



The Warwick Consortium Evaluation

# A Better Start Implementation Evaluation Workstream Report 3 - Transitioning Into Early Delivery

May 2018

Emily Smith, Anita Schrader-McMillan,  
Geoff Lindsay, Jane Barlow

Warwick Medical School, University of Warwick

Department for Evidence-based Intervention  
and Policy Evaluation, University of Oxford

CEDAR, University of Warwick

Warwick  
Consortium



NATIONAL  
LOTTERY FUNDED

## Acknowledgements

The authors of this report would like to thank the interviewees and local ABS team members for their participation in the evaluation process.

Emily Smith would also like to acknowledge that she holds an NIHR-funded Academic Clinical Fellowship at Warwick Medical School. The views expressed in this report are those of the authors and do not represent those of NIHR, the NHS or the Department of Health.

# Table of Contents

---

<b>Executive Summary .....</b>	<b>1</b>
<b>1.0 Introduction .....</b>	<b>4</b>
1.1 Fulfilling Lives: A Better Start.....	4
1.2 Evaluation Approach .....	5
1.3 Implementation evaluation: overall approach.....	5
1.4 Focus of the implementation evaluation of the early delivery phase	6
<b>2.0 Method .....</b>	<b>7</b>
2.1 Evaluation of system level and organisational change.....	7
2.2 Service mapping .....	8
<b>3.0 Results .....</b>	<b>9</b>
3.1 Obtaining explicit buy in from critical stakeholders and fostering a supporting community/organizational climate.....	9
3.2 Building general/organisational capacity .....	21
3.3 Staff recruitment/maintenance, pre-innovation training and creation of an implementation team .....	23
3.4 Developing an implementation plan.....	24
3.5 Technical assistance/coaching/supervision .....	38
3.6 Process evaluation and supportive feedback mechanism .....	39
3.7 Limitations.....	41
<b>4.0 Conclusions.....</b>	<b>42</b>
<b>Appendices.....</b>	<b>43</b>

## List of figures

Figure 1: Relating the Quality Implementation Framework (Meyers, 2012) to our implementation evaluation .....	5
Figure 2: The three levels of implementation encompassed in the evaluation.....	6
Figure 3: Roles of local ABS staff interviewed for third implementation evaluation report	9

## List of tables

Table 1: Challenges of working with partner organisations .....	10
---	----

Table 2: Approaches taken by local teams to developing relationships with partner organisations at a senior level .....	11
Table 3: Strategies for engaging frontline workforce with ABS goals.....	14
Table 4: Examples of types of engagement activities .....	15
Table 5: Facilitators of connectivity at practitioner level .....	18
Table 6: Facilitators of connectivity at provider level.....	19
Table 7: Facilitators of connectivity at commissioner level.....	19
Table 8: Barriers to connectivity at practitioner level.....	19
Table 9: Barriers to connectivity at provider level.....	20
Table 10: Barriers to connectivity of commissioner level.....	20
Table 11: Examples of kinds of governance reviews undertaken locally .....	21
Table 12: Approaches to community representation within local ABS governance structures	22
Table 13: ABS services in Blackpool.....	26
Table 14: ABS services in Bradford.....	28
Table 15: ABS services in Lambeth.....	29
Table 16: ABS services in Nottingham .....	30
Table 17: ABS services in Southend .....	31
Table 18: Types of services in delivery as of January 2017 .....	31
Table 19: Services in delivery as of January 2017, categorised by whether they were introduced by ABS .....	32
Table 20: Type of evidence available for services in active delivery as of January 2017	33
Table 21: Additional ABS programmes in delivery in Blackpool.....	35
Table 22: Additional ABS programmes in delivery in Bradford.....	35
Table 23: Additional ABS programmes in delivery in Lambeth .....	36
Table 24: Additional ABS programmes in delivery in Nottingham.....	36
Table 25: Additional ABS programmes in delivery in Southend.....	36

# Executive Summary

---

The Big Lottery Fund has committed to invest £215 million over 10 years (2015 to 2025) in *A Better Start* which aims 'to deliver a step change in the use of preventative approaches for babies and children from pregnancy to three years of age. It is being implemented in five selected areas of England: Blackpool, Bradford, Lambeth, Nottingham, and Southend. Each *A Better Start* area comprises specific wards with a population of 30,000 to 70,000 people where there is evidence of deprivation and high levels of need among children.

This is the third report of the implementation evaluation of *A Better Start*. Report 1 focused on the evaluation of the bid development phase, which led to the five areas being selected to be part of *A Better Start*. Report 2 had a focus on the grant set up phase. This Report 3 examines system level and organisational change that had occurred in the transition period from set up to early delivery. A detailed mapping of the nature of the services and work programmes that were live in the sites at the time of the third evaluation is also examined. The report draws on information gathered from semi-structured interviews and service mapping which occurred between November 2016 and March 2017. The key findings are summarised below.

## “Obtaining explicit buy-in” (Meyers, 2012)

The need to develop strong partnership with both public sector and other voluntary organisations locally was identified, specifically:

- Leadership with decision-making powers in the organization/community
  - ▶ Senior leadership across partnerships had bought into the shared aim of ABS as a long-term programme that was going to shift the emphasis toward prevention;
  - ▶ A number of challenges were identified including: understanding of ABS vision but not approach; unrealistic expectations; long lead-in time;
  - ▶ Partnerships required ongoing work and approaches including both formal mechanisms and strategic decisions about the position of ABS within the local early years ecosystem (e.g. developing open and honest relationship to facilitate constructive dialogue; positioning of ABS as somewhere to test new ideas and approaches; offering tangible system wide benefits; acting as an 'enabler' for system wide projects such as shared IT; representing a beacon of good practice; using service design approach to engage partners);
  - ▶ Current external financial pressures have added to tension due to reliance of ABS on wider infrastructure, and disparity of funding, creating tensions;
  - ▶ Over time, ABS may come to represent a platform for advocating for high quality, preventive early years services.
- Frontline staff
  - ▶ Importance of engaging frontline staff recognised and of changing working culture, which was seen to be a challenge;
  - ▶ Strategies included offering common training programmes; engaging frontline professionals with the service design approach; funding the employment of workforce development practitioners; embedding of core ABS team members into partner organisation; development of a new workforce.
- The local community

- ▶ Engagement covers a spectrum of activities including: involvement in governance structures; co-production of services; participatory-budgeting type programmes; involvements as volunteers/paid staff; consultation and representation;
- ▶ Training is needed to enhance confidence and enable contributions;
- ▶ There continues to be a need for additional strategies for 'hard to reach' groups.

### **“Building general/organisational capacity” (Meyers, 2012)**

- The transition from set-up to delivery has involved all sites reviewing their governance structures including reviews of entire governance structure through to reviews of the role of community representatives within the overall structure, and also at a strategic level;
- Ensuring adequate operational decision-makers has taken different forms in each site (e.g. maintenance of separate formal board comprising operational leads from strategic partners; use of thematic groups based on outcomes and involving senior operation leaders with frontline workforce and community members).
- Community representation within governance
  - ▶ Varied approaches to representation;
  - ▶ Large representation increases potential for tensions around decision-making;
  - ▶ Formal and informal training is seen as beneficial but may result in loss of some of the distinctiveness of the community's voice.

### **“Staff recruitment/maintenance” (Meyers, 2012)**

- Make-up of core ABS teams has changed since the set-up phase;
- Most sites struggled to recruit to at least one position;
- Difficulties of recruitment due in part to the different way of working required by ABS;
- Support with tasks such as communications has often had to be developed in-house due to the differences between the standard and the ABS approach.

### **“Developing an implementation plan” (Meyers, 2012)**

- Service design model viewed positively across the board despite process being lengthy;
- All have services in delivery; there are more universal than targeted services at most sites; all sites have new services in delivery in addition to enhancing/modifying pre-existing services; all sites are using evidence/science-based programmes; all sites have undertaken modifications to programmes already in existence in their areas;
- In addition to services, all sites have workforce development programmes for the wider early years workforce; 3 have programmes with potential to deliver capital investment; 3 sites have planned communications or educational campaigns; 3 sites have services focussed on social determinants of health;
- All sites have dropped services that were originally planned. Reasons for this include having too many services for the commissioning process to be managed effectively by local ABS; service incorporated into or replaced by another service that is more effective; service was decommissioned by another commissioner.

## “Technical assistance/coaching supervision” (Meyers, 2012)

- Support and advice from BLF greatly appreciated (e.g. training to core staff in service design; performance monitoring with feedback; professional development and learning opportunities; commissioning of specific pieces of work; development of communities of practice).

## “Process evaluation and supportive feedback” (Meyers, 2012)

- Data:
  - ▶ Different approaches to data collection and sharing across the sites, partly due to status as service commissioner or provider;
  - ▶ Gaining access to data from partners has been challenging including development of data infrastructure and data sharing agreements;
  - ▶ A further challenge was coaching and supporting wider frontline workforce in inputting accurate data;
  - ▶ Sites have had to adapt evaluation methods to better fit their local communities.
- Evaluation approaches:
  - ▶ Most sites aiming to undertake short- and long-term evaluations to help inform test and learn approach; and to compare with in other non-ABS wards;

On the basis of the evidence at the time of interviews (March 2017) in most of the sites, the transition from set-up phase into delivery of services is proceeding in a manner that fits with the ABS ethos of delivering evidence- and science-based services, co-produced with local communities and with an evaluation framework that should enable a culture of test-and-learn to become embedded. In one of the sites, this process is not as advanced as the others; however, the benefit of a lengthy period of funding, such as is the case with ABS, is that it allows time for a site to address areas that may require more work.

# 1.0 Introduction

---

## 1.1 Fulfilling Lives: A Better Start

Fulfilling Lives: A Better Start (referred to in this document as A Better Start or ABS) is a 10 year programme funded by Big Lottery Fund (BLF) from 2015-2025 (Big Lottery Fund, n.d.), which is operating in 5 areas of the UK. The five areas are Blackpool, Bradford, Lambeth, Nottingham and Southend.

The aim of this programme is to improve outcomes for children living in targeted wards in each area through an emphasis on prevention during pregnancy and the early years, with a particular focus on children aged 0-4 years. The areas that the programme targets are:

1. “Social and emotional development – preventing harm before it happens (including abuse and/or safeguarding, neglect, perinatal mental health and domestic violence) as well as those that promote good attunement and attachment;”(Evaluation, unknown)
2. “Speech and language development – developing skills in parents to talk, read and sing to, and particularly to praise – their babies and toddlers and to ensure local childcare services emphasise language development;” (Warwick Consortium, n.d.)
3. “Nutrition – starting out by encouraging breast-feeding and promoting good nutritional practices.” (Warwick Consortium, n.d.)
4. System change: “By the end of the 10 year period all local health, public services and voluntary sector will prioritise the healthy development in pregnancy and the first years of a child’s life.” (Big Lottery Fund, 2014)

Each site has been given a share of £215 million over the course of the programme to use in a number of target wards (Big Lottery Fund, n.d.). For each site, the target wards are:

- Blackpool: Bloomfield, Brunswick, Claremont, Clifton, Park, Talbot and Victoria
- Bradford: Bowling and Barkerend, Bradford Moor and Little Horton
- Lambeth: Coldharbour, Stockwell, Tulse Hill and Vassall
- Nottingham: Arboretum, Aspley, Bulwell and St Anns
- Southend: Westborough, Victoria, Milton, Kursaal, West Shoebury and Shoeburyness

Each site has a voluntary, community and social enterprise (VCSE) organisation leading the programme in that area. The five lead organisations are (Big Lottery Fund, n.d.):

- Blackpool: NSPCC
- Bradford: Bradford Trident
- Lambeth: National Children’s Bureau (NCB)
- Nottingham: Nottingham CityCare
- Southend: Pre-school Learning Alliance

## 1.2 Evaluation Approach

A Better Start will be closely evaluated for evidence of its effectiveness. The evaluation is being undertaken by the Warwick Consortium, which is a group of researchers affiliated to a range of institutions (the Universities of Warwick, Oxford, Imperial, King's College London, Glasgow, and Durham; Ipsos MORI; Bryson Purdon Social Research; and ECORYS). The team are taking a mixed methods approach to the evaluation, which has 3 components: the implementation evaluation, the impact evaluation and the dissemination of learning from the programme. This report forms part of the implementation evaluation, which seeks to understand how change is achieved; the impact evaluation will involve an analysis of the cost-effectiveness as well as a cohort study to examine outcomes for children in the intervention sites, and the dissemination strand will collate and distribute the outputs of the implementation and impact evaluations.

## 1.3 Implementation evaluation: overall approach

The research questions that the implementation evaluation aims to answer overall are listed below (Warwick Consortium, 2016):

1. "Which ABS service configurations are associated with better outcomes for children?"
2. "What CMO (context; mechanism; outcome) trajectories were identifiable across the ABS sites?"
3. "Is the system change identified above associated with improved outcomes for children and parents?"

The implementation evaluation process is structured into two phases, phase 1 and phase 2. These phases relate to the timeline of process involved in an implementation process. This has been discussed in previous implementation evaluations, but is reproduced here, in adapted form, for reference in figure 1. The full list of steps in the framework is contained in Appendix 1.

**Figure 1: Relating the Quality Implementation Framework (Meyers, 2012) to our implementation evaluation**

Quality Implementation Framework	Phases of our implementation evaluation
1. Initial consideration of the host setting	Phase 1
2. Creating a structure for implementation	
3. Ongoing structure once implementation is underway	Phase 2
4. Improving further application	

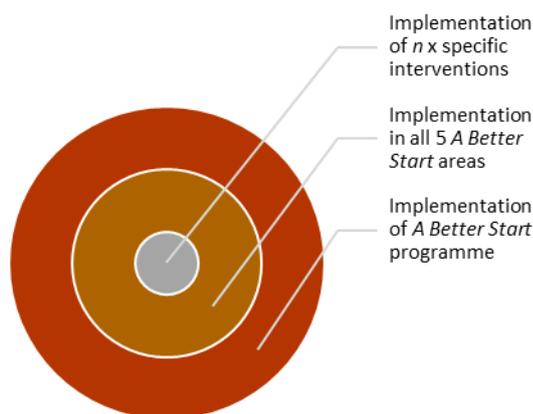
Source: Based on a figure from Warwick Consortium: A Better Start Evaluation Implementation Workstream Report 1. Learning from the bid development phase (Cullen, 2016a), which is based on Warwick Consortium: Fulfilling Lives: A Better Start evaluation and learning contract bid

Reports 1 and 2 (Cullen, 2016a; Cullen 2016b) focussed on phase 1 of the evaluation. They examined the bid development phase and the set-up phase in sites. This report, which is the third implementation evaluation report, also fits into phase 1 of the implementation evaluation, where the focus is on the set-up phases of the sites, with some overlap with point 3, “ongoing structure once implementation is underway” (Meyers, 2012), as sites were starting to have multiple services in delivery at the time of the evaluation. It looks at the transition from set-up into early delivery, and the planned management of the move from initial delivery of a partial range of services to delivery of a full range of services by individual sites.

## 1.4 Focus of the implementation evaluation of the early delivery phase

This report focuses on the evaluation of the transition phase in each site. It seeks to consider this process in the wider context of the three levels of “implementation” that are simultaneously taking place: implementation of the A Better Start programme approach by BLF, the development of the organisational-level structures and capacities in each of the five sites, and the implementation of individual services and work programmes by each site. Figure 2, taken from the first implementation evaluation report, shows these multiple levels and is reproduced here again for reference (Cullen, 2016a):

**Figure 2: The three levels of implementation encompassed in the evaluation**



Source: Based on a figure from from Warwick Consortium: A Better Start Evaluation Implementation Workstream Report 1. Learning from the bid development phase (Cullen, 2016a)

The research question objectives that guide phase 1 of the implementation evaluation and this implementation evaluation report reflect those outlined in the revised implementation evaluation protocol (Warwick Consortium, 2016):

1. “What system change has been implemented in each of the 5 ABS sites?”
2. “What processes were implemented in order to a) set up and; b) maintain the programme of services in each site?”
3. “Is the system change identified above associated with improved outcomes for children and parents?”

## 2.0 Method

---

The implementation team took a mixed methods approach to this piece of work, consistent with the first two reports and the implementation evaluation protocol.

There were two component parts to this third evaluation:

1. An evaluation of the system level and organisational change that had occurred in the 12 months prior to the time of the third evaluation, to inform research question objectives 1 and 2, as listed in section 1.4;
2. A detailed mapping of the nature of the services and work programmes that were live in the sites at the time of the third evaluation, as a baseline for further work that will be carried out in phase 2 to answer the main implementation evaluation research questions listed in section 1.3.

The information gathered from the evaluation of system level and organisational change will form the predominant part of this report, supplemented with detail from the service mapping. Information gathering took place from November 2016 to March 2017. Supplementary information for the section on “Connectivity” (3.1.4) was collected in December 2017.

### 2.1 Evaluation of system level and organisational change

A semi-structured interview guide (see Appendix 2) was developed for use in a series of key informant interviews with core ABS staff members across all sites. The development of the questions in the guide was informed by the Quality Implementation Framework (a synthesis of multiple implementation frameworks) (Meyers, 2012), which looks at the steps for implementing change, together with the Collective Impact Framework (Kania, 2011), which is a broader framework that considers what is necessary for sustained social change (see Appendix 3).

Interviews were carried out with a range of core staff at each site. As this report focussed on sites’ transition from implementation into delivery, the focus of the interviews was on the work of the core team. Consequently, interviewees were drawn from core ABS teams, rather than from wider system partners. Although this means that this report does not reflect local sites’ partners’ perspectives, it has allowed for a deeper understanding of the changes happening in the local ABS organisations. Future reports will consider wider perspectives as part of looking at the longer term system changes.

As with the previous reports, the emphasis of interviews varied slightly depending on the role of the interviewee; for example, an interviewee who worked in a business role would not be expected to answer detailed questions about evaluation processes. Consent was obtained from interviewees for use of their interviews in this report. All interviews were carried out face-to-face, recorded and transcribed. They were coded and analysed using a thematic analysis approach (Braun, 2006; Boyatzis, 1998). A mixture of inductive and deductive codes was used. Transcripts were coded in NVivo Pro 11.

Additionally, sites provided supplementary documents to help provide further detail on relevant topics. These documents included maps of site-wide governance structures, strategy documents and staffing information. Analysis of these documents provided context to the interviews as well as further

supporting evidence for comments made during interviews. Supplementary information was provided by sites in written form relating to the section on “Connectivity” (3.1.4).

## 2.2 Service mapping

In order to begin to track the process of service delivery and development over time, a service mapping exercise was carried out for each of the five sites. This was intended to capture information about the nature of the services and programmes that each site was actively delivering as of January 2017. Given the broad nature of the aims of A Better Start, it was decided to take a comprehensive approach to deciding which services and programmes would be included in the service mapping. Therefore, the types of services and programmes included in this mapping encompassed:

1. New services for children and/or caregivers set up as part of A Better Start with primary outcomes linked to one of the three main ABS outcomes;
2. Pre-existing services for children and/or caregivers which an A Better Start site had actively modified or invested money in, with primary aims linked to one of the three main ABS outcomes;
3. Work looking at how to streamline or improve care pathways;
4. Workforce development programmes (including those for staff and/or volunteers directly employed by A Better Start, working in a service commissioned by A Better Start, or working in an associated service that would come into contact with children aged 0-3 years and/or families in the target wards);
5. Capital investment in buildings or an element of the physical environment, such as in parks;
6. Communications or education campaigns;
7. Interventions aimed at the social determinants of health.

A structured proforma was developed (see Appendix 4). This proforma was completed for each A Better Start service through a combination of documentary analysis of service design documents (and/or other similar documents) provided by sites, along with additional information provided specifically for this purpose by sites. The documents provided for the service mapping provided further context for the interviews.

## 3.0 Results

---

Figure 3 shows the mix of individuals interviewed for this report, using identical categorisation as report 1 (Cullen, 2016a):

**Figure 3: Roles of local ABS staff interviewed for third implementation evaluation report**

Role category	Number
ABS Director	5
ABS programme manager	3
ABS strand lead (e.g. early years, workforce, evaluation)	4
ABS business support (e.g. finance, administration)	1

As in previous reports, to protect anonymity, exact job titles will not be given. Where direct quotations are used, participants will be anonymised. Given the small number of interviewees and sites, information that may lead to sites being directly identified (such as a programme title) will not be included, nor will the participant's site.

Results are presented through the lens of the Quality Improvement Framework (Meyers, 2012). Sites are beginning delivery of services, but are also still refining and developing their capacity building strategies (Meyers, 2012), so this report begins at that point in the framework. Section headings are taken from the Quality Improvement Framework (Meyers, 2012).

### 3.1 “Obtaining explicit buy in from critical stakeholders and fostering a supporting community/organizational climate”(Meyers, 2012)

The range of public and voluntary sector organisations that deliver early years services in any given local area is broad. The use of voluntary, community and social enterprise (VCSE) organisations to lead ABS locally, after grants were allocated, means that there has been a need to develop strong partnerships with public sector and other voluntary organisations locally. The lead organisations in each site also represent a variety of VCSEs, with a range of experiences in commissioning or delivering early years services, and as such, have a range of historical relationships with other strategic partners. Understanding this wider context is crucial in understanding the ongoing development and maintenance of relationships with strategic partners.

#### 3.1.1 “Leadership with decision-making power in the organization/community” (Meyers, 2012)

Sites generally felt that the senior leadership in their strategic organisational partners (including their local authority, local political leaders, NHS Clinical Commissioning Groups (CCGs), NHS service delivery organisations such as hospital or community trusts, other VCSEs and academic partners such as universities) had bought into a shared aim of ABS in the local area as a long-term programme

that was going to shift emphasis towards prevention in the early years, with the aim of improving outcomes for children in the target wards.

However, having a shared aim has not prevented challenges as sites have moved from initial set-up into delivery. A number of consistent issues were identified by sites as they have taken the programme forward with the senior leadership of their partners. These are summarised in Table 1.

**Table 1: Challenges of working with partner organisations**

Issue	Evidence from interviews
Partners understanding the ABS vision but not the nature of the ABS approach when asked to start delivering	“I think there’s still a sense that it’s ‘oh, this is nice, we’ve got ten years worth of money and we’ve got, which we all need because there’s no other money in the system forever’, when I go into the partnership board I still don’t get the sense of my goodness, they think this is a programme that’s going to change the system for children in [City]. “ ”
Unrealistic expectations from partners around timescale, particularly to do with when tangible evidence of outcomes would be available	“...the sense that I get is that it’s a challenge because our local politicians have said to [name] that we’re not delivering it fast enough”
Long lead-in time during the set-up phase causing strategic partners to become frustrated with the process; this was a particular problem in one site, where a lack of leadership from ABS locally in bringing strategic partners along with the process was seen as having set back the programme in that area	“...people [strategic partners] were kind of gee-ed up and anticipated this ambitious programme, it then didn’t happen and I think people got quite disenchanted and dropped away.”

All sites recognised the crucial value of these partnerships. Significant ongoing effort has been required by senior leaders from the ABS local teams to develop and maintain relationships. They have taken a number of approaches through both formal mechanisms, such as the local ABS area partnerships (the local body providing strategic oversight) (The Social Research Unit, 2013), referred to in this report as “partnership boards” on which these partners sit, as well as strategic decisions taken by the ABS teams about how they positioned ABS within the local early years “ecosystem” of organisations. Table 2 illustrates the key approaches taken.

**Table 2: Approaches taken by local teams to developing relationships with partner organisations at a senior level**

Approach	Evidence
Developing an open and honest relationship between senior leaders, that allows for constructive dialogue and challenge at the local executive boards	“...we’ve had an away day and we’ve been quite open with each other and I’ve had to say to the [partnership board] that I sometimes get the feeling you think I’m doing to you rather than doing what you’ve asked to be done, and they’ve recognised that...”
Positioning local ABS projects as somewhere that new ideas and approaches can be piloted before being used in other wards in their local authority	“...Better Start has been used as the blueprint for public services across the town so anything that wants to be piloted, gets piloted with the nought to four age group so in terms of workforce reform, looking at what type of people we need to work in the town, what kind of skills, what kind of workforce we want in public services...”
Offering tangible system-wide benefits such as common workforce training	“...we’re bringing together a steering group at a more operational level to look at planning and rolling out some multi-agency training as a way of engaging people in workforce development. So through the task of the strategic partners coming together to plan a multi-agency training programme, that is starting to bring them together.”
Acting as an “enabler” to accelerate and strengthen pre-existing system-wide projects, such as developing shared IT systems or common care pathways	“...thinking about [how] to change things across the [area]. Data-sharing is a really good example, that we haven’t set up, but we have worked with a partner to set up what we think is needed...We’ve worked very hard to get them to a point of thinking about some of our principles, ways of working for the [area]. There’s an information sharing group across the – there’s one group that’s about the integrated care pathway, which is [helping ensure] a sense of collaboration, but there’s another group looking at systems more generally, and I think – I’d like to think that we’ve been instrumental really in bringing them to the fore because we’ve crystallised what needs to happen.”
Offering the local ABS programme as a beacon of good practice that can be used to highlight the local authority positively	“...we’re not seen as an add on, we’re kind of seen as, as I say, something to be celebrated, something integral to the thinking...”
Use of the service design approach to engage partners	“We’ll use them in service design ...it’s really important that these senior people understand this process and are happy with the service design because they’re going to have to implement it ultimately.”

The benefits of maintaining and strengthening these relationships are many, as they are critical for operational functioning of ABS programmes; for sites to work towards systems change and embedding the ABS approach in other organisations, and so that the gains made during the ten years of ABS funding are maintained after it comes to an end. The second implementation evaluation documented the dual role of local ABS organisations both as the accountable organisation for the local programme, with the responsibility to challenge partners to deliver specific outcomes or approaches, and as part of a partnership with other organisations who had collective responsibilities for outcomes (Cullen, 2016b). The current data suggests that as these partnerships have matured, sites have had to maintain a delicate balance between pushing forward to meet their goals and managing the demands of partnership working:

“I mean we’re very much doing that in partnership with the local authority and we would have liked to have got some of those up and running sooner but in order to kind of remain in step with them in terms of the overall thinking and with an eye to obviously future systems change outcomes, you know, we wanted to kind of maintain that kind of synergy with them in terms of working with them so that’s why they are kind of in the process...”

The current external financial pressures being imposed on public sector organisations (as well as voluntary sector organisations who are reliant on public sector contracts) due to ongoing austerity have added a further tension to these strategic relationships in many sites, for a number of reasons. Local ABS teams (including those that are providers of services) rely on an infrastructure such as Children’s Centres, and a workforce such as health visitors, which are often controlled by external partners. Consequently, decisions made by external partners can have significant impacts on the viability of ABS projects, which were originally envisaged before the extent of the impact of austerity had started to be realised. For instance, examples were given in interviews of partner organisations that were no longer able to leverage the funds they had originally committed to the programme.

It is also important to acknowledge that due to the inter-connectedness of the early years “ecosystems” within which ABS programmes sit, if a partner organisation makes significant cuts to a workforce or piece of infrastructure on which an ABS programme is dependent for delivery, such as Children’s Centres, this may cause severe disruption to the progress of ABS delivery in that area:

“...it’s all well and good saying you can’t prop up existing services but if the services you need to be able to deliver what you are saying you’re going to, there’s no point in delivering this up here if this down here is gone.”

Furthermore, the disparity between the funding that is available for the ABS wards and the funding that is available for other areas in the local authority and partner organisations may well increase over time. BLF has given clear guidance to local ABS programmes that the ABS funding should not be used to prop up existing services whose funding has been cut; while the interview data provides evidence that sites took this very seriously, it also identified a potential strain on inter-organisational relations that may become harder to manage over the lifespan of the project:

“The other challenge as part of that is that we need to make sure that we’re not seen as someone with lots of money who can plug those gaps because we’re about changing the system however it is and not about trying to prop up the old system, and we haven’t had to have that conversation where you’re actually saying to people ‘well sorry, if you’re going to go under, you’re going to go under’. But, you know, that’s something we have to be prepared for and those are people who have given years of their commitment to [local ABS organisation].”

Decisions made at regional or national level, which a local ABS programme might struggle to impact on such as, the decisions made about the NHS's regional Sustainability and Transformation Plans, are unpredictable and may also have significant impacts on local ABS programmes. However, as relationships begin to mature, there is some evidence from the interviews that the progress local ABS programmes have made in developing understanding of the importance of good quality early years services has had a protective effect at a local level:

“...this year and we know it's this year because the tender's going out, there's only been a 1% cut in [service name]. Now if we didn't have this programme and we didn't have the relationships we do, I am... I feel sure that we would have seen a...A different decision being made.”

One interviewee suggested that the wider grouping of ABS programmes might provide a platform for advocating for early years services at a higher level:

“This programme is really, you know, what we're trying to do locally but actually what we're trying to do is influence national policy, we want to see a shift in that around early childhood development...Do I think people know about that anywhere, no. So there's our [local] bit and I think, you know, our [local] brand, I think we've got quite a strong brand and it's still a work in progress but I think A Better Start, more broadly, I think there is something, we're missing a trick there.”

The role of ABS as a national platform for advocating for high quality, preventive early years services is something that will develop as the programme moves forward. Indeed, some interviewees saw public sector cuts as an opportunity to think more creatively about how services are delivered.

### 3.1.2 “From front line staff who will deliver the innovation” (Meyers, 2012)

All sites recognised the importance of engaging front line staff in the work of ABS. The local lead ABS organisations are a mix of purely commissioning organisations, and organisations that are dual commissioners and providers of services; the interview data suggests that this means that organisations take a different approach to engagement with the frontline early years workforce. The local programmes that provided services recognised that it was easier for them to influence the behaviours and engagement of their workforce than commissioning-only organisations. However, all sites recognised that changing working culture was a challenge. Examples of strategies for engaging the frontline workforce are outlined in Table 3.

**Table 3: Strategies for engaging frontline workforce with ABS goals.**

Strategy	Example
Offering common training across the early years workforce, regardless of organisation or professional background	Common training around how to communicate with parents about early child development cascaded through all early years workforce
Offering opportunities for professional development	Regular networking events for early years professionals
Offering specific training matched to the needs of the ABS programme	Funding for a small group of practitioners to undergo high-level, intensive training in an evidence-based psychotherapy approach
Engaging frontline professionals with the service design approach	Development of community-level groups to ensure consistent representation of frontline workforce in service design process
Funding the employment of workforce development practitioners who can work on a long term basis with settings	Recruitment of a specialist in working with children with special education needs or a disability, who can work intensively with a range of settings
Embedding core ABS team members into partner organisations, to facilitate engagement of their frontline workers	Senior ABS local team members who have a dual role with a partner organisation
Development of a new workforce whose training and management will be done by local ABS team, enabling easier engagement	Recruitment of entry-level community members to staff a home visiting programme

Offering training and professional development opportunities were seen as serving a dual purpose of incentivising frontline staff and partner organisations to engage with ABS and hear about the wider “ABS message”, whilst also up-skilling the wider workforce, with a wider benefit to ABS outcomes and partner organisations. Embedding core ABS members into partner organisations and developing a new workforce were viewed as making it easier to direct that workforce to the ABS aims.

A particular challenge that was identified by several sites was engaging “middle managers” within partner organisations. It was acknowledged that even with engaged senior leadership and enthusiastic frontline practitioners, there may be difficulties in engaging frontline practitioners:

“The bit where I think we’ve still got more work to do is the kind of middle tier, so it’s those members of staff coming back from the training and saying ‘oh I’d really love half a day to consolidate this for my team’, the managers need to be saying, ‘yes, that’s absolutely part of what you’re here to do, why you went on it in the first place’ because that person isn’t managed by the strategic lead, who’s saying ‘well yes, you definitely should spend time on it because it’s [local ABS organisation]’, so I think that that’s the next bit that we have to tackle.”

This is an area where work commissioned by BLF on workforce engagement, to support the five sites, may be able to assist further.

Recent work commissioned by BLF on the Enhanced Healthy Child Programme in the sites (Day, 2017a ; Day, 2017b; Day, 2017c; Day, 2017d; Day, 2017e)- (which was made available after the interviews were conducted) also identified quality of supervision of frontline workers as an area for improvement in a number of areas. This topic was discussed in some of the interviews carried out for this report (although not across all sites); there was no sense in the sites where it was discussed that ABS has had any impact in this area so far, but the limited amount of data available to the authors at present makes it difficult to draw any further conclusions. This is an area which will be developed in future evaluations.

### 3.1.3 “The local community” (Meyers, 2012)

Engaging community members, which in this section will be defined as families and carers of children aged 0-3 years who live in the ABS wards, is a core activity of ABS sites. The term “engagement” covers a spectrum of activities within the ABS sites, shown in table 4:

**Table 4: Examples of types of engagement activities**

Activity	Evidence
formal representation of community members in governance structures (which will be discussed in detail in section 3.2);	“...so in that governance structure, we probably have between 40 and 80 parents, so quite significant numbers, they’re not always the same people...”
co-production of services;	“...what we found really does seem to work is two things, the parents doing real work, so they quite enjoy the fact that they’re properly designing services...”
participatory budgeting-style programmes	ABS funds delegated to a parent forum to spend on engagement activities
recruiting community members as volunteers or paid staff within ABS services;	“The seven are going to be [name of job] and they’re going to be very much entry level jobs, aimed at parents who have volunteered for many years and want to move into the next stage of paid employment...”
ad hoc events to introduce families to ABS services or to enable consultation	“...so in the summer we just had a big summer fun day but actually within it there was bits of consultation work that was taking place, we were signing people up for service design workshops, so they came to have fun and we involved them in all this different stuff!”

Interviewees felt it was important to have this range of levels of engagement for community members, so that people could commit at a level with which they felt comfortable:

“...so we’ve split the community work into community action projects, which are easier to understand because if you said to somebody ‘oh we’d really like you to work on a group with us to look at improving outcomes for children’, they might think ‘I don’t really want to do that, I just want to kind of volunteer at the local allotment’. But actually our allotments that we’re putting in, it is helping with child development, it’s just looking at it in a different way...”

This has also resulted in a route where parents could progress from low to high level engagement with ABS, developing their skills and confidence in the process.

As all of the five sites are led by VCSE organisations, it was expected that they would be strong at community engagement; however all sites felt that this had been one of the most challenging and time-consuming aspects of the process. The contexts that sites are operating in are very varied; in some areas, there is a long history of community development, either from the ABS lead organisation or other community groups, whereas in others, there was no real history of significant community development work and as such links have been developed from scratch. Often, there was a history of mistrust of traditional services:

“...so if you’re looking at community and then you kind of pull back and look at families, if we’d started at an individual level, you know, they don’t particularly engage in a lot of... individually in services or... so you start off at that level and then you replicate it across the community, it takes, as [name] said, a lot of resource, a lot of time, a lot of building trust and I think in some of those communities, there are – well in all of them really, there’s a kind of lack of trust about the system...”

This mistrust was also apparent in a number of the focus groups completed as part of the Enhanced Health Child Programme reports (Day, 2017a; Day, 2017b; Day, 2017c; Day, 2017d; Day, 2017e).

Interviewees in all sites identified that there were sectors of their community who they considered “hard-to-reach” because they did not engage with traditional services:

“...we’re actually looking at performance data on a monthly basis, we can see that the parents who are currently coming into children’s centres aren’t the most deprived parents in our target wards, and actually we’ve got to re-think how we engage with those families.”

These groups varied between sites: some sites were targeting fathers, others were targeting particular ethnic or linguistic groups. Engaging them has required significant commitment of time, leading some sites to recruit additional community development workers (in some capacity), and increasing flexibility, so that accessing services can be made feasible to target families. In some cases, it has involved a very granular approach, targeting very small geographical areas (such as single streets or blocks of flats) or even individual families.

However, despite the challenges, this work was seen as being of vital importance: it allows community members to have influence and control over what was being delivered by ABS; it was seen as leading to better quality, more relevant services, and it was important in helping ABS meet its long-term outcome goals by engaging as many parents as possible who could benefit from its services.

### 3.1.4 Connectivity

This section considers “connectivity of services” within ABS services. “Connectivity” is defined as the links and relationships that are necessary in order to provide a seamless pathway of evidence-based, high quality services for pregnant women and children aged 0-3 years. In order to examine connectivity fully, there are a number of levels of links and relationships that must be looked at, including between practitioners, service providers and commissioners. Interviewing individuals across these levels is beyond the scope of this report; however, the Big Lottery Fund has commissioned complementary work which involved focus groups with a number of these groups (specifically, practitioners and parents), capturing their perspectives on connectivity as part of the wider scope of their work (Day, 2017a; Day, 2017b; Day, 2017c; Day, 2017d; Day, 2017e).

Consequently, this report draws heavily on those five reports, as well as additional information from interviews and written responses provided by core ABS staff, to give their perspective on these issues and how ABS has impacted on them. Examples that come from the enhanced Healthy Child Programme reports have been shown with a star (\*) (Day, 2017a; Day, 2017b; Day, 2017c; Day, 2017d; Day, 2017e) ; individual reports have not been referenced in order to preserve the anonymity of sites. The authors of the above reports caution that they interviewed small numbers of practitioners and parents across the five areas and were not able to get representatives of all Healthy Child Programme services in all areas; however, this work does provide some valuable preliminary insights into what issues exist across the five ABS areas. Examples that come from interviews or written answers provided for this report is marked by (^).

#### 3.1.4.1 What does connectivity look like in the ABS sites?

Examples of where ABS has influenced connectivity in their local areas are outlined in the next sections. Some examples are taken from other sections of this report.

- **ABS influence on connectivity at the practitioner level**

ABS sites have worked hard to engage with practitioners. As discussed earlier, sites have placed an emphasis on workforce development; the way that this is delivered can have important influences on connectivity between practitioners. For instance, one site has developed common core training for professionals across multiple sectors; as well as enhancing their individual skills and knowledge, this has the potential to enhance their understanding of the remits of other services. Furthermore, delivery of this training and other learning opportunities in a multi-professional setting offers the opportunity for informal networks and relationships to develop further.

- **ABS influence on connectivity at the provider level**

Examples of influence at provider level include helping providers to develop common IT systems and pool data through “data warehouse” to facilitate monitoring of outcomes across the system, rather than for a single provider.

Several sites have had strong influence into the commissioning of core Healthy Child Programme services, such as Health Visiting, including influencing visit schedules and the use of common assessment tools.

- **ABS influence on connectivity at the commissioner level**

At commissioner level, there is evidence of ABS being represented at a number of multi-agency strategic groups outside of the ABS-specific governance structures. This representation could be through direct representation by a member of the ABS core team; representation of ABS's interests by partner organisations, or regular attendance by a member of the ABS core team to provide updates to the membership of the relevant body. These groups include:

- Statutory bodies specific to children's services, such as Local Children's Safeguarding Boards;
- Statutory bodies concerned with at health across the whole population, such as Health and Wellbeing Boards;
- Local bodies concerned with locally or nationally initiated systems change work in health or early year's services.

Depending on the specific board, these groups are likely to be attended by a wide range of both commissioners and sometimes providers, including representatives from the NHS, local authority, schools and the police.

The wide variety of examples listed here shows the complex nature of the system in which ABS operates, and the potential challenges in aligning strategic commissioning priorities across all groups. The challenges come not only from the range of organisations involved, and their differing priorities, but also the relative size of ABS (financially and organisationally) compared to organisations such as CCGs or acute hospital trusts. The presence of ABS on these boards does however offers an opportunity to input into these strategic priorities across the wider local authority, as well as shape other aspects of the local agenda, such as workforce transformation.

### 3.1.4.2 *Facilitators of connectivity*

Examples were also given in the enhanced Healthy Child Programme and People in the Lead reports and also interviews and written responses of activities that were facilitating connectivity, whether initiated by ABS or by other organisations.

**Table 5: Facilitators of connectivity at practitioner level**

Common training and other opportunities for inter-professional networking*^	This enables shared understanding across professionals, both through common knowledge and informal relationship building
Clear referral pathways*	Clear service eligibility criteria and pathways; simple referral routes; opening up services to referral from a wide range of professionals to facilitate access for families
Safeguarding processes*	This was given as an example of a way of multi-agency working can be successfully catalysed around the needs of a family

**Table 6: Facilitators of connectivity at provider level**

Co-location of services*	Locating different services in the same building, such as a GP surgery or Children’s Centre, can facilitate both formal and informal communication and shared professional understanding
Shared IT systems*^	Common IT systems allowing for easier sharing of information about individuals as well as more sophisticated outcome evaluation
Development of a single point of access for services*	Facilitates navigating pathways for both practitioners and families

**Table 7: Facilitators of connectivity at commissioner level**

Joint Strategic Needs Assessment*	This is a statutory document, requiring multi-agency cooperation to analyse a local authority’s population needs. This can help develop a shared understanding across organisations of what the local need is.
Alignment of performance monitoring*	KPIs and other performance indicators that are aligned, meaning that services are pulling in the same direction
Multi-agency strategic boards^	Each ABS area has a number of multi-agency boards, both statutory and non-statutory, where provide fora for commissioners and providers to meet and align strategic vision and priorities

### 3.1.4.3 Barriers to connectivity

There are pre-existing barriers to connectivity within ABS sites. Examples of these at practitioner, provider and commissioner levels are given in tables 8-10.

**Table 8: Barriers to connectivity at practitioner level**

Lack of inter-professional understanding of roles and services*	Not all professionals were confident in their understanding of the remit of other HCP services and associated practitioners; this was particularly a problem with more specialised services such as CAMHS
Lack of clear routes for communication between services*	Practitioner confidence in communicating with other professionals involved in a family’s care was sometimes limited by practical issues (e.g. telephone routes of contact that were complicated and inflexible) and lack of a clear

	communication pathway (e.g. between health visitors and obstetricians)
Reliance on an individual practitioner's approach rather than a common systematised method*	Lack of a systematised approach to addressing families' needs can lead to variation within services as well as between; for families, this means potentially they receive varying advice from different services

**Table 9: Barriers to connectivity at provider level**

Frequent organisational restructuring*	This is a challenge for several reasons: reconfiguring services can be time-consuming and shift focus from other work; it can be difficult for practitioners from other services to keep track of new pathways and roles; loss of staff can mean loss of pre-existing relationships
Lack of understanding at middle manager level of shared vision or strategy^	Even if strategic priorities are aligned, if managers are not attuned to the work that is being done at more senior level, these priorities may not be adequately translated into operational changes
Reduced financial resources *^	Reduced resources and staffing can lead to competing priorities, and in turn increase workloads for practitioners

**Table 10: Barriers to connectivity of commissioner level**

Reduced resources*^	This can lead to prioritisation of resource usage over other aspects of service development
Lack of understanding of services being commissioned by other agencies*	This can lead to duplicative programmes
Ongoing wider systems transformation plans, e.g. NHS Sustainability and Transformation Plans (STPs)^*	Ongoing, nationally driven systems transformation work, such as STPs, has the potential to create competing priorities and visions, as well as lack of certainty for services moving forward

### 3.1.4.4 Summary

In summary, enhancing connections between other parts of the early years systems in ABS areas is necessary to bring about alignment in vision and outcomes, and ultimately provide well-coordinated pathways for families to move along. Work has been undertaken to try to categorise what some of the barriers and facilitators to this are in order to support sites to strengthen their existing work. There are some early examples of where sites have started to have influence.

### 3.2 “Building general/organisational capacity” (Meyers, 2012)

The process of developing and operationalising plans for governance structures during the set-up phase was described in detail in the second implementation evaluation (Cullen, 2016b). As noted in that report, sites were given a document by BLF outlining the types of structures that were expected (The Social Research Unit, 2013). This document concentrated on how sites could create an area partnership (commonly referred to by sites as a partnership board), which contained senior representatives of partner organisations together with community representatives, and which would be mandated to make strategic decisions; it also outlined possible means by which sites could create community partnerships so that local people would be represented within the governance structure in a meaningful way (The Social Research Unit, 2013). The current governance structures in place at the sites at the time of this evaluation were more complex than those outlined in the original document, and had evolved according to local need.

Since transitioning from set-up into delivery, sites have all reviewed their governance structures in some way. These reviews varied in scope; only one site has felt it necessary to make wholesale changes to their structures. Table 11 gives examples of the kinds of reviews undertaken in some of the sites.

**Table 11: Examples of kinds of governance reviews undertaken locally**

Nature of review	Reason for undertaking review
Review of entire governance structure	As part of a commitment to reviewing the governance structure annually to ensure fitness for purpose
Review of entire governance structure	Response to specific concerns that governance structure was not functioning effectively
Review of place of community representatives within the governance structure overall	Response to request from community representatives
Review of role of community representatives at a strategic level	Response to concerns expressed by community representatives

Sites also reported the need to shift the focus of their governance structures to ensure that there was adequate representation of operational decision makers:

“....really I think in this review we are moving from development of the bid and early set up into a full implementation phase really, and within that really we could see that the board moving forward will have to make more decisions than it has and it needs these people around them, not just a programme management team, to be supporting their decisions...”

This has taken different forms in each site: some have maintained separate, formal boards comprising operational leads from strategic partners to drive delivery; others have developed thematic groups, based around outcomes, which have senior operational leaders together with frontline workforce and community members.

### 3.2.1 Community representation within governance structures

The role of community representatives within the governance structures was something all sites had reflected on deeply. There was consistent commitment to giving real power to these representatives, in what was seen as a contrast to traditional public sector community engagement:

“...they’re [traditional public services] not actually designing, producing and procuring those services alongside the people who are going to be using them, they’re doing it based on what they think could happen and then, you know, having a little bit of consultation or doing a bit of a survey or something like that. So actually doing it I think differently and really involving those communities in terms of, you know, this is what the evidence says, this is the activity that we think we’re going to be doing, it’s an evidence based programme but actually that evidence based programme doesn’t tell you how to deliver it or where to deliver it, or by who or what time or, you know, what’s going to make the biggest impact. So actually working with those communities to understand that and then when we’ve got that, bringing them in to the procurement process, so actually they’re scoring all those tenders, they’re evaluating those, they’re coming back with alongside the workforce to do that and award those things as well...”

As described previously, sites continue to take a varied approach to community representation within their governance structures. The current approaches taken by each site are documented in Table 12.

**Table 12: Approaches to community representation within local ABS governance structures**

Approaches
Community representation at all boards and working groups; 50% parents on the partnership board.
Ward based community forums feeding into the partnership board; 25% parents on the partnership board.
Ward based community forums feeding into the partnership board; 50% parents on the partnership board.
Single community group that feeds into the partnership board; representative from community group attends the partnership board.
Community representation at all groups below partnership board; ward level community forums; plans to train group of parents to join partnership board.

The second implementation evaluation (Cullen, 2016b) noted that the large representation of parents at a strategic level gave the potential for tensions around decision-making; this tension was recognised as ongoing in the interviews conducted for this evaluation, and had manifested itself at partnership board level in some areas:

“...because the academic world has got very strong beliefs in what works and “Why would you be doing something if it’s been demonstrated not to work?” and that kind of argument, and then you’ve got the community saying “Why would you be spending that amount of money on that thing for only that number of people?!””

This tension was not necessarily viewed negatively by interviewees; rather, it was seen as inevitable given the different professional backgrounds and experiences of the majority of the community

representatives compared to the professional representatives. Sites recognised that at times this could provide a welcome challenge to traditional ways of thinking. However, there was also a recognition that community members often needed substantial support and personal development to enable them to function effectively and fulfil a role at a strategic level. The majority of sites provided substantial and ongoing, formal and informal, training and development opportunities for their community representatives. This training was seen as giving community representatives skills and confidence in activities like speaking in public in a formal situation such as a board meeting; several interviewees also felt that has helped community members understand more about the nature of the choices that were being made, and how to make strategic decisions:

“...so one of these [things] we've got to do is how do we support those parents to speak for their communities and not just speak for the individual... And so actually it's not as easy as just putting parents around a table, actually they have got a significant development programme, so we literally deliver ourselves, some of it we buy in some experts for them to support them so they need their space and time away from the programme management team if you like to be able to truly challenge us. But actually to be challenging on system things and programme related issues, not necessarily individual problems.”

However, it was recognised that in doing this, parents' perspectives could become more aligned with those of the professionals, losing some of the distinctiveness of their voice:

“So then that's got other issues for the programme, so those parents then become professional advocates for their community and actually what you lose then is their ability to help truly shape service design because they're not just, you know, a mum from a community anymore.”

This challenge was seen as likely to be an enduring part of the ABS programme.

### **3.3 “Staff recruitment/maintenance, pre-innovation training and creation of an implementation team” (Meyers, 2012)**

Core local ABS teams were in place at the time of the previous ABS implementation evaluation report (Cullen, 2016b). However, the make-up of these teams has changed as sites transition further into delivery. As with the previous report, this report considers recruitment, induction and creation of a core team together. There was reluctance across sites to recruit too large a core team, due to the recognition that ABS is a time-limited programme, as well as the desire to emphasise the ABS programme's primary role as a system enabler, rather than a provider of services.

Sites reported a number of challenges with core staffing. Firstly, most sites had struggled to recruit to at least one position in their core team, despite offering what they saw as a high quality post. A particular difficulty was noted in recruiting candidates with sufficiently high level statistical or data analytical skills to be able to lead and/or deliver on the very intensive, detailed evaluation processes that local sites are developing and embedding for both individual programmes and site-wide outcomes. One site did not decide to recruit an evaluation lead until relatively late in their set-up process, which interviewees felt had impacted on their ability to embed the “test-and-learn” process as effectively as they would have liked.

We observe that a number of the local ABS sites are situated in areas where public sector skilled workforce recruitment is difficult across many sectors; this represents a challenge to those sites. We

also note that the local ABS sites are likely to have higher expectations of their evaluation teams than many other public sector organisations (outside of academic institutions), meaning that the pool of potential candidates with the right skills is smaller. A number of sites have also established or strengthened existing partnerships with local universities to help improve their capacity to deliver in this area. The interview data suggests that as part of the wider learning that comes from the national ABS programme, a consideration of how to develop this part of the wider early years workforce would potentially be helpful.

One site identified developing their community engagement workforce as a specific focus, particularly as there was a lack of external organisations doing that type of work in their local area. Interviewees reported that this work had been more time-consuming and intense than had been anticipated, resulting in demands on core staff time that were unsustainable, and thus the need to prioritise developing that workforce:

“So it’s a massive piece of work, much – and my background is community development – it’s much bigger than I ever imagined it being in terms of what needed to be done because the infrastructure here is so poor around community development, and it’s just not been there.”

Second, a number of sites highlighted the difficulties they had had in recruiting staff who were able to meet the challenges of working in ABS, which was seen by interviewees as a very different way of working to traditional public/voluntary sector working practices:

“...you’re walking into something that is brand new and actually that level of uncertainty I think, and that level of clarity that a lot of people need in order to be able to do the job, isn’t there; some of the processes aren’t there; some of the procedures aren’t there, you’re going to have to write them, figure out what they look like, you know, you’re being employed by the programme because we want you to be the expert, we want you tell us what you think the issue and what the way forward is and what the options are, we’re not necessarily the people who are able to tell you. And I think that’s quite a different mind set for lots of people coming in... quite often people have to find their own sort of path and we can support them and guide them, induct them and help them as much as we can, and we do, but actually quite often it’s sink or swim and we’ve seen quite a few people sink...”

Finally, interviewees identified that there may be differences between local lead organisations that had support from a wider umbrella organisation with functions such as communications, and those that were self-reliant and had to recruit to a wider range of support functions. However, it was suggested by some interviewees that the support offered from umbrella organisations was not always helpful, due to the differences between the “ABS approach” and their umbrella organisation’s standard approach, meaning that they developed some of those capacities internally, despite the availability of other support:

“...the Comms post was something that we felt quite strongly that we needed, obviously we were getting... I mean being a national organisation, they’re not service deliverers so their kind of way of doing Comms is quite different to what was needed...”

### 3.4 “Developing an implementation plan”(Meyers, 2012)

Sites were all moving forward with the implementation process. The service design process that core teams were trained in at Dartington is described in the second implementation evaluation(Cullen,

2016b). Sites were universally positive about this approach, seeing it as rigorous and as a valuable tool for engaging partners and parents in meaningful co-production:

“I think the other bit of learning that could be used from this with commissioners is that service design process, you know, when you are looking at trying to commission really well because if it’s done well it can be transformational but actually more often than not, it’s not done well.”

However, sites acknowledged that the process was lengthy, and had contributed to a longer set-up time than many had anticipated.

All sites had some services that focus directly on the core ABS outcomes 1-3 (which we define here as corresponding to service types 1 and 2 under 2.2 of this document) in delivery as of January 2017. These services are described in tables 13-17. Services or programmes that have come directly from the national programme, such as “Preventonomics” (a tool for looking at economic evaluation locally) have been excluded.

**Table 13: ABS services in Blackpool**

	Name of service	Summary of service	Delivery organisation	Referral route
Universal	Baby Steps	Structured universal antenatal programme (mostly group based with some home visits)	NSPCC	Signposted by midwife.
	Baby Buddy	Mobile app that provides information for pregnant women and new mothers	Best Beginnings	Download via website.
	Community sports activities: Fit2Go	Structured series of group sessions for families centred around healthy eating and physical activity	Blackpool FC Community Trust	Self-referral.
	Community sports activities: Outdoor activities	Use of trained parent volunteers to deliver physical activity sessions for families	Sport Blackpool	Self-referral.
	Activity cards	Series of cards with suggested structured activities for families to do with their children; available from children's centres.	Blackpool Community Voice	Available from Children's Centres and selected community venues.
	Engagement of dads	Series of activities to improve engagement with fathers, led by father's engagement worker, including sessional activities, engagement with other organisations on this area and recruitment of peer support volunteers.	Blackpool Better Start	Dependent on activity.
	Raising Early Achievement in Literacy (REAL)	Group based course for parents about how to provide a good quality learning environment for their children.	Blackpool Council Family Learning Team	Self-referral.
	Sandgrown card	Families in ABS wards register for a card that provides them with discounts for local activities and attractions that broadly link with ABS outcomes.	Blackpool Better Start	Accessed through registration at Children's Centres.
	Fathers Reading Every Day (FRED)	Programme to encourage fathers to read regularly with their children	Children's centres	Self-refer.
	Targeted	Survivor Mum's Companion	Structured, self-guided programme for pregnant women who have experienced trauma or abuse, aimed at improving maternal mental health.	NSPCC

			NSPCC practitioners. Other professionals can also support women to self-refer.
Family Nurse Partnership (FNP)	Nurse led home visiting programme for mothers aged under 19 years who are first time parents	Blackpool Teaching Hospital NHS Trust	Midwives refer in women who are eligible.
Parents Under Pressure	Structured home visiting programme for parents with substance misuse problems to support their parenting skills.	NSPCC	Multiple professionals can refer in women who meet eligibility criteria, including treatment services, social care, health visitors and children's centre workers.
Safecare	Structured home visiting programme for parents whose children are not having their emotional or physical needs met	NSPCC	Multiple professionals can refer in women who meet eligibility criteria, including social care, health visitors and children's centre workers.
Video Interaction Guidance (VIG)	Structured home based programme that uses video recording to improve parent-child relationships where it has been identified that children are not having their emotional or physical needs met.	NSPCC	Multiple professionals can refer in women who meet eligibility criteria, including social care, health visitors and children's centre workers.

**Table 14: ABS services in Bradford**

	Service	Summary	Delivery organisation	Referral route
Universal	Personalised midwifery	Adaptation of case-loading midwifery approach, designed to enhance continuity of care for pregnant women through the use of a named midwife.	Bradford Teaching Hospitals NHS Foundation Trust	GP referral.
	Welcome to the world	Structured, group based, universal antenatal programme. Based on Family Links programme.	Bradford Council	Self-referral; all professionals who have contact with pregnant women are also able to refer in.
	Baby Buddy	Mobile app that provides information for pregnant women and new mothers	Best Beginnings	Download from website.
	Home-Start Better Start	Home based peer support programme	Home-Start Bradford	Any professional working with families who might be eligible can refer in.
	Health, Exercise and Nutrition for the Really Young (HENRY)	Group based structured programme focussed on healthy eating. Additional offer of one-to-one support for those who face barriers to attending group based programmes.	HENRY	Self-referral; health visitors and children's centre staff can also refer in.
	Better Start Imagine	Imagination library: delivery of a book per month to children from birth until they are aged 4 years or move out of area.	Canterbury Imagine	Majority will be referred through health visitor (enrolment is on an opt-out basis, with health visitor giving information about scheme); automatic enrolment with registration at Children's Centre; women can also self-refer as can children's centre staff.
Targeted	English for Speakers of Other Languages (ESOL) classes	ESOL classes for pregnant women focussed around language relevant to pregnancy, birth and navigating health services.	ShIPLEY College	Self-referral; community midwives, children's centre staff and health visitors can also refer in.
	Family Action Peer Support	Volunteer befriending scheme for women who are pregnant and have or are at risk of mild-moderate mental health difficulties.	Family Action	Self-referral; other professionals working with eligible women are also able to refer in, including Children's

			centre staff, early years workers and healthcare professionals.
Family Nurse Partnership (FNP)	Nurse led home visiting programme for mothers aged under 24 years (this is adaptation of standard FNP) who are first time parents; programme of visits has been made more flexible compared to standard.	Bradford District Care Trust	Majority will be referred through community midwives and specialist midwife for teenage pregnancy; other professionals working with pregnant women are also able to refer in.
Talking Together	Home based one-to-one programme for children aged 2 identified as having speech and language difficulties.	Sure Start BHT	Parents receive written invitation to assessment to determine eligibility.

**Table 15: ABS services in Lambeth**

	Service	Summary of service	Delivery Organisation	Referral pathway
Universal	Raising Early Achievement in Literacy (REAL)	Group based course for parents about how to provide a good quality learning environment for their children.	Children's centres	Managers and practitioners in the setting who are involved in the service (Children's Centres and
	Breast Feeding Peer Support	Supports mothers through the peri-natal period through n to one and group support . The service also delivers First Milk Matters training for the wider workforce	Breast Feeding Network	Via midwives and other early years practitioners
	Parent Champions	Parent champions are supported to use their skills and knowledge to create supportive connections in their local community. Parents participate in accredited training to develop their knowledge about early years and development of engagement skills	London Borough of Lambeth	Parents can refer themselves onto the training course
Targeted	Community Action and Nutrition Programme (CAN)	Health trainer-led programme for overweight pregnant women.	Guy's and St Thomas's NHS Foundation Trust	All potentially eligible women who book at King's College Hospital or Guy's and St Thomas' Hospital are sent to the CAN midwife for screening

	Parent and Infant Relationship Service (PAIRS) one-to-one programme	Parent-infant psychotherapy. Based on the Wait, Watch and Wonder approach.	LEAP	Self-referral; any healthcare or early years professionals who have contact with potentially eligible women can refer.
	Parent and Infant Relationship Service (PAIRS) group programme	Parent-infant psychotherapy. Based on the Wait, Watch and Wonder approach.	LEAP	Self-referral; any healthcare or early years professionals who have contact with potentially eligible women can refer.
	Family Nurse Partnership (FNP)	Home visiting programme for mothers aged under 19 who are first time parents	Guy's and St Thomas's NHS Foundation Trust	Mainly referred by midwives and other professionals

**Table 16: ABS services in Nottingham**

	Service	Summary of Service	Delivery Organisation	Referral pathway
Universal	Bump, Birth and Baby	Universal group structured antenatal programme.	Nottingham CityCare	Community midwives refer.
	Baby Buddy	Mobile app that provides information for pregnant women and new mothers.	Best Beginnings	Download from website.
	Infant Massage	Group based infant massage classes.	Nottingham CityCare	Self-referral
	Cook and play	Structured group based cooking classes with childcare.	Small Steps Big Changes	Self-referral
	Imagination Library	Imagination library: delivery of a book per month to children from birth until they are aged 4 years or move out of area.	Dolly Parton's Imagination Library UK	Enrolment through health visitors on an opt-out basis.
	Small Steps at Home	Peer-led structured home visiting programme.	Consortium of local VCSE organisations	SSBC contact all eligible women directly by telephone to offer them the service.
	Triple P Level 2 programme (Seminars)	One-off seminars on parenting with tip sheets.	Consortium of local VCSE organisations	Self-referral.
	Triple P Level 3 programme (discussion groups)	4 structured group discussion sessions.	Small Steps Big Changes	Self-referral.

Targeted	Maternal Mental Health intervention	Screening and structured listening intervention for women screening as at risk for postnatal depression. Based on PONDER trial.	Nottingham CityCare	Offered at discretion of health visitors as part of their care to family.
	Family Nurse Partnership	Nurse led home visiting programme for mothers aged under 19 years who are first time parents.	Nottingham CityCare	Majority through community midwives.

**Table 17: ABS services in Southend**

	Service	Summary of service	Delivery organisation	Referral route
Universal	Baby Buddy	Mobile app that provides information for pregnant women and new mothers.	Best Beginnings	Download from website.
	Fathers Reading Every Day (FRED)	Programme to encourage fathers to read regularly with their children.	Fatherhood Institute	Self-referral.
	Let's Talk	Structured group based programme for parents with children under 1 year aimed at promoting speech and language development.	Preschool Alliance	Referral by health visitors, midwifery, children's centre staff and Early Help.
Targeted	Family Nurse Partnership	Nurse led home visiting programme for mothers aged under 19 years who are first time parents.	South Essex Partnership Trust	Majority referred through community midwifery.
	Specialist Autism Support	Group based programme for parents of children with an autistic spectrum disorder or who are considered likely to be diagnosed with one.	Southend Borough Council	Referral by Special Educational Needs and Disability Team at Southend Council.

Table 18 categorises these services into universal or targeted at specific groups.

**Table 18: Types of services in delivery as of January 2017**

Site	Universal	Targeted		Total
Blackpool	9	5		14
Bradford	6	4		10
Lambeth	1	3		4
Nottingham	8	2		10
Southend	3	2		5

Although the number of services in delivery is small across the sites, it is interesting to note that most sites have more universal services in active delivery than targeted

services; this may reflect the fact that delivery of these services may be more straightforward, for example because they require less specialised training for the staff who are delivering them, or they do not require the introduction of specialised referral pathways.

Of the services in delivery at each local site, table 19 shows how many are services that ABS has introduced to their local wards, compared to the number that were pre-existing and have been modified or added to by ABS.

**Table 19: Services in delivery as of January 2017, categorised by whether they were introduced by ABS**

Site	New services	Modifications to pre-existing services in that site
Blackpool	9	5
Bradford	3	7
Lambeth	3	1
Nottingham	5	5
Southend	1	4

There is no clear pattern to which types of services sites have opted to focus on first for delivery; all sites have new services in delivery and all sites have completed modifications of pre-existing services. There is a big range of types of modifications to pre-existing services including:

- ABS funding additional delivery staff posts or training of pre-existing staff to enable delivery to a higher number of families in current delivery areas and/or expansion to all of the ABS target wards with or without changes to the nature of the service;
- Changing eligibility criteria to ensure they fit ABS target age groups or based on experience of who might benefit from service;
- Adaptation of delivery modes or materials for programme based on existing experience, so that they are a better fit the target families (for example, use of additional translators; adding in extra sessions to a group for wider family members; developing 1:1 versions of pre-existing group programmes for higher need families);
- Additional content so that the service better fits ABS aims;
- Increasing the intensity of an intervention by increasing the number of sessions or switching from group sessions to 1:1 sessions or a home visiting approach.

One of the emphases of ABS has been on the use of evidence-based and science-based approaches to choosing which services to deliver. The ABS definitions document defines these as follows (Big Lottery Fund, 2016):

- “Evidence-based interventions - When an intervention is ‘tested and effective’: ‘tested’ means that the intervention has been put through its paces by a high-quality impact evaluation; ‘effective’ means that there is strong evidence from that evaluation that the intervention makes life better for

children or families. An intervention is therefore ‘evidence-based’ when it has been evaluated robustly and found to have a clear positive effect on a relevant outcome for children or families.”

- “Science-based interventions - An intervention that is ‘science-based’ is not yet evaluated but is a new intervention, developed using a mixture of science and evidence, and logic.”

It is expected that local sites will choose a mixture of the two types of interventions; the evidence review completed for ABS by the Social Research Unit notes that the current evidence base in this area is not always robust (The Social Research Unit, n.d.):

“...there is currently not enough high quality research evaluating the effectiveness of interventions for this time period (i.e. conception to three years) in the UK... much of the evaluation and implementation science is relatively new, and even when we feel confident about particular ways of working, the real world is a messy place with different contexts, cultures and systems to complicate the delivery process. This means that ‘what works’ is ‘what is most likely to work’.”

Many of the interviewees discussed this tension:

“And you see, we’ve been trawling all round the [area] going, oh, evidence and science, evidence base, and what works... And then you start to analyse what you’ve got actually and...you lose some of your credibility somewhat, although we are still streets ahead of the rest of the [area], to be fair.”

Similarly, programmes that had been robustly evaluated elsewhere were not necessarily easily generalizable to the ABS areas, and needed modifications, such as creating materials for parents with low literacy skills, to make them suitable.

For those services that were in delivery at the time of this evaluation, table 20 shows the type of publicly available evidence available for each one. The highest level of evidence that showed an effect is listed. Programmes that are based on an existing programme, but which are being delivered to a wholly different population, by a wholly different type of professional or in a wholly different manner (e.g. in a group rather than individually) are classed as theory-based.

**Table 20: Type of evidence available for services in active delivery as of January 2017**

	At least one RCT or cluster randomised trial	Pre/post evaluation	Theory-based service
1	5	3	6
2	3	3	4
3	2	1	1
4	5	1	4
5	1	1	3

For four sites, the majority of interventions in delivery had some sort of pre-existing evidence base.

With regards to the other types of services (types 3-7 in section 2.2):

- All sites had live workforce development programmes for the wider early years workforce;

- 3 sites had live or planned programmes that have the potential to deliver capital investment into buildings or areas like parks;
- 3 sites had planned communications or educational campaigns;
- 3 sites had live or planned programmes that acted on the social determinants of health

These programmes are listed in tables 21-25.

**Table 21: Additional ABS programmes in delivery in Blackpool**

Type of programme	Programme	Summary
Workforce development	Early Assessment Worker - SEND (Special Educational Needs and Disabilities)	Recruitment of specialist worker to Blackpool Council Early Years Team to provide support to a range of early years settings in their provision for children with SEND.
	Step Up	Recruitment of worker within Blackpool Council Families in Need Team to help signpost families identified as being at standard risk of domestic violence to existing services.
	Frameworks	Common training across the early years workforce in the “Frameworks” metaphors for brain development in young children.
Social determinants of health	Baby Rover Clothing Bank	VCSE-run clothing bank offering very low cost secondhand baby clothes.
	Selective licensing	Recruitment of a worker to Blackpool Council Families in Need team to support Selective Licensing programme to identify families living in poor quality private rental housing and provide them with additional assessment and support.
Capital investment	Parks and Open Spaces	Capital investment into parks and green spaces in ABS wards; recruitment of park rangers to encourage usage.

**Table 22: Additional ABS programmes in delivery in Bradford**

Type of programme	Programme	Summary
Workforce development	Learning together	Multi-component workforce development programme, including both generic common training across the workforce linked to ABS outcomes; more specialised training for advanced practitioners to enable them to deliver specific commissioned services; informal professional development and networking opportunities for wider workforce, and training programmes for volunteers involved in delivering ABS commissioned services.
Capital investment	Capital development programme	Capital investment into delivery venues.

**Table 23: Additional ABS programmes in delivery in Lambeth**

Type of programme	Programme	Summary
Workforce development	Wider early years workforce training	Brief Encounters: training for frontline workforce to support parents who are having relationship difficulties; Family Partnership Model: training for frontline workforce in helping families with goal setting and planning.
	Family Partnership Model	A workforce development approach based upon an explicit model of the helping process that demonstrates how specific helper qualities and skills, when used in partnership, enable parents and families to overcome their difficulties, build strengths and resilience and fulfil their goals more effectively. FPM trains early years practitioners across children's centres early help and health visiting.
	Parent Champions	Recruitment of pool of trained volunteers for community engagement work and peer support.

**Table 24: Additional ABS programmes in delivery in Nottingham**

Type of programme	Programme	Summary
Workforce development	Family Mentors	Recruitment of paid workforce from local community to provide peer support, deliver some ABS programmes and offer opportunities for local community to gain employment and skills.
	Talking Twos	Collaboration with Nottingham City Council Early Years Team on wider workforce training on language and communication.

**Table 25: Additional ABS programmes in delivery in Southend**

Type of programme	Programme	Summary
Workforce development	Creche workers	Recruitment of pool of crèche workers who can be used to support ABS programmes.
	Workforce development	System-wide work looking at developing common workforce training.
Social determinants of health	ABSS Work Skills Project	Programme to improve employability of parents

System-wide work	Perinatal mental health project	No available information at time of writing report
	Infant feeding programme	Promotion of breastfeeding across the wider early years sector

All sites had a different profile of planned services from their original bids; all sites had dropped or significantly altered planned services. Although sites were not asked directly about this, it was a topic that came up spontaneously in some interviews and as part of the service mapping process, and is an area that will need to be given consideration in later evaluations, as the full test-and-learn process starts to work. Examples of reasons given for dropping services included:

- Total number of planned services was too high for core ABS local team to manage the workload involved in planning and delivering them (this was a particular issue in one site);
- Service replaced by, or incorporated into, an alternative service with the same aim that was felt to be more effective or more appropriate for local families;
- Planned service was a modification of an existing service that was then decommissioned by another commissioner.

It is difficult to draw conclusions at this point about the impact of dropping individual services, because the sites are not yet delivering services fully across all of the three target areas (although the “test-and-learn” approach means there will likely never be a totally constant set of services in delivery). To an extent, in a programme as complex as ABS, it is to be expected that the initial submitted bids would be modified as sites moved into implementation, and have adapted to changing systems and needs in their local area.

With regards to accessing services, sites have predominately tried to make services as open as possible. Universal services are largely open-access, with parents able to attend without needing a professional referral. Most targeted services are open to referral from a wide range of professional staff. These referral pathways are intended to increase accessibility and reach of these services, although it was also noted in one interview that many parents would need support to access services that were open to self-referral, something that is likely to be true across all sites.

### 3.5 “Technical assistance/coaching/supervision”(Meyers, 2012)

The provision of technical assistance is a consideration on two levels: first, there is the support that all local ABS programmes are offering to their wider workforce and project delivery teams, which has been discussed previously, and which is ongoing in all areas.

Second, there is the assistance and advice that BLF has offered to local ABS programmes. This has taken a range of forms, including:

- initial training offered to core staff members, for example in the service design process;
- ongoing regular performance monitoring of sites with feedback by BLF;
- ongoing professional development and learning opportunities, for example the communities of practice (regular cross-site meetings on a defined theme for members of the core teams who are in similar roles) and broader cross-site learning and development events;
- commissioning of specific pieces of research work, for example around community and workforce engagement, or the enhanced Healthy Child Programme to support sites in a delivering a specific ABS objective;
- core ABS programme staff have visited other sites to see what work they are doing in specific areas of interest to them.

Interviewees praised the quality of both their relationship with BLF, and the quality of the training and professional development opportunities offered to them. The training in the service design process was seen by all sites as pivotal, and game-changing in the way they were now approaching their work:

“...we were committed from the very beginning about doing the Dartington model of the service design that we’d all been trained in and actually we were, we went in a bit willing to learn but thinking ‘is this going to be for us, it sounds very intensive’, and then supported by Dartington, we did the first pilot of that process with one of our services, and by the end of the design process it was so clear where the value lay...”

Interviewees particularly valued the communities of practice and the opportunities it gave them to exchange ideas and support each other. This was partly embedded in sense of a shared experience and of doing something different to ordinary practice in public sector organisations. There are echoes of BLF’s approach to cross-site learning and development in some of the workforce learning programmes being developed locally by sites.

It will also be interesting to see the effects of this shared learning between sites on the types of programmes offered or approaches taken to things like communication:

“I came to visit the other sites, and it’s just about sharing their learning and it’s just about how it can help you develop your ways of thinking. It can give you just a bigger insight of what, well, they tried that and that was really good, or they’ve done that, and, you know, sharing things. They’ve just done a review of their speech and language services, for example, [in other ABS area], and we shared that. It’s just invaluable for what experience it brings you, and looking at things in a different perspective, and not repeating things, not thinking, well, we can do this, but then actually somebody else has done it, so let’s share it.”

### 3.6 “Process evaluation and supportive feedback mechanism” (Meyers, 2012)

Developing and embedding high quality process and outcome evaluation for individual programmes and site-wide outcomes is a key component of how ABS is being implemented in the sites. In four of the five sites, this approach has been embedded into the projects explicitly commissioned or provided as part of ABS. As part of the service mapping that took place, evaluators saw consistent evidence that sites were planning both process and outcome evaluations as part of the service design process. In the fifth site, this process was planned, although more embryonic, and evaluation plans for services that were in delivery had largely not been finalised at the time of completing this report.

#### 3.6.1 Data

Essential for the success of the evaluation plans is access to the necessary data. Sites have taken different approaches to how they collect and share data; in part, this was due to local context and pre-existing data systems that they were able to access. One site had found accessing routinely collected health data much more straightforward than the other sites because of their dual role as commissioner and provider of services; consequently, they had been able to incorporate longer term outcomes into their individual services’ evaluation plans, as well as short-term outcomes and process data, because it was easy for them to link the data. They had then developed information sharing agreements with other services.

For the other sites, gaining access to other partners' data had been very challenging, and the process of developing the required data infrastructure and data-sharing agreements had been lengthy. However, these sites saw this as crucial:

“...the reason we want to integrate data is not [just] for us for ten years, it's because it's one of our big systems change indicators so we need to kind of go at their pace...”

By enabling system-wide data sharing, sites believe they can help embed a stronger, system-wide evaluation approach in partner organisations:

“So for a lot of organisations, you know, so many public services... they're not evidence based, they're not evaluating their services so this is part of the transformative aspect of this programme, isn't it, to get people to be much more rigorous and only do the things that we know are either going to make a positive difference or are not going to cause any damage.”

A further challenge for sites was coaching and supporting the wider frontline workforce in accurately and consistently inputting the data to the standard they need to carry out their evaluations:

“...it's been quite a good hands on working relationship, we found out very early on that the hospital staff have very little [data]... very little, and it's not recorded very well so the evaluation and research team here have actually hands on worked with them to actually look at things so we've been trying, they go down, they work with them...”

The recently completed ABS Enhanced Healthy Child Programme reports ((Day, 2017a; Day, 2017b; Day, 2017c; Day, 2017d; Day, 2017e) consistently highlight that frontline practitioners find data collection burdensome and don't feel that the routine data they collect is used in a way that is helpful to them or their service; this highlights the importance of the work sites are doing to work with practitioners on this topic, as well as the value of the ABS approach's emphasis on high quality evaluation.

Sites had also had to work with evaluation materials to ensure they were appropriate for their families; common issues focused on the adaptation of materials for a low literacy audience, and translating into community languages. Some sites have used non-traditional approaches to engage parents in the evaluation process:

“...things like focus groups and traditional kind of methods, just haven't been working and so it's been for us, thinking outside of the box about how we can talk to people and oversee that information as well. So for community consultation we did cards, picture cards that people could talk around issues and prioritise those issues with cards...”

### 3.6.2 Evaluation approaches

Most sites are aiming to conduct both short- and long-term evaluations. Short term evaluations help inform the “test and learn” approach that has been adopted across the sites to help develop interventions rapidly. This was also seen as a requiring a shift in mindset by partner organisations:

“...all that about the quarterly monitoring etc., I'm not saying it's easy, I mean it is a process of change for our providers, the notion that we want you to tell us where it's not working; we want you adapt it; we want you to take on that responsibility. That's new to them because particularly many of the statutory providers, this is about 'I'm being monitored, I need to show the best thing I can show.’”

A common goal across most sites for their long-term evaluations was to be able to compare children in ABS wards with children from non-ABS wards in order to evaluate the long-term effectiveness of their programmes locally. This was complicated by the diffusion of ABS approaches across non-ABS wards:

“...one of those partners who’s [name of service], they’ve actually taken it on board themselves and they’re actually spreading it across the rest of their service so we’re seeing... I mean it’s a bit of a nightmare from an evaluative way really but we’re seeing the spread of a lot of these things beyond [name of ABS organisation]....”

### 3.7 Limitations

As with any qualitative work, there are limitations to our findings. We have interviewed key informants within the core ABS teams as the focus of the report was on the core team’s implementation processes; in future work we will also interview other key stakeholders to get an external perspective on the ABS implementation process. Limitations to the mapping exercises are outlined elsewhere in this report.

## 4.0 Conclusion

---

In conclusion, this evaluation has looked at how sites have transitioned from the set-up phase into the delivery of services through the lens of the Quality Improvement Framework (Meyers, 2012). It has considered the first two research questions of phase 1 of the implementation evaluation, namely “What system change has been implemented in each of the 5 ABS sites?” and “What processes were implemented in order to a) set up and; b) maintain the programme of services in each site?” (Warwick Consortium, 2016).

This evaluation has explored elements of the system change that has been implemented to date in each site, considering governance structures; community engagement activities; workforce development and shared data systems. It has also considered the set up and delivery of the services each site is offering, including recruitment of staff; service design processes and evaluation process.

On the basis of the evidence we have seen in interviews and documentation for the service mapping, we conclude that at the time of interviews (March 2017) in most of the sites, the transition from set-up phase into delivery of services is proceeding in a manner that fits with the ABS ethos of delivering evidence- and science-based services, co-produced with local communities and with an evaluation framework that should enable a culture of test-and-learn to become embedded. In one of the sites, this process is not as advanced as the others; however, the benefit of a lengthy period of funding, such as is the case with ABS, is that it allows time for a site to address areas that may require more work.

Moving forward, it is expected that sites over the next year will continue to increase the number of services in delivery until they are actively delivering a full range of planned services. The next implementation evaluation in this series will repeat the service mapping, together with the key informant interviews, to explore this process.

# Appendices

---

## Appendix 1: References

Big Lottery Fund. (2014). ABS outcomes Guidance 5 Feb 2014.

Big Lottery Fund. (2016). A Better Start Glossary & Illustrations – Version 2: June 2016.

Big Lottery Fund. (n.d.). A Better Start. Retrieved from <https://www.biglotteryfund.org.uk/betterstart>

Boyatzis, RE. (1998). Transforming qualitative information: Thematic analysis and code development: Sage Publications.

## Appendix 2: Quality implementation framework steps (Meyers, 2012)

“Phase One: Initial considerations regarding the host setting

“Assessment strategies

1. Conducting a needs and resources assessment
2. Conducting a fit assessment
3. Conducting a capacity/readiness assessment

“Decisions about adaptation

4. Possibility for adaptation

“Capacity-building strategies

5. Obtaining explicit buy-in from critical stakeholders and fostering a supportive community/organizational climate
6. Building general/organizational capacity
7. Staff recruitment/maintenance
8. Effective pre-innovation staff training

“Phase Two: Creating a structure for implementation

“Structural features for implementation

9. Creating implementation teams
10. Developing an implementation plan

“Phase Three: Ongoing structure once implementation begins

“Ongoing implementation support strategies

11. Technical assistance/coaching/supervision
12. Process evaluation
13. Supportive feedback mechanism

“Phase Four: Improving future applications

14. Learning from experience”

## Appendix 3: Semi-structured interview guide

### Site-wide questions (implementation):

1. For the site as a whole, please comment on a) any current plans for additional professional development for paid staff, above what was offered prior to ABS and b) any recent opportunities for additional professional development for paid staff, above what was offered prior to ABS.
2. For the site as a whole, please comment on a) any current plans for additional professional development for volunteers, above what was offered prior to ABS and b) any recent opportunities for additional professional development for volunteers, above what was offered prior to ABS.
3. For the site as a whole, please comment on your perception of any changes to the skill mix of paid staff since the ABS programme began.
4. For the site as a whole, please comment on any changes to internal staff appraisal and/or mentoring process since the ABS programme began.
5. For the site as a whole, please comment on any changes to the local service evaluation processes since the ABS process began (please consider general trends; the service-specific questions will give details of individual service evaluation plans).

### Wider engagement questions

1. Please comment on your perception of the extent to which you feel the site's vision for change for its target population is shared by other partner organisations.
2. For the site as a whole, please comment on whether the governance of ABS services is different from the processes that existed pre-ABS.
3. Please comment on any new or planned cross-organisational structures that have been developed between agencies in your ABS area to enable oversight of the ABS-related programmes since the ABS process started (please consider NHS, local authority, third sector and private sector organisations).
4. Please comment on your perception of any changes to ease of communication between the site and partner organisations, at individual practitioner, managerial, and senior level.
5. For the site as a whole, please outline the roles of any volunteers or parents in service provision, management or governance.
6. For the site as a whole, please comment on your perception of any changes to the relationship between the site and families that use your services since the ABS programme started.
7. For the site as a whole, please comment on your perception of any changes to the relationship between the site and its surrounding community since the ABS programme started.
8. For the site as a whole, please comment on what kind of community engagement activities currently take place, and if this has changed since the ABS programme began.
9. What do you think some of the most important lessons are that the site has learnt since the ABS programme began?
10. Please comment on any new or planned data sharing processes that have been developed between the site and other agencies since the ABS programme began (please consider NHS, local authority, third sector and private sector organisations).
11. Please comment on any site-wide indicators that are being developed, in addition to service-specific outcomes. Please also comment on how these indicators were developed, and the role (if any) of any other partner organisations.
12. Please describe what workforce support the ABS programme has (strategic, managerial, administrative, evaluative, service delivery) in terms of types of staff involved and what proportion of their time is allocated to ABS work.

### Family pathway questions:

1. Please could you outline how families are directed towards initial contact with the site?

2. Please could you outline for the following groups how they would be directed towards appropriate services on initial contact with the site:
  - a) Pregnant mothers
  - b) family with baby under 1 year
  - c) family with a child aged 1-5 years
3. Please could you outline examples of how you might direct a family towards services not offered by the ABS site if you felt they were appropriate.
4. For the site as a whole, please comment on your perceptions of how referral processes with partner organisations have changed since the ABS programme began.

## Appendix 4: Summary of Collective Impact Framework (Kania, 2011)

The Collective Impact framework (Kania, 2011) is based around five components that its authors argue are essential for successful social change:

1. “Common agenda”
2. “Shared measurement systems”
3. “Mutually reinforcing activities”
4. “Continuous communication”
5. “Backbone support organization”

## Appendix 5: service-mapping questionnaire

### Service specific questions

For each service offered by the site as part of ABS, please answer the following questions:

Name of service:

### Background questions

1. What is the main aim of this service?
2. a.) Are you aware of any research evidence to support the design of this service? Y/N
  - i) If yes, please could you briefly outline it or note where this evidence base is outlined?
  - b.) Please could you note where this programme's theory of change is outlined?
3. a) Did this service exist pre-ABS? Y/N
  - i) If yes, have any modifications been made to it since the ABS programme started? Y/N
  - ii) If yes, please summarise briefly.
  - ii) If yes, who provided the service pre-ABS?
4. Who provides the service currently?
5. a) Has the service provider changed since the ABS programme began? Y/N
  - b) If yes, why?
6. a) Are there any planned modifications going forward? Y/N
  - b) If yes, please summarise briefly:
7. a) How is this service funded?
  - b) Please could you indicate the approximate proportion of the funding that comes from ABS?
  - c) Please could you indicate whether this proportion has increased or decreased since the ABS programme has started?

### Target population of service

7. Which age group is the service aimed at?
8. How do families access this service?
9. a) Are there eligibility criteria? Y/N
  - i) If yes, what are they?
  - b) Who can refer?
  - c) How do they refer?

### Data collection

10. a) Do you collect information on families prior to them using the service? Y/N
  - i) If yes, what kind of information?
  - ii) How do you plan to use this information?
  - iii) Will this data be individual-level data or aggregate data?
11. a) Will any outcome data be collected? Y/N
  - i) If yes, what will be measured?
  - ii) When will this be measured?
  - iii) How will this be measured?

### Service delivery

12. What is the expected length of intervention time for this service? (e.g., is this a service that will be delivered over a short time frame, or a service that will run indefinitely?)
13. How long do sessions last for?
14. How frequently do they run?
15. Please outline briefly the format of a typical session:  
What kind of staff deliver this service?

