is the first of four annual reports that will be published as part of the national evaluation of ABS. As the national evaluation will run alongside the programme until 2025, findings in this report are interim and evidence of the impact of ABS will build as the evaluation progresses. Analysis will continue after the ABS programme comes to an end and the final evaluation report will be published in 2026.

The purpose of this report is to inform audiences of the national evaluation, evaluation activity delivered in 2022, findings to date, and next steps.

Findings to date

The annual report presents findings to date across the four objectives. Each evaluation objective is working towards a different time scale, which is reflected in the report.

Objective 1

Interim findings for Objective 1 are about the structure and design of ABS partnerships and the practicalities of establishing a quasi-experimental design (QED) for the programme using opt-in consent.

- ‘Activity Mapping’ spreadsheets completed by each partnership in 2022 have shown the priority outcomes that active ABS services have been working to address are: communication, school readiness, perinatal mental health, breastfeeding initiation, and breastfeeding at six to eight weeks. From the data, these outcomes appear to be the highest priority across the ABS partnerships.

Using publicly available data, we have identified non-ABS wards that are statistically similar to ABS wards according to attributes relevant to early childhood outcome. Covariates used to carry out the matching included area-level deprivation indicators, area-level demographic characteristics, and health statistics. The main analysis for Objective will take place in 2024.

Objective 2

Interim findings for Objective 2 are about the views and experiences of those involved in delivery ABS. Findings cover what is working well and the challenges associated with implementing ABS, achieving child-level outcomes, and achieving systems change. Non-ABS respondents provide a counterfactual for this objective, to better understand what is unique about ABS in the Early Years sector as well as similarities to non-ABS practice in the sector.

There are common themes as well as findings unique to each outcome. Some shared themes of what worked well in achieving child-level outcomes include: building relationships and trust with families to encourage engagement; leveraging opportunities for

peer-to-peer support; and adapting services and recruitment strategies to improve accessibility and increase engagement. Challenges and what worked less well are also presented in the report.

Mechanisms, the processes triggered by ABS programmes which lead to the achievement of ABS outcomes, are described in the ABS Theory of Change and have been explored in Objective 2. Findings show the range in how delivery partners understand and implement mechanisms, their views on what works well, where there are challenges, and how they contribute to outcomes.

Objective 3

Interim findings for Objective 3 show the complex lives of families accessing services and the role of ABS in family life. Across the sample in the five partnership areas, families were managing complex and often challenging socio-economic circumstances.

Findings show that families value that ABS provision aligns with their priorities, needs of their families and fits within the pressure and circumstances of their lives. ABS is viewed as playing a key role in enabling access to resources that they would otherwise struggle to afford, and that activities contribute to every day family practices across the outcome areas. The analysis has also illuminated challenges that associated with ABS participation and barriers to involvement for some families.

Over time, the qualitative evidence about families' lived experience with ABS will examine: how ABS activities and interventions concerned with child outcome can be embedded and sustained in family lives and practices; the implications for families of ABS systems change; and families' contribution to systems change associated with involvement in ABS.

Objective 4

Interim findings for Objective 4 show variation in how partnerships allocated ABS grants across three categories of expenditure: portfolio management; revenue projects; and capital projects. Analysis of spend to 31st March 2022 shows the majority of grant spend going to revenue projects.

Each partnership was asked to map their project spend to one or more ABS outcome that the project was trying to change. Outcomes that saw some of highest allocations of spend across the partnerships in 2022 included systems change, communication, and perinatal maternal mental health.

Progressing the national evaluation

As the national evaluation progresses, evidence of the impact of ABS and its contribution towards outcomes will build. Detailed next steps are provided for each evaluation objectives that show how the objectives work collaboratively to build a mosaic of evidence for ABS.

We will synthesise findings from across this mosaic of evidence, drawing on principles of contribution analysis, to provide conclusions as to if, how, and why ABS contributed to the intended change.

2 Introduction

This is the first of four annual reports of the A Better Start (ABS) national evaluation commissioned by the National Lottery Community Fund ('The Fund'). It presents progress against the evaluation's four key objectives and outlines next steps for the evaluation.

The purpose of this report is to inform audiences of the national evaluation and evaluation activity delivered in 2022, findings to date, and next steps.

As noted in the evaluation aims, the ABS national evaluation's primary audiences are ABS partnerships and secondary audiences are local and national commissioners and other local and national audiences. This report supports audiences as follows:

- **For ABS partnerships,** this content can help inform the ongoing going delivery of the programme.
- **For practitioners**, service commissioners, and policy makers in the Early Years sector, this report provides information about the outcomes of ABS programmes and how the ways of working across ABS influence them.
- **For parents and carers**, this report demonstrates the difference that ABS programmes make to the lives of families with young people, and how their voice and input is impacting the delivery of the programme and reaching into other parts of the Early Years sector.
- **For those with an interest in the mechanics of large-scale, complex evaluation work**, this report illuminates the evaluation methods used, challenges encountered in data collection and ways of mitigating challenges.

As the national evaluation will run alongside the programme until 2025, findings in this report are interim and evidence of the impact of ABS will build as the evaluation progresses. Analysis will continue after the ABS programme comes to an end and the final report will be published in 2026.

The report is structured under each of the national evaluation's four objectives, with additional chapters providing an overall introduction to the programme and evaluation, the approach to contribution analysis and mosaic of evidence, an overarching summary and next steps.

- **Chapters three and four** provide a summary of the ABS programme and the national evaluation design. This includes the Theory of Change (ToC) that articulates the core components and principles that underpin ABS delivery and provide a framework for the national evaluation. Methods presented in chapter four are high-level, with more detailed methodologies provided in the chapters for each evaluation objective.

- **Chapter five** describes the approach for the contribution analysis and mosaic of evidence which underpins the entire evaluation, bringing together rich and varied forms of evidence to understand the impact of ABS.
- **Chapter six** covers Objective 1: the contribution of ABS to the life chances of children. This chapter outlines the process for establishing a robust comparison group for quasi-experimental design (QED) by using administrative data to identify non-ABS wards with sufficient similarities to ABS wards to form a matched comparison group. The main analysis will take place in 2024.
- **Chapter seven** covers Objective 2: factors that contribute to improving child-level outcomes. This objective explores, at depth, how ABS is implemented within the five partnerships to improve child-level outcomes and enable systems change. Findings from three waves of in-depth interviews are presented in this chapter along with next steps for exploring implementation further in the coming years.
- **Chapter eight** covers Objective 3: experiences of families through ABS systems. This objective explores families' experiences of their interactions and engagement with ABS, and the difference that ABS services make to their lives. Findings presented in this chapter are from in-depth qualitative fieldwork with families across the five ABS partnerships areas. Fieldwork with these families will continue throughout the evaluation to understand how their engagement and experiences with ABS change over time.
- **Chapter nine** covers Objective 4: contribution made by ABS to reducing costs to the public purse relating to primary school-aged children. The main cost-consequence analysis will take place in 2024 alongside Objective 1's QED. Findings to date include how ABS funding has been allocated and spent across the partnerships and programme outcomes.
- Finally, **Chapter ten** provides an overall summary and next steps.

Throughout 2022 the evaluation focused on the theme of 'place-based approaches' which was explored in depth in Objective 2 evaluation activity; an additional report has been published on this theme. Findings in the place-based approaches report include how partnerships understand place-based working, what is working well, and challenges in place-based working. That report can be found on the ABS website <insert link when available>.

Considerations for reading this report

This report should be read in the context of being the first of four annual reports. Findings should be treated as interim and overall conclusions for the four evaluation objectives and the impact of ABS are not yet being drawn. These will develop over the course of the evaluation as we will be more assertive with claims in time.

We refer to the team members collating and analysing data for this report as 'we' throughout: researchers and analysts from NatCen, University of Sussex, and RSM. Findings in this report include both presentations of data and our interpretation of them.

Whilst reading the report, it is important to remember that the qualitative data collected reflect a relatively small number of interviews with stakeholders across the five ABS partnerships (see methods sections for Objectives 2 and 3 for full details). Throughout the

interviews we explored respondents' experiences, thoughts, and perceptions and how these are influencing their behaviour and outlooks.

3 About the A Better Start programme

A Better Start (ABS) is the ten-year (2015-2025), £215 million programme set-up by The National Lottery Community Fund (The Fund), the largest funder of community activity in the UK. Five ABS partnerships based in Blackpool, Bradford, Lambeth, Nottingham, and Southend-on-Sea are supporting families to give their babies and very young children the best possible start in life. Working with local parents, ABS partnerships are developing and testing ways to improve their children's diet and nutrition, social and emotional development, and speech, language, and communication. The work of the programme is grounded in scientific evidence and research. ABS is also place-based and working to enable systems change. It aims to improve the way that organisations work together and with families to shift attitudes and spending towards preventing problems that can start in early life. ABS is one of five major programmes set up by The Fund to test and learn from new approaches to designing services which aim to make people's lives healthier and happier. Learning and evidence from ABS enables The Fund to inform local and national policy and practice initiatives addressing early childhood development.

4 About the ABS national evaluation

The Fund have commissioned NatCen and partners from the National Children's Bureau (NCB), Research in Practice, RSM and the University of Sussex, to carry out the national evaluation of ABS.

Phase one of the national evaluation was a scoping Phase carried out from April – November 2021. Key activities of phase one were:

- A document review of outputs from the first national evaluation and local evaluations and initial interviews with site directors and other key representatives from the core staff teams of each of the ABS partnerships.
- A series of 30 workshops (six per site) followed. These were on the themes of: introduction to our evaluation, ToC, mapping of services and stakeholders, and each site's approach to data collection, research and evaluation. This work resulted in the production of a site summary for each partnership.
- Mapping work of the partnership- and programme-level ToCs, which, combined with the site workshops and a ToC workshop with The Fund, helped us to clarify, understand and synthesise the different existing ToCs, in order to establish a cohesive overarching conceptualisation of the theory behind ABS.
- As part of establishing feasibility related to the collection of child-level outcome data, we also carried out a mapping of external data sources. This helped us to determine which data sources we will be able to interrogate as part of work under Objectives 1 and 4 in Phase two. And to minimise duplication with the work of local evaluation

teams, we have met with each site's local evaluators to map our proposed fieldwork and priorities for the first year of Phase two against their planned work.

This chapter sets out phase two of the national evaluation, which are built on the learning form phase one.

4.1 Aims and objectives

The aims of the national evaluation are to:

- Draw upon the evaluation objectives (see below) and provide evidence for primary audiences (ABS grant holders and partnerships) and secondary audiences (commissioners – including local and national government – and local and national audiences).
- Provide evidence to support ABS grant holders to improve delivery outcomes throughout the lifetime of the project.
- Enable The Fund to confidently present evidence to inform policy and practice initiatives addressing early childhood development.
- Work with local ABS evaluation teams to avoid duplication of evidence and enable collation of evidence from local ABS evaluations.

The evaluation is working to address four objectives:

- **Objective 1**: To identify the contribution made by the ABS programme to the life chances of children who have received ABS interventions.
- **Objective 2**: To identify the factors that contribute to improving diet and nutrition, social and emotional skills and language and communication skills through the suite of interventions, both targeted and universal, selected by ABS partnerships.
- **Objective 3**: To evidence, through collective journey mapping, the experiences of families from diverse backgrounds through ABS systems.
- **Objective 4**: To evidence the contribution the ABS programme has made to reducing costs to the public purse relating to primary school aged children.

To address these four objectives, the evaluation includes a range of research activities, to build a mosaic of evidence to help tell the story of the impact of ABS. We will synthesise findings from across this mosaic of evidence, drawing on principles of contribution analysis, to provide conclusions as to if, how, and why ABS contributed to the intended change set out in the ToC (Figure 1).

4.2 Theory of Change

Figure 1 shows the ToC developed by the national evaluation team for ABS that underpins the national evaluation. The ABS ToC was developed by synthesising information from the

most recent national-level and partnership-level ToC and draws on scoping activities conducted in May – August 2021 in Phase one of the national evaluation.

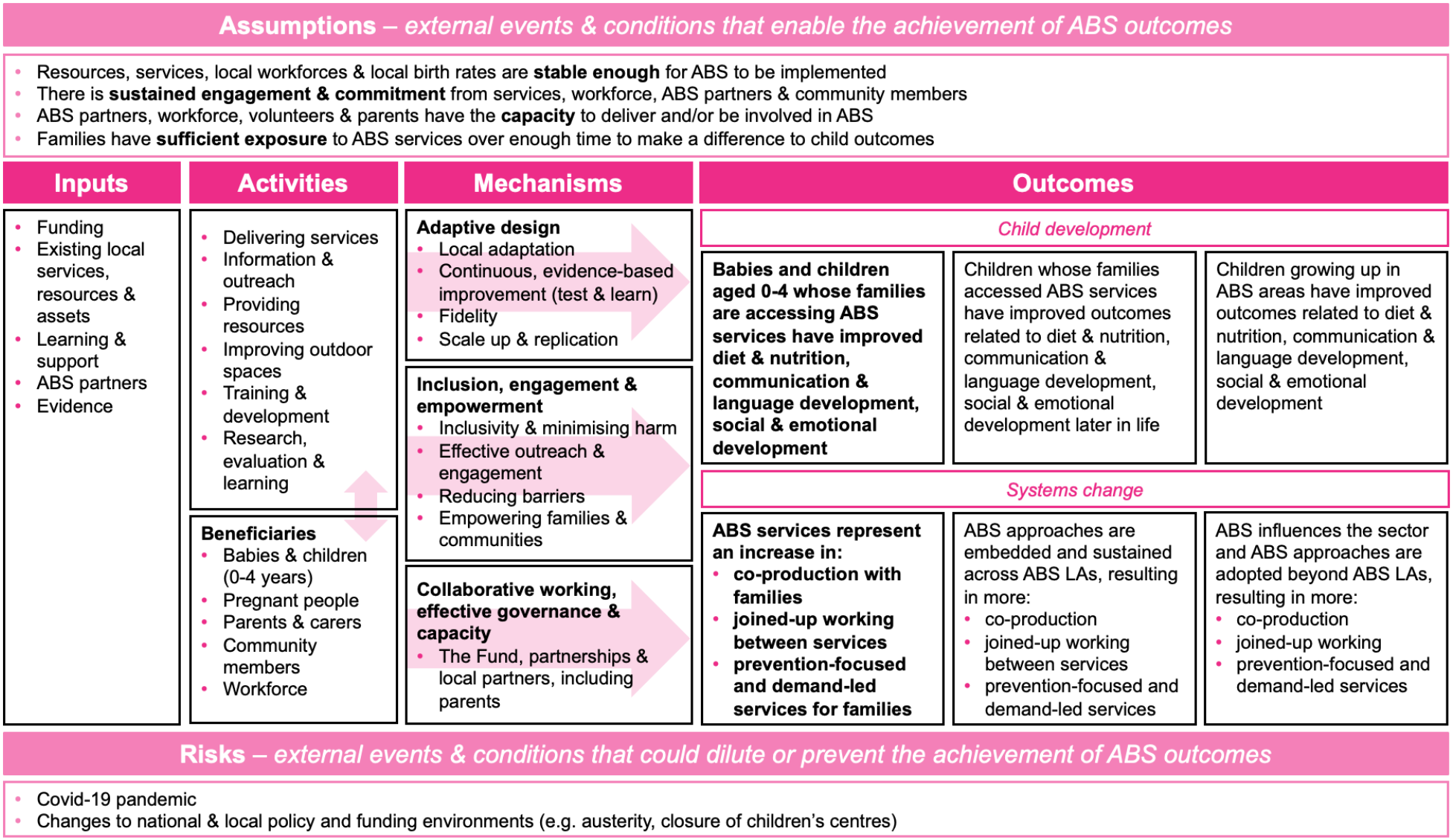
We define each component of the ToC as follows:[1]

- **Assumptions**: the external[2] events and conditions that enable the achievement of ABS outcomes.[3]
- **Inputs:** the resources required for ABS to be delivered.[4]
- **Activities:** the services and other activities delivered by ABS.[5]
- **Mechanisms**: processes within ABS delivery that act as triggers to achieve the intended outcomes.[6]
- **Outcomes**: the benefits and changes expected as a result of ABS in the short, medium and long term.[7]
- **Risks**: the external events and conditions that could dilute or prevent the achievement of ABS outcomes.[8]

The research activities carried out through the four evaluation objectives are generating robust evidence for each ToC component and the relationships between components. The research methods and findings described in this report follow the structure of the ToC and it is referred to throughout.

[1] Note that our updated ToC does not include 'outputs', even though this is a common ToC component. While outputs are articulated in national-level ABS ToC documents, they are not included in any partnership ToCs. All other updated ToC components were synthesised based on partnership-level and national-level information, and as this was not possible for outputs, they have been excluded from our updated ToC.
[2] When referring to 'external' events and conditions in assumptions and risks, our understand is that these events and conditions are beyond the control of the ABS programme at national and local levels.
[3] Mayne, J. (2012) Contribution analysis: Coming of age? *Evaluation* 18 (3), 270 – 280.
[4] Noble, J. (2019) Theory of change in ten steps. London: NPC. Available at: https://www.thinknpc.org/resource-hub/ten-steps/.
[5] Noble (2019).
[6] Bunge, M. (2004). How Does It Work?: The Search for Explanatory Mechanisms. *Philosophy of the Social Sciences*, 34 (2), 182–210.
[7] Nobel (2019).
[8] Mayne (2012: 274).

Figure 1. A Better Start Theory of Change



4.3 Methods

In this section we provide an overview of the methods being used in the ABS national evaluation and types of evidence generated through each objective. More detailed methodologies are described within each objective's individual chapters.

Objective 1: To identify the contribution made by the ABS programme to the life chances of children who have received ABS interventions.

We assume that the Common Outcomes Framework (COF) indicators, agreed with ABS partnerships in 2018, articulate how ABS can improve life chances and are a core part of the ABS ToC and partnership management. To estimate the contribution of ABS requires gathering evidence of relevance to the counterfactual: 'If ABS had not been funded in this area, what would ABS beneficiary outcomes have been?'

To answer the counterfactual requires evidence about people who have not received ABS interventions. Phase one activity has revealed that no primary data collection at scale is feasible, either for ABS partnerships or non-ABS area and we are therefore using administrative data to form the counterfactual to carry out the impact analysis.

Objective 2: To identify the factors that contribute to improving diet and nutrition, social and emotional skills and language and communication skills through the suite of interventions, both targeted and universal, selected by ABS partnerships.

Addressing this objective requires us to investigate implementation of ABS at the national level. We are generating evidence of what has happened and why, and identifying internal and external factors that may have affected ABS' contribution to intended outcomes. This is done through in-depth fieldwork in each ABS partnership with respondents involved in ABS delivery as well as those not involved with ABS.

Objective 3: To evidence, through collective journey mapping, the experiences of families from diverse backgrounds through ABS systems.

Addressing Objective 3 requires us to gather qualitative evidence about lived experiences over time, examining how ABS activities and interventions can become embedded and sustained in family lives and practices. Our analysis will build a contextually situated understanding of families' diverse experiences of ABS in relation to the four core outcome domains for the programme. This includes addressing what ABS systems change means for the lives of children and families, in terms of:

- What systems change means for professional support and involvement in family lives, and how that is experienced by families over time; and

- Understanding families' contribution to systems change associated with their involvement with ABS, and the implications of that contribution for families themselves, and for local systems.

Evaluation activity for Objective 3 also provides evidence that addresses Objectives 1 and 2: illuminating how and why ABS contributes to family lives. It is identifying enablers of engagement and impact, as well as barriers to their engagement with ABS.

Objective 4: To evidence the contribution the ABS programme has made to reducing costs to the public purse relating to primary school aged children.

Objective 4 reflects that ABS' focus on prevention, early intervention and systems change has the potential to create public benefit by avoiding costs at a later point in children's lives. To address this objective, we will evidence the extent to which the ABS outcomes evidenced in response to Objective 1 have contributed to reduced public sector costs relating to primary school aged children (5-11 year olds) and to assess the value for money of this public benefit in relation to the cost of the intervention (i.e. the cost of delivering ABS).

Panels

The Parent and Practitioner panels ensure that these key stakeholder groups are engaged throughout the evaluation and that the evaluation is informed by their perspectives.

Parent Panel

NCB facilitates a Parent Panel on behalf of the ABS national evaluation team. The panel is aligned to ABS 'People in the Lead' principles and includes a commitment to co-production and embedding service user voices throughout ABS work. The panel aims to:

- Inform and advise the evaluation team from design through to dissemination of findings.
- Ensure the evaluation reflects the experiences of the diverse range of parents/carers across ABS partnerships.
- Provide feedback on outputs, ensuring they are meaningful to parents/carers as well as to practitioners/policy makers and researchers.

Each ABS partnership has been allocated five Parent Panel places. To date 18 parents have been recruited and the panel met online three times in the first year of the evaluation. Meetings have covered the following themes/areas of work:

- Commenting on draft documents, such as information and consent forms that were developed to recruit parent participants in the evaluation.

- Feeding into the Objective 3 evaluation plans, helping to inform and shape how these are implemented.
- Giving their views on podcasts, which are a key output from the evaluation.
- Reflecting and providing feedback on progress to date regarding the research with parents and staff at ABS settings.

Practitioner panel

Research in Practice convenes the Practitioner Panel for the ABS national evaluation. The purpose of the Practitioner Panel is to:

- To act as a critical friend and sounding board for the ABS national evaluation.
- To help us ensure that the evaluation and its outputs are as useful as possible to those involved in the work.
- To ensure that the evaluation reflects the current practice context.

The panel meets virtually three times per year where they:

- Provide scrutiny, feedback, advice and constructive challenge to the ABS National Evaluation team so that the work and outputs are informed by local practice knowledge.
- Share insights/perspectives about new and emerging practice issues in the five ABS partnerships.
- Act as a sounding board and a critical friend to sense-check and contextualise findings as they emerge.
- Contribute to dissemination and product development. For example reviewing evaluation outputs, submitting case studies or supplementary insights to help other local areas benefit from their learning.

Advisory Group

The ABS Evaluation Advisory Group has been established to advise the ABS National Evaluation Team on the evaluation design and delivery. Members of the Advisory Group: supported the ABS National Evaluation Team to develop its approach to Phase two of the national evaluation; advise the ABS national evaluation team on the design of the evaluation to ensure that it has a rigorous and informed methodology; act as a 'critical friend' to the national evaluation that supports and, where appropriate, challenges its design and delivery; and provide check and challenge to the national evaluation team to support with ensuring that the national evaluation aims and objectives are met.

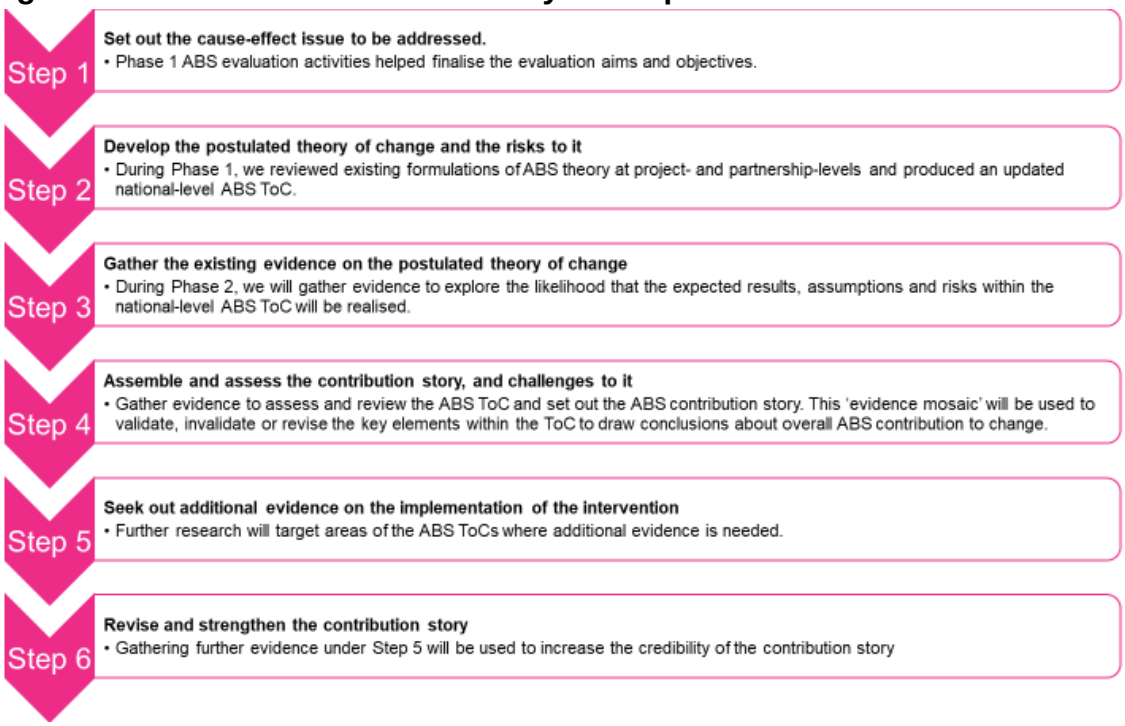
Members have been invited to participate in the ABS Advisory Group because they have expert knowledge in complex evaluation approaches or specific knowledge and expertise in key areas relevant to the evaluation, such as systems change, family lives, engagement of parents and communities, early childhood development, early support and intervention, diet and nutrition, and/or Early Years outcomes and measures.

5 Contribution analysis and the mosaic of evidence

To address the four national evaluation objectives and draw conclusions about the extent to which ABS contributes to intended outcomes and to the life chances of children who have received ABS interventions, our evaluation design draws on the principles of contribution analysis (Mayne, 2019).

ABS is a diverse, systems based and contextually sensitive programme that promotes an innovative and holistic approach to improving children's life chances. The programme is complex, involving a wide range of agencies working together with communities in different ways to deliver outcomes at individual, family, community and organisational levels. The dynamic nature of ABS demands an evaluation approach that enables us to evidence how and why ABS has contributed to change or not, and that accommodates multiple contributory or causal factors. Contribution analysis provides a useful method for this. It is based on a generative approach to causality, where the goal is to describe the causal mechanism (how the change came about). It also considers the intervention (here ABS) as occurring as part of a causal package involving ABS and other contributory factors (Mayne, 2012). For this evaluation our approach to contribution (Fig. 2) is adapted from the classic 6 steps (Mayne, 2011).

Figure 2. The ABS Contribution Analysis Steps



In contribution analysis causality is demonstrated through an evidenced chain of cause-effect events. As such it relies upon a clearly-articulated ToC to identify and analyse the chains of cause-effect events and facilitate claims about the

extent to which a programme has contributed to observed changes in outcomes (HM Treasury, 2020). The result of a contribution analysis should be a credible "contribution story" (the narrative description of the ToC and its supporting evidence).

In Phase 1 of the national evaluation we undertook steps 1 and 2 of the contribution analysis, reviewing and synthesising existing formulations of ABS theory to produce a national-level ABS ToC (as shown in Section 4.2 of this report). The ABS ToC articulates the key inputs and activities of the ABS programme, the intended outcomes that these activities are expected to lead to and the assumptions and mechanisms that underpin ABS and that need to occur if the expected results are to be realised. The ABS ToC is essentially an outline of the anticipated contribution story for ABS and as such provides the framework for the national evaluation. Using the contribution analysis approach, to infer causality, we will be looking to demonstrate:

- Plausibility – that the chain(s) of results and underpinning assumptions are plausible, informed by existing research and supported by stakeholders.
- Fidelity – activities were implemented as outlined in the ToC.
- Verified ToC – the ToC is verified by evidence that shows that the chain of results occurred and causal assumptions held.
- Other contributory factors have been accounted for – that context and other influencing factors have been assessed and discounted if no significant contribution was made or if a significant contribution was made this is recognised as part of the causal package (Befani and Mayne, 2014).

Conducting the contribution analysis will be a highly iterative process. We are currently working through steps 3 and 4 of the contribution analysis. In Step 3 we are gathering evidence from objectives 1-3 to explore the likelihood that the expected results, assumptions and risks within the ToC will be realised.

Alongside this, to support the development of a comprehensive and robust contribution narrative and enable a clear focus for the contribution analysis, we are developing contribution pathway(s) based on the ToC. These high-level contribution claims will be formulated using findings from the evidence gathered on the ToC so far pointing to ABS's likely influence on intended child development and systems change outcomes. They will describe the pathway(s) to change through a series or multiple series of steps, detailing any enabling factors, barriers and safeguards to achieving impact. The development of the claims will be an iterative process throughout the evaluation and offer parallel lines of inquiry to assess the validity of different explanations and contributing factors to achieving impact (Befani et al, 2016).

The national evaluation includes gathering evidence from a wide range of perspectives using a variety of quantitative and qualitative research activities. Together the findings from these research activities will be used to gradually build a mosaic of evidence to validate, revise or invalidate the contribution

claims to begin draw conclusions about the extent to which and how ABS contributed to its intended outcomes alongside other influencing factors (Step 4). Through this analysis we will assess the strengths and weaknesses of the ToC, in light of the available evidence and the relevance of other influencing factors. This work will inform the targeting of additional evidence gathering to strengthen the contribution claims.

As mentioned above, the ultimate aim of the national evaluation will be to provide a strong narrative as to if, how and why ABS contributed to change and to evidence the relative roles played by the ABS intervention and other external factors (the 'contribution story'). The contribution story will be based on credible contribution claims that ABS made a contribution and played a causal role where there is evidence to demonstrate that the steps between the inputs and activities and outcomes (the mechanisms) are sufficient to link cause and effect. Equally the evaluation evidence may result in claims that explain why expected changes did not occur as a result of ABS or why no difference was made by ABS.

To produce a credible and robust contribution narrative, it will be important to gather evidence that informs this narrative comprehensively and in an unbiased way. The contribution analysis approach will inform the focus of ongoing data collection in Objectives 1-3 to ensure a focus on testing and developing the credibility of the contribution narrative through actively seeking verification of the mechanisms underpinning the causal links between the inputs, activities and outcomes as well as between immediate and longer-term outcomes and impacts. Essential to this is the exploration of alternative explanations for impact. In conjunction with collecting evidence for ABS impact, it will be important to evidence other external factors that are influencing the outcomes. Through this approach to data collection, we can strengthen the evidence for the ABS contribution claims as well as identify and assess the evidence for alternative explanations to enrich the overall narrative of ABS's contribution within the 'causal package'.

6 Contribution of ABS to the life chances of children (Objective 1)

6.1 Aims of the objective

Objective 1 uses a quasi-experimental design to identify the contribution made by ABS to the life chances of children who have received ABS interventions. The more specific evaluation question is:

- What is the average causal impact of taking part in ABS interventions, on key outcomes for children under 4 and their families, in each partnership?

6.2 Methods used

The quasi-experimental methods involve developing a comparison group that helps us to infer what an ABS partnership's beneficiaries' outcomes would have been, if the partnership had not been funded. Objective 1 will use two main kinds of quasi-experimental methodology to assess causal impact.

Main analysis: individual-level weighting

Our main analysis will estimate the average causal effect of ABS on key outcomes using an individual-level weighting approach. Formally, we will estimate the average treatment effect on the treated (ATT). This captures the average difference between the outcomes of beneficiaries who participated in ABS, and what their outcomes would have been if ABS had not been funded in their area.

The individual-level weighting approach involves the following steps:

- Compile data on publicly available area-level characteristics (electoral ward and local authority level) that are likely to be associated with children's life chances. This includes demographic structure, deprivation, health outcomes and spend on children's services.
- Match ABS wards with non-ABS wards using this area-level data.
- Seek opt-in consent from ABS beneficiaries to have their identifiable information collated and securely shared with NatCen, and then transferred to NHS Digital (NHS-D) and Department for Education (DfE) for data linking.
- Request pseudonymised individual level data from NHS-D and DfE for consented ABS beneficiaries and non-ABS individuals living in matched wards.
- Develop a comparison group of individual parents/carers and children for each partnership. This is done by using propensity scores to weight the data by the inverse probability of treatment weights (IPTW). The idea is that a comparison group weighted by the IPTW should share a similar distribution of individual and household-level characteristics to the ABS group, and therefore be comparable.
- Estimate the average causal effect of ABS based on the difference in outcomes between the ABS group and weighted non-ABS comparison group. These average effects will be estimated separately for each partnership and outcome of interest.

Whole-ward analysis

We will carry out a 'whole-ward' analysis for outcomes where the evaluation timeframe is not long enough for the individual-level impact analysis to be appropriate. For these longer-term outcomes we will examine whether there is evidence of any shifts across the whole wards where ABS is implemented,

compared to non-ABS wards. We plan to use this approach for educational outcomes that are observed in later childhood.

Alternative approaches

Our planned impact analysis can be adapted if there are insufficient consents, or if there are restrictions on partnerships being able to share identifiable beneficiary data with NatCen for the purpose of data linking. One possible adaptation is to carry out the statistical weighting method at an aggregate level, involving the construction of weights for distinct sub-groups rather than individuals. A second is to carry out the approach using fully anonymised data. We plan to use this second alternative in Lambeth, as it is more suitable for the nature of the data systems in place in Lambeth.

Outcomes

Objective 1 will focus on a subset of the 25 outcomes in the ABS Common Outcomes Framework (COF) (See Bonin et al. 2016[9]). This will help ensure that our data requests are proportionate, analyses have sufficient statistical power (each additional outcome means penalising analyses to take account of increased risk of chance findings), and theoretical interpretation is sufficiently rich.

The selected outcomes for the weighting analysis are outlined in

Table **1**.

[9] Bonin, E., Matosevic, T., Beecham, J., and A Better Start partnerships. 2016. “Developing an early years Outcomes Framework using area-level routine data’. LSE PSSRU. Available at: https://www.tnlcommunityfund.org.uk/media/insights/documents/COF-External-Report-2017-v3-1.pdf?mtime=20211126121811&focal=none

Table 1. Outcomes that we will assess

Indicator	When is it measured?
Key outcomes for individual-linked beneficiary analysis	
Perinatal maternal mental health – depression and anxiety	At antenatal booking and may be available postnatally. We will assess the impact of ABS on postnatal maternal mental health, if this is available. We will not include the antenatal measurement in our impact analysis.
Smoking in pregnancy - smoking status at delivery	Delivery
Birth weight	Delivery
Gestational age at birth	Delivery
Breastfeeding at 6-8 weeks	6–8 weeks
School readiness	Reception
Healthy weight at reception	Reception
Communication skills (Ages and Stages Questionnaire; ASQ)	2.5 years
Social emotional development (ASQ)	2.5 years
Child development (ASQ)	2.5 years
Child abuse and neglect - Children aged 0-4 who are Children in Need (CIN) due to abuse or neglect	Ages 0-4
Child abuse and neglect - Children aged 0-4 on Child Protection Plan (CPP)	Ages 0-4
A&E attendances or emergency hospital admissions of children 0-4	Ages 0-4
Key outcomes for the 'whole-ward' analysis of longer-term educational outcomes	
Key Stage 1 attainment	~Age 7
Key Stage 2 attainment	~Age 11

The final choice of key outcomes for the quasi-experimental evaluation will be determined in the process of developing data requests in 2023 (see Section **Error! Reference source not found.**).

Other analysis

We will also carry out descriptive analysis of data about the services used by ABS beneficiaries. For example, this includes summarising the number of unique services accessed by beneficiaries, the frequency or engagement with particular services and whether participants were recorded as having 'completed' their planned engagement with a service or not.

This analysis will help us contextualise the impact findings and situate the results within a broader understanding of how participants have engaged with ABS in each site. The exact form of the descriptive analysis will be permitted to vary, depending on what level of data about service use it is practical for them to provide.

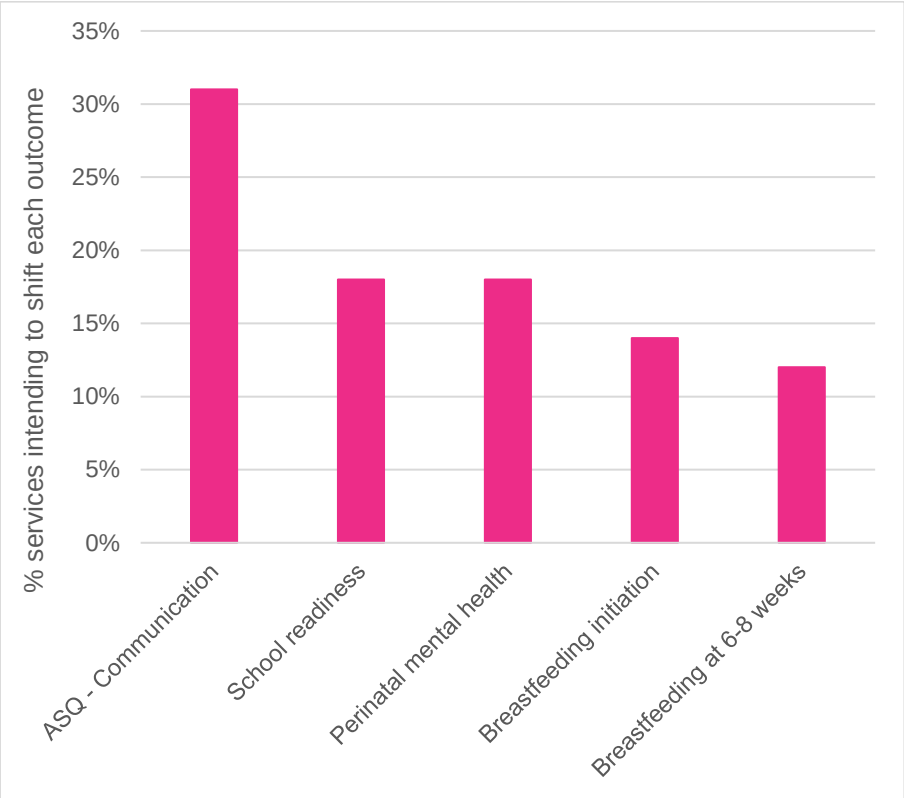
6.3 Findings to date

The main quasi-experimental impact analysis will commence in 2024. However, we have interim findings about the structure and design of ABS partnerships, as well as the practicalities of establishing a quasi-experimental evaluation design for a programme like ABS that uses opt-in consent.

Activity mapping

We have analysed information provided by the partnerships regarding their ABS-funded services. An example of the kind of evidence we can draw from this data is to identify the outcomes that are more frequently reported as relevant to each service. Looking exclusively at ABS services active in 2021/22, we identified the five outcomes that seem to be the highest priority across all partnerships.

Figure 3. Top 5 outcomes targeted by ABS services in 2021-22



Source: Activity mapping spreadsheets completed by partnerships in 2022. The figure shows the proportion of all ABS services active in 2021-22 that were reported by the partnership team to be relevant to shifting each outcome, for the top-5 highest priority outcomes.

Area-level matching

As described above, the first step in our methodology is to identify a set of wards in England that are statistically similar to the ABS wards according to attributes that are relevant to early childhood outcomes. We have carried out this step using publicly available information. The comparison group local authorities selected for the ABS LAs belonging to each partnership are shown in Appendix 1.

ABS funding was designed to be focused on specific wards within the selected LAs. Initially, we planned to match these priority ABS wards with other wards in England to form our comparison group. Since ABS started, service provision has expanded to include beneficiaries living in other wards in the same LA, beyond the 'target' wards. In response to this, we changed our approach to include all wards in ABS-funded LAs. to be 'ABS wards' for the purposes of matching, and we have matched all of these to a non-ABS ward. The rationale for this was that ABS funding is being used to deliver some services outside of the designated 'target' wards in each partnership.

We used a wide range of area-level covariates to carry out the matching. This included area-level deprivation indicators (such as the Index of Multiple Deprivation rank and long-term unemployment figures), area-level demographic

characteristics (including age and ethnicity) and health statistics (such as the prevalence of breast cancer and overweight children). The matching approach aimed to locate comparison wards that were as similar as possible to the ABS wards across all these characteristics.

Progress in obtaining opt-in consent

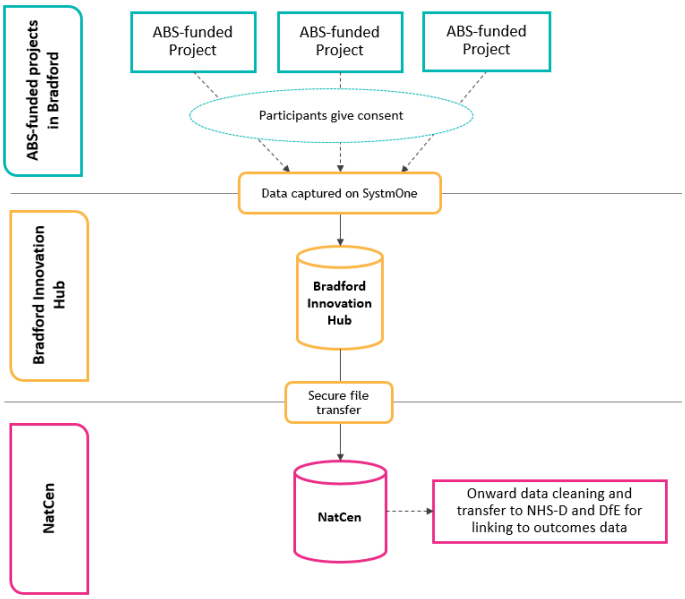
We are seeking opt-in consent from ABS beneficiaries in Nottingham, Southend-on-Sea, Bradford and Blackpool to be included in the quasi-experimental evaluation. We decided to use opt-in consent so that the use of participant data in our evaluation is as transparent as possible. This is especially important given a broader context of growing public scrutiny over the use of personal information for research purposes. We are not establishing a new consent process in Lambeth for the quasi-experimental evaluation, because the planned impact estimation approach will rely on data that is fully anonymised at every stage. Lambeth has already obtained beneficiary consent for anonymised data to be collected and used, for example for the partnership's own local evaluation work.

At the time of writing, the consent process for our evaluation has been established in all four of the planned partnerships. As of March 2023, 395 adults and 444 children under 4 had been consented into the evaluation.

How data requests will work

The quasi-experimental evaluation draws on a relatively complex data landscape. This includes engaging with unique systems that each partnership has already established for managing their own data. NatCen needs to align with each of these systems to allow beneficiary data collected by each partnership to flow to us, so that it can then be transferred to NHS-D and DfE for linking. One example of how this data flow will operate is shown in Figure 4 below. which describes the set-up for Bradford. In this case, all beneficiary data flows through the Bradford Innovation Hub which is the local evaluation partner for Better Start Bradford.

Figure 4. Flow of beneficiary data to NatCen in Bradford



We have found that there is very little information available about fathers and other caregivers in the family beyond the birth parent. We have also discovered some issues with quality issues and limited availability of some data. This includes perinatal mental health information, which has had a high prevalence of missing data in previous years, and the National Child Measurement Programme data, which we are currently unable to confirm whether it will be potentially accessible through the Data Access Request Service (DARS). These findings will inform our final choice of key outcomes for the quasi-experimental evaluation.

6.4 Next steps

The next steps for Objective 1 are given below.

Applications for datasets:

We plan to continue preparing applications for the datasets needed for the evaluation and finalising the exact variables needed.

The outcomes we have chosen for the QED are operationalised using administrative health and education datasets maintained by the NHS-D and DfE. We will request access to these data in 2023, after the recruitment window for ABS participants has come to an end. The health datasets will be requested through the Data Access Request Service (DARS) provided by NHS-D. The education datasets will be requested through from the National Pupil Database (NPD) and are accessed via the ONS Secure Research Service. The NPD is a longitudinal database containing a variety of data on pupils and schools in state schools in England. For both health and education data, our request will cover consenting ABS beneficiaries and a contemporaneous group of non-ABS beneficiaries from matched wards.

Defining comparison group:

Moreover, we plan to continue work on some pending decisions about how to define the comparison group sample for the individual-level weighting analysis. The key decisions we need to refine are:

- How large the available pool of comparison group units should be, from which we will further refine the comparison group using the individual-level weighting approach.
- What process we should follow to generate this comparison group pool (for example, whether it should be selected at random, or chosen with some particular criteria in mind).
- How to address issues with linking where there is more than one match for available identifiers.

We will document the final approach in a Supplement document[10]. We anticipate producing this Supplement in Summer 2023. This is close to the time when we will be preparing data requests for DARS and will have an opportunity to discuss the specifics of our request with them.

Structure of beneficiary data:

ABS partnerships will be responsible for collating three categories of beneficiary data and securely sharing this with NatCen in 2024. This beneficiary data can be grouped under three categories (1) identifying information; (2) information about when consent was obtained; and (3) information about ABS service use.

The exact form of service use data we can access may vary between ABS partnerships depending on what is possible given their data systems. We will aim to collect the most fine-grained information available – for example, about which ABS services beneficiaries attended and on what dates. If fully broken-down information is not readily available, we can also use aggregate information – for example, the overall numbers of beneficiaries accessing each service. After consultation with partnerships to understand what level of service use data could be made accessible to the evaluation team, we will request that partnerships pilot their systems using simulated data. We will analyse this information descriptively to enrich interpretation of impact estimates.

Combining evidence across the evaluation:

This QED is taking place in the context of a broader evaluation, which includes a variety of complementary elements structured within an overall theory-based evaluation approach. The findings from the QED strand will be interpreted alongside other evidence generated across this overall evaluation; our findings are not intended to stand in isolation.

[10] This will include decisions about how to define the comparison group sample for the individual-level weighting analysis and will be based on our discussions with DARS at the time of preparing applications for NHS-D datasets.

We plan to update our plans for combining evidence across the evaluation, based on emerging findings from Objectives 2 and 4.

7 Factors that contribute to improving children's diet and nutrition, social and emotional skills and language and communication skills (Objective 2)

In this chapter, we present our findings to date on Objective 2 of the national evaluation. This chapter reflects findings from three waves of fieldwork in 2022.

7.1 Aims of the objective

The aim of Objective 2 of the national evaluation is:

To identify the factors that contribute to improving diet and nutrition, social and emotional skills and language and communication skills through the suite of interventions, both targeted and universal, selected by ABS partnerships.

In other words, we aim to find out more about how the ABS partnerships are trying to change children and families' lives for the better, and what supports and hinders ABS partnerships when doing this.

7.2 Methods used

For this objective, we have used qualitative methods to investigate how ABS works at both partnership and national levels. This has included conducting in-depth interviews with:

- Respondents working within ABS partnerships ('ABS respondents').
- Respondents working in organisations which do not receive ABS funding but operate within the Early Years sector ('non-ABS respondents').
- Respondents working at the Fund ('representatives from the Fund').

We spoke to ABS and non-ABS respondents about similar topics.

Table 2. Topics for ABS and non-ABS interviews

ABS respondents	Non-ABS respondents
Their involvement in their local ABS partnership	Their involvement in the Early Years sector
Key successes and challenges for ABS in their area	Key successes and challenges in the Early Years sector in their area
What worked well and less well in achieving key child-level outcomes	What has worked well and less well in achieving key child-level outcomes in their area
What has worked well and less well in achieving systems change	What has worked well and less well in achieving systems change (if relevant)
Their understanding of place-based approaches and what has worked well and less well when applying them (annual theme)	Their understanding of place-based approaches and what has worked well and less well when applying them (if relevant

When speaking to ABS respondents, we chose to focus our interviews on the specific project(s) or service(s) that they were involved in rather than discuss ABS 'as a whole'. This allowed us to explore their experiences of ABS in depth and understand better what ABS looks like in practice. This enabled respondents to speak from a place of knowledge and expertise, and provide us with nuance and detail rather than general, broad statements.

Recruitment of ABS respondents

At the beginning of the first wave of fieldwork, NatCen contacted all ABS partnership leads to request a list of potential respondents from within their partnerships. Out of this sample, NatCen chose a subset for the first two waves of data collection. For the third wave, we contacted:

- Any potential respondents who had either not been chosen, or did not respond, during the first two waves. These ABS respondents were invited to take part for the first time.
- All ABS respondents who took part in the first two waves. They were invited to a follow-up interview (unless there were any reasons not to do so).[11]

[11] For example, any respondents who had requested not to be contacted again.

Table 3. Sample of ABS respondents

ABS partnership	Number of interviews
Blackpool	11
Bradford	10
Lambeth	14
Nottingham	10
Southend	11

Recruitment of non-ABS respondents

Before data collection began in 2022, NatCen built a list of non-ABS respondents to approach for interviews at two time-points between 2022-2026. This list included non-ABS respondents working within the Early Years, health and social care sectors. These non-ABS respondents had different degrees of proximity to the ABS partnerships:

- Working within ABS local authorities. These were non-ABS respondents who worked within local authorities that have an ABS partnership, but the respondent's role or service(s) were not funded through ABS.
- Working outside of ABS local authorities. These were non-ABS respondents working in relevant sectors in areas without ABS partnerships. This included respondents working in local authorities neighbouring ABS partnerships, or working in areas that share similar characteristics to the ABS partnership areas.

A list of non-ABS respondents working within ABS local authorities was then sent to the ABS partnership leads to ensure that there was no overlap with ABS respondents. After the partnership leads provided their input, a subset of respondents on the list were contacted for each wave. In 2022, we did not invite any non-ABS respondents to follow-up interviews.

There were some respondents who have contributed to both project delivery both within ABS and non-ABS wards within one local authority. This position means that they were able to reflect on the differences between ABS and non-ABS wards and the services offered in both.

Table 4. Sample of non-ABS respondents

Proximity to ABS partnerships	Number of interviews
Working within ABS local authority	7
Working outside of ABS local authority	6

Recruitment / selection of The Fund respondents

Two respondents from The Fund's ABS programme team participated in the first two waves of data collection.

Method

In-depth interviews took place across three waves of data collection in 2022:

- Wave 1: February and March.
- Wave 2: May and June.
- Wave 3: Late September to early November.

Interviews were conducted by a NatCen researcher via Microsoft Teams. Interviews lasted around 60 minutes. Topic guides were developed to ensure consistent topic coverage across respondents. The topic guides were drafted to suit the different child-level outcomes as well as systems change. Separate topic guides were drafted for the different respondents depending on their level of ABS involvement, and whether the interview was a first, or follow-up, interview.

Analysis

Interviews were audio-recorded with respondents' permission and transcribed verbatim. At the end of each interview, respondents had the option to remove certain information from the analysis. We used the Framework approach - a systematic approach to qualitative data management, developed by NatCen, to chart (collate and summarise) transcribed data by theme and case (Ritchie et al. 2013).[12]

Once all interviews were coded in our analysis matrix, we analysed the data. This involved a phase of 'detection', which included studying the elements respondents said about a given topic, listing these and then sorting them thematically. Once we had identified different themes in the data, we then created higher-level categories that worked as meaningful conceptual groupings for respondents' views and experiences. This allowed for an in-depth analysis of the commonalities and differences across respondents.

7.3 Findings to date

The following sub-sections summarise findings related to the three child-level outcome areas across the three waves of fieldwork for Objective 2 in 2022. Common themes and findings from across the outcome areas are presented together, while those that are that are unique to each outcome are highlighted separately. These sections are structured to include respondents' discussions on:

- The key aim(s) for the outcome.

[12] Using the themes covered in topic guides and new emerging themes, we assembled a matrix in which each row represented an individual interview and each column a theme and any related sub-themes. We then summarised the interview data in the matrix, including illustrative verbatim quotes where appropriate.

- What has worked well, covering both ways of working and outcomes for children and families.
- Areas where respondents have had mixed views or experiences within and across waves.
- What has worked less well.

Findings relating to systems change and mechanisms are also presented following a similar structure to child-level outcomes.

Similarities across child-level outcomes

All three child-level outcomes shared some themes, which are outlined below.

What worked well

Engaging families. Several ABS respondents noted that building relationships and trust with families helped to engage families in services. ABS respondents described a range of approaches that service deliverers use to achieve this including: sharing their own personal experiences to build rapport with families, ensuring constant contact with families, avoiding 'preaching' language or tone, and ensuring families meet with a single professional, rather than 'being pushed from pillar to post' between services. An ABS respondent noted that, as a consequence, families **learn to trust the professional and are more open to taking on their support and advice**, creating behaviour change.

Connecting parents/carers through peer-to-peer support. For example, an ABS respondent noted how 'co-production' activities in children's centres, focused on SEND, had led to the formation of informal parent support networks. The ABS respondent felt that it was helpful for parents/carers of children with additional needs to connect with one another. Moreover, several ABS respondents felt the community presence encouraged take up of services and spread information by word of mouth.

Adapting services to improve accessibility. Several ABS respondents reported that improving access to their services was working particularly well. This included: having both day and evening classes; offering a drop-in approach to enable families to be more flexible; and **practitioners reaching out to families directly** about the support on offer. For example, one ABS respondent reported how phone calls had been more effective than the initial letter when recruiting women to their nutrition service, with the final sign-up rate at 35-40%. This ABS respondent perceived this to be because phone calls are more personable as practitioners are more able to address any concerns.

What worked less well/ challenges

Poverty and deprivation. Several ABS respondents and representatives from The Fund identified poverty and deprivation as challenges across the outcome areas. Multiple ABS respondents noted that living in poverty, particularly when

entrenched across generations, can impact upon the way parents are able to care for, and support, their children:

Housing. One ABS respondent outlined how deprivation and low-quality housing is a barrier to achieving outcomes. This respondent mentioned it specifically in the context of social and emotional development, but it applies to all outcomes area due to how it impacts engagement with services. The ABS respondent explained that families living in low-quality housing are more likely to be transient due to the instability of their living situation, and so are unable to engage fully with services.

Nutrition. One respondent described a 'hierarchy of need', where healthy and nutritious food competes against bills and other costs. Representatives from The Fund similarly highlighted how the cost-of-living crisis was creating additional financial challenges for families. This respondent noted that families were struggling to find low-cost healthy food due to rising prices, and that some families were 'reverting' back to less healthy food.

Supporting families to make changes. Several ABS respondents reported that families can struggle to take on recommendations or adjust their parenting approach. ABS respondents highlighted several potential reasons for this:

- **Families see advice as a personal challenge.** An ABS respondent stated that families can be reluctant to take advice on something they see as personal, such as diet, whereas they are more open to input on areas they see as requiring expertise.
- **Shifting generational mindsets**. One ABS respondent described how difficult it is for someone who has themselves experienced a challenging model of parenting as a child to develop effective communication skills with their young children and emotional awareness of how their parenting practice affects their children.
- **Practical challenges.** This includes parents' limited capacity, because they are working full-time.

Diet and Nutrition

Understanding and achieving child-level outcomes

Multiple ABS respondents across partnerships, and representatives from The Fund, outlined a range of aims for ABS diet and nutrition services. These included improving diet and lifestyle choices for parents/carers, improving breastfeeding rates, improving children's oral hygiene and reducing childhood obesity with the **overarching aim of preventing negative health impacts on infants.**

Numerous ABS respondents emphasised the importance of **effective messaging** as part of improving diet and nutrition outcomes. This included ensuring professional bodies were consistent in their messaging, countering

harmful or inaccurate messages, and getting key messages out to families; including to family members other than parents who might have influence over a child's diet and nutrition (e.g. grandparents).

Several ABS respondents in more than one partnership reported having to **adapt their aims for the diet and nutrition outcome due to the impacts of the cost-of-living crisis**. One ABS respondent stated that their partnership now focuses less on childhood obesity and are focusing instead on ensuring families do not go hungry. Another ABS respondent for a different partnership described how the cost-of-living crisis was negatively impacting the aims of the diet and nutrition services, as health inequalities, like access to healthy food, were widening.

What worked well for achieving diet and nutrition outcomes has been covered in the earlier section on similarities across outcomes. Aspects that were unique to this outcome were what worked less well/ challenges.

What worked less well/ challenges

Streamlining referral criteria. ABS respondents in one partnership agreed that **complex eligibility criteria to access ABS diet and nutrition services had a negative impact on the number of referrals** from partner agencies. These respondents explained that their services relied on referrals from midwives and health visitors. However, those professionals were often reluctant to refer families because it was too burdensome to work out whether a family was eligible for an ABS service e.g. due to complex record-keeping systems. If there were additional eligibility criteria, health professionals often felt it was not the best use of time to establish eligibility and, consequently, did not refer.

Challenges in reaching some groups. Numerous ABS respondents reported working with less engaged groups to be a challenge. Several ABS respondents from across the partnerships consistently mentioned **formula feeders** as one group in the context of the diet and nutrition outcome. An ABS respondent and representatives from The Fund described how this group can feel alienated by the 'breast is best' messaging, and so supporting on bottle feeding was difficult.

Communication and language

Understanding and achieving child-level outcomes

ABS respondents have identified both **preventing poor communication and language and improving children's skills** as key aims of this outcome area. Several ABS respondents were concerned about the impact that unidentified communication and language issues can have on children as they grow older. In line with this key aim, ABS respondents discussed the importance of **identifying children's communication and language needs as early as possible** and intervene with support and specialist services.

ABS respondents also highlighted the importance of **creating environments at home and in nurseries** which enable children to develop their communication and language skills. Many ABS respondents noted that ABS services work directly with parents/carers to raise their awareness and understanding around the **role of the home environment**. In nurseries and other Early Years settings, ABS respondents discussed a range of training[13] that was provided to staff to **create language-rich environments** and ways in which staff were supported to **better identify communication and language needs** and refer onwards.

Some ABS respondents reported that parents/carers saw noticeable improvements in their children's **communication skills and volume of vocabulary** and Early Years settings reported being better equipped **to identify children with additional needs**. These findings are encouraging.

What worked well

Working closely with Early Years settings and practitioners. Many of the ABS respondents believed successful relationships ABS services and Early Years settings enabled setting staff to see the value of communication and language services. This in turn meant they took time to engage with the services despite their limited capacity. Some ABS respondents highlighted key aspects for facilitating this relationship building. These included **free training**; making it easier to engage Early Years settings who are already under financial strain; **supportive management** to facilitating relations; and **tailoring training** to each setting to engage staff and help with staffing issues. Tailoring could include adjusting the content of the training depending on what the setting needed or being flexible with the location or timing of the training.

Increased focus on communication and language needs. ABS and non-ABS respondents, and representatives from The Fund, reported that the **COVID-19 pandemic had helped to 'shine a light'** on the importance of speech, communication and language. For example, one ABS respondent reported an increase in demand for communication and language drop-in sessions for babies and the respondent attributed this to families wanting greater levels of interaction after a period of isolation.

What worked less well/ challenges

High demand for specialist support means long waiting times and limited access. An ABS respondent and a representative from The Fund highlighted that one of the most significant challenges is access to specialist support. They noted that children who are identified as having language and communication support needs have to wait a long time for services. This is because of high

[13] Training programmes for Early Years settings included: I CAN; Well Comm, Early Words Together at Two, Natural Thinkers and the Evelina Award.

demand as well as staffing pressures. To help combat this, one ABS partnership has developed activities that parents/carers and workers can use with children to start to make changes while they are waiting for appointments with professional speech and language therapists.

Some Early Years staff with limited prior knowledge about communication and language. Several ABS respondents reported concerns about the knowledge levels of some Early Years practitioners related to communication and language. This meant that in some cases, training had to be adapted in service of establishing a baseline level of knowledge that was previously assumed. Another ABS respondent noted that some practitioners had **low expectations of Early Years development** and were unclear about milestone. They therefore did not identify children with additional support needs appropriately.

Some Early Years staff reluctant to adapt new approaches. Similarly, an ABS respondent in one partnership noted that some Early Years practitioners can be hesitant to implement new approaches. The ABS respondent reflected that some practitioners may be used to their own approaches to child speech and language development and feel uncomfortable trying new approaches or having their work challenged. This can particularly be the case if they have worked in the Early Years or childcare sectors for a long time.

Supporting families around children's additional needs. Multiple ABS respondents noted that parents/carers can find it difficult to accept a diagnosis. This is because parent/carers may fear what this means for a child's future or are concerned they will be judged for having done something wrong. As a consequence, ABS respondents observed that parents/carers might not follow treatment recommendations or consent to the referral process. An ABS respondent did acknowledge that some families are more willing to engage at a later stage, once they have processed the diagnosis.

Supporting families who speak English is an additional language. ABS respondents frequently stated that it can be difficult supporting families who speak English as an additional language. For example, an ABS respondent noted that some practitioners are not able to identify if there is a speech delay or whether there are language barriers, as children might be speaking less because English is not their first language. To overcome this, practitioners have begun conducting screenings in more than one language. Furthermore, an ABS respondent in a different partnership stated that some families who have migrated to the UK **might have limited literacy skills in their first language, too**. The ABS respondent noted that this can make it challenging to effectively support these families as they were dealing with both a language barrier, and language and communication support needs.

Social and emotional development

Understanding and achieving child-level outcomes

ABS respondents consistently reported **supporting parents/carers** as a key aim of the social and emotional development outcome. This was seen by most ABS respondents as integral to improving children's social and emotional development; they described social and emotional learning services as helping families to build strong relationships and resilience. ABS respondents saw this as a means to reduce stress and anxiety for parents/carers, which might have otherwise been detrimental to children's development in this area.

What worked well

Sharing learning from ABS practice in non-ABS areas. Some ABS respondents reported successfully sharing ABS learning in non-ABS areas. For example:

Service offer and learning from ABS wards implemented in non-ABS wards. One ABS respondent reported that learning from ABS was being implemented in other parts of the local area to try and ensure the offer city-wide could be as 'close as possible' to what was being delivered within the ABS wards. Another ABS respondent explained that in their area, the ABS perinatal mental health offer was influencing the broader local area's perinatal mental health offer.

Individual practitioners using knowledge gained through ABS in non-ABS wards. One ABS respondent in another partnership described that there had been good uptake of training and consultation as part of their infant mental health service. The ABS respondent reported that the professionals attending the training, such as health visitors and midwives, work both within ABS and non-ABS wards, and so they had applied the ABS training with non-ABS families. Similarly, a non-ABS respondent spoke about their experience of attending training on trauma-informed approaches, which an ABS partnership conducted. The non-ABS respondent has since applied this learning in their own service delivery and passed on the training to others, such as placement students.

Mixed views/experiences

Referral processes. Multiple ABS respondents in different partnerships reported **increased referral rates to their services**. For example, an ABS respondent explained that referrals to their service through formal pathways, for example via the NHS, had increased in the last 18 months. The ABS respondent attributed this to health professionals having an improved understanding of ABS social and emotional development services. Another ABS respondent in a different partnership noted that their service has an effective

referral process thanks to working closely with the local ABS peer supporters. This is because the peer supporters are well informed about all local ABS services and so can refer families to the right service for them.

However, an ABS respondent from a different partnership reported that they **continued to receive inappropriate referrals** such as for families outside of ABS wards. This ABS respondent, along with others, noted that stakeholders and professionals struggle to promote ABS services because they are unsure who can access them.

Reaching a range of families. ABS respondents were divided in their perceptions of reaching a range of families. For example, one ABS respondent reported that their service has reached a range of different families, such as those with a disabled family member or foster carers. However, several ABS respondents saw **reaching all types of families as an area for improvement.** One ABS respondent outlined their partnership's strategy to engage families on postnatal wards, which should enable them to reach all families 'naturally' rather than trying to target less engaged groups at a later stage.

Multiple ABS respondents in different partnerships explained that they are **not able to support families with complex needs**, such as those who receive support from children's social services. One of these ABS respondents described how families with complex needs are beyond what volunteer-led services can address while another acknowledged that they offer specific support to these families.

Stigma attached to accessing support for social and emotional development. For example, several ABS respondents noted that **some families feel they will be judged for accessing support** and it can be challenging to counter this concern. However, some ABS respondents described some **successes in changing this narrative.** These respondents explained that they did so by emphasising that support might be needed to juggle multiple pressures of family life, rather than it being a value judgement on parents/carers.

What worked less well / challenges

Limited venues to deliver services outside of working hours. One ABS respondent reported difficulties getting venues for their service, particularly venues for evenings and weekends. The ABS respondent perceived this to be impacting their service reach, as weekday sessions primarily attracted mothers on maternity leave. To counter this, the ABS respondent is giving the attendees advice to share with other caregivers for the child who are unable to attend sessions during the day, such as dads.

Evaluating social and emotional outcomes. Some ABS respondents described evaluating social and emotional development services as a

challenge. One ABS respondent expressed concern that **some evaluation activities carried out by ABS services are not inclusive enough for some families** and are too reliant on form-filling (online or paper), which can be challenging for those families with limited language skills. Another ABS respondent explained that monitoring and evaluation in this area is challenging because the scope of social and emotional development is very broad and can be impacted by other factors, such as a child having SEND or a parent's mental health. The ABS respondent acknowledged that this makes it **difficult to find an appropriate tool to measure clear change**.

Systems change

Understanding and achieving systems change

Systems change is the fourth ABS outcome domain. ABS respondents noted four key points relating to their understanding of systems change and how to achieve it: a shift in culture; a focus on prevention; collaborative working; and sustainability. For ABS respondents, **achieving systems change was fundamentally about a change to ways of working** rather than creating new services or greater financial investment, for example.

Shifting the culture. Several ABS respondents described systems change as a process of **shifting the culture** within local health and family support services**.** ABS respondents described this shift as a move towards a common understanding and acknowledgement of the importance of Early Years and child development. ABS respondents suggested that a **shared vision** is crucial to enable joint working, allowing different organisations to work together towards a common goal rather than working in silos.

Focus on prevention. ABS respondents described one of the aims of systems change as an improved understanding of, and increased focus on prevention. Several ABS respondents noted that systems change should involve **a shift from investment in acute services towards prevention,** to better meet the needs of children and families. For instance, an ABS respondent described the new early help strategy that was recently produced by their local authority. This new strategy set an expectation for services to support the identification of families who need help earlier, particularly around the social and emotional development outcome.

Collaborative working. Multiple ABS respondents commented that systems change should aim to make services and processes more cohesive and joined up. Several ABS respondents highlighted how partnership working enables services to be more effective, ensuring they are not duplicating efforts and **developing joint solutions** so outcomes for children and families are improved.

Ensuring sustainability. Multiple ABS respondents expressed that it was important for systems change to have lasting impact within their local areas, and for collaborative and system-wide working to continue. Several ABS respondents expanded on this, commenting that **sustainability** of ABS services and approaches was crucial to maintain systems change after ABS funding ends.

What worked well

Collaborative working. ABS respondents who spoke positively about their partnerships expressed how strong relationships are fundamental for collaborative working. Strong relationships enable partnerships to address challenges successfully, identify solutions, share learning, and hold each other accountable. Examples of successful collaborative working included:

Knowledge and information sharing with families and professionals. For example, one ABS respondent described how their community services can act as 'hubs', signposting families to other services. Quarterly partnership meetings and provider events[14] were seen to enable information sharing between professionals.

Partnering with projects and services. Multiple respondents explained how services partnering created a more holistic and joined-up way of working. For example, several ABS respondents working in diet and nutrition noted working with social and emotional development services to tackle the social aspects of mealtimes.

Uncovering gaps in service provision. For example, one ABS respondent explained that in their partnership all stakeholders (such as children's centres and health visiting) had cut potty training services. Collaborative working had shown this to be a gap and had led to services commissioning a joint service.

Peer-to-peer services bridging the gap between different services, and between services and families. Multiple ABS respondents commented how peer-to-peer supporters were particularly effective in connecting families and services.

Upskilling the workforce was described as another successful way to enable systems change, in particular, to create a shared vision, culture and understanding. Training offered to staff via ABS was usually connected to wider ABS strategy and priorities across different partnerships. Different partnerships focused on different 'themes' for upskilling the workforce, these included:

- **Trauma informed approaches.** Several ABS respondents reported that there was a core offer of training on trauma informed approaches across all

[14] These provider events take place once a term in this partnership. They offer a chance for providers of services to meet either face-to-face or virtually to build connections.

staff levels, from strategic to frontline staff, within their partnership. This was seen as an example of systems change, with the **acknowledgment of adverse childhood experiences** (ACEs) encouraging a shift in mindset on the part of practitioners and more joined-up working with partner agencies.

- **Father-inclusive practice**. One ABS respondent gave the example of their partnership developing a workforce strategy, which included training to encourage the workforce to think about fathers and their roles across different services, such as Early Years and health visiting teams.
- **Data collection and evaluation**. As part of local evaluation work, one partnership supported and trained ABS services in quality data collection and understanding of evaluations. The local ABS evaluation team supported individual projects in improving their feedback forms and data collection processes.
- **Child-level outcome specific training**. One ABS respondent described training which provided knowledge around key learnings from child-level outcomes. Another ABS respondent reflected on how this training is then informally cascaded by staff members to others in their teams or organisations. For example, health visitors in ABS wards receive training, they then speak to colleagues in other wards and pass that information on.

Mixed views and experiences

Data collection, management and data sharing. Effective and regular data collection was recognised by ABS partnerships as integral to systems change, enabling ABS to assess the journey that partnerships and services have been on. However, partnerships have struggled with this for different reasons:

Data collection and data processing were time intensive. One ABS respondent noted that staffing shortages post-COVID meant that services could spend limited time on collecting data and had limited capacity to conduct analysis.

Data sharing with NHS providers was reported as a challenge by multiple ABS respondents from across partnerships. One ABS respondent noted that because of the geography of their partnership, they must work with three NHS foundation trusts with different data sharing policies. Another ABS respondent working in a communication and language service commented that the NHS use different data management systems[15], which do not align with their own or the local authority systems.

Quantitative data was, at times, perceived as more important than qualitative data. However, quantitative data can be difficult for some services to collect. One ABS respondent reported that there was a disconnect between what families and professionals say they value, and what can be shown to have value within an evidence-based framework.

[15] The respondent reported that the NHS use EMIS.

Child-level outcome specific challenges. For example, a representative from The Fund discussed how dentistry data was difficult to obtain and the quality and consistency of the data was poor.

However, several ABS respondents highlighted successful examples of data sharing. ABS respondents highlighted the value of a **joined-up approach for data collection and management.** For example, one ABS respondent discussed a joint project between a local authority and a hospital, linking NHS and local authority data. This project should enable this ABS partnership to understand who is participating in ABS services and consider the extent of impact it is having on health, education, training and employment in the longer term. Other ABS respondents working in language and communication also reported **improvements to data management**. These changes included adopting new data management systems and simplifying forms for Early Years settings. For example, in one partnership, an ABS respondent reflected that this had made it **easier to obtain consent** from settings to participate in ABS services and provided settings with **extra administration capacity**.

Pressures brought on by COVID-19. COVID-19 was generally seen as a challenge for systems change, affecting staffing, increasing workload pressure and reducing referrals. However, several ABS respondents also viewed COVID-19 as positively influencing changes in practice, for example, continuing to use online platforms to suit different families' needs. Furthermore, one ABS respondent who was a parent champion described the way using virtual platforms during the **pandemic broke down barriers and hierarchies** between parent champions and professionals. The respondent suggested that this was because it is not possible to see the clothes people are wearing on Teams and virtual meetings cannot have two 'sides at a table'.

What worked less well/challenges

Other areas prioritised over Early Years services. In particular, ABS respondents suggested that there was more focus on adult social care, A&E and people with comorbidities. This is thought to be because of external pressures to **reduce local authority and NHS costs**. Multiple ABS respondents explained that this can make engagement and implementation more difficult. For example, one ABS respondent reported that senior directors were not regularly attending ABS meetings because they are dealing with other challenges in the council, NHS or relating to commissioning changes.

Want for greater systems change beyond ABS. For example, an ABS respondent described how they would like to see changes to food advertising policies and how take-away apps influence diets.

Staffing and resourcing pressure. Multiple ABS respondents reported that staffing capacity and high turnover were a key challenge across different partnerships and services, and this was exacerbated by the COVID-19

pandemic. Staff were experiencing fatigue and increased pressure, particularly those working in the health and Early Years sectors. These staffing challenges were not limited to ABS staff. One ABS respondent reported that this meant there was less, or no, capacity to engage with ABS. Staffing issues made it difficult to achieve their aims or workload in the intended timelines. For instance, an ABS respondent in one partnership explained how the shortage of NHS dentists made it difficult for families to access dentistry services. This was challenging for the partnership's ABS oral health service, which promotes messages about regular dental visits for children. Limited staffing also made it more challenging to create strong relationships with partners, as existing staff were stretched and/or new staff needed to be brought up to speed. Mechanisms

Understanding of mechanisms

We understand mechanisms as the processes triggered by the ABS programme, which lead to the achievement of ABS outcomes. While activities are **what** ABS does; mechanisms are **how** activities are done, or the guiding principles determining how the programme is implemented. The mechanisms discussed below are all included in the ABS ToC. Below, we discuss the key mechanisms ABS respondents spoke to us about during interviews.

Service design and delivery informed by evidence

Several ABS respondents emphasised that **evidence, data and learning on 'what works'** were key for delivering high quality services and achieving outcomes. Respondents viewed evidence as important for two related reasons:

- To understand the needs of communities and families in order to design services.
- To understand which services are working for families, and which are not.

ABS respondents who discussed evidence-based working offered mixed views on its success. When discussing local evidence, multiple ABS respondents across partnerships commented on the successful work of their local evaluation teams. One ABS respondent reported that their local ABS evaluation team were **working with academic partners to** ensure they were **creating high quality evidence**. Another ABS respondent gave the example of the Born in Bradford research project, who are experienced in collecting evidence and have supported Bradford ABS in putting sound processes in place to collect data. For instance, they have helped ABS services develop logic models, design evaluation processes, and capture both qualitative and quantitative data.

Several ABS respondents also reported that services built on a strong evidence base are better able to show their impact. This is because, usually, their outcomes are more clearly defined from the start making it easier to measure. One ABS respondent commented that demonstrating the impact of programmes also **enabled decision making around sustainability of services** and future

commissioning. This ABS respondent commented that their local authority finance board use evidence from the ABS partnership to demonstrate the financial sustainability and impact of services, allowing decision makers to see tangible financial benefits.

However, another ABS respondent suggested that while there was much greater awareness that decisions about services should be based on evidence, this was not always the case in practice. For example, instead of considering whether a service is cost-effective, commissioning decisions were instead based on overall cost.

Test and learn

Test and learn aims to capture accurate and relevant evidence and learning, in a feedback loop to improve future services and project design. ABS respondents talked of the ways in which 'test and learn' was being implemented locally across partnerships. This included:

Trying approaches on a smaller scale. One ABS respondent described a project focusing on infant mental health. This project was expanded to cover the whole district, because it was having a positive impact on families and on health service, reducing escalation to specialist services.[16]

Refining and improving services, based on data, evidence and learning. This also included ending services if they were unsuccessful. One ABS respondent gave the example of a project which supports women who have experienced, or are at risk of, repeated removals of children from their care. This project was discontinued following the pilot as evidence showed tension between fidelity to the programme and adaptation to local needs. Learnings from this project were used when introducing a similar service, focusing on domestic abuse.

Ongoing monitoring and evaluation of projects. ABS respondents spoke about getting formal feedback from families and parents/carers through feedback forms at the end of a project. These comments were taken into consideration when adapting services. Feedback from professionals and practitioners at quarterly service review meetings and through learning logs was also mentioned as a method of reflection.

Despite successes**, approaches to collecting feedback from staff and families were often informal**, rather than systematic. Furthermore, while an ABS respondent welcomed the test and learn approach in principle, they questioned whether the cycle of test and learn is implemented frequently enough to maximise learning and impact.

[16] Data was not provided to verify this.

Scale up and replication

As part of scale up and replication, several ABS respondents reported **sharing learning** from ABS with non-ABS professionals, both **within their local authorities and more widely**.

Within ABS local authority areas. For example, one ABS respondent spoke of 'learning labs' which had been set up within their integrated care board (ICB) and are attended by commissioners from the NHS and the council. One of these ICB sessions focused on the work of ABS. **Scaling up services in the context of legacy and future planning** was highlighted as another aspect of shared learning. An ABS respondent highlighted the positive impact of peer support within their partnership and was keen to see this continue when recommissioning the 0-19 service.

Sharing with government to inform policy. Multiple ABS respondents discussed being increasingly outward facing when sharing learning. This involved transferring learning about ABS, partnerships and systems change from ABS onto policy makers. For example, one respondent reported that they had presented on ABS work at a Westminster forum and fed into all-party parliamentary committees on the Early Years sector.

Capacity

One ABS respondent suggested that what differentiated the interventions run in ABS areas compared to non-ABS areas was the **wider staffing infrastructure** around projects. This infrastructure included higher levels of staffing to enable neighbourhood engagement, marketing and communication, and a dedicated project delivery team. The respondent reflected on how one of the projects, which had previously run in ABS and non-ABS parts of the local area, had become embedded within ABS wards but had 'dwindled' in non-ABS wards. This was perceived to be because of a lack of infrastructure to support its delivery, rather than a lack of need. However, respondents also questioned the extent to which these higher levels of staffing would be sustained when ABS ends in 2025, especially in the context of ongoing funding challenges for children's services and preventative services.

Inclusion

Multiple ABS respondents discussed how ABS encouraged **engagement and inclusion of different families**. These ABS respondents were aware that they were not engaging all target families in their services. Several ABS respondents mentioned a number of different groups of parents who are less engaged in ABS services, outlined below:

Fathers. Multiple ABS respondents highlighted the **that children and childcare continue to be seen as the responsibility** of the primary caregiver, who is usually the **mother**. These respondents believed that this assumption

created a barrier to fathers' involvement in ABS services. Similarly, some ABS respondents perceived that fathers were reluctant to attend services as they are predominantly female environments. In order to address this, one ABS respondent discussed their partnership-wide **father-inclusive approach**. This involved a workstream around engaging fathers. Other ABS respondents spoke of project-specific solutions, such as promoting services through local 'Dads groups', working directly with a father-focused organisation and running services during non-work hours or online.

Families from ethnic minority and/or cultural backgrounds. Across partnerships, multiple ABS respondents discussed engaging and including families from ethnic minority backgrounds and several ABS respondents highlighted this as a challenge. For example, ABS respondents working in diet and nutrition services reported challenges with reaching the local Jewish communities and the Black African and Caribbean communities, because each of these groups require services specific to their culture and/or nutritional need. When considering future solutions, one ABS respondent believed it would be helpful to employ people from ethnic minority groups to ensure the ABS workforce was representative of their local community.

Refugee and asylum seeker families. One ABS respondent stated that including refugee and asylum seeker families was going well in their partnership. This partnership had previously struggled to engage these families. They had overcome this by working with several organisations and charities who specifically work with refugees and asylum seekers. As a result, these organisations are now signposting to ABS services.

Families who do not speak English as a first language. ABS respondents from all partnerships identified **language barriers as a challenge**. A common solution mentioned by multiple ABS respondents was the use of **translators and interpreters**. Other approaches included **actively recruiting staff or volunteers who speak community-based languages** or using parent champions who speak languages other than English to help with engaging parents. Another ABS respondent reported that their partnership is now running multilingual cafes where parent champions and befrienders can work as translators.

Coproduction

Including the voices of parents at all stages of the programme, including design, governance, and delivery is a key aim of ABS and in interviews, ABS respondents discussed:

Coproduction within service design. Some services have been set up by parents/carers, or at least, had **significant parent involvement**. For example, multiple ABS respondents gave the example of their 'People in the Lead' sessions, which involve a panel of parents who can be consulted by ABS

professionals. These sessions were used to get feedback from families on the cost-of-living crisis, and diet and nutrition services within their partnership.

Coproduction within governance. Several ABS respondents gave examples of **parents, carers and community members involved in governance**, including sitting on partnership boards or chairing partnership meetings. An ABS parent respondent on a partnership board described the community representation in ABS governance structures as 'revolutionary'. They felt it gave communities the opportunity to bring their perspective to decision-making. Another ABS respondent reported that governance boards were putting coproduction on the agenda to ensure it remains a priority across the partnership. This respondent highlighted a new cross-system coproduction group, with a post to be co-funded by the integrated care board (ICB) in their partnership area, which will remain after ABS finishes.

There were also several challenges with involving community members in governance. For instance, one ABS participant who was a parent champion highlighted that **parents were not always 'well received' by professionals**, because of preconceptions about parents' skills. However, they described how these relationships have improved over time, as professionals have seen the value of including parents. Additionally, an ABS respondent highlighted that it was **challenging to get parents to volunteer for leadership roles**, such as chairing. They suggested this was because parents were concerned that they did not have sufficient knowledge of the 'system', or the confidence to challenge other board members, which were skills needed for the role.

Peer-to-peer support projects. These projects were highlighted as a key success of coproduction across different partnerships. One ABS respondent spoke about how the volunteers working within these programmes acted as **agents of change in their communities**, educating people about projects and encouraging friends and family to participate in ABS services. The outreach done through community members was seen as more effective than when it came from ABS professionals or health visitors, **because it is an equal relationship**.

Coproduction and sustainability. One ABS respondent who was a parent champion noted that coproduction was being incorporated into plans for sustainability. Some ABS partnerships explicitly aimed to provide training and volunteering opportunities to **generate a locally-trained workforce**, which will exist beyond the length of the ABS programme.

The Fund respondents reported that co-production has been a useful tool for re-engaging with families and **strengthening relationships between partnerships and their communities, following the pandemic**. They indicated that parental involvement has been successful due to the flexible manner in which it is being implemented by partnerships.

Despite the successes of co-production and collaborative working, both ABS respondents and representatives from The Fund noted that not all stakeholders take this seriously, leading to **perceptions that sometimes attempts at engagement can be tokenistic**.

7.4 Next steps

Objective 2 fieldwork will continue for the remaining research years of the evaluation. This will include two further waves of data collection per year with ABS respondents and one wave of data collection per year with non-ABS respondents.

Mapping of activities and interventions across all five sites is carried out annually in June.

The first local evidence synthesis will be produced in 2023 and focus on implementation. To address Objective 2, we anticipate a focus on:

- Fidelity: the extent to which ABS and individual services were delivered as intended and/or as appropriate.
- Adaptation and variation: what changed and why
- Barriers and enablers to success at project- and site-level
- Timescales of implementation.

The thematic focus for 2023 is parental engagement.

8 Experiences of families through ABS systems (Objective 3)

Objective 3 aims to evidence, through collective journey mapping, the experience of families from diverse backgrounds through ABS systems. This component of the evaluation is designed to build a contextually situated understanding of diverse family experiences with ABS, and the contribution of ABS to family lives, including barriers/facilitators of engagement and impact in relation to the four core outcome domains. This will be achieved by establishing qualitative evidence about families' lived experiences over time, examining: how ABS activities and interventions concerned with child outcomes can become embedded and sustained in family lives and practices; the implications for families of ABS systems change; and families' contributions to systems change associated with involvement in ABS.

Full answers to the focused evaluation questions underpinning Objective 3 (presented in Appendix 1) will be established over time, as interviews with families will be conducted at regular intervals over a four-year period. At this

interim stage, we present analysis relating the first wave of research with families, as set out below.

8.1 Methods used

Sample

To date, we have conducted interviews with 25 families, five from each of the ABS partnership areas. The recruitment strategy was designed to generate a diverse sample of families, emblematic of a variety of family characteristics and patterns of engagement with ABS[17]. Families were invited to join the evaluation by a member of staff in their ABS area,[18] sampled to incorporate diversity in relation to the following criteria: levels of involvement with ABS (as appropriate for the local area); child age (0-12 months or 24-36 months)[19]; family size and structure; ethnicity; and home languages.

Key characteristics of families who took part in wave 1 interviews were:

- 12 families with a child aged 0-12 months, and 13 with a child aged 24-36 months; family size ranged from 1-7 children.
- Four sole-parent, 18 two-parent, and 3 complex/multi-generational households.
- 14 families where the main respondent identified as White British, and 11 families where the main respondent identified with one of a range of Black and Minoritised Ethnic Groups, including families of Black African, South Asian, and European origin;
- Across the sample, levels of involvement with ABS provision were described by partnerships as low (five families); medium (seven families) or high (13 families), although it should be noted that 'high involvement' was a diverse category, depending on the local context of provision and variations in patterns of use.[20]

Interviews with families

As detailed in the Phase 2 Protocol for the national evaluation, families will be interviewed twice a year over a four-year period (four waves of in-person data collection, complemented by three interim catch-up telephone interviews in each wave). Wave 1 in-person data collection took place from July-November 2022 and comprised two interviews with each family, involving all members of

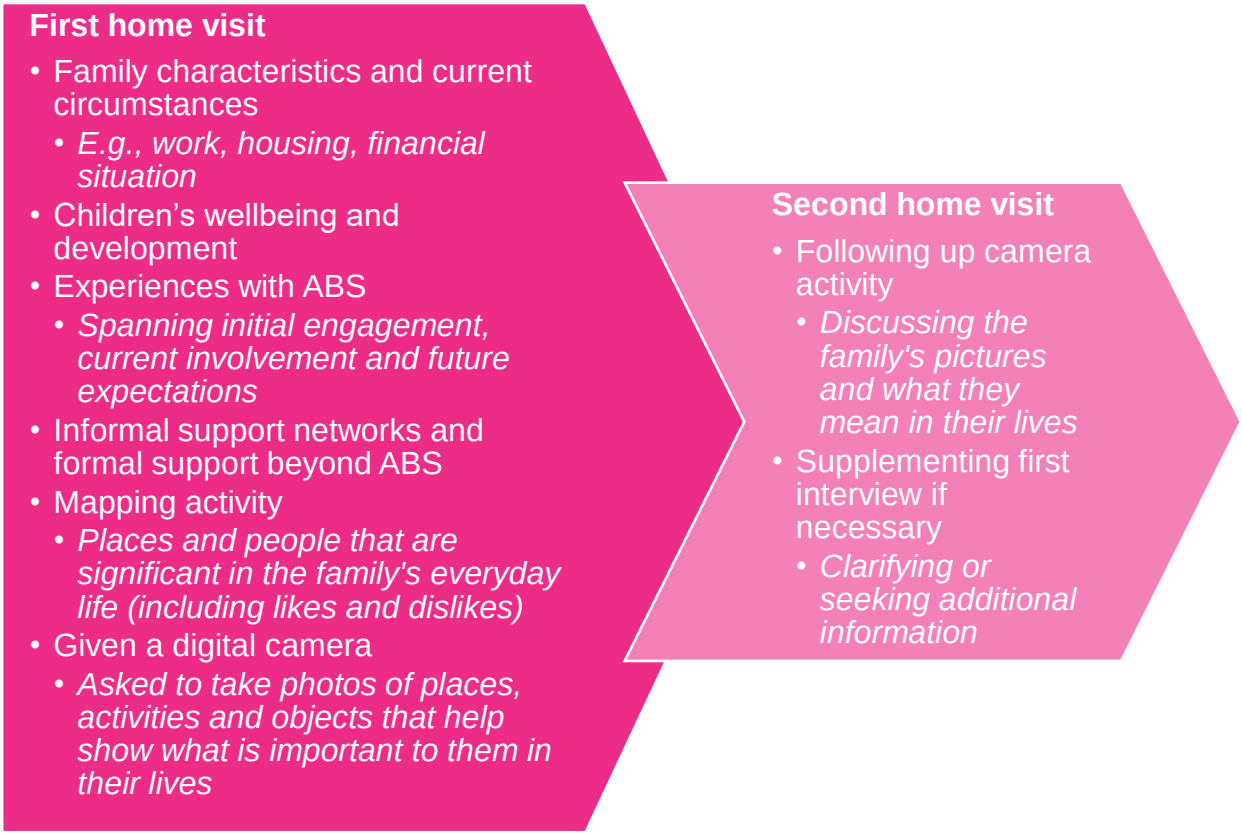
[17] Gobo (2004) describes this as *social* rather than *statistical* representativeness, designed to capture complex experiences and relations between variables, especially within populations that are known to be diverse.
[18] Details of recruitment materials (including information sheets and videos) can be found here: https://www.sussex.ac.uk/esw/circy/research/a-better-start
19 The 'focal child' in the family for the purposes of the research. By targeting families with children in these age groups, it is possible to: (i) follow some families as their children are ageing out of the programme by the end of the study; and (ii) generate data on older pre-school children's experiences with ABS early in the evaluation, not just in the final years.
[20] For example, a family could be categorised as highly involved because they are working closely with one service, such as family mentoring, or because they participate in multiple activities, or in roles such as volunteering.

the household who wished to take part[21]. In addition to the primary caregiver in the home (the mother, in all but one family), seven fathers took part in at least one interview; in one family the grandmother was the primary respondent, and in another the grandmother and mother participated. Children were present for 22 interviews. Figure 5 shows the content and process of wave 1 interviews.

Interviews were first analysed for each family individually, and then for families within the local area. A cross-area analysis was conducted to provide an overview of common themes and key considerations arising from research with families.

Within this interim annual report, we provide an overview of initial findings across areas. To avoid repetition (where themes arise across different research questions), findings are organised thematically, and discussed in relation to key relevant components of the ABS ToC.

Figure 5. Wave 1 interviews



[21] All interviews were digitally audio-recorded and transcribed; transcription conventions are as follows:

- R=researcher; M=mother; F=father; C1=Child 1 (descending birth order); I=interpreter, etc.
- […] indicates edit in the transcript (e.g., for confidentiality).
- - at the end or beginning of a line indicates overlapping talk, for example:
  M: So I said –
  F: You did, you told them.
  M: - that I thought…

8.2 Findings to date

Complex lives and challenging circumstances

Across the sample of 25 families, a high proportion in all five areas were managing complex and often challenging circumstances. Given the targeting of ABS in areas with high levels of relative deprivation, it is perhaps unsurprising that almost half the sample (12/25) described **significant economic and/or housing insecurity,** including unpredictable or limited income. Economic insecurity spanned different family structures and circumstances (e.g., lone parent professional, working couple household, and families reliant on state benefits, including refugee families); the reasons varied in line with specific circumstances, but had implications for parenting and family practices across households.

Fuel and food poverty were evidently critical issues for some, and could intersect with other factors, such as difficulties with private landlords and housing repair. Equally apparent were potential vulnerabilities relating to **social isolation because of lack of informal and/or extended family support** (12 families, including three parents who are care experienced and have complex relationships with their families of origin).

A significant proportion of parents/carers in the sample (16, including those living in economically secure circumstances) described **past or ongoing issues with parental mental health**, most commonly anxiety or depression; three reported living with **chronic illness or disability**; and two discussed their own **neurodivergence/learning disability**. The sample also includes two families with a **disabled child**, and seven families where one or more children has **special educational needs**.

Four families discussed **language barriers**, of whom two also had experienced **insecure visa status** (now resolved in one family, ongoing for the other); two other families have settled **refugee status**.

These patterns indicate that ABS partnerships are reaching families with complex and intersecting needs. Moreover, even when families within the sample were better resourced in some ways (e.g., in terms of economic security) they sometimes described other areas of vulnerability, such as isolation, lack of family support or poor mental health. Disadvantaging factors also accumulate for families (e.g., the association between citizenship status and poverty). The challenges outlined above are important context for understanding both the nature of families' involvement with ABS, and their accounts of the difference that ABS provision makes within their lives.

An adaptive, inclusive and empowering approach

Overwhelmingly, parents/carers taking part in the research emphasised the value of ABS **provision that supports them to be the kind of families they want to be**, facilitating their aspirations for their parenting and for their children.

A consistent theme in wave 1 interviews across ABS areas was that access to **free, flexible, scaffolded activities for children** enables parents/carers to structure family routines in a way that aligns with their priorities and values, and to plan play and learning opportunities that fit with children's interests and preferences. For example, one mother discussed her children's engagement with ABS forest school activities, commenting that 'they both love it, the outdoor stuff', and going on to explain:

> I don't want them to just be on computers all the time. […] I know it sounds a bit controlling but I like to have a schedule because I think everything they do at school, they have a schedule, don't they? It's good to keep it. Even in the summer holidays, we do more relaxed things […] We'll go out at a certain time, have lunch at a certain time, come back at a certain time. It's like a bit of a routine.

The flexibility and availability of activities was seen as especially important in the context of busy, complex and often challenging family lives, and was particularly significant for families with limited financial resources. Several described ABS provision facilitating access to opportunities and experiences that families would otherwise struggle to provide, and which they recognised as important for their children's development.

Affordability was evidently crucial for engagement and accessibility for those with limited financial resources. For example, one mother, commenting that 'there is so much around us that you can do for free', explained:

> We've been to like all the family fun days at the family centres. And again, those things that during the summer holidays, not having much money as a family, we couldn't have given [child] that great of a summer holidays. […] So to have all these free events meant that we could give him a really great summer holidays and he didn't know that we hadn't paid, do you know what I mean? […] Like literally I've got a little folder actually, up there on the window sill! And it's called ABS Events that are on.

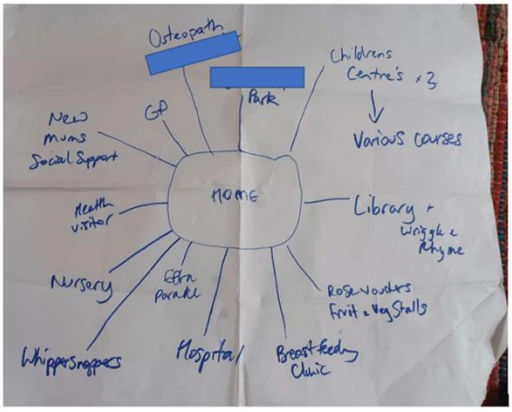
Some respondents did not draw an explicit link between the affordability of provision and their use of ABS, but their descriptions (often supplemented by photographs) of managing on very limited incomes coincided with accounts of participation in ABS provision. In one family of five, a single-earner couple household, the mother spoke about pressure on their finances, which was partly linked to the cost of their privately rented accommodation. Across the two interviews, she provided a detailed account of her efforts to save money – for example when buying food, or clothes for the children – but she and her

children had also taken multiple photographs of them participating in ABS activities and events. Reflecting on the photos as a whole, she said:

> The socialising is there, we, yeah, we move, we go out, we're not always indoors and they explore as well […] it makes them to know new things. […] And also they love it still.

For several parents, the **structure and routine** afforded by ABS was evidently a fundamental part of everyday family life and practices. One mother commented that 'it's a massive part of our life. Like if the ABS services weren't around, I think I don't know what I would generally do on a daily basis'. Discussed further below, the importance of ABS provision for parents/carers' own mental health and wellbeing was highlighted by parents/carers in all five areas. The mother of a child in the younger age group, living on her own with very limited family support, drew a family map (see Figure 6) that presents her home surrounded by ABS provision including the 'new mum' friends she has made through ABS. Looking at the map as a whole, she commented that without ABS she would be 'bereft'.

Figure 6. Map of important people and places



Enabling family practices that support development across outcome domains

The example of forest school, above, is typical of parents/carers valuing provision that complements their children's interest and enjoyment. Equally, they particularly valued activities that enable their aspirations for parenting and child development, and this was evident across all three of the core ABS child outcome domains.

Diet and nutrition

Several participants discussed the importance of ABS support for enabling breastfeeding, particularly in the context of challenges such as lack of intergenerational familial support or difficulties with statutory professional support, and other complications. This is exemplified by the experience of one mother:

> Well, we wouldn't have been able to breastfeed. There's no way. I'm the third generation. So my mum tried to breastfeed me, didn't work, my sister tried to breastfeed three of her children, it didn't work. […] So, I'm the third generation that's tried and almost didn't succeed. And we discovered after a lot of the stuff that [baby] was tongue tied. It was a very, very deep tongue tie, so it wasn't like a major issue, but it was causing issues with feeding. But without all the support and help and Bump to Breast, I would have stopped. We had endless nights where it was like, go and get the formula, no don't do it! (R: Yeah, yeah.) It was just so, so hard. So, without that support, there was no way that we would have got there.

Across all five areas, the affordability of food – and healthy food in particular – was a critical issue for families on low incomes. Food projects were highly valued, and described as 'lifesavers' by one mother who took photos for the research of the vegetables she got through her local scheme. In one area, a family that otherwise had very little engagement with ABS had made some connections with a local outreach worker who, they said, had brought them food parcels occasionally. The one respondent to comment critically on her food project was in a couple household where both parents worked; she had stopped using her local food project, and thought that others had also done so, because of the unpredictable contents and quality of their food boxes:

> I think for some people, like, I don't mind. For a long time, I've cooked from scratch, so if someone gave me loads of half mouldy veg, I'd turn it into a soup or a pasta or you know it's not an issue. But I think for some people, I think some people stopped doing it because they didn't think it was value for money.

Her comments indicate the importance of knowing how to cook the unpredictable contents of food parcels. Some participants also spoke about their enjoyment of collective cooking sessions, such as one mother who explained that they were useful for:

> Learning new things, new skills, like the cooking session has really helped me as well [to] know more what to cook, what to add to your diet.

Given the perceived benefits of provision such as food projects, community cooking, and of support for breastfeeding, it is striking that participants spoke relatively little about more structured diet and nutrition courses. Most had completed some form of weaning workshop (mainly HENRY[22]), but they were often neutral or equivocal in their feedback, as illustrated by one mother's description of an online course as 'a bit of an info dump' with 'lots of information to take in, but like the kind of key takeaways were really helpful at letting him feed himself'. While positive overall, the contrast with her enthusiasm in

[22] HENRY is an non-governmental organisation, working across the UK nations including in ABS partnership areas, which delivers a range of support, including structured workshops and short-term courses, aimed at whole-family nutrition, healthy weight and child development. For more information about HENRY, see: https://www.henry.org.uk/about

speaking about the support of ABS food ambassadors was notable (edited for length):

> And we went on the breastfeeding walks, didn't we? Those were fun. […] And then at the end you have a sit-down meal that they've, that one of the food ambassadors has made. […] Yeah, so they give you the recipe and everything, and it's all about you know what's nutritious, what's good for breastfeeding as well, like building your milk supply. Yeah, it was really, really great. That was a really nice way of meeting people and because it's food, you know you're having lunch, you don't have to think about making lunch! You know! And it was a really lovely thing! That very much felt like a proper support network.

A related consideration, indicated by the example in Box 1, is whether provision with a standardised and instructional element might be experienced as less relevant to family priorities in the context of challenges in other aspects of their lives. Another example – of one-to-one advice rather than standardised provision – indicates the importance of fit with the parent/carer's own understandings and priorities. In this family[23], the mother expressed doubts about an ABS worker's advice about overnight feeding of her baby:

> To give you an example, last time, she asked me if [child]'s still feeding in the night, because [child]'s breastfeeding. And I was saying, yes, maybe once or twice, just for comfort, then [child] fell back to sleep. Ehm, 'Oh maybe you need to reduce it because […] they can get like a problem in their teeth […] Which I know for a fact that it's bullsh*t. […] Yeah, I just listen to it but in the end, I do however I think it's best.

[23] Some details redacted for confidentiality.

Box 1. Family food practices and concerns about dietary health

This household comprised a mother and two children, including a school-aged child with significant SEND. Discussing a standardised weaning course, the mother commented, 'I haven't really had to use it'. She did not express any direct criticisms, but there was an evident contrast between this brief comment and her consistently positive discussion of other forms of ABS provision. Whilst weaning the younger child was not described as an issue for this mother, family food practices, diet and nutrition were important concerns, discussed in detail and documented in her research photographs and accounts of food shopping. In particular, she spoke about managing the fussy eating of her older child, concerns related to the affordability of food and the insecurity of her gas pre-payment card. She took a picture of her gas meter, and another of cooking a family meal (fish and mushrooms) in the oven because the gas supply had run out. She also noted concerns for her own dietary health, mentioning that she has been referred to a dietician, but commented that the affordability of food was a barrier to eating healthily. She also spoke about the difficulty of maintaining healthy eating for herself when she is 'on the go all the time' and has to cook two separate meals to accommodate her older child's limited preferences.

Communication and language development

Across areas, families were overwhelmingly positive about the ways in which ABS provision is **enabling children to access books**. Fourteen respondents spoke directly about the availability of books and/or about increased use of local libraries through ABS. Eight families received home delivered books for children every month, described by one as 'really good books, yeah, they are obviously age appropriate'. Parents/carers spoke about how these were woven into everyday practices with children, such as one who (discussing weekly bedtime story home visits) observed that 'the kids read them at nights before they go to bed'. The pleasure that books afforded was exemplified by the comments of a grandmother who reflected that 'they love [the deliveries], they'll show me their books that come through'. The significance of this home delivery of resources was underlined by her reflection that she struggles with significant anxiety, and sometimes finds it very difficult to take the children out.

Nine families said they regularly participated in **interactive story activities** with ABS (e.g., Story Sacks, interactive story time[24]). Again, these were universally appreciated by those who took part, and – as with the book deliveries – they could be seen to have additional value for parents/carers who live with poor mental health. One mother, who had experienced significant postnatal depression and described anxiety about going to busy outdoor places with her

[24] The National Literacy Trust describes the story sacks method as 'a collection of items in a bag or container that can be used to support and extend the telling of a story' – for example, including toys and/or craft materials. For an example of the use of the story sack approach in interactive story telling sessions at A Better Start Southend, see: https://abetterstartsouthend.co.uk/all-events/storytelling-with-southend-story-sacks/

children, spoke about how Story Sacks facilitated outdoor exploration, fun and play:

> Yeah, so it's like a bag that has, it's like orientated around different books […]. And then there's like maps of [local area] in there and it's like, oh take your story to this [place] for example. […] And I went to [the suggested place] […] and I took some pictures of [younger child] with the book, [older child] was reading it down there, you know, we was having fun because of that Story Sack, and we potentially wouldn't have gone down there if we didn't have the book. […] It was like sing these songs, and it was all like songs orientated around the [suggested place], so we sat down [there] singing nursery rhymes together.

Above, we noted that parents/carers particularly valued activities that align with their children's preferences, and this was apparent in accounts of interactive story activities. This is exemplified by the account of one mother, who has a physical disability herself and a two-year old child undergoing assessment for SEND, discussing a photo (cropped for anonymity, see Figure 7) of her child at an interactive story time session:

> The interactive story times, we go to them quite a lot because [child] loves being outside, so they're usually held at a community garden. And so basically what they do is they pick a book and then they base all the outdoor activities on that book. […] So, there was a book about seashell, but he never sits and listens to the story! *(laughter)* But, so they have loads of sandpits out and water play and things like that and loads of different shells and stuff.

Her comments and photograph also indicate the value of flexible inclusive provision: story-time is accessible and enjoyable for both mother and child, even though, still non-verbal at two years old, he 'never sits and listens' to the story.

Figure 7. Pirate-themed interactive story time

In contrast to more equivocal accounts of structured diet and nutrition courses, **standardised courses** to support communication and language development were clearly valued by those who participated in them. One mother praised an early language course as 'just so informative', even as she questioned how well

it had been promoted, commenting that she had not initially realised it was suitable for pre-verbal children:

> It's interacting with your children through play, but ways to encourage speech and development. […] I think a lot of people the same as me would have thought, mmm, my child's not going to be reading for a long time, is it appropriate or not? Then I just thought, oh it's free and it might be useful for something else to do.

Her comment, 'oh it's free', reinforces the earlier point about affordability enabling access, and is perhaps particularly striking since this was a relatively more affluent family in the sample, a professional couple household.

In three families in the sample, the 'focal' child (on which our sampling is based) had a diagnosed speech and language delay. For all three, ABS had played a key role in providing **specialist support and onward referral**: their parents/carers said specialist assessment had been expedited by ABS, and they had also received additional targeted support through ABS. In one case, the mother of a two-year old (who had not previously been engaged with ABS) said she had struggled to get the GP or Health Visitor to act on her concerns. She described her first contact with an ABS worker as a turning point for the family:

> I was like [to ABS worker], 'Oh my God you're the first person that's listened to me, blah blah blah'. And then she went, 'Everything you've told me, I'm not even going to give him an assessment, I'm going to get you straight on to speech therapy courses with ABS'.

This initiated one-to-one speech therapy sessions with ABS, and a facilitated referral to a paediatrician. The speech therapist's involvement of *both* parents was evidently helpful for the family:

Father: It was good in the sense of obviously I've not had as much involvement as you have – *[Mother: No but you were still there]* – But I went to one, the lady there basically sort of said that […] as an adult that can communicate effectively, my expectation of communication is that [it is] like how we're speaking to one another now. *[Mother: Yeah, yeah]* She sort of said to me, like look at the end of the day it's not about that, like it's about whether the fact that he like pulls your hand because he wants you to go get something from the cupboard, that's communication, you know what I mean? […] And I think it's just sort of, until you actually take a step back and look at him and go, well actually he's communicating in a different way -

Mother: Yeah, this is what he's doing, yeah. […] It was so good because like I can come back and I can say, [partner] they've said, this, this, this and this, but […] until he was actually there absorbing it, I think he, like, [partner] understood it. […] Like, you got it more because you were seeing him, do you know what I mean?

Father: Yeah, yeah, and interacting with him and everything like, yeah.

In another of these three families, the mother explained that one-to-one sessions at home with an ABS speech therapist had reinforced her understanding of the value of practices that the family were already trying:

> Well anything that he does, like noises like that, we imitate them, which encourages him to do them more and like make more sounds and stuff because he's excited about us copying him. Which actually we were, we've always done. But then this week when [ABS practitioner] came round for speech therapy, she was like we're focusing on imitation today! And I was like, wow!

Social and emotional development

Most families tended to talk about social and emotional development in terms of play and social opportunities. As noted above, key priorities included children's enjoyment of activities and fit with their interests, and the importance of activities for enabling structure and routine and building social networks.

Access to enriched play environments and activities – indoor and outdoor – was highly valued by parents/carers, many of whom commented that these spaces were important for social development, especially if children were not attending nursery. Family events and fun days were mentioned in all five ABS areas as something that children enjoy (and which were inclusive of older children) and that facilitate community connections. Parents/carers also valued activities as a resource for supporting them with other aspects of family life. For example, one father shared a photo of him cooking with his daughter (Figure 8, cropped for anonymity), and spoke about accompanying his youngest children to activities at the weekend. This family, who came to the UK as refugees, live with significant financial insecurity. The father works long shifts, and he explained that the ABS activities were important because they were fun for him and his children, as well as giving their mother some respite at the weekends.

Figure 8. A father and child making biscuits together

In terms of **standardised courses** designed to support social and emotional development, two parents specifically commented on the value of Circle of Security, described by one as 'kind of like a roadmap almost to like

understanding your kid or like kids in general!'. However, in another area, a mother indicated that her postnatal anxiety was exacerbated by an antenatal course she had done that emphasised being highly responsive to her child. She explained:

> I'm sure it's probably just the way I took it, but they said, when your baby cries, you pick your baby up, you respond to your baby. So, when [child] was born, I had the most immense fear of [them] crying, because that meant I was doing something wrong *(long pause).* Because they constantly say, if your baby cries, you respond. […] The health visitor said that they have to sell it like that because some people think that babies cry and, therefore, they just leave them. But to me, the immense fear it gave me of anything that resulted in her crying *(long pause).* I've had to have counselling.

This was an isolated example, but it warrants consideration in contrast to the value that parents/carers attached to support that was tailored to their needs and concerns, including one-to-one support through practitioners such as family mentors.

Perhaps unsurprisingly, in the context of a sample where almost two-thirds of parents/carers discussed struggles with mental health, activities designed to support children's social and emotional development were also felt to benefit **parents and carers' mental health and wellbeing**. For families who were navigating complex or intersecting challenges, including mothers who had experienced postnatal depression and had very limited informal support, ABS provision could provide a 'safe space', offering supportive relationships with trusted members of staff. This was summed up by one mother (who was care-experienced and had limited support from her family):

> I couldn't leave the front door, I was so scared, I couldn't get dressed, I barely wanted to open the curtains, I was so isolated, and the only thing for a long time that kept me going and getting up and out the house was knowing that OK, I had to face the world, but I was going to a family centre where it was a safe place, I could have a cup of tea, a chat, talk to people, they weren't judgemental, and actually it was so normal, other mums were going through similar things.

The importance of strong and trusting relationships between families and ABS professionals was emphasised by participants in all areas. One mother (a single parent who had two children, one with complex additional needs) reflected:

> There's been quite a few like, you know, like people along the way that's like really just made an effort and like gone the extra mile and just like they don't have to do it and it's not part of their job and they just like reach out to you basically and just like *(long pause).* If you didn't have that, you think, well what would you have done, you know what I mean? […] And it's like [name of worker] from A Better Start, she's like that, you know what I mean? […] It's like someone cares about you and about your wellbeing.

Tailored and specialist support was especially valued by parents/carers who found themselves struggling, as with one mother in the sample who said she has learning difficulties. Through a specialist ABS service, she said she had learned to respond to her child's needs, commenting that:

> I think if I didn't have [ABS], because they helped me so much with [child], if they weren't around, it would be harder to manage your child, like to bond with your baby […] it's helped me to more understand her.

In another area, one family was subject to an Interim Care Order[25] and the parents were receiving targeted support from a specialist ABS service. Both parents described a long history of poor relationships with professionals, and highlighted the contrast between social services involvement since the birth of their child, and their positive experiences with ABS:

Father: Yeah, it's been a constant battle.

Mother: We've done, literally, when they've say jump, we've jumped even higher than they've asked. […] *[Father: Yeah]* Like I've passed every drug and alcohol test -

Father: - Well we've been working with [ABS specialist service], and [that service] has been like amazing, you know […] because if it wasn't for them, like I reckon we we would have kind of succeeded but we would have got a different … *(tails off).*

Volunteering, Skills Development and Community Participation

Several parents/carers discussed the diverse ways in which their engagement with ABS had provided **new opportunities for skill development and community participation**. Four parents/carers described themselves as trained ABS parent champions and another was considering training to be a parent champion and breastfeeding mentor. Across the sample, parents/carers referred to a variety of other voluntary roles, including digital champions, food ambassadors, and befrienders, and one mother had secured funding via ABS to run an arts and crafts project.

All those who had been involved in volunteering said it was valuable for **building confidence and supporting aspirations**. The mother who was training to be a parent champion and breastfeeding advocate believed it would improve her career prospects, commenting that:

> A lot of parent champions have gone on to work for the ABS team, so it opens doors as well you know.

[25] At the time of our wave 1 interim interview, they reported having secured custody of their child.

She also described it as ‘a massive confidence boost, and it gets me out there, do you know what I mean?’. In two families – including the example in Box 2 – this kind of involvement was described as life-changing: addressing isolation, building confidence, and opening up new opportunities. However, it should be noted that while parents who participated in ABS training and volunteering were optimistic that involvement would help them to get work, some were not clear about the potential pathways or mechanisms for this. Some also spoke about barriers such as the (in)affordability of college courses.

Box 2. The wider benefits of volunteering

This family lives in a three-generation two-parent household, with two school-aged children and a young baby. The mother came to the UK as a teenager, but her insecure visa status has only recently been resolved. The family have very limited financial resources and welfare entitlements. The mother explained that opportunities to learn English had been minimal: ‘when I start to work here, I have to do cleaning job. So, you can’t talk with anybody, I just have to do my job and that’s it.’ Her involvement with ABS began with visits to a children’s centre, as she explained: ‘We start to go out when the COVID is finish and they say, oh you can come to play again. So, we went there and then they speak about the parent champion. And I was curious about what happened and what they tell me is, oh you can do courses, you can do something for you and your happy, you can do voluntary or you can have experience and then have a better job in the future.’ Since then, she has undertaken training through ABS, become a Parent Champion and regularly volunteers, including with a mentoring scheme for families who struggle to access services because of language barriers. She commented that the group activities provide a supportive way for people, including herself, to gain confidence in speaking English: ‘you know there is a lot of people from different countries, so was like, mm, everybody was not talking, but now it’s like everybody we’re talking, we know each other’. She also reflected that, along with benefits for her in building social networks, her ABS involvement was enabling her future aspirations for herself and her child: ‘I try to find a way to improve my English because I know it’s the time when [child]’s going to grow and go to the school and I can work, but the thing is with [ABS], I can practise and know people as well’.

Several mothers talked explicitly about how important it was for them to feel that they were **giving back to the community** through their volunteer work. One mother, living with significant financial precarity, liked the fact that, with ABS:

> You can do things and you can give and you can receive as well. […] So, I feel like good, you know, I give to them something, and they give something for me, I don’t like, you know, [if it was] just they give me’. Her comments resonate with those of other parents/carers who described feeling empowered by making a difference to their local community.

A key element of this feeling of empowerment was the feeling that they were engaged in **meaningful co-production** where they felt they had the power to influence and effect change. This sense of empowerment through voluntary work was summed up by one mother who said:

> For me, being able to do all of these things, I think it gets me back out there, it gives me a purpose again, it makes, you know helps me to find that little bit of me again […] making a difference'.

She discussed how she navigates local commissioning and decision-making processes to lobby for change, using the example of swimming lessons for young children:

> So, like say for example, like as a mum […] I'd like to see there being more free swimming services for babies. So, then I would sit down with the people, the governors, in a meeting, and I would say, look, as a mum, this is what I think. So, then I would talk to other parents at baby groups and things like that and I would say, what do you think about this? […] Would you like more swimming services? And actually I already know there is a lot of mums that think that. So, then I would sit down with the governor and say, this is what's been said, blah blah blah, have we got funding to maybe provide some free swimming sessions? We would then find somewhere which would either give us cheap prices or offer their services, then hold an event, and it might be over four weeks there's four free swimming sessions or […] And it's kind of like that, it's providing services, or creating the services.

Earlier, we noted the role of ABS provision in addressing social isolation, and across areas, several parents/carers also reported feeling more positively **connected with the local community** through their involvement with ABS. Perhaps unsurprisingly, those with higher levels of involvement, including families who had actively engaged in volunteering, were most likely to discuss these benefits. One mother, who had recently returned to the area after several years and had pro-actively engaged with ABS in planning that move for her family, said 'I feel like I'm getting roots again'. A grandmother spoke about how much she enjoyed being more visible in the local community because of her voluntary work with ABS, commenting that 'It's nice, because when you're out like around here, parents recognise who I am!'.

Perceptions of the local area

The perception that ABS has enhanced local communities was reported across all five ABS partnerships. Several parents/carers recognised that ABS provision was in their area because of relatively high levels of disadvantage, but commented that its presence helped foster a sense of **pride in local communities and services**. This was summed up by one mother who commented that she would not consider moving out of the area because of services provided by ABS:

> I tell people we live in the [ward] and people like snigger and laugh, but actually for what? *(laughs)* Whatever. The funding we have received for our area has been absolutely life changing to our family.

Some parents with older children commented on how local services had changed since the implementation of ABS. The mother in a family with seven children, ranging in age from 10 months to 15 years, commented on the difference in provision for young children, noting that 'the older kids didn't really go playgroups or anything like that […] Yeah, I think [first child to be involved with ABS], he had the benefit of everything'. Her comments were echoed by a mother living in another area, who observed that when her oldest child was born, 'there was nothing like this, nothing'.

Respondents also commented on the quality of resources within ABS provision, such as one mother discussing her local children's centre:

> [They have] just got new sensory equipment. So, they've got that cushion, they've got a big box of new books. […] And then they've got loads of like light up pebble stones. […] She loved it when I took her there. We must have been one of the first to go because she was pulling out all the little tabs on the books that make noises. […] That was after nursery last Wednesday, we've got it booked for tomorrow after nursery.

Other parents contrasted Early Years' services in their area with non-ABS neighbourhoods, commenting that the range and quality of services provided by ABS was not the norm in other areas. This could be a source of tension in terms of access to provision when parents/carers' friendship groups crossed ward boundaries, as one mother commented:

> I just think we're really lucky. I think mums who are outside of [the ABS ward] have noticed how much we're being offered. Particularly I've noticed some of the younger mums that haven't maybe already got these support networks or have got other issues going on and things, that [they] have developed quite close friendships with people and then they feel excluded.

Barriers and challenges

Considered as a whole, the analysis summarised above indicates that families' experiences of involvement with ABS have been positive, linking to all four outcome domains, with clear areas of strength. These correspond to core elements of the ToC and demonstrate the value of an inclusive, adaptive and empowering approach within all five ABS partnerships. Nevertheless, wave 1 interview analysis also identified some common barriers and challenges, across all five ABS partnerships.

The recruitment strategy for Objective 3 was designed to include families with low levels of involvement in ABS provision; their perspectives help to illuminate potential barriers relating to awareness and engagement with ABS. Five parents/carers, all of whom were actively involved in ABS, raised questions about **awareness of the ABS local offer**. Two mothers mentioned that they wished they had learned about services sooner: one expressed regret that she

had not been aware of ABS antenatal provision, and the other did not learn about ABS until after the pandemic, when her child was two years old. Three other parents/carers said they felt that ABS was not sufficiently known by others in their area. Four families (from three areas) reported very limited knowledge about local ABS provision. All were dealing with complex challenges, including parental physical and mental health needs, domestic violence, overcrowding and housing insecurity, and a multi-generational household where several family members had complex health needs. Parents/carers in three of the four families had migrated to the UK, including a refugee family and one with insecure visa status. **Language barriers** were also an issue, but not straightforwardly, as illustrated by the example presented in Box 3.

Box 3. Intersecting barriers to engagement

This family came to the area where they live when they arrived in the UK as refugees three years ago. At the time of our interviews, they were evidently very isolated. The parents do not speak English, although the older children do, and they emphasised that English-language learning was a key concern for them both. The mother explained[26] (via the interpreter) that, 'The problem is getting increased and increased, because if [older children] are not in here, so looks like we have got no tongue'. Yet their lack of awareness and engagement with potential support can be understood in relation to multiple intersecting barriers. One parent has a significant chronic health condition, and they said they became more isolated during the pandemic because of the implications for COVID risk. Living in insecure private rental accommodation, they were expecting to be moved, and this was a barrier to accessing ESOL[27] classes, because they had been told they might end up living in a different area. The mother explained that classes would need to be 'in our vicinity because of kids going to school and a new baby, so it's difficult to you know to travel'. The family have had contact with an ABS outreach worker but appeared to understand these visits as isolated contacts, and have otherwise engaged very little with local provision, including services available in their home languages. They are members of a minoritised religion and ethnicity in their country of origin and described experiences of perceived discrimination or suspicion when meeting people in their local area. They gave examples linked to everyday life (e.g., meeting people while taking children to school) as well as in attempts to access services, including a local community centre they attended for benefits advice[28], which the mother described as 'not friendly'. The older child explained, 'they [staff] are not too good with us […] when they hear like we are [minoritised group].'

The experiences documented in Box 3 indicate the need to consider how barriers to engagement intersect for families where **complex needs coincide with limited confidence or knowledge of working with services**. Enhanced support may be necessary to understand the barriers families perceive and determine how best to support them to engage with the diverse ABS local offer. The outreach worker's ongoing efforts – texting, visiting and inviting them to

[26] All quotes from the parents are based on the interpreter's translation within the interview.
[27] ESOL – English for Speakers of Other Languages.
[28] This was not an ABS service, although the centre does host local ABS provision.

events – were clearly pivotal in the participation this family had tried, but had not (or not yet) enabled them to engage more fully with local provision. Future interviews will illuminate whether this changes.

Crucially, for all families with low levels of involvement with ABS, this did not reflect (a lack of) perceived support needs. This finding is unsurprising given how many families were managing complex vulnerabilities and disadvantage. As one mother (isolated, with limited English, living in a bedsit with her baby and partner who works very long hours) explained:

> It's not difficult to look after [child], but I want to meet some [people], change the environment for baby […] So, if I would know about these things, like ABS, how they are and what's happening like in them, I would like to go.

Seven families have a child with special educational needs or disabilities (SEND), and they discussed potential barriers in terms of the **perceived relevance and inclusivity of provision for children with SEND** (but see also Figure 7). The mother of a child with an autistic spectrum condition (ASC) said that they tend to go to small, familiar groups because the child finds new settings and larger activities to be very difficult. Others spoke of concern about how the behaviour of their child might be perceived by parents whose children do not have complex needs. One spoke of her concern that 'you might get judged and stuff', and in a different area, another mother observed:

> Because you know there's all little, the other mums sitting there. […] So I took him to a musical one and all the other kids knew how to play their instruments and [my child] was just literally running around, running up and down, trying to get out of the back door – not unhappy.

The potential for **involvement of older children** was also highlighted by several families, particularly in terms of scheduling of provision after school and during term time. Some ABS partnerships were flexible about allowing older children to access activities with their siblings, and this was clearly highly valued when it had been available, but it was not always guaranteed. For example:

> And [older child] loves going there, he's five now, so the services are like zero to four, but when he's with us they accept us in you know if it's not busy or whatever, and he loves it there too, you know they're really good with the whole family and it's just, it is, it's brilliant. […] There's lots of things to do with the babies during the day. But also, with ABS, which is something which I do stress to them a lot, is that I don't think it's fair that it ends at four.

This mother went on to highlight her concerns about what will happen when ABS funding comes to an end:

> But then it also, it's like you know the parent champions, what is the future for them and *(long pause)* you know there's quite a lot of

> uncertainty. And like I said to the [member of staff] today as well is that once this money runs out and the – well, not money runs out, but once the, you know, the years are up, OK, so what then for our family? Because that's three years' time, [youngest child] will be four – but what if I have another child?

Successful and sustained engagement often depends on how well ABS services **fit with family circumstances**, including over periods of transition such as children starting nursery and mothers returning to work. **Scheduling of activities** was mentioned as a barrier to participation by nine parents/carers. While the reasons given varied, it is interesting to note that all those who mentioned this topic said they would prefer scheduling of services in the afternoon as well as the morning. For some, this was to ensure that participation could fit around work, nursery attendance, or nap times, but it was also raised for families who struggle to get out in the morning for more complex reasons. Scheduling may also be a barrier in relation to the **involvement of fathers**. In only three families were fathers described as significantly involved with ABS provision, although there were examples (as noted above) of fathers' involvement in weekend activities and one-to-one specialist support (e.g., speech and language).

Considering what was involved in overcoming barriers to engagement, it was clear that time and continuity in relational work with families played a key role. **One-to-one relationships with ABS staff** were often very significant in this regard, establishing trust and developing relationships, and were clearly effective in enabling identification of child and family support needs (see also the discussion of outcome domains, above).

Summing up

At this early stage, based just on the first wave of in-person interviews with families, it is important to be cautious in interpreting the findings presented here. Time will tell whether the reported benefits and challenges documented here persist, and the further rounds of data collection with families are key to exploring questions arising from the analysis presented here. Nevertheless, the evaluation activity to date has documented both the value and the challenges associated with ABS involvement for families across all five partnerships. Two key points stand out in summing up.

Firstly, the research shows that families consistently value an approach that aligns with the principles of adaptive design laid out in the ABS ToC, particularly in relation to **services that fit with families' life pressures and circumstances**, and **inclusive practices that ensure services are accessible to families** (e.g., in terms of affordability and opening times). Notwithstanding the barriers to engagement discussed above, it is also evident that parents/carers particularly value **ABS provision that aligns with their priorities and perceived needs for their children and their families**. This finding appears consistent with the model's emphasis on **locally driven co-produced services that meet families' needs**. **Time and continuity in**

relational work was also emphasised by families, who consistently valued being able to build relationships with known and trusted ABS staff. This was particularly important for socially isolated or otherwise vulnerable families.

Secondly, and equally, the analysis shows that ABS activities are contributing to family lives and everyday family practices in relation to all four outcome domains. For those living with poverty and financial insecurity, ABS was seen to play a key role in enabling access to **resources and activities that families might otherwise struggle to afford**; this included books, healthy food, enriching events, and access to training and personal development opportunities for parents/carers. Across outcome domains, **interactive provision** (e.g., story activities, community cooking) was also highly valued, allowing space for more tailored discussions in relation to family needs and priorities and for parents/carers and children to build friendships and informal networks. Enabling **access to targeted and specialist support** – directly from ABS and through onward referral – was also critically important for families who were managing complex challenges. Examples in our interviews included breastfeeding support, specialist speech and language therapy, domestic violence provision, and one-to-one support from ABS staff. In addition to perceived benefits for their own families, some respondents also spoke in terms of **the difference that ABS has made in their communities**, enriching opportunities for children and families, but also countering the stigma attached to the neighbourhoods where they live.

Beyond these consistently positive messages, the analysis also illuminates challenges associated with ABS participation, highlighting **barriers to involvement** for some families, and particularly those with more complex and challenging family lives. In concluding this section, it is also important to note that, within the length constraints of this interim report – and guided also by concerns about the potential identifiability of individual families – we have not attempted to discuss variation between ABS partnerships. This is a matter for further future analysis, including linking Objectives 2 and 3 within the mosaic of evidence of the evaluation as a whole.

8.3 Next steps

Wave 1 interim telephone interviews with parents/carers

This next phase of work for Objective 3 is well underway. These interviews (5-6 months after the first in-person interviews with families) serve two core functions: they form part of the evaluation strategy for keeping in touch with families over time; and in a sample where complex challenges may affect family circumstances and priorities, interim interviews provide the opportunity to learn from families about change in their lives and in their involvement with ABS and other services.

These interviews are tailored around a common structure, to build on information from the initial in-person interviews with families along with any other issues that the parent/carer wishes to discuss. At the time of writing, 24/25 interviews have been completed.

Wave 2 in-person interviews

The next stage of in-person data collection will take place approximately 12 months after wave 1 in-person interviews, and will be informed by wave 1 analysis and learning from other facets of the evaluation. Interviews will follow the same flexible family-centred methodological approach. This includes:

- Asking families to take pictures in advance of the interview (using the digital camera already provided, replaced if necessary).
- Revisiting information shared in wave 1 to elicit family reflections on change in their lives (e.g., taking the family map back to talk about what is the same or different, and why).
- Questioning in line with the same overall domains of enquiry as in previous rounds of data collection.
- Incorporating a focus on critical considerations arising from wave 1 analysis (e.g., a specific focus on fathers' experiences, given the apparently low levels of fathers' involvement in ABS identified in the first wave 1 interviews) or from other components of the work (e.g., linked analysis with Objective 2).

Updated ethics approvals will be secured for this new data collection. Discussion with each of the five partnerships will help to inform suitable strategies for (a) maintaining the participation of families already in the sample, and (b) replacing families in the sample if necessary, so the target sample size at each face-to-face wave of data collection will always be 25 families (five per ABS partnership).

Further analysis

Objective 3 data forms part of the mosaic of evidence for the ABS national evaluation, and so the next stages of work include linking the analysis summarised here with evidence from other components of the work. In particular, developing links with Objective 2 data analysis will illuminate area-specific and cross-area considerations, as well as points of connection and disjuncture between family and professional perspectives.

9 Contribution made by ABS to reducing costs to the public purse relating to primary school aged children (Objective 4)

9.1 Aims of the objective

The aim of Objective 4 is to evidence the contribution the ABS programme has made to reducing costs to the public purse relating to primary school aged children. To do this we need to understand:

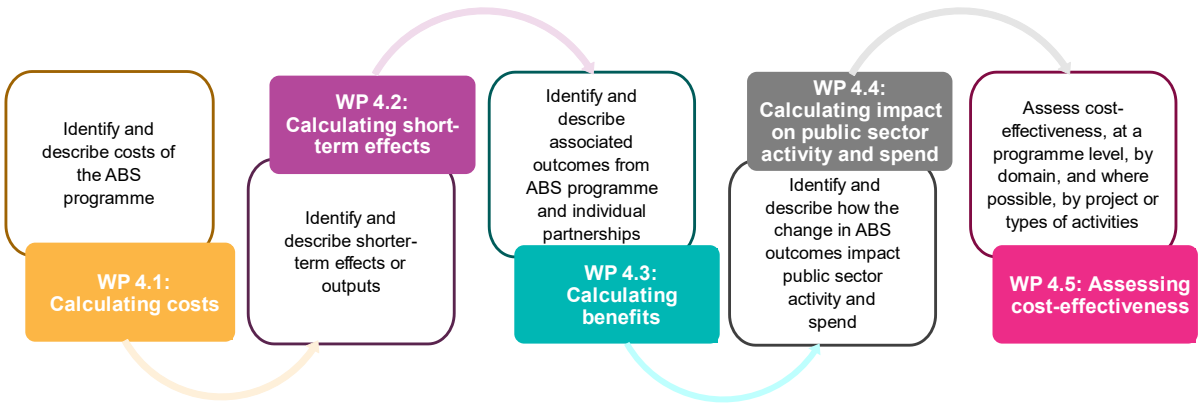
The costs associated with delivering the ABS programme:

- What outputs have been delivered.
- Any change in child and parent level outcomes as a result of involvement in ABS activities (Objective 1).
- What public sector activities will change if the ABS programme causes a change in the above outcomes.
- Any change in public sector spend as a result of that change in public sector activity.

9.2 Methods used

We will use Cost-consequence Analysis (CCA) to assess the value for money of the ABS programme. This will include five work packages as summarised in Figure 9.

Figure 9. Overview of approach



In 2022 the focus of work on Objective 4 has been primarily on identifying and describing the costs of the ABS programme (WP 4.1: Calculating costs). Later in the evaluation, once Objective 1 has measured the change ABS has made in terms of outcome measures and Objective 2 has assessed systems change, we will use this information to analyse the cost per change in outcome and net that off any potential public sector cost savings identified in WP 4.4.

ABS is a complex, place-based programme designed to be responsive to the needs of the local area. The test and learn cycle and 'no one size fits all' approach adopted by The Fund to support greater flexibility has resulted in partnerships adopting different approaches to programme delivery and reporting in response to local needs. This has created challenges for Objective 4 in terms of making sure there is consistency in what is being reported. To overcome this, we involved the partnerships in the development of our approach to make sure that it is robust, but still pragmatic. This involved hosting two virtual workshops with the five ABS partnerships, in Spring 2022, to agree a consistent approach to:

- Reporting their leverage funding.
- Mapping spend data to outcomes.

We then worked with each partnership individually to map their spend to date to selected ABS Common Outcome Framework measures, as far as possible.

We have also progressed our review of existing research from cohort studies (such as Born in Bradford[29], the Millennium Cohort Study[30] and Understanding Society[31]) to help provide the conceptual links between observed changes in parental and Early Years outcomes and the correlated outcomes for children during their primary school years. The review will be used to identify and describe how any change in ABS outcomes, measured through Objective 1, is likely to impact public sector activity and spend on primary school aged children (WP 4.4: Calculating impact on public sector activity and spend) along with our review of existing economic studies of the impact of Early Years interventions on public sector spending in relation to those children during their primary school years.

As an output from this review, we are currently developing a schematic that links each of the selected ABS Common Outcome Framework measures with a set of related outcomes for primary school aged children. Each of these primary

[29] Raynor, P., Born in Bradford Collaborative Group. (2008) *Born in Bradford, a cohort study of babies born in Bradford, and their parents: Protocol for the recruitment phase*. BMC Public Health 8, 327.
[30] Connelly, R., Platt, L. (2014) *Cohort Profile: UK Millennium Cohort Study (MCS)*, International Journal of Epidemiology, Volume 43, Issue 6, pp.1719–1725.
[31] Buck, N., McFall, S. (2011) *Understanding Society: design overview*. Longitudinal and Life Course Studies, [S.l.], Volume 3, Issue 1, pp. 5 – 17.

school aged outcomes is then further linked to potential public sector costs and cost savings.

For example, our review of existing evidence shows that ABS COF measure 1, Perinatal Maternal Mental Health (Depression and Anxiety), is linked to the following child-level outcomes during the primary school years:[32]

- Higher risk of reduced child growth (stemming from higher risk of low birth weight).
- Higher risks of intellectual issues and lower attainment in communication, language and literacy and mathematical development.
- Higher risk of behavioural and socio-emotional issues and lower attainment in personal, social, and emotional development.
- Childhood injury.

The Personal Social Services Research Unit (PSSRU)[33] estimates the child level costs associated with perinatal depression and anxiety based on mean probabilities of children developing the above adverse outcomes. The economic consequences are calculated based on the additional use of public sector services (e.g., health and social care, education and criminal justice system). The public sector costs of perinatal depression were estimated at £10,336 per child and £6,112 per child for perinatal anxiety. Note these are lifetime costs relating to the child. They will need to be adjusted in our evaluation to reflect the costs associated with primary school aged children.

Although our review helps establish the linkages between ABS outcome measures and outcomes for primary school aged children as well as the linked costs/savings to the public purse, some gaps remain. These will be explored though the remainder of the evaluation. For example:

- Not all studies quantify the relationship between Early Years and primary school aged outcomes.
- Connections and inter-relationships between one or more outcomes will need to be explored to avoid double counting.
- The time periods covered vary by study, therefore, some cost calculations will need to be adjusted to reflect potential cost savings during the primary school years.
- Frequency and duration of public sector intervention during the primary school years will need to be understood, e.g., generating scenarios to

[32] Jones, KC. and Burns, A. (2021) Unit Costs of Health and Social Care 2021. Unit Costs of Health and Social Care. Personal Social Services Research Unit, Kent, UK;
Mensah, F. and Kiernan, K., (2010) Parents' mental health and children's cognitive and social development, Social Psychiatry and Psychiatric Epidemiology;
Hope, S., Deighton, J., Micali, N., and Law, C. (2019). Maternal mental health and childhood injury: evidence from the UK Millennium Cohort Study. *Archives of disease in childhood*, *104*(3), 268–274.
[33] Jones, KC. and Burns, A. (2021) Unit Costs of Health and Social Care 2021. Unit Costs of Health and Social Care. Personal Social Services Research Unit, Kent, UK.

understand how shifts in parental outcomes (e.g., reduction in perinatal depression) shift total cost savings linked to primary school age children (e.g., fewer/less intensive interventions required for children with conduct issues etc.).

The gaps identified in the existing evidence base will be filled by further research, including interviews with practitioners (see Section 9.4 for details).

9.3 Findings to date

Inputs

Funding committed

The Fund has committed a total of £216m in grant funding to the five partnerships to deliver the ABS programme (from 2012/13 to 2024/25), with a further £18m grant funding allocated for 'support and delivery activity' (e.g. the learning and development contract and national evaluation activity). Central programme costs, incurred by The Fund directly, for the management, administration and oversight of the programme are estimated to be £3m for the duration of the programme.[34]

In addition to ABS grant funding the five partnerships have also secured an estimated £29m in leverage funding or non-monetary (in-kind) commitments from partners (from 2014/15 to 2024/25) to support ABS activities.[35]

Spend to 31st March 2022

Total spend to 31st March 2022 was £169m of which:

- Central programme costs: £2m.
- Support and delivery activity: £14m.
- ABS grant spend by partnership £131m:
    - Blackpool £25m
    - Bradford £32m
    - Lambeth £30m
    - Nottingham £25m
    - Southend £20m
- Leverage funding secured by partnerships: £22m.

Central programme costs

[34] These costs include pre-programme spend associated with design, assessment and set up (i.e. from 2012/13). They are based on actual spend to 31st March 2022 and spend forecast or committed to 31st March 2026, £5,950,560.

[35] Note: Leverage figures for Southend primarily relate to partner time associated with ABS governance activities. While these are expected to continue for the remainder of the programme period, forecast figures for leverage have not been provided by the partnership.

The Fund spent £2,321,991 on central programme costs relating to the ABS programme between 1st April 2012 and 31st March 2022. This includes time and expenses for the staff responsible for the management and oversight of the programme at The Fund. This is equivalent to around 1% of ABS grant spend during this time.

Support and delivery activity costs

The Fund has spent £13,981,090 on support and delivery costs to 31st March 2022, including development grants paid to the initial 15 sites to develop their ABS proposals, as well as contracts for communication campaigns, evaluation and learning. This equates to 79% of the £18m budget for these costs, which predominately relate to building capability and supporting the development of the programme across the five partnership areas. Over half of this spend (£7,785,269) occurred during the set-up / mobilisation period (pre 1st April 2015).[36] Leaving 21% remaining to fund learning and evaluation during the final three years of the 10 year programme period.

ABS grant spend by partnership

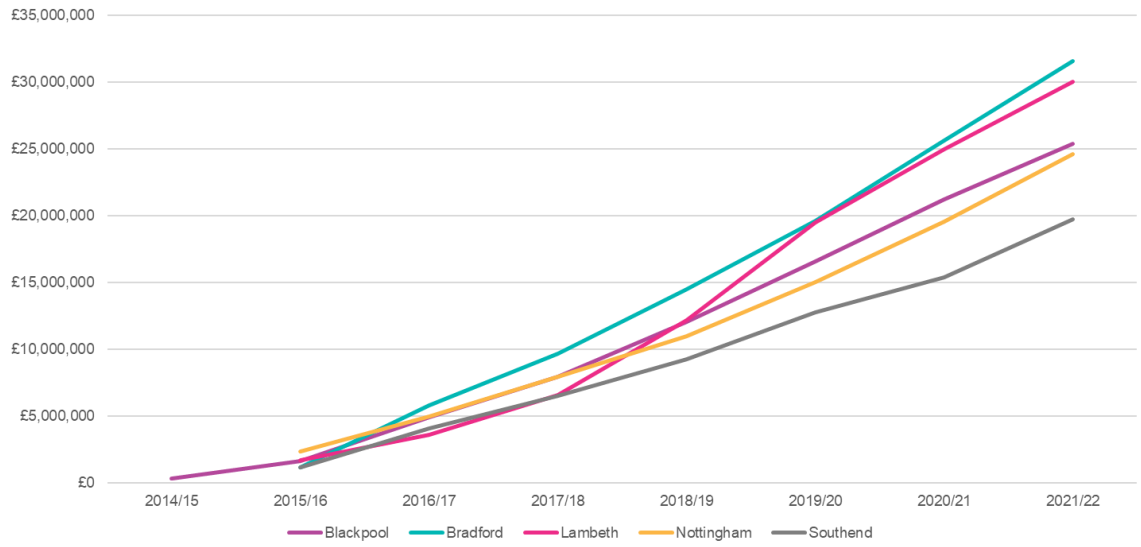
Together the five partnerships had spent £131m or 61% of their 10 year ABS grant as of 31st March 2022. Analysis by partnership, presented in the tables below, indicates considerable variation by partnership.

Each year in May, budgets from each of the five partnerships are revised and reviewed by The Fund. Following this review, full unspent grant award is allocated against budget headings for the upcoming years, up to the agreed end of the grant period (31st March 2025). The annual revision of budget and review by the Funding Managers at The Fund, ensures that the allocation of grant funding is within the scope of the ABS programme.

Analysis by financial year shows that programme spend grew slowly during the test and learn cycle (1st April 2015-31st March 2018), with the vast majority of programme spend (71%) occurring between 1st April 2018 and 31st March 2022.

Figure 10. **Cumulative ABS Grant Spend by Partnership by Financial Year**

[36] This includes £5,455,567 of development grants paid to the initial 15 sites to develop their ABS proposals.



The tables below provide the total ABS grant spend by partnership.

Partnerships divide grant spend into:

- Portfolio management costs (e.g. staff time and resources required to manage the portfolio of ABS services).
- Revenue projects.
- Capital projects.

Analysis of spend to 31st March 2022 shows that the majority of grant spend was on revenue projects, which account for £88m or 67% of total grant spend. Portfolio management costs account for £36m or 27% of total grant spend to 31st March 2022, while capital projects account for just £7m or 6% of total grant spend. This is broadly in line with the overall 10 year budgets for the partnerships. However, there is considerable variation in the distribution of spend across these areas at partnership level (as shown below). This is due to the differing spend profile of each partnership. For instance, Blackpool spread out their grant spend more equally across 2014/15 – 2021/22. Whereas Lambeth prioritised the spend of leveraged funding from the Clinical Commissioning Group during the initial years, and then drew down large proportions of grant funding between 2018/19 and 2021/22.

Further, the variation in portfolio management costs across the partnerships results from individual decisions of the partnerships in relation to sourcing staff to deliver services. For instance, some partnerships commissioned out services, while others delivered services with their own programme staff. This led to differences as some wages for programme staff were then included in commissioned services (revenue project spend) rather than calculated under portfolio management costs.

Blackpool[37]

Blackpool spent £25m (or 56%) of its total ABS grant allocation by 31st March 2022. While the partnership had spent the majority of its capital project budget (99%), only half of its revenue budget has been allocated to date (50%). Blackpool reported the highest proportion of grant spend devoted to portfolio management costs (46% of spend to 31st March 2022). This is due to having a considerable number of seconded or co-funded posts within the organisations that form part of the partnership, as well as posts designed to support systems change across the partnership, to ensure sustainability of all activity.

Table 5. **Blackpool grant allocation by 31st March 2022**

Type of expenditure	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	**Total**
Portfolio management	£284,821	£955,718	£1,359,034	£1,556,306	£1,978,920	£2,113,821	£1,912,130	£1,643,404	**£11,804,154**
Revenue project	£25,938	£402,279	£1,647,393	£1,503,965	£1,733,278	£2,383,228	£2,267,351	£2,554,455	**£12,517,887**
Capital project	£0	£0	£224,628	£0	£368,107	£62,077	£438,319	£0	**£1,093,131**
Annual total	**£310,759**	**£1,357,997**	**£3,231,055**	**£3,060,272**	**£4,080,305**	**£4,559,126**	**£4,617,800**	**£4,197,859**	**£25,415,173**

[37] During the outcome mapping exercise Blackpool provided revised expenditure data per annum, including a breakdown of spend for 2014/15. As agreed with The Fund, this revised data has been used instead of the annual claim returns for Blackpool, which The Fund had previously shared with the evaluation team.

Bradford

Bradford spent £32m (or 64%) of its total ABS grant allocation by 31st March 2022. This was largely driven by the £8m portfolio management costs which were equivalent to 94% of the original 10 year budget allocated for the partnership's portfolio management costs. A revised 10 year budget, shared with the evaluation team in May 2023, indicated a reallocation of project revenue to cover portfolio management costs for the remaining three years of the programme.

Table 6. **Bradford grant allocation by 31st March 2022**

Type of expenditure	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	**Total**
Portfolio management	£934,172	£882,874	£1,140,252	£1,137,474	£1,153,325	£1,167,007	£1,137,906	**£7,553,011**
Revenue project	£0	£3,646,295	£2,702,013	£3,697,795	£3,982,254	£4,288,739	£4,225,362	**£22,542,459**
Capital project	£242,576	£107,682	£7,609	£0	£10,231	£550,481	£561,835	**£1,480,414**
Annual total	**£1,176,748**	**£4,636,851**	**£3,849,874**	**£4,835,269**	**£5,145,810**	**£6,006,228**	**£5,925,104**	**£31,575,883**

Lambeth
Lambeth spent £30m (or 75%) of its total ABS grant allocation by 31st March 2022. The profile of Lambeth's spend across the three categories of expenditure is broadly in line with its 10-year budget.

Table 7. Lambeth grant allocation by 31st March 2022

Type of expenditure	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	**Total**
Portfolio management	£906,782	£518,983	£638,381	£767,550	£1,012,637	£1,150,901	£1,205,951	**£6,201,184**
Revenue project	£579,985	£991,106	£2,112,173	£3,812,203	£4,685,927	£3,878,560	£3,817,804	**£19,877,757**
Capital project	£249,536	£350,436	£260,736	£984,258	£1,609,888	£474,101	£40,110	**£3,969,066**
Annual total	**£1,736,303**	**£1,860,524**	**£3,011,290**	**£5,564,010**	**£7,308,453**	**£5,503,562**	**£5,063,864**	**£30,048,006**

Nottingham
Nottingham spent £25m (or 55%) of its total ABS grant allocation by 31st March 2022. This included 100% of its 10 year capital project budget, 70% of its 10 year budget for portfolio management costs and just 53% of its 10 year revenue project budget.

Table 8. Nottingham grant allocation by 31st March 2022

Type of expenditure	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	**Total**
Portfolio management	£403,152	£449,135	£476,541	£412,744	£493,275	£482,437	£471,859	**£3,189,144**
Revenue project	£1,570,588	£2,201,060	£2,462,639	£2,635,597	£3,538,229	£4,054,035	£4,618,634	**£21,080,782**
Capital project	£363,759	-£17,126	£17,210	£0	£0	£0	£0	**£363,844**
Annual total	**£2,337,499**	**£2,633,070**	**£2,956,390**	**£3,048,341**	**£4,031,504**	**£4,536,472**	**£5,090,493**	**£24,633,769**

Southend

Southend spent £20m (or 53%) of its total ABS grant allocation by 31st March 2022. It has devoted a larger proportion of its total spend to date to portfolio management costs (35% of spend to date, compared to 26% of its 10 year budget devoted to these costs). At the same time it has devoted a smaller proportion of its total spend to revenue projects (63% of spend to date, compared to 73% of its 10 year budget devoted to revenue project).

Table 9. Southend grant allocation by 31st March 2022

Type of expenditure	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	**Total**
Portfolio management	£893,994	£1,816,753	£716,043	£664,548	£1,095,747	£797,577	£858,525	**£6,843,187**
Revenue project	£199,599	£1,064,655	£1,280,677	£2,090,477	£2,381,851	£1,876,642	£3,450,514	**£12,344,417**
Capital project	£86,191	£0	£456,277	£0	£14,065	-£22,192	£8,127	**£542,468**
Annual total	**£1,179,784**	**£2,881,408**	**£2,452,997**	**£2,755,025**	**£3,491,663**	**£2,652,027**	**£4,317,167**	**£19,730,072**

Leverage secured to 31st March 2022

In addition to ABS grant funding the five partnerships have secured leverage funding and non-monetary commitments from partners to support the delivery of the ABS programme in their area. This includes non-ABS grants, funding and donations that have been allocated to support ABS activity as well as non-monetary commitments, such as provision of services or facilities to ABS beneficiaries or services on a free or reduced fee basis (e.g. not invoicing for HR or finance support). Together the ABS partnerships secured £21,748,541 in leverage between 2015/16 and 2021/22. This is equivalent to 17% of ABS grant spend to 31st March 2022. This is substantially lower than the leverage forecasts submitted by partnerships as part of the original applications, which indicated that leverage funding would almost equal the value of ABS grant funding. However, The Fund has confirmed that it is aware that many of the partnerships' proposed leverage funding plans have not materialised and leverage funding has become less of a focus from The Fund's perspective.

Among the five partnerships, Blackpool secured the largest amount of leverage funding (£14m leverage funding or 55% of their total grant spend to 31st March 2022). Bradford's leverage funding of £3m, accounts for 11% of their ABS grant spend to 31st March 2022. This is in line with Bradford's original application, which proposed leverage funding at 10% of the ABS grant amount. The leverage funding secured by Southend, Lambeth and Nottingham account for 8%, 6% and 4% of their total ABS grant spend to 31st March 2022 respectively. These are all substantially lower than proposed in their original applications.

Table 10. Leverage funding secured to 31st March 2022

Partnership	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	**Total**
Blackpool	£2,447,000	£2,392,000	£2,301,000	£2,184,367	£2,015,315	£1,215,068	£1,365,818	**£13,920,568**
Bradford	£141,102	£287,005	£430,717	£834,847	£452,986	£466,251	£704,877	**£3,317,784**
Lambeth	£409,498	£670,502	£300,076	£258,347	£78,439	£53,000	£409,498	**£1,769,862**
Nottingham	£147,026	£118,362	£170,008	£219,827	£132,555	£214,173	£93,333	**£1,095,285**
Southend	£118,000	£134,607	£192,143	£257,350	£289,593	£294,894	£328,318	**£1,614,905**
Total	**£3,262,626**	**£3,602,476**	**£3,393,943**	**£3,754,738**	**£2,968,888**	**£2,243,386**	**£2,492,347**	**£21,718,403**

Mapping spend to outcome area at partnership level

During 2022 we worked with the five partnerships to map their project spend (to 31st March 2022) to selected outcomes as far as possible. These include the following selected ABS COuF measures as well as systems change:

- Perinatal maternal mental health – depression and anxiety
- Smoking in pregnancy - smoking status at delivery
- Birth weight
- Gestational age at birth
- Breastfeeding 6-8 weeks
- School Readiness
- Key Stage 1 attainment
- Key Stage 2 attainment
- Healthy weight – reception
- Healthy weight - end of Key Stage 2
- Communication (ASQ)
- Social emotional development (ASQ)
- Child development at age 2 - 21/2 (ASQ)
- Child abuse and neglect - Children aged 0-4 CIN due to abuse or neglect
- Child abuse and neglect - Children aged 0-4 on Child Protection Plan
- A&E attendances and any emergency hospital admissions due to unintentional and deliberate injuries of children 0-4
- Systems change

These outcomes were selected to align with the outcomes being measured through Objectives 1 and 2 of the evaluation.

In addition to the selected outcomes listed above, the partnerships mapped their project spend under a category of 'Other outcomes'. These included some of the ABS Common Outcome Framework measures not selected above, as well as partnership specific outcomes related to children and maternal health and well-being. 'Other outcomes' included:

- Smoking in pregnancy – smoking status at booking
- Smoking in pregnancy – cigarettes smoked per day
- Alcohol use in pregnancy – weekly alcohol units
- Other substance use in pregnancy
- Low birth weight
- Pre-term birth
- Breastfeeding initiation
- Children free from oral decay at age 5
- Child abuse and neglect - Children under 5 Looked after
- Hospital admissions due to unintentional and deliberate injuries of children 0-4

- Social capital
- Improved parental mental health and wellbeing
- Secure attachment to a trusted caregiver
- Improved maternal physical health and nutrition
- More families have strong support networks
- Children have a BMI that's neither high or low
- More survivors of domestic abuse are accessing appropriate specialist support

Each partnership was asked to map their project spend to one or more of the above outcomes[38] based on the outcome measure(s) that each project was trying to change. This included ABS grant and leverage funded revenue and capital spend.

Any remaining 'unmapped' spend was then split by outcome on a pro rata basis. This included:

- Partnership portfolio management costs.
- Central programme expenditure (£2m central programme costs + £14m support and delivery activity = £16m, split evenly across the five partnerships at £3m each).
- Any project spend that could not be mapped to one or a limited number of outcomes (because the project covers all key outcomes or is historic).
- Any leverage that was not allocated to a specific project.

Blackpool

The largest proportion of Blackpool's project spend was allocated to achieving 'System change' (63.0%). At least some of the spend from 26 different projects was mapped to this outcome. The projects contributing the largest amount of spend towards this outcome for Blackpool were 'Family HUB Funding' (all of the project's £12,763,528 spend was allocated to Systems change), followed by 'CAP Community Connector Team' (all of the project's £938,127 spend). Other projects that allocated large amounts to this outcome included 'Early Years Volunteering and Representative Voice' (all of the project's £641,633 spend), 'Capital Parks Development' (£546,566 or 50.0% of the total spend on this project) and 'Workforce Development' (all £373,583 of the total spend on this project).

[38] This includes outcomes being measured through Objectives 1 and 2 of the evaluation, additional ABS Common Outcome Framework measures, as well as partnership specific outcomes related to children and maternal health and well-being.

Table 11. Blackpool spend allocation to outcomes

Outcome	Project spend allocated to outcome	% of total allocated spend	Total spend allocated to outcome
Systems change	£16,860,703	63.0%	£26,843,257
Other outcomes	£1,735,059	6.5%	£2,762,318
Social emotional development (ASQ)	£1,060,035	4.0%	£1,687,639
Child abuse and neglect - Children aged 0-4 CIN due to abuse or neglect	£945,471	3.5%	£1,505,247
Child abuse and neglect - Children aged 0-4 on Child Protection Plan	£882,952	3.3%	£1,405,713
Perinatal maternal mental health – depression and anxiety	£828,641	3.1%	£1,319,246
Child development at age 2 - 21/2 (ASQ)	£633,087	2.4%	£1,007,912
School Readiness	£498,367	1.9%	£793,430
Communication (ASQ)	£488,690	1.8%	£778,024
Birth weight	£427,680	1.6%	£680,893
Gestational age at birth	£427,680	1.6%	£680,893
A&E attendances and any emergency hospital admissions due to unintentional and deliberate injuries of children 0-4	£427,124	1.6%	£680,007
Breastfeeding 6-8 weeks	£403,320	1.5%	£642,111
Smoking in pregnancy - smoking status at delivery	£326,071	1.2%	£519,125
Key Stage 1 attainment	£294,317	1.1%	£468,571
Key Stage 2 attainment	£294,317	1.1%	£468,571
Healthy weight – reception	£123,838	0.5%	£197,157
Healthy weight - end of Key Stage 2	£98,139	0.4%	£156,243
Sub total	**£26,755,490**	**100.0%**	**£42,596,357**
Unmapped project spend	£164,622		
Portfolio management spend	£11,804,154		
Unmapped leverage	£611,475		

Outcome	Project spend allocated to outcome	% of total allocated spend	Total spend allocated to outcome
Central programme, support and delivery activity costs (20% of total)	£3,260,616		
	£42,596,357		

Bradford

The largest proportion of Bradford's project spend was allocated to 'Perinatal maternal mental health – depression and anxiety' (28.7%). In particular, spend from nine projects was mapped to this outcome. The project contributing the largest amount of spend to this outcome was 'SLA Family Action Perinatal Support', with £2,410,898 or 100.0% of the total spend on this project. The projects 'SLA Baby Steps' (£875,265, 100.0%) and 'SLA Little Minds Matter' (£706,270.50, 50.0%) also allocated a large amount of their spend toward this outcome.

The second largest proportion of Bradford's project spend was allocated to the outcome, 'Communication (ASQ)' (21.7%). Seven projects contributed to this outcome. The project contributing most spend to this outcome was 'SLA Incredible Years Parenting Programme' with an allocated spend of £493,543 (or 50.0% of the total spend on this project). The projects 'SLA BSB Imagine' (£326,521, 50.0%) and 'SLA Little Minds Matter' (£211,881, 15.0%) also allocated a considerable amount of spend towards the outcome 'Communication (ASQ)'.

Table 12. Bradford spend allocation to outcomes

Outcome	Project spend allocated to outcome	% of total allocated spend	Total spend allocated to outcome
Perinatal maternal mental health – depression and anxiety	£5,074,591	28.7%	£10,941,398
Communication (ASQ)	£3,842,475	21.7%	£8,284,816
Social emotional development (ASQ)	£1,361,755	7.7%	£2,936,099
Systems change	£1,336,653	7.6%	£2,881,977
Breastfeeding 6-8 weeks	£1,190,100	6.7%	£2,565,992
Other outcomes	£1,101,968	6.2%	£2,375,970
School Readiness	£1,005,029	5.7%	£2,166,957

Outcome	Project spend allocated to outcome	% of total allocated spend	Total spend allocated to outcome
Healthy weight – reception	£948,295	5.4%	£2,044,632
Child abuse and neglect - Children aged 0-4 on Child Protection Plan	£531,382	3.0%	£1,145,720
Child abuse and neglect - Children aged 0-4 CIN due to abuse or neglect	£531,381	3.0%	£1,145,718
Smoking in pregnancy - smoking status at delivery	£168,057	0.9%	£362,351
Birth weight	£168,057	0.9%	£362,351
Gestational age at birth	£168,057	0.9%	£362,351
Child development at age 2 - 21/2 (ASQ)	£166,411	0.9%	£358,801
A&E attendances and any emergency hospital admissions due to unintentional and deliberate injuries of children 0-4	£101,641	0.6%	£219,150
Key Stage 1 attainment	£0	0.0%	£0
Key Stage 2 attainment	£0	0.0%	£0
Healthy weight - end of Key Stage 2	£0	0.0%	£0
Sub total	**£17,695,853**	**100.0%**	**£38,154,284**
Unmapped project spend	£8,973,043		
Portfolio management spend	£7,553,011		
Unmapped leverage	£671,760		
Central programme, support and delivery activity costs (20% of total)	£3,260,616		
	£38,154,284		

Lambeth
Lambeth allocated most of their project spend to 'Other outcomes' (£11,873,490 or 65.9%). These included:

- 'Social capital', which accounted for £2,110,676 or 17.8% of the total project spend allocated to 'Other outcomes'.

As well as ABS COF measures such as:

- ‘Breastfeeding initiation,’ which accounted for £613,385 or 5.2% of the total project spend allocated to ‘Other outcomes’.
- ‘Pre-term birth’ which accounted for £454,069 or 3.8% of the total project spend allocated to ‘Other outcomes’.
- ‘Hospital admissions due to unintentional and deliberate injuries of children 0-4’, which accounted for £100,955 or 0.9% of the total project spend allocated to ‘Other outcomes’.

The remaining £8,594,405 or 72.3% of the total project spend allocated to ‘Other outcomes’ was allocated to six different parent or child level outcomes, including ‘Improved parental mental health and wellbeing’, ‘Secure attachment to a trusted caregiver’, ‘Improved maternal physical health and nutrition’, ‘More families have strong support networks’, ‘Children have a BMI that's neither high or low’ and ‘More survivors of domestic abuse are accessing appropriate specialist support’. However, in many cases the totals were combined so it was not possible to disaggregate spend across these remaining ‘Other outcomes’.

At least some of the spend from seven different projects was mapped to ‘Social capital’. The projects contributing the most to this outcome were ‘Community Engagement’ and ‘Parent Champions’ contributing £739,031 and £596,065 respectively (or 50.0% of total spend for each project).

The second largest proportion of Lambeth’s project spend was allocated to the outcome, ‘Child development at age 2 - 21/2 (ASQ)’ (10.6%). Five projects contributed spend towards this outcome. The project contributing the most towards this outcome was ‘Making It REAL/ Sharing REAL with Parents’ with an allocated spend of £847,974 (or 96.1% of the total spend on this project), followed by ‘Overcrowded Housing’ (all £475,002 of this project’s spend was allocated to this outcome).

Table 13. Lambeth spend allocation to outcomes

Outcome	Amount of project spend allocated to outcome	% of total allocated to outcome	Total spend allocated to outcome
Other outcomes	£11,873,490	65.9%	£23,124,575
Child development at age 2 - 21/2 (ASQ)	£1,906,986	10.6%	£3,714,008
Communication (ASQ)	£1,447,218	8.0%	£2,818,573
Systems change	£1,430,268	7.9%	£2,785,563
Birth weight	£559,876	3.1%	£1,090,404
Breastfeeding 6-8 weeks	£339,929	1.9%	£662,038
Smoking in pregnancy - smoking status at delivery	£136,845	0.8%	£266,517

Outcome	Amount of project spend allocated to outcome	% of total allocated to outcome	Total spend allocated to outcome
Social emotional development (ASQ)	£114,794	0.6%	£223,571
Child abuse and neglect - Children aged 0-4 CIN due to abuse or neglect	£100,955	0.6%	£196,618
Child abuse and neglect - Children aged 0-4 on Child Protection Plan	£100,955	0.6%	£196,618
Perinatal maternal mental health – depression and anxiety	£0	0.0%	£0
Gestational age at birth	£0	0.0%	£0
School Readiness	£0	0.0%	£0
Key Stage 1 attainment	£0	0.0%	£0
Key Stage 2 attainment	£0	0.0%	£0
Healthy weight – reception	£0	0.0%	£0
Healthy weight - end of Key Stage 2	£0	0.0%	£0
A&E attendances and any emergency hospital admissions due to unintentional and deliberate injuries of children 0-4	£0	0.0%	£0
Column total	**£18,011,317**	**100.0%**	**£35,078,484**
Unmapped project spend	£7,589,368		
Portfolio management spend	£6,217,184		
Unmapped leverage	£0		
Central programme, support and delivery activity costs (20% of total)	£3,260,616		
	£35,078,484		

Nottingham

The largest proportion of Nottingham's project spend was allocated to achieving 'System change' (34.8%). In particular 13 projects allocated spend to this outcome. The projects contributing the largest amounts to this outcome were 'Specialist Delivery and Supervision Team' with an allocated spend of £3,927,663 (or 100.0% of the total spend on this project), followed by 'Programme Evaluation & Learning' (£900,964, 96.9%). Other projects that

allocated a large amount of spend towards this outcome included 'Community Voice, Community Connections' (£491,675, 100.0%) and 'Programme Communications & Marketing' (£442,168, 91.8%).

The second largest proportion of Nottingham's project spend was allocated to 'School Readiness' (18.1%). Among the 13 projects that contributed to this outcome, the 'Family Mentoring' project contributed the most (£2,595,485 or 25.0% of the total spend on this project). Other projects that allocated a large amount of their spend towards 'School Readiness' included 'Book Gifting' (£484,281, 100.0%) and the 'Innovation Fund' (£393,693, 91.6%).

Table 14. Nottingham spend allocation to outcomes

Outcome	Amount of project spend allocated to outcome	% of total allocated to outcome	Total spend allocated to outcome
Systems change	£7,456,751	34.8%	£10,083,304
School Readiness	£3,879,691	18.1%	£5,246,267
Communication (ASQ)	£2,092,899	9.8%	£2,830,099
Social emotional development (ASQ)	£2,092,899	9.8%	£2,830,099
Child development at age 2 - 21/2 (ASQ)	£2,084,378	9.7%	£2,818,576
Healthy weight – reception	£1,038,194	4.8%	£1,403,886
Healthy weight - end of Key Stage 2	£1,038,194	4.8%	£1,403,886
Other outcomes	£809,857	3.8%	£1,095,120
Breastfeeding 6-8 weeks	£275,512	1.3%	£372,557
Perinatal maternal mental health – depression and anxiety	£271,244	1.3%	£366,786
A&E attendances and any emergency hospital admissions due to unintentional and deliberate injuries of children 0-4	£243,330	1.1%	£329,040
Child abuse and neglect - Children aged 0-4 CIN due to abuse or neglect	£76,437	0.4%	£103,361
Child abuse and neglect - Children aged 0-4 on Child Protection Plan	£76,437	0.4%	£103,361
Smoking in pregnancy - smoking status at delivery	£2,462	0.0%	£3,329
Birth weight	£0	0.0%	£0

Outcome	Amount of project spend allocated to outcome	% of total allocated to outcome	Total spend allocated to outcome
Gestational age at birth	£0	0.0%	£0
Key Stage 1 attainment	£0	0.0%	£0
Key Stage 2 attainment	£0	0.0%	£0
Column total	**£21,438,285**	**100.0%**	**£28,989,670**
Unmapped project spend	£6,340		
Portfolio management spend	£3,189,144		
Central programme, support and delivery activity costs (20% of total)	£3,260,616		
Total	**£28,989,670**		

Southend

The largest proportion of Southend's project spend was allocated to 'Communication (ASQ)' (23.9%). In particular, 14 projects mapped their spend towards this outcome. The project contributing the largest amount to 'Communication (ASQ)' was 'Let's Talk' with an allocated spend of £1,750,000 (87.4% of the total spend on this project). The project 'Fathers Reading Every Day' allocated £131,140, or 56.7% of its total spend, and 'EPEC Baby & Us/Being a Parent' contributed £75,000 (23.1%).

A substantial proportion of Southend's project spend was also allocated to 'Perinatal maternal mental health – depression and anxiety' (21.6%). Among the 13 projects that contributed to this outcome, the project 'Family nurse partnership' contributed the largest amount (£1,000,000, or 55.9% of the total spend on this project). The projects 'Perinatal Mental Health' (£300,934, 100.0%) and '121 breastfeeding' (£100,530, 22.3%) were also substantial contributors to this outcome.

A considerable proportion of Southend's project spend was also allocated to 'Breastfeeding 6-8 weeks' (14.4%). Nine projects contributed to this outcome. The project contributing the most was 'Family nurse partnership' with an allocated spend of £600,000 or 33.6% of the total spend on this project. The projects '121 breastfeeding' (£300,000, 66.6%) and 'Group breastfeeding' (£220,000, 57.9%) also allocated a large amount of their spend toward this outcome.

The outcome 'Systems change' was allocated 13.1% of the total project spend in Southend. Among the 18 projects that mapped their spend to this outcome, the project 'Co-production champion' contributed the most spend (£350,000,

75.3% of the total spend on this project), followed by 'Let's talk' (£201,697, 10.1%). In addition, the projects 'Engagement' and 'Work skills' also allocated £200,000 each towards this outcome (or 44.3% and 54.9% of the total spend on these projects respectively).

Table 15. Southend spend allocation to outcomes

Outcome	Project spend allocated to outcome	% of total allocated spend	Total spend allocated to outcome
Communication (ASQ)	£2,195,390	23.9%	£5,888,322
Perinatal maternal mental health – depression and anxiety	£1,984,464	21.6%	£5,322,590
Breastfeeding 6-8 weeks	£1,322,784	14.4%	£3,547,879
Systems change	£1,200,071	13.1%	£3,218,745
Healthy weight – reception	£796,293	8.7%	£2,135,763
Other outcomes	£744,931	8.1%	£1,998,003
Social emotional development (ASQ)	£651,620	7.1%	£1,747,731
Child development at age 2 - 21/2 (ASQ)	£231,346	2.5%	£620,501
Smoking in pregnancy - smoking status at delivery	£20,000	0.2%	£53,643
Child abuse and neglect - Children aged 0-4 CIN due to abuse or neglect	£12,000	0.1%	£32,186
School Readiness	£10,000	0.1%	£26,821
Child abuse and neglect - Children aged 0-4 on Child Protection Plan	£5,000	0.1%	£13,411
Birth weight	£0	0.0%	£0
Gestational age at birth	£0	0.0%	£0
Key Stage 1 attainment	£0	0.0%	£0
Key Stage 2 attainment	£0	0.0%	£0
Healthy weight - end of Key Stage 2	£0	0.0%	£0
A&E attendances and any emergency hospital admissions due to unintentional and deliberate injuries of children 0-4	£0	0.0%	£0
Sub total	**£9,173,900**	**100.0%**	**£24,605,593**
Unmapped project spend	£3,712,985		

Outcome	Project spend allocated to outcome	% of total allocated spend	Total spend allocated to outcome
Portfolio management spend	£6,843,187		
Unmapped leverage	£1,614,905		
Central programme, support and delivery activity costs (20% of total)	£3,260,616		
	£24,605,593		

9.4 Next steps

WP 4.1: Calculating costs

We will build on the analysis of costs above updating the figures annually for the remainder of the evaluation period based on annual spend data shared by The Fund (in June each year).

WP 4.2: Calculating short-term effects

The Fund is currently undertaking an exercise to collate and validate output data from each of the partnerships for the period 1st April 2015 to 31st March 2022, with data for 1st April 2022 to 31st March 2023 to be collected in May 2023. It is agreed that the ABS national evaluation team will use this validated dataset to inform our analysis of the effectiveness of ABS in terms of its contribution to achieving short-term effects. The Fund will share this data with the ABS national evaluation team in June 2023 and provide annual updates thereafter for the rest of the evaluation period.

It is important to note that data submissions for the period 1st April 2015 to 31st March 2018 predate the agreement of a consistent template and definitions. Our main concern is that beneficiary numbers reported for this period may not be unique. However, the scale of double counting is unknown. Therefore, data will be treated with caution for this period.

After 1st April 2018 data has been submitted using a consistent template and agreed definitions. However, there are gaps in some annual outcome data (e.g. EYFS data). The partnerships are in discussion about how best to address these gaps.

Partnerships report data on workforce training events and volunteer training to The Fund on a quarterly basis. Therefore, there is potential for double counting of this data. RSM will work with The Fund to agree how best to treat this data to minimise the impact of double counting.

WP 4.3: Calculating benefits

WP 4.3 will be based on the evidence collected through:

- Objective 1 to identify the positive outcomes achieved and negative outcomes avoided as a result of the ABS programme (analysis based on individual and ward level data in 2025).
- Objective 2 to measure partnerships' perceptions of Systems change resulting from the approaches ABS partnerships have taken to enable Systems change. This is likely to be a qualitative assessment given the complex and multifaceted nature of Systems change.

WP 4.4: Calculating impact of ABS on public sector activity and spend relating to primary school aged children

We have undertaken a review of existing economic studies of the impact of Early Years interventions on public sector spending in relation to those children during their primary school years. We are currently developing a schematic to identify gaps in that evidence base. We will supplement gaps in the existing evidence base with a series of interviews with practitioners (in Summer 2023 with follow up interviews 2024 if required) to explore how a change in outcome will impact public sector activity in terms of time and resources.

WP 4.5: Assessing cost-effectiveness (based on individual and ward level data in 2025)

We will use the analysis from WP 4.1-4.4 of Objective 4 to produce outputs, which will be of use to The Fund, the partnerships and other local commissioners and stakeholders, particularly as the partnerships progress their sustainability plans (e.g. cost-consequence summary tables, unit cost benchmarks and, where possible, breakeven analysis).

10 Summary and next steps

In summary, we made substantial progress against the four objectives in the national evaluation in 2022 and are excited by the findings to date.

As highlighted in the introduction of this report, the evaluation aims to be both formative and summative. This report presents insights which can be applied to inform the ongoing delivery of ABS, Early Years, and complex, large scale evaluation.

The connections between objectives are of particular interest, and something that we look forward to exploring further as the evaluation progresses and we continue to build the mosaic of evidence.

In looking at the relationship between Objective 1 and Objective 4, there are differences in how activities and spend are allocated against outcomes. The activity mapping in Objective 1 show that, on the whole, the two outcomes with the most activity are communication and language, school readiness, and perinatal mental health; however the data on spend do not always follow these same trends. This is an area that we can explore further as we understand ABS implementation through Objective 2 – particularly, in how outcomes are understood, conceptually and practically, by ABS partners and how services are operationalised to impact on them.

The findings from Objective 2 and Objective 3 triangulate each other well. Together they show how ABS partnerships are implementing mechanisms to influence outcomes and how families experience those outcomes. Two examples of this in the data are in the relational ways of working and the accessibility of services. Findings from objective two provide insight into how ABS services are designed and delivered to foster these key mechanisms and the findings in Objective 3 are promising in that families both recognise and value these elements of ABS. We are also able to see how the challenges and complexities of families' lives and circumstances in objective 3 play out in ABS delivery and outcomes in objective 2. Those combined perspectives offer depth to the findings for Objectives 1 and 4 and will continue to as the evaluation progresses.

For ABS partnerships, the findings provide opportunities to celebrate achievements of ABS to date and areas to reflect on for ongoing improvement and attention. Partnerships can reflect on the extent that spend is proportionate to their priorities for ABS. As ABS is entering into its final third of delivery, concern from delivery partners and parents about the ABS concluding should be listened to and considered by ABS partnerships. The will further ABS's contribution towards systems change.

For practitioners, service commissioners, and policy makers in the Early Years sector, the findings to date highlight elements of service design and

practice that are perceived to having a positive influence on enabling engagement and outcomes. We encourage practitioners, services commissioners, and policy makers within ABS partnerships and beyond to reflect on their own practices in line with the findings to identify ways in which they can improve their offer to families and young children. Additionally, by naming challenges associated with delivery and the impact they have on outcomes, this report highlights areas that warrant attention across the Early Years sector.

For parents and carers, this report demonstrates value of parents working together with ABS service and the difference that makes on family life. The findings in this report highlight the range of family contexts, experiences, and ambitions of those involved in ABS services. This report presents these voices and experiences with the aim that they can inform our understanding of impact of ABS and to ongoing delivery of Early Years services.

For those with an interest in the mechanics of large-scale, complex evaluation work, this report demonstrates how different evaluation teams and objectives can work collaboratively to develop a comprehensive and inclusive narrative of ABS's contribution to child outcomes. The detail provided in the methods sections within each objective provide insights into the practicalities and theoretical underpinnings of this evaluation and chart how the evaluation as shifted along with evolving delivery contexts and to overcome challenges. We hope that the ABS national evaluation can serve as an example of complex, large scale evaluation design.

Next steps

Detailed next steps are provided in each of the objectives' respective chapters. These include immediate actions for progressing their workplans and ways in which methodologies are being adapted to continue to generate the most meaningful and relevant evidence to answer the key evaluation questions. For an intervention and evaluation of this scale and complexity, it essential to pause, take stock, and adjust where required. An update protocol will be the published in Spring 2023 that will reflect all adjustments to the evaluation design and plans moving forward.

As the 2022 theme for year of the evaluation was 'place-based approaches', the theme for 2023 will be 'parental engagement'. By exploring this theme through the evaluation, particularly in Objectives 2 and 3, we will generate evidence about the full spectrum of how parents engage with ABS. This will include, but won't be limited to, how parents are involved in co-production of ABS services.

11 References

Befani, B., D'Errico, S., Booker, F., and Guiliani, A. (2016) Clearing the fog: new tolls for improving the credibility of impact claims. London, England: International Institute for Environment and Development.

Befani, B. and Mayne, J. (2014) Process Tracing and Contribution Analysis: A Combined Approach to Generative Causal Inference for Impact Evaluation. IDS Bulletin Volume 45 Number 6

Buck, N., McFall, S. (2011) Understanding Society: design overview. Longitudinal and Life Course Studies, [S.l.], Volume 3, Issue 1, pp. 5 -17

Connelly, R., Platt, L. (2014) Cohort Profile: UK Millennium Cohort Study (MCS), International Journal of Epidemiology, Volume 43, Issue 6, pp.1719 – 1725.

HM Treasury (2020) Magenta Book Annex A: Analytical methods for use within an evaluation London: HM Treasury.

Hope, S., Deighton, J., Micali, N., and Law, C. (2019). Maternal mental health and childhood injury: evidence from the UK Millennium Cohort Study. Archives of disease in childhood, 104(3), 268–274.

Jones, KC. and Burns, A. (2021) Unit Costs of Health and Social Care 2021. Unit Costs of Health and Social Care. Personal Social Services Research Unit, Kent, UK

Mayne, J. (2011) 'Contribution Analysis: Addressing Cause and Effect' in K. Forss, M. Marra and R. Schwartz (eds.) Evaluating the Complex, Piscataway: Transaction Publishers

Mayne, J. (2012) Making causal claims. ILAC Brief.

Mayne, J. (2019) 'Revisiting Contribution Analysis' Canadian Journal of Program Evaluation, 34(2), pp. 171-191.

Mensah, F. and Kiernan, K., (2010) Parents' mental health and children's cognitive and social development, Social Psychiatry and Psychiatric Epidemiology.

Raynor, P., Born in Bradford Collaborative Group. (2008) Born in Bradford, a cohort study of babies born in Bradford, and their parents: Protocol for the recruitment phase. BMC Public Health 8, 327

Ritchie, J., Lewis, J., McNaughton Nicholls, C., and Ormston, R. eds. (2014). Qualitative Research Practice. London, England: Sage.

Appendix 1: Objective 1 Area-level matching using the Index of Multiple Deprivation

For each partnership, the wards in ABS LAs are shown in yellow and orange on the right of each figure, and all wards in the rest of England are shown on the left, with those selected as a match in purple. The more horizontal the line, the more closely the comparison area resembles the ABS area in terms of this covariate. We can see that matches on this particular covariate are close in Lambeth, and somewhat more distant in Blackpool.

Figure 11. visualisation of area-level matching for one covariate

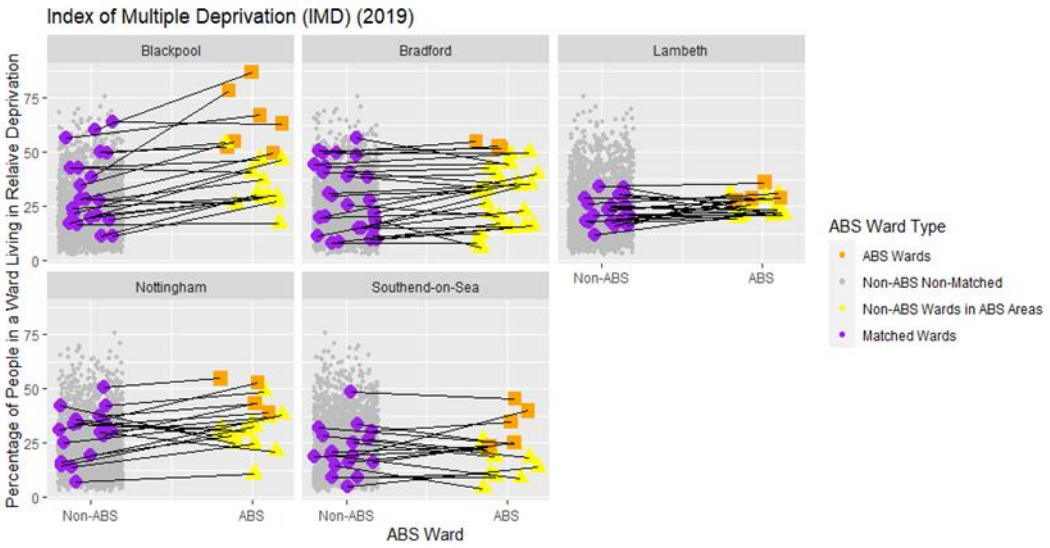
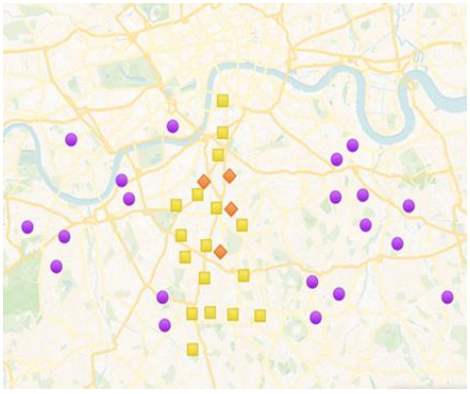


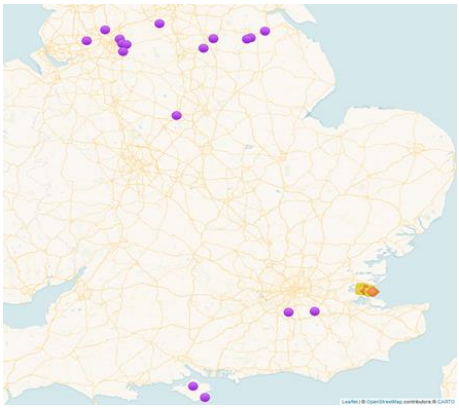
Figure 12. ABS wards and matched wards

Lambeth



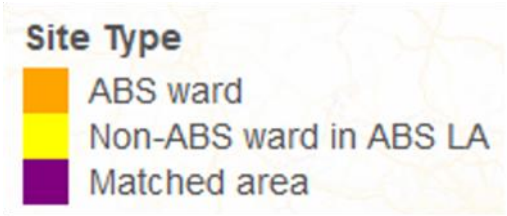
Bradford

Southend



Nottingham

Blackpool



Appendix 2: Objective 3 evaluation questions

The focused evaluation questions underpinning Objective 3 are as follows:

1. What is the nature of families' engagement with ABS, and how is this situated within the wider context of lives over time?
2. What do families understand as the key motivators and facilitators for, and benefits from, participating in ABS provision and activities, including in relation to the four core outcome domains?
3. What are the barriers, challenges, and limitations of ABS from families' perspectives?
4. How does experience of ABS services directly or indirectly shape family members' individual and collective practices in relation to the four outcome domains?
    a. To what extent, and in what ways, are families' regular, everyday and habitual practices shaped by involvement with ABS over time?
    b. To what extent are practices maintained or developed over time, and what is associated with development, maintenance or attenuation of practices relating to the four outcome domains?
5. What are the implications for families of ABS work on systems change, including: experiences of formal/informal support and professional involvement in family lives, to illuminate the difference that ABS systems change has made to their experiences of services and/or professional involvement in family lives?
    a. Experiences of parent/carer or family members' involvement in ABS work on systems change, and understandings of the implications of this involvement for (a) family lives and (b) for local systems?
6. Which factors correspond to variation between families in experiences and pathways through ABS, including: the extent and timing of engagement with ABS and the nature of services that are/are not used?
    a. The implications for children of variations in involvement in ABS, particularly with regard to outcome domains concerned with child development?

Full answers to these questions will be established over time, as interviews with families will be conducted at regular intervals over a four-year period.

Delivered by

NatCen
Social Research that works for society