ABS National Evaluation Third Annual Report

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Contents

Glossary

ABS partnership: Throughout the report, those involved in ABS delivery are referred to as 'ABS partnership(s)'. ABS delivery is led by a director in a local area and delivered through a network of partnering organisations. We occasionally use the term 'site' to refer to the ABS partnerships and areas.

ABS partnership area: We refer to a geographical location of where ABS is delivered as a partnership area. ABS is delivered in five areas in England. They are: Bradford, Blackpool, Southend-on-Sea, Lambeth, and Nottingham. Within these areas, ABS activity is delivered within particular wards rather than across the whole area. We occasionally use the term 'site' to refer to the ABS partnerships and areas.

Contribution analysis: An evaluation methodology that relies upon a clearly-articulated Theory of Change (ToC) to identify and analyse chains of cause-effect events and facilitate claims about the extent to which a programme has contributed to observed changes in outcomes (HM Treasury, 2020).

Mosaic of evidence: We refer to the body of evidence being generated by the national evaluation as the 'mosaic of evidence'. Through the four evaluation objectives, we are gathering different types of data to evaluate the elements of the ABS theory of change. That evidence is being synthesised by way of the contribution analysis to enable a wholistic evaluation of the impact of ABS.

Pseudonymised data: Data is pseudonymised when identifying information is removed from the datasets to ensure that no specific individuals can be identified without additional information. All datasets for Objective 1 are pseudonymised.

Theory of Change: Theory of Change (ToC) is a way of interlinking activities or inputs of a programme to a chain of outcomes, and then using this model to guide an evaluation (Rogers et al., 2000). It shows how change happens in the short-, medium-, and long-term to achieve the intended impact of an intervention or series of interventions. A ToC also describes the conditions that need to be present for a programme to achieve its intended impact, processes triggered by a programme, and risks to achieving impact.

Quasi-experimental design: A quasi-experimental design evaluates the impact of an intervention without using randomisation to establish a comparison group. We are using quasi-experimental methods in Objective 1 of to develop a comparison group that will help us to infer what an ABS area's beneficiaries' outcomes would have been if the area had not been funded. Our approach uses both area-level and individual-level information to develop this group.

1 Executive Summary

This is the third annual report of findings in progress from the national evaluation of A Better Start. The report includes findings on child development outcomes and ways of supporting families with children aged 0-4 in the areas of diet and nutrition, communication and language, and social and emotional development. Our evaluation also reports on how A Better Start is achieving systems change across the early years sector. We report on findings from the third year of work on the national evaluation across each of the evaluation objectives. Our findings will be of relevance to those with an interest in early childhood development and in what works well in supporting parents/carers with children aged 0-4.

A Better Start is a ten-year, £215 million programme supporting communities to give their babies and toddlers the best start in life. A Better Start is funded by The National Lottery Community Fund (The Fund), the largest community funder in the UK. Between 2015 and 2025 A Better Start has supported five partnerships based in Blackpool, Bradford, Lambeth, Nottingham, and Southend to develop and test ways to improve their children's diet and nutrition, social and emotional development, and speech, language, and communication. Working with local parents and communities, A Better Start partnerships have changed local systems, including the way services are commissioned and delivered, taking a preventative, place-based approach and using evidence and learning to refine and adapt to local needs and contexts. Evidence from A Better Start is used to inform local and national policy and practice initiatives addressing early childhood development.

The national evaluation of A Better Start (ABS) is being undertaken by The ABS national evaluation team led by the National Centre for Social Research (NatCen) with their partners: University of Sussex; Research in Practice; the National Children's Bureau; and RSM. The ABS national evaluation team are working with the ABS grant funded partnerships to achieve the following four evaluation aims:

1. To draw upon the evaluation objectives and provide evidence for ABS national evaluation audiences including local and national policy makers, academics, funders, civil society, ABS partnerships, practitioners, parents and communities.
2. To provide evidence to support ABS grantholders to improve delivery outcomes throughout the lifetime of the programme.
3. To enable the Fund to confidently present evidence to inform policy and practice initiatives addressing early childhood development.
4. To work with local ABS evaluation teams to avoid duplication of evidence and enable collation of evidence from local evaluations.

There are four evaluation Objectives:

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

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

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

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

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

This is the third annual report to be published as part of the national evaluation of ABS. The final evaluation report will be published in 2026. The purpose of this report is to inform audiences of the national evaluation, evaluation activity delivered in 2024, findings to date, and next steps.

1.1 Findings to date

The annual report presents emerging findings across the four objectives. Each evaluation objective is working towards a different time scale, which is reflected in this report. While we await the findings from the quasi-experimental design (QED) for Objective 1 and the cost-consequence analysis (Objective 4), we are able to start reporting on how evidence from Objective 2 and Objective 3 is enabling us to respond to some of the contribution claims.

Findings on child development outcomes include:

- **Diet and nutrition:** ABS services have increased the accessibility of information about services which offer diet and nutrition-related support. Staff have been supported to increase their knowledge through training and the use of accessible resource materials. Tailored support has helped families to improve their diets, encouraging small, achievable goals taking into account personal circumstance

- **Communication and language:** ABS is helping to prevent poor communication and language skills in children through listening to and responding to families' needs; offering greater flexibility in service delivery; provision of free resources; and support for multi-lingualism. Greater joined up working between services has enabled more streamlined referral routes and has also encouraged upskilling for staff in both ABS and non-ABS areas. Improved parental confidence with literacy was identified as a key success.

- **Social and emotional development:** The use of a peer support approach was found to be particularly successful especially in relation to the role of parents as co-

facilitators; challenging potential social stigma which can be associated with seeking support in parenting skills and approaches; and more appropriate identification of families' needs. The offer of group activities was particularly welcomed by families. Joined-up working with partners enabled smooth transitions in and out of services.

Findings on systems change across the early years sector include:

- ABS staff buy-in towards the importance of **joined-up working** in improving outcomes, helped increase recruitment, referrals, and signposting, across all the child development areas. This has resulted in more streamlined referral routes.

- Establishing **strong communication** is seen as key in enabling **successful partnership working**. This has resulted in more developed structures of continued care, especially between ABS and non-ABS services across the early years sector, which can then offer complementary support, instead of overlapping services.

- The **offer of training** by ABS professionals to both ABS and non-ABS staff was seen as **key in upskilling** the early years workforce across the different child-level outcomes.

- Across partnerships, ABS services have implemented a variety of strategies to **engage parents**, with a strong focus on **improving accessibility**, minimising any additional burden potentially faced by parents when accessing and attending services. Partnerships have made intentional steps to be inclusive of families within their local areas. The offer of peer-led programmes was seen to be key in both reducing social stigma, and in encouraging sustainability once grant funding comes to an end. Parents' involvement in service delivery has been reported as increasing as the programme has developed, at all stages, from service design, delivery through to evaluation. This has helped services to be become more tailored to the specific needs of local families. Parents/carers are positive about the upskilling opportunities on offer to them as part of ABS, including both voluntary and paid work, opportunities to be involved in the governance of ABS, and opportunities to develop their own projects and services.

- Evidence is also emerging about **how the ABS programme is achieving change**. This is being implemented through services which are adaptive to families' needs; an approach (test and learn) to learning from evidence in making decisions about changes to services; upskilling the workforce; sharing data and information; and using evidence to inform future service delivery. **Parental engagement and co-production** are also cornerstones of the ABS approach. ABS services have implemented a variety of strategies to engage parents, many with a focus on improving accessibility and inclusivity, especially engagement of fathers, using more accessible language, and representing all ABS communities and families. Co-production was viewed as important for the **legacy of ABS**. Respondents were clear about the benefits that co-production brought to services and communities, with

some mentioning that their legacy arrangements already included plans for ongoing co-production.

As the ABS programme draws to a close, some services are continuing through acquiring alternative sources of funding, especially those founded on a strong evidence base. Some legacy services will change in terms of design or might be run on a smaller scale. There is support available for families, staff, volunteers and parent champions during the transition period where funding is ending. Sharing learning with partners was considered key to sustaining the legacy of ABS for services which were ending as well as continuing.

1.2 Progressing the national evaluation

There is one further wave of qualitative data collection to be carried out in Spring 2025 for both Objectives 2 and 3. We are analysing education outcome data as part of Objective 1 and are awaiting receipt of NHS data to begin analysis of health outcomes. The cost consequence analysis model, under development for Objective 4, was reviewed in 2024 by the evaluation's University of Sussex partner and by the evaluation advisory panel. It is currently being refined based on their guidance. Outputs from the modelling work will be presented in the final evaluation report.

More detailed next steps are provided for each evaluation objective in their respective chapters. The final results will be published in 2026.

2 Introduction

This is the third annual report of the ABS national evaluation commissioned by The Fund. It presents progress against the evaluation's four key Objectives and outlines next steps for the evaluation.

The purpose of this report is to inform audiences of the national evaluation and evaluation activity delivered in 2024, findings to date, and next steps.

The ABS national evaluation's audiences include local and national policy makers, academics, funders, civil society, ABS partnerships, practitioners, parents and communities.

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

The final evaluation report will be published in 2026. The report is structured under each of the national evaluation's four Objectives, with additional chapters providing an overall introduction to the programme and evaluation, the approach to contribution analysis and mosaic of evidence, an overarching summary, and next steps.

- **Chapters three and four** provide a summary of the ABS programme and the national evaluation design. This includes the Theory of Change (ToC) that articulates the core components and principles that underpin ABS delivery and provide a framework for the national evaluation.
- **Chapter five** describes the national evaluation methodology highlighting how we are bringing together rich and varied forms of evidence to understand the impact of ABS.
- **Chapter six** presents a synthesis of findings to date, particularly as they relate to the contribution claims (with a focus on data from Objectives 2 and 3) from which the mosaic of evidence is being built

- **Chapter seven** covers Objective 1: the contribution of ABS to the life chances of children. This chapter summarises progress made on finalising the analytical approaches for this Objective.

- **Chapter eight** covers Objective 2: factors that contribute to improving child-level outcomes. This Objective explores, in depth, how ABS is implemented within the five ABS partnerships to improve child-level outcomes and enable systems change. Findings from the waves of in-depth interviews that were carried out in 2024 are presented in this chapter with connections made with findings from previous annual reports.

- **Chapter nine** covers Objective 3: experiences of families through ABS systems. This Objective explores families' experiences of their interactions and engagement with ABS, and the difference that ABS services make to their lives. Findings presented in this chapter are from in-depth qualitative fieldwork with families across the five ABS partnerships areas.

- **Chapter ten** covers Objective 4: contribution made by ABS to reducing costs to the public purse relating to primary school-aged children. Findings to date include how ABS funding has been allocated and spent across the partnerships and programme outcomes.

- **Chapter eleven** presents some conclusions and next steps.

Considerations for reading this report

This report should be read in the context of being the third annual report. Findings should be treated as interim and overall conclusions for the four evaluation Objectives and the impact of ABS are not yet being drawn. These will develop over the course of the evaluation as we will be more assertive with claims following the final wave of data collection and analysis of education and health outcomes data.

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

Whilst reading the report, it is important to remember that the qualitative data collected reflect a relatively small number of interviews with stakeholders across the five ABS partnerships (see methods sections for Objectives 2 and 3 for full details). Throughout the interviews we explored respondents' experiences, thoughts, and perceptions and how these are influencing their behaviour and outlooks.

3 About the A Better Start programme

A Better Start is a ten-year, £215 million programme supporting communities to give their babies and toddlers the best start in life. A Better Start is funded by The National Lottery Community Fund, the largest community funder in the UK. Between 2015 and 2025 A Better Start has supported five partnerships based in Blackpool, Bradford, Lambeth, Nottingham, and Southend to develop and test ways to improve their children's diet and nutrition, social and emotional development, and speech, language, and communication. Working with local parents and communities, A Better Start partnerships have changed local systems, including the way services are commissioned and delivered, taking a preventative, place-based approach and using evidence and learning to refine and adapt to local needs and contexts. Evidence from A Better Start is used to inform local and national policy and practice initiatives addressing early childhood development.

4 About the national evaluation

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

Phase one of the national evaluation was a scoping phase carried out from April – November 2021. A summary of key activities from phase one can be found in the first annual report and the evaluation protocol.[1]

4.1 Aims and Objectives

The aims of the national evaluation are to:

- **Draw upon the evaluation Objectives** (see below) and provide evidence for ABS national evaluation audiences, including local and national policy makers, academics, funders, civil society, ABS partnerships, practitioners, parents and communities.
- **Provide evidence to support ABS grant holders to improve** delivery outcomes throughout the lifetime of the project.
- **Enable The Fund to confidently present evidence** to inform policy and practice initiatives addressing early childhood development.
- **Work with local ABS evaluation teams** to avoid duplication of evidence and enable collation of evidence from local ABS evaluations.

[1] https://natcen.ac.uk/ABS-national-evaluation

The evaluation is working to address four Objectives:

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

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

4.2 Theory of Change

Figure 1 shows the ToC developed by the national evaluation team for ABS that underpins the national evaluation. The ABS ToC was developed by synthesising information from the most recent national-level and partnership-level ToC and draws on scoping activities conducted in May – August 2021 in Phase one of the national evaluation.

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

Figure 1. A Better Start Theory of Change

Assumptions – *external events & conditions that enable the achievement of ABS outcomes*

- Resources, services, local workforces & local birth rates are **stable enough** for ABS to be implemented
- There is **sustained engagement & commitment** from services, workforce, ABS partners & community members
- ABS partners, workforce, volunteers & parents have the **capacity** to deliver and/or be involved in ABS
- Families have **sufficient exposure** to ABS services over enough time to make a difference to child outcomes

Inputs

- Funding
- Existing local services, resources & assets
- Learning & support
- ABS partners
- Evidence

Activities

- Delivering services
- Information & outreach
- Providing resources
- Improving outdoor spaces
- Training & development
- Research, evaluation & learning

Beneficiaries

- Babies & children (0-4 years)
- Pregnant people
- Parents & carers
- Community members
- Workforce

Mechanisms

Adaptive design

- Local adaptation
- Continuous, evidence-based improvement (test & learn)
- Fidelity
- Scale up & replication

Inclusion, engagement & empowerment

- Inclusivity & minimising harm
- Effective outreach & engagement
- Reducing barriers
- Empowering families & communities

Collaborative working, effective governance & capacity

- The Fund, partnerships & local partners, including parents

Outcomes

Child development

Babies and children aged 0-4 whose families are accessing ABS services have improved diet & nutrition, communication & language development, social & emotional development	Children whose families accessed ABS services have improved outcomes related to diet & nutrition, communication & language development, social & emotional development later in life	Children growing up in ABS areas have improved outcomes related to diet & nutrition, communication & language development, social & emotional development

Systems change

ABS services represent an increase in: • **co-production with families** • **joined-up working between services** • **prevention-focused and demand-led services for families**	ABS approaches are embedded and sustained across ABS LAs, resulting in more: • co-production • joined-up working between services • prevention-focused and demand-led services	ABS influences the sector and ABS approaches are adopted beyond ABS LAs, resulting in more: • co-production • joined-up working • prevention-focused and demand-led services

Risks – *external events & conditions that could dilute or prevent the achievement of ABS outcomes*

- Covid-19 pandemic
- Changes to national & local policy and funding environments (e.g. austerity, closure of children's centres)

The national evaluation benefits from the input and advice of a parent panel, practitioner panel, and an advisory group. More information about the roles of these groups is at Appendix 5.

5 Methodology

In this section we provide an overview of the methods being used in the ABS national evaluation and types of evidence generated through each Objective. More detailed methodologies of the work presented in this annual report are described within each Objective's individual chapters. For full technical detail of the methodology, refer to the evaluation protocol.

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

We assume that the Common Outcomes Framework (COF) indicators[2], agreed with ABS partnerships in 2018, articulate how ABS can improve life chances and are a core part of the ABS ToC and partnership management. To estimate the contribution of ABS requires gathering evidence of relevance to the counterfactual: 'If ABS had not been funded in this area, what would ABS beneficiary outcomes have been?'

To answer the counterfactual requires evidence about people who have not received ABS interventions. We are using administrative data to form the counterfactual to carry out the impact analysis. We are in receipt of education outcomes from the National Pupil Database. We are awaiting receipt of NHS health outcomes data before finalising our approach to analysis of health data.

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

Addressing this Objective requires us to investigate implementation of ABS at the national level. We are generating evidence of what has happened and why, and identifying internal and external factors that may have affected ABS' contribution to intended outcomes. This is done through in-depth

[2] https://www.tnlcommunityfund.org.uk/media/insights/documents/COF-External-Report-2017-v3-1.pdf?mtime=20211126121811&focal=none

fieldwork in each ABS partnership with respondents involved in ABS delivery as well as those not involved with ABS.

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

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

- What systems change means for professional support and involvement in family lives, and how that is experienced by families over time; and
- Understanding families' contribution to systems change associated with their involvement with ABS, and the implications of that contribution for families themselves, and for local systems.

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

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

5.1 Contribution analysis and mosaic of evidence

To address the four national evaluation Objectives and draw conclusions about the extent to which ABS contributes to intended outcomes and to the life chances of children who have received ABS interventions, our evaluation design draws on the principles of contribution analysis (Mayne, 2019). Through the four evaluation Objectives, we are building a mosaic of evidence from which we can construct the contribution narrative and draw conclusions about the impact of ABS.

The dynamic nature of ABS demands an evaluation approach that enables us to evidence how and why ABS has contributed to intended change or not, and that accommodates multiple contributory or causal factors. Contribution analysis provides a useful method for this. It is based on a generative approach to causality, where the goal is to describe the causal mechanism (how observed change came about). It also considers the intervention (here ABS) as occurring as part of a causal package involving ABS and other contributory factors (Mayne, 2012). For this evaluation our approach to contribution is adapted from the classic 6 steps (Mayne, 2011) which can be found in Appendix 1 and the evaluation protocol. In 2023, the evaluation developed 'contribution claims' which provide a causal narrative to some of the most important causal pathways on the ABS theory of change. These are also included at Appendix 1. The contribution claims will be further refined as we approach analysis of the mosaic of evidence from each of the objectives throughout 2025, in preparation for the final evaluation report in 2026.

6 Synthesis of findings

This third annual report has begun to highlight elements of the ABS programme where evidence is emerging to support the impact which ABS is having and where evidence is weaker or challenges the plausibility of the contribution claims. In using the contribution claims to take stock and consolidate what we know about ABS and where there are gaps still to explore, we can prioritise topics to explore in the final wave of qualitative fieldwork in 2025. This will help to complete our mosaic of evidence from which to tell the contribution story of ABS. We present below some initial discussion against some of the contribution claims using evidence from objectives 2 and 3. We also summarise some of the evidence on how ABS is achieving change. Our full mosaic of evidence will be complete when we have finalised analysis from each of the four objectives.

Child-level outcome: diet and nutrition
Children whose families are accessing ABS services have improved diet and nutrition / ABS services are preventing negative health impacts of poor nutrition on infants whose families engage with their services.

ABS services have increased the accessibility of information about services which offer diet and nutrition-related support. Staff have been supported to increase their knowledge through training and the use of accessible resource materials. Similarly to the services provided under the communication and language outcome, the flexibility of support on offer is seen as a definite

positive, especially related to breastfeeding support and advice about weaning. Tailored support has helped families to improve their diets, encouraging small, achievable goals whilst taking into account personal circumstance (for example, family budgets). The impacts of the cost-of-living crisis continue to be felt in terms of the balance between healthy food choices and affordability.

Child-level outcome: communication and language
Children whose families are accessing ABS services have improved communication and language development/ ABS services are preventing poor communication and language skills in children whose families engage with their service.

During the course of the programme, and through listening to and responding to families' needs, ABS services have offered greater flexibility in service delivery, in terms of timings and locations of services offered; provision of free resources to aid child communication and language development; provision of interpreting support and support for multi-lingualism for families whose first language is not English. Greater joined up working between services has enabled more streamlined referral routes and has also encouraged upskilling for staff in both ABS and non-ABS areas. Improved parental confidence with literacy was identified as a key success. Some of the challenges highlighted include limited capacity within the early years sector, which has had an impact on services' ability to deliver. The ongoing affects of the COVID-19 pandemic, especially in terms of a greater demand for communication support for younger children, continue to be felt.

Child-level outcome: social and emotional development
Children whose families are accessing ABS services have improved social and emotional development / build strong relationships and resilience.

The use of a peer support approach was found to be particularly successful especially in relation to the role of parents as co-facilitators; challenging potential social stigma which can be associated with seeking support in parenting skills and approaches; and more appropriate identification of families' needs. Supporting positive parenting approaches, through parenting courses or access to trusted advice and support, was seen as particularly key to provide a challenge to perceptions of stigma. Both staff and parents reported a positive impact on parental wellbeing and confidence levels. The offer of group activities was particularly welcomed by families but in some areas, staff reported needing to work on messaging around who the service was aimed at, to encourage more engagement and inclusivity. Joined-up

working with partners enabled smooth transitions in and out of services. Stigma continued to be a barrier for some families who felt as though by being referred for support they had 'done something wrong'. Limited staff capacity in some services, especially with some staff expected to take on a dual role was also a barrier.

Systems change

There is some available evidence from this third annual report against the first three of the systems-change-related contribution claims: 1) upskilling and joined-up working; 2) partnerships; and 3) parental engagement.

- **Upskilling and joined-up working:** ABS staff buy-in towards the importance of joined-up working in improving outcomes helped increase recruitment, referrals, and signposting, across all the child development areas. This has resulted in more streamlined referral routes. Establishing strong communication is seen as key in enabling successful partnership working. This has resulted in more developed structures of continued care, especially between ABS and non-ABS services across the early years sector, which can then offer complementary support, instead of overlapping services. Various services have offered upskilling opportunities, such as webinars, workshops and sessions, and other training and support, including specific training for child-level outcomes. This was found to particularly helpful in encouraging contact with other organisations (potentially leading to systems change). However, staff capacity can pose a challenge to effective joined-up working – both in ABS core teams and in partner agencies. The offer of training by ABS professionals to both ABS and non-ABS staff was seen as key in upskilling the early years workforce across the different child-level outcomes.

- **Partnerships:** across partnerships, ABS services have implemented a variety of strategies to engage parents, with a strong focus on improving accessibility, minimising any additional burden potentially faced by parents when accessing and attending services. Partnerships have made intentional steps to be inclusive of families within their local areas. The offer of peer-led programmes was seen to be key in both reducing social stigma, and in encouraging sustainability once grant funding comes to an end.

- **Parental engagement**: parental engagement and **co-production** are also cornerstones of the ABS approach. ABS services have implemented a variety of strategies to engage parents, many with a focus on improving

accessibility and inclusivity, especially engagement of fathers, using more accessible language, and representing all ABS communities and families. Some of this parental engagement work has included ABS services responding to perceived stigma in offering certain kinds of support (especially around social and emotional development, for example). Involving parents in the co-production of service design and delivery is seen as a key mechanism of empowerment, encouraging increased parental confidence, and providing upskilling opportunities for parents/carers. Co-production was viewed as important for the **legacy of ABS**. Respondents were clear about the benefits that co-production brought to services and communities, with some mentioning that their legacy arrangements already included plans for ongoing co-production. Parents' involvement in service delivery has been reported as increasing as the programme has developed, at all stages, from service design, delivery through to evaluation. This has helped services to be become more tailored to the specific needs of local families. Parents/carers are positive about the upskilling opportunities on offer to them as part of ABS, including both voluntary and paid work, opportunities to be involved in the governance of ABS, and opportunities to develop their own projects and services.

Evidence is also emerging about **how the ABS programme is achieving change**. This is being implemented through services which are adaptive to families' needs; an approach (test and learn) to learning from evidence in making decisions about changes to services; upskilling the workforce (highlighted above); sharing data and information; and using evidence to inform future service delivery.

- **Services which are adaptive to the needs of families:** examples included changes in the timing of referral processes, widening of eligibility criteria, and increasing the regularity of contact points with families to match development milestones.

- **Test and learn:** implementing a 'test and learn' approach to service design and delivery means that services are able to adapt in an agile and responsive manner. Adapting to something which has been found to not work well is not considered a failure but a legitimate response to evidence-based learning. Evidence is emerging on the implementation of test and learn to decisions around geographical areas of service delivery and changes in venues for where support is offered. Services also used a

test and learn to determining the best ways to engage with families and in communicating about the kinds of service available.

- **Sharing data and information:** clear guidelines for sharing data, as well as partnership working, have resulted in increased and streamlined data sharing across ABS services. However, not all ABS services had the same data tracking systems, which caused difficulties when transferring data across ABS services. Some services also faced challenges around GDPR and privacy, and one parental engagement service struggled with their staff not having enough capacity and time to collect and share registration and enrolment data with ABS and other partners. Increased data sharing has been helpful in the identification of potentially-eligible families; has enabled partners to be updated on families' care; and has increased opportunities for learning about ABS in non-ABS areas and services.

- **Evidence-informed service design and delivery:** the gradual building of the ABS evidence base was viewed as good practice. The ABS approach to the use of data has included datasets including assessment data on childhood development outcomes and feedback from parents and staff.

The ongoing legacy of ABS as the programme draws to a close has been a focus of attention over the last 12 months, in particular. In some cases, services are continuing through acquiring alternative sources of funding, especially those founded on a strong evidence base. Some legacy services will change in terms of design or might be run on a smaller scale. There is support available for families, staff, volunteers and parent champions during the transition period where funding is ending.

Sharing learning with partners was considered key to sustaining the legacy of ABS for services which were ending as well as continuing.

7 Evaluating impact on child-level outcomes (Objective 1)

7.1 Aims of the objective

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

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

7.2 Progress made in 2024

The focus for Objective 1 in 2024 was to obtain data for analysis, with additional progress made on analysis. This section describes the processes undertaken for getting access to data from various sources, and the progress made with analysis to date.

Data applications and requests

We completed the following key steps in 2024 relating to data applications and requests:

- We proceeded with the request for NHS England data required to analyse impacts on health outcomes. The application has now been approved and a data sharing agreement (DSA) between NHS England and the Fund was signed on 29 Jan 2025. The data request is now being processed by NHS England. It is expected that the requested data will be made available up to sixteen weeks after a DSA is signed.

- We completed the application process for Department for Education data. As part of this process, we finalised that there will be no impact analysis for child abuse and neglect outcomes due to limited data availability. We have been granted access to the requested data and have started with data preparation and analysis.

- We received pseudonymised data on ABS beneficiaries from three ABS partnership sites: Blackpool, Lambeth, and Nottingham. This data

primarily covered health outcomes and would enable additional analysis approaches in conjunction with NHS England data.

These steps have been in preparation for completing impact analysis this year. We will estimate the impact of ABS on the outcomes of interest using individual- level weighting to compare the outcomes of ABS beneficiaries with outcomes of non-ABS individuals weighted to be similar in characteristics to the ABS group.

Analysis approaches

Main estimates of impact

Our main planned analysis approach for most outcomes and sites is a **'whole ward' analysis.** This approach compares residents of ABS electoral wards (henceforth 'wards') to those of residents of non-ABS wards to understand whether ABS had an impact on their outcomes. ABS may have had a direct impact on residents who participated in, and therefore directly benefited from, programme activities. It may also have had an indirect impact on residents' outcomes (even if they did not directly participate) by bringing about systems-level change in the area. This approach will make use of publicly available data from NHS England and the Department for Education. Details about the datasets and outcomes analysed are included in Appendix 2.

Whole-ward analysis will be the only analysis approach for most education outcomes.[3] ABS interventions are targeted at children four years old or younger. We will measure the impacts of ABS on education outcomes at older ages, such as Key Stage 1 and Key Stage 2 attainment, captured when children are about 7 and 11, respectively. This assessment will help us determine whether the impacts of ABS contribute to longer-term development for children. Specifically, we aim to evaluate benefits for a broad group of children who might have benefitted from systems-level change in their local communities.

Initial analysis of education data to date has involved descriptive analysis of the three main education outcomes using inverse probability of treatment weighting at the individual level (school readiness, Key Stage 1 and Key Stage 2 attainment).

[3] We will not be able to estimate impacts on child abuse and neglect outcomes using any of the approaches due to limitations with data availability. Details are included in Appendix 1.

Additional analysis approaches

We have planned two additional approaches for analysing direct impacts of ABS on the health outcomes of beneficiaries. These approaches will be used for outcomes (within sites) where data is available and there are sufficient individuals included in the data to be able to detect meaningful effects.[4]

- The first approach will consider the impact of ABS on beneficiaries who provided opt-in consent to link their records from NHS England datasets. The resulting data will be stripped of any identifying information (pseudonymised) before being shared with NatCen.

  The decision on whether this approach will be conducted for each outcome and site depends on the available sample sizes in the analysis dataset after linking.

- The second approach will use pseudonymised data shared by sites on outcomes and characteristics of ABS beneficiaries. Due to the number of consents being too low to detect meaningful effects in most cases, this approach was considered where suitable data was available. This approach would estimate the impact of ABS on the outcomes of *all* beneficiaries in ABS wards compared to their outcomes had ABS not been active in their area.

  As all ABS beneficiaries in ABS wards would be included in this analysis, this approach would allow for larger sample sizes in comparison to only using data from consented beneficiaries. This is the only approach for Lambeth, where a consent process was not run as existing data systems within the partnership allowed for pseudonymised data to be shared. It was additionally explored for sites where this data existed, and consent numbers were too low or where data was not available for a subset of outcomes (Blackpool and Nottingham).

[4] The whole ward analysis approach is not feasible for the analysis of breastfeeding and ASQ outcomes in Nottingham as this data will not be available from NHS England for all Nottingham residents.

Datasets and outcome definitions

Education data from the Department for Education

We applied for Department for Education data in December 2023. The application requested data from the National Pupil Database (NPD), including information on outcomes and characteristics of all children resident in ABS wards in the five ABS partnership areas, as well as all children in matched non-ABS wards. The data request included data for these children corresponding to the 2022-23 academic year (or the data cohort that most closely aligns with this period).

Data on children from ABS and non-ABS wards in the following datasets have been included in the request, with outcomes defined as specified in the Common Outcomes Framework (Bonin and others, 2016):

- Early Years Foundation Stage Profile (EYFSP) data from the 2022-23 academic year. This dataset is linked at the individual pupil level to school and early years census data, and is used to define the **school readiness** outcome. Most children were assessed for their Foundation Stage Profile assessment by their teachers at the end of the reception year, with their records included in the school census for 2022-23. A smaller number of children, assessed in non-school settings, have records included in the early years' census. The early years census primarily covers children aged 2 to 4 who receive early years entitlements.[5]

- Key Stage 1 (KS1) data from the 2022-23 academic year. This dataset is linked to school census data from 2022-23 at the individual pupil and school level. This dataset is used to define the **KS1 attainment** outcome.

- Key Stage 2 (KS2) data from the 2022-23 academic year. This dataset is linked to school census data from 2022-23 at the individual pupil and school level. This dataset is used to define the **KS2 attainment** outcome.

- Children in Need (CIN) data from April 2022-March 2023 to identify outcomes related to abuse and neglect:

    - Children aged 0 to 4 years who are assessed to be **CIN due to abuse or neglect**. This measure includes children at risk of abuse and

neglect or domestic violence. The data includes all children assessed by social services, out of whom some are identified as CIN.

- **Children aged 0 to 4 years on Child Protection Plans** (CPP). This measure includes children assessed as being at risk of harm at child protection conferences, who are subjects of CPPs.

The CIN data does not include information on children who are not assessed by social services. Without information on *all* children aged 0 to 4, we would not be able to compare children in ABS wards to a weighted group of children with similar characteristics in non-ABS wards on their likelihood to be identified as CIN. This means we will not be able to assess if ABS had an impact on whether children were likely to be identified as CIN or be on CPPs.

CIN data does not have information on electoral wards and only identifies children's local authorities. Analysis would describe whether the rate of CIN aged 0-4y in ABS local authorities is different from the average rate of CIN in this age group across other English local authorities. The analysis will therefore not allow for a meaningful estimate of ABS on CIN status.

The data application was processed by the Department for Education in early 2024. As part of this process, the data request and planned analysis approaches were updated to reflect data availability, particularly for sensitive data. For instance, the CIN data request and analysis was updated to reflect the sensitivity and limited availability of geographical information in the data.

Health data from NHS England

We applied for NHS England data in October 2023 through the Data Application Request Service (DARS).

The following datasets and outcomes were included in the DARS application:

- Community Services Data Set (CSDS): This dataset includes wide-ranging information on children and adults including their personal and demographic information, diagnoses, and scored assessments. The following outcomes will be analysed from this dataset:

    - Children's **overall development**, which is measured using the overall Ages and Stages Questionnaire (ASQ), the ASQ-3.

- Children's **communication skills**, which is measured using the score on the communication domain of the ASQ-3.

- Children's **socio-emotional development**, which is measured using the ASQ-SE (Ages and Stages Questionnaire: Social Emotional) where available. The ASQ-SE is a supplement to the ASQ-3 which monitors children's behavioural development and screens them for the risk of social and emotional difficulties. In some areas, the ASQ-SE is only administered after the ASQ-3 indicates a potential problem. Where it is not available, the personal-social domain of the ASQ-3 will be used instead.

- Emergency Care Data Set (ECDS): This dataset includes records of emergency department admissions, with multiple records for individuals with multiple admissions. The following outcome will be identified from this dataset:

    - **A&E attendances or emergency hospital admissions** of children aged 0-4. To define this outcome, we will link data from the ECDS with Maternity Services records. This linkage will use data from April 2018 onwards to identify birth records of all children in the UK aged 0 to 4 from June 2022 to June 2024.

- Maternity Services Data Set (MSDS): This dataset includes key information about individuals across stages of the maternity care pathway, including details on mothers' and babies' demographics, antenatal bookings, screening tests, diagnoses, and labour and delivery. The following outcomes are to be identified from this dataset:

    - Perinatal **maternal mental health**, which is defined using mothers' scores on the Generalised Anxiety Disorder (GAD-7), the Patient Health Questionnaire (PHQ-9), or the two Whooley questions which are used to screen for depression. Impact on this measure will only be assessed using postnatal assessments.

    - Mother's **smoking status at delivery**, which is measured using information on mother's smoking status collected at the time of delivery.

    - Child's **birth weight**, which is measured using birth weight information captured on deliveries completed to term (gestation of 37 weeks or longer).

- Child's **gestational age at birth**, which is measured using information on the gestational age of the baby at birth.

- Child's **breastfeeding status at 6-8 weeks**, which is measured using information collected during the 6-to-8-week check-up on breastfeeding status, where babies are recorded as being totally, partially, or not breastfed.

The data application includes two cohorts of data[6]:

- A cohort of beneficiaries who provided opt-in consent for us to link their personal identifying information to NHS England records. We will provide NHS England with identifying information including names and NHS numbers. This information will be used to identify records for these individuals in the datasets of interest.

- A second larger cohort will include data on individuals across the whole of England. This data will be minimised upon receipt to only include residents of ABS and non-ABS wards that were identified previously through area-level matching. This data will be used to identify the comparison group for all analysis approaches and will also be used to identify residents of ABS wards for whole-ward analysis.

Pseudonymised data from sites

As outlined above, we have explored the possibility of using pseudonymised data on all ABS beneficiaries within sites to supplement our analysis approach. We requested and have received pseudonymised data from three sites: Blackpool, Nottingham and Lambeth.

From each site, we received pseudonymised data for beneficiaries residing in both ABS and non-ABS wards within the sites[7]. However, for the analysis we will only use data from residents in ABS wards. The reason for this is that we conducted area-level matching to identify non-ABS electoral wards outside each site that were comparable to the ABS wards within the sites. Consequently, pseudonymised data provided for individuals residing in non-ABS wards will not be included in our analysis as the impact analysis seeks to compare the outcomes of individuals in ABS wards to those in the matched non-ABS wards.

[6] Additional detail on the cohorts requested from NHS England are included in Appendix 1.
[7] Appendix 1 summarises the data completeness of the pseudonymised data shared by sites.

Pseudonymised beneficiary analysis was not explored for Southend as the data was not available. It was also not considered for Bradford as sample sizes from the recruitment of consented beneficiaries are already sufficiently large to expect analysis to be well-powered to detect at least a 'medium'-sized effect.

7.3 Next steps

Completing analysis across all approaches and synthesising findings

The impact analysis will investigate whether ABS had a causal impact on outcomes of exposed or benefitting individuals. Upcoming work will involve finalising the analysis approaches to be used following assessment of the NHS England data available. We will make a final decision on which approaches will be used for analysis of health outcomes once we have the final sample sizes available for analysis after datasets on outcomes are linked. This is expected in Spring 2025, at the earliest.

The impact evaluation findings from the quasi-experimental design (QED) of Objective 1 will feed into the broader evaluation of ABS. The QED impact evaluation findings will therefore be interpreted alongside other evidence generated across the overall evaluation. For instance, findings that there were no differences between ABS and non-ABS wards would be interpreted alongside information on reach and recruitment to infer the nature of the impact.

Additional information on ABS programme implementation would also inform the interpretation of findings showing differences between ABS and non-ABS wards. Contextual information would indicate whether these differences may arise due to high levels of service use or overall systems change, or particularly high effects among specific targeted beneficiaries. Contextual information may also inform the extent to which findings are biased due to selection bias or unobserved characteristics that are not captured in the data.

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

8.1 Aims of the objective

Objective 2 sets out to identify the factors that contribute to outcomes of diet and nutrition, communication and language, social and emotional development and systems change in interventions delivered by ABS partnerships. Through interviews with practitioners, we explore the successes and challenges associated with working towards these aims and lessons learned about how best to achieve positive change in children and families' lives.

8.2 Methods used

Objective 2 uses qualitative methods to understand how ABS partnerships work and how this has changed over time. This comprises in-depth interviews with:

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

In-depth interviews took place across two waves of data collection in 2024:

- Wave 1 (July 2024): ABS respondents.
- Wave 2 (November – December 2024): ABS and non-ABS respondents.

In total, we conducted interviews with 32 ABS respondents and six non-ABS respondents including The Fund in 2024. Interviews were conducted by NatCen researchers on Microsoft Teams and lasted around 60 minutes. Topic

guides were developed to ensure consistent topic coverage across respondents. Separate topic guides were drafted for ABS and non-ABS respondents consisting of a number of question sets, which were used flexibly depending on respondents' involvement with ABS. Qualitative data was managed and thematically analysed (charted) using NatCen's Framework approach[8]. More information on methods is available in the evaluation protocol. The topics asked in interview with ABS and non-ABS respondents are presented in Table 1 below.

Table 1: Topics for ABS and non-ABS interviews

ABS respondents	Non-ABS respondents
Their involvement in their local ABS partnership	Their involvement in the Early Years sector
Key successes and challenges for ABS in their area	Key successes and challenges in the Early Years sector in their area
What worked well and less well in achieving key child-level outcomes	What has worked well and less well in achieving key child-level outcomes in their area
What has worked well and less well in achieving systems change and the mechanisms that underpin these changes	What has worked well and less well in achieving systems change (if relevant)
Their understanding of parental engagement strategies and what has worked well and less well when applying them	Their understanding of parental engagement strategies and what has worked well and less well when applying them
The arrangements for services and projects after ABS funding ends	

In interviews with ABS respondents, we focused on the specific project(s) or service(s) that they were involved in rather than discussing ABS as a whole. This allowed us to explore respondent experiences of ABS in depth and understand better what ABS looks like in practice. This enabled respondents to speak from a place of knowledge and expertise and provide us with nuance and detail rather than general, broad statements, especially as many respondents were not involved in ABS at a strategic level.

[8] Ritchie J., Lewis J., Nicholls C., Ormston, R. (2014). Qualitative research practice: A guide for social science students and researchers. London: Sage

Table 2: Sample of ABS respondents by interview type

Interview type	Number of interviews
First interview	18
Follow-up interview	14
Total	32

Table 3: Sample of ABS respondents by partnership

ABS partnership	Number of interviews
Blackpool	7
Bradford[9]	6
Lambeth	7
Nottingham	5
Southend	7
Total	32

8.3 Findings to date

The following sections summarise findings related to the three child-level outcome areas across the two waves of fieldwork for Objective 2 in 2024. Common themes and findings from across the outcome areas are presented together, while those that are unique to each outcome are highlighted separately. These sections are structured to include respondents' discussions on:

- The key aim(s) for the outcome.
- What has worked well, covering both ways of working and outcomes for children and families.
- Areas where respondents have had mixed views or experiences within and across waves.
- What has worked less well.

Findings relating to systems change and mechanisms, parental engagement and legacy are also presented.

Similarities across child-level outcomes

Aims and priorities of child level outcomes

ABS services and projects continued to prioritise early intervention, as opposed to employing a corrective approach. This was evident across child-level outcomes and was seen to be closely connected to **school readiness**, which was a key outcome for many services. ABS staff saw school readiness as something individual to each child which should involve working to meet the child's potential rather than ticking off a set of development outcomes.

> I don't like to talk about school readiness in a deficit way in terms of, children must be able to do this, and if they can't do that, then they're not ready. What I like to talk about school readiness is around them being able to access what's available to them and to make best use of it. **Delivery partner**

What worked well

Across child-level outcomes, staff discussed progress in **reaching a more representative mix of families**, by providing a service offer that was inclusive of different groups. Examples of this included reaching families who spoke other languages by utilising volunteers fluent in languages other than English, and supporting families in foster care arrangements to deliver maternal expressed breast milk to looked after children. Respondents also explained that expanding provision to areas outside of ABS wards resulted in a natural increase in the diversity of families attending activities.

Services establishing a **physical presence in the community** was another area of success for many services. Examples of this included services having a presence in maternity wards, children's centres, drug and alcohol services and homeless shelters where families would already be, which helped improve awareness of, and access to, services. One respondent said this also helped them access fathers who they might otherwise not have access to. Being co-located with other services also improved opportunities for partnership working.

What worked less well / challenges

A prominent theme across both waves of fieldwork was **uncertainty about funding** and the inevitable impact this would have on the future of services and their ability to operate on reduced budgets. Funding for early years more

broadly was also a concern; one respondent was worried about children's centres closing as that is where their service was based.

> It's unfortunately, uncertain times. That's not a direct challenge because of [ABS's] exit, but if there aren't buildings, if there aren't people, if there isn't training, how can you sustain? **Delivery partner**

Diet and nutrition

Aims and priorities of diet and nutrition outcome

ABS respondents highlighted similar aims and priorities to those reported in previous waves of fieldwork.

Across partnerships, breastfeeding support services **worked towards different objectives regarding breastfeeding**. Whilst improving initiation rates remained a key outcome for some services, other respondents suggested focus had shifted as initiation rates in their area had surpassed the national average. Instead, one partnership focused on supporting women to maintain breastfeeding particularly at 6-8 weeks and 4 months (which were identified as points when women often stopped breastfeeding). Alternatively, one respondent suggested focus of services had shifted to boosting women's willingness and confidence to breastfeed.

> In terms of breastfeeding, to increase breastfeeding, not necessarily breastfeeding initiation rates […] those rates already look great, […]. More looking at the breastfeeding rates at six-to-eight weeks, and then at four months […] for families to feel confident and comfortable to be practising extended breastfeeding, if that's what's right for them and their child. **Service manager**

Similarly to previous waves, respondents described ways their service **facilitated social and community support** which helped parents meet and share advice, in addition to practitioner-led activities. One respondent described an annual event which included free activities and food to help families learn about diet and nutrition whilst expanding their social network. Another respondent described how support groups in community settings, such as family cooking classes and food ambassador courses, allowed families to share learning with one another whilst cooking.

> We ran a lot of events and there'd always be a food element and food being the connecting thing that holds you there a little bit longer [...]

> whilst you're waiting, you're having a conversation with someone else and comparing notes with your kids' eating habits or whatever it is. We do a lot around creating spaces and moments where food facilitates a lot more other than just quelling your hunger. **Programme manager**

Focus moved from childhood obesity towards the **promotion of healthy lifestyle choices** more generally, with a focus on early intervention to reduce the burden on statutory services. Across partnerships, introducing solid foods was a focus of services for parents with children over six-months and, under the extended breastfeeding support offer, some services focused on information about healthy snacks or balanced food plates for early years. Respondents highlighted that the promotion of healthy lifestyles also led other family members to making improvements in their own diets.

> Often parents will report healthy lifestyles themselves, and often you'll see things like maternal weight loss as well, as a side outcome from the two ones that are ours, which are that the child has a healthier diet and that they're more physically active. **Service manager**

What worked well

As in previous waves, ABS respondents described successfully **increasing the accessibility of information** about services. Respondents outlined different ways in which they achieved this:

- **Resources and training:** ABS staff were supported to increase their knowledge by accessing training from the institute of Health Visiting and using the accessible resource materials which they could then use with families. Another example was staff being given an updated training booklet about breastfeeding and bottle feeding, which increased their confidence to share information with parents.

- **Signposting and referrals.** Respondents described adding links to the council website to make it easier for families to access information about services. One respondent highlighted how information about ABS services is shared in non-ABS groups such as the health visiting-run clinic where babies are weighed.

- **Multi-channel support**. Support and advice were provided to parents via a range of channels, including on post-natal wards, so women could learn how to breastfeed before leaving the hospital. Respondents also cited

support through workshops, drop-in services, home-visits and telephone services.

Similarly, accessible information was a priority for a non-ABS breastfeeding support service, which had a presence on maternity wards and was working towards having documents translated for the benefit of the diverse community.

In some instances, **tailored support helped families improve their diets.** One respondent suggested that 'smart goals', describing a set of personalised goals, were particularly successful in enabling families to make small changes in their diet, whilst taking into account their unique circumstances. For example, showing families living in temporary accommodation to add tinned vegetables to pot noodles.

> Involving families in the decision-making about what sessions they want, and in around making their own smart goals at the end of each session, and then reviewing those smart goals at the start of the next session, has helped to personalise it, individualise it, and for them to be able to embed it […] , it empowered the parent to start to make those changes, even if they're just small. **Service manager**

Across partnerships, respondents described **different modes of training** which increased staff confidence and relieved staffing challenges. For example, one service developed an online training pathway with the National Breastfeeding Service and the Association of Breastfeeding Mothers, which enabled three members of staff to qualify as infant feeding practitioners, resolving challenges previously caused by understaffing in service delivery. A respondent from a non-ABS breastfeeding support service also noted the importance of frequent training in infant feeding, but due to limited funding they often relied on free learning resources provided by the NHS. Additionally, they recruited accredited infant feeding workers, rather than training practitioners in-house.

What worked less well / challenges

Respondents illustrated ongoing challenges associated with the **cost-of-living crisis**. A food club, which hosts activities where families can try new foods and share recipe ideas, struggled to provide a sufficient quantity and variety of food due to rising costs and a decline in donations. One respondent suggested that food pantries remained inaccessible for some groups, where prices for food bundles remained too high. Services worked with the council

to provide one-off food vouchers to help groups such as asylum seekers, but due to limited budgets, this solution was only short-term.

> They don't have the money, so initially, we had pantry vouchers that would help support them to access, but […] being sanctuary seekers, they can't really, they can only rely on the vouchers, because they get what, £7 a week or something. **Programme manager**

In one partnership, a respondent in a breastfeeding support service identified a **gap in knowledge about infant feeding for families who had not considered breastfeeding.** This respondent felt infant feedings was not always given enough attention by health visitors and midwives due to time constraints. As the ABS service was focussed on working with families who had been referred, they also did not have scope to address this gap without longer-term funding, and the respondent suggested that a more comprehensive programme of work would be needed to make this a reality.

> It takes a lot of investment and time to see any change within a community and unfortunately we don't have a lot of that left. […] We have no scope within the current commission to look at how we might work with people who might not have considered breastfeeding […] That's a longer piece of work. **Programme manager**

One respondent reported **difficulties around discussing children's Body Mass Index (BMI) with parents.** This respondent highlighted that health-visiting staff rarely have BMI calculated when doing other assessments and the child's red book does not include a BMI chart. Despite the ABS project giving health visitors a laminated copy of the BMI chart, it is still not always used. This puts the onus on parents to calculate their child's BMI using an online calculator which is not intuitive. The respondent suggested conversations around children's BMI need to happen earlier, so that it is easier for parents to identify when their child is becoming an unhealthy weight and take the appropriate action.

> As a parent, that BMI measurement, as a parent, the first time you hear about your child being overweight or obese shouldn't be on a letter when they're five years old and in school. We should be looking at that BMI from the age of two, which is when it's recommended to start measuring their BMI. A barrier is not having the tools to be able to do that. **Service manager**

Communication and language

Aims and priorities of communication and language outcome

The aims and priorities identified by ABS respondents drew similarities to those reported in previous waves of fieldwork, with some new themes also identified.

As in the previous wave, services aimed to **provide appropriate support for children with delayed speech and language**, by working with them and their families to reduce its potential future impact. Expanding the reach of this support was important; one respondent spoke about ensuring those who live on the outskirts of the city were able to access them.

Several respondents emphasised that their work aimed to **translate formal communication and language support into activities which could take place in the family home.** By focusing on the parent-child relationship and how communication and language development integrates into daily life, these services aimed to empower parents to support their child's communication and language development. This was via activities such as reading, singing or chatting to their child. This strategy ensured that work was able to continue after service input ended, as parents had the knowledge and confidence to support their child's development.

> We understand that parents are their child's most important teacher [...] Our long-term goal is to give those skills and knowledge to that parent to continue supporting their child within their home **Programme Manager**

Lastly, ABS respondents noted the importance of **projects targeting communication and language, and social and emotional development**. Several respondents explained that the priorities for these outcome areas overlap, as children with language delays often present with behavioural difficulties due to frustration about not being able to communicate. Understanding and recognising different presentations upon referral into the project to best support the child was therefore a priority.

What worked well

Several ABS respondents emphasised the importance of **listening to families' needs** to improve the service they offered. Key strategies included:

- **Flexibility in service delivery.** Flexible session timings and locations increased attendance; those who faced barriers to attending sessions in the community could receive them at home, whilst those who preferred not to have staff enter their home could attend specific locations, such as Family Hubs.

- **Provision of free resources.** Families in financial hardship highlighted that the availability of free ABS resources, such as books and activities to do at home, enabled them to engage in enjoyable activities with their child that also supported their child's communication and language development.

- **Tailored language support.** Providing interpreters for families whose first language was not English enabled those who may typically not be able to access a service to receive support.

Working with other services also allowed for **upskilling of both ABS and non-ABS staff**. Since the previous wave of fieldwork, one service had delivered training to staff working at a Family Hub so that they could deliver their universal communication and language group. The benefits of this were twofold: Family Hubs staff were in receipt of training and therefore upskilling, whilst ABS staff were left with increased capacity to deliver more targeted work, which required their specific expertise. Separately, ABS staff in one service helped nursery staff with strategies to support parents whose children had communication and language difficulties. They noted how staff often knew what they should be doing to support children's language, but not necessarily how to help parents to support their children. They addressed this through hosting five to six weekly sessions, showing them strategies to use with parents.

Improving parental confidence with literacy was deemed a success by several partnerships. Services were able to support parents to have the confidence, knowledge and skills to engage with their children from an early age. Examples were given of organising library visits to aid parents with making the first step in accessing local support, particularly those who may have been reluctant to engage with books due to their own lower levels of literacy. In addition, working in the family home allowed for parents to attempt modelling without the pressure of a larger group setting, fostering confidence.

What worked less well / challenges

Respondents shared how the **wider context** within which ABS services are operating continues to be pressured, with the effects of the COVID-19 pandemic on service operations and the cost-of-living crisis prominent. These have often disproportionately impacted disadvantaged families who have other, often more pressing needs, that need to be met. This has meant that services "haven't been able to turn the dial" as much as they would have liked in supporting these families with improving their child's communication and language.

Other contextual factors shared by respondents include the ripple effect felt as a result of **limited capacity in early years settings**. While some services hoped that settings would use materials they had provided, such as books and activities aimed at supporting children's communication and language development, only a small number of settings have had the time and resource to reach out and access them. This has meant that the intention for widespread impact and joined up working has not always been achieved. Respondents also recognised that whereas ABS staff are able to promote the benefits of the resources to early years staff, the staff themselves were less able to relay the value of resources to parents. This process of training early years staff requires time, which is frequently in short supply.

Some ABS respondents described **conflicting communication and language strategies** promoted to parents, early years practitioners and the community by non-ABS bodies. For instance, one external strategy from the Social Mobility Commission, an advisory body to the Department for Education, asks children to identify a scrambled word using capital letters. The respondent noted how children under five are often taught using lower case and are only just starting to recognise the letters in their name at this age. Conflicts such as this have led to confusion around which strategies families should use.

> So, [the Social Mobility Commission is] anti the strategies that we've embedded and they're very stoic in terms of it's our way or no way sort of thing. **Service manager**

One respondent highlighted **incorrect perceptions of service capacity,** explaining that other services were hesitant to refer children to them due to perceptions of poor capacity within the speech and language team. This was a particular challenge for children who presented with moderate speech and language delays, as those with greater communication needs were prioritised. In reality, the team encouraged referrals and felt the lower referral rate for

this group of children was detrimental to early intervention, delaying the age at which children received appropriate support.

Social and emotional development

Aims and priorities of social and emotional development outcome

In line with previous waves, **early intervention** was a key priority for services working towards social and emotional development. This meant both universal and targeted services were aiming for families to receive support as soon as possible. The reasons for this included:

- Preventing reliance on statutory services later in life, which one respondent said could be more “invasive” and “stigmatising”.
- Creating a safe environment for emotional development and to develop healthy coping strategies before they are needed.
- Ensuring parents receive the right information before they learn misconceptions about parenting from other sources.

As well as working to promote the bond between children and parents, respondents also spoke about the importance of **increasing parents’ own wellbeing and confidence** in achieving positive outcomes for children. This work was seen as an important part of the intervention as parents’ ability to manage their own emotions was key to helping them manage their children’s emotions. It was also important for parents to have the confidence to use the skills they had learned outside of the therapeutic setting.

> The intention is to increase parental confidence, increase their knowledge and give them some resilience, so that if they're in that situation again they've got something to pull out the bag and say, 'Well, I've done it before, so I'm going to do it again’. **Service manager**

Universal services aimed to provide opportunities for families to connect with each other, to **reduce feelings of isolation and improve wellbeing**. Activities were delivered in a relaxed setting, e.g. a community garden, and gave families the flexibility to drop in, rather than having to be available at a particular time. Staff were also mental health trained and could provide more support where necessary.

In the last two waves of fieldwork, we also talked to respondents from services with **specific, targeted aims around social and emotional development**. These included:

- **Prevention of harm**. Respondents from two services described their services specifically working towards reducing or preventing harm to children. This came in the form of creating a safe home environment for children, education about how to make the right choices about children's health, and supporting parents to address trauma and prevent future abuse.

- **Keeping families together**. Another service worked with families with children's social care involvement to avoid separations where possible and taking a trauma-informed approach to separations where this was necessary for the safety of the child.

What worked well

Using a **peer support approach** was seen as particularly successful for services targeting social and emotional development. Respondents described two ways in which parents brought value to their service delivery:

As co-facilitators. Respondents from services providing universal support described a number of ways parents were involved in service delivery, which had the following positive impacts:

- **To challenge social stigma**. Services that had peer-led elements, such as a parenting programme where facilitators are parents themselves, worked well as there is stigma around parents needing support with parenting. Having these messages come from peers who have lived experiences of the same challenges made parents more amenable to the messages.

- **Identifying families' needs**. In one parenting service where parents co-delivered sessions, their knowledge of the families attending the sessions allowed them to better tailor the sessions to the group.

As a community. The group element of some services was important for helping families get the most out of the support. The benefits of group work included:

- **Reducing isolation**. One respondent recognised the impact of the connections fostered in group sessions, as it created bonds between parents and reduced feelings of isolation.

- **Establishing social support networks**. Parents continued to connect with each other even after the end of the programme which enabled parents to support each other and for children to have opportunities to interact with each other.

Social support was also a key priority for a non-ABS perinatal mental health service. Staff helped to facilitate this by holding group sessions in different locations, e.g. a soft play area, to give parents a natural place to meet again on their own.

Respondents described successes in meeting families' needs more effectively through **employing an adaptive and flexible approach**. This included:

- **Dedicating time to understanding families' needs**. One service allocated 3-5 sessions to therapeutic assessment. Not only did this help staff understand families' needs and so they could get the most out of the service offer, but this also increased engagement.

- Spending that time with a family […], really understanding them and connecting with their story, taking our time to do that. It shouldn't feel like a luxury and a privilege to have the time to do that. **Service manager**

- **Drawing on staff expertise.** For one service, having a multidisciplinary team of practitioners with a range of backgrounds and specialisms, including psychologists, social workers and specialist midwives, meant they were able to assess who was best placed to provide support and in turn, offer a bespoke service to families depending on their needs.

Respondents also reflected on successful **joined-up working with partners** to ensure smooth transitions into and out of services. Services worked closely with health visitors to identify families who needed support with the parent-infant relationship, and with public health to strengthen the pathways of support for children who aged out of ABS services, where necessary. This ensured families in ABS services were supported in their transition into statutory provision and enabled a cohesive experience for families with children of different ages. For both ABS and non-ABS services in areas with Start for Life funding, working with Family Hubs was a crucial for ensuring families were signposted to the range of support on offer for older children.

What worked less well / challenges

Stigma continued to be a barrier to some families engaging with social and emotional development services. Some parents felt that being referred for

support meant that they were failing or doing something wrong as parents. One respondent highlighted that young parents were a group that particularly feared being judged which made them resistant to accepting support. In response to these challenges, service staff employed a number of strategies, including using groups such as craft sessions and play and learn sessions to identify parents who may benefit from more targeted support. They also avoided marketing interventions for specific demographics of families, e.g. those experiencing domestic abuse, as they found it "put people off" as they felt singled out.

> Sometimes it can be a struggle. Parents think that, 'Are you saying that we're neglecting our children because we're having to do this?' […] I suppose it's just about having those conversations and just saying, 'It's not like that. We're doing this to support you to have all the skills you need. **Delivery partner**

Respondents identified **staff capacity** as another barrier. Limited staff capacity in one service impacted their ability to deliver training to the workforce. There is high demand for training on infant mental health, to improve practitioners' confidence to talk about parent-infant relationships, however time restrictions limited the number of full-day sessions one service could deliver. In response, staff in one service have started to run shorter online sessions to deliver the key messages, in addition to their longer sessions.

Lastly, staff noted the challenges around services **shifting focus from universal support to more targeted support**. One reason for this shift was that services were seeing a higher number of families requiring specialist support and having to respond accordingly, moving away from the model that was designed for ABS. Another respondent described their service needing to restructure to a more targeted model to be more attractive to potential funders. One challenge around this was non-clinical staff lacking confidence in their ability to deliver more targeted interventions. However, the respondent felt this had been a good opportunity for staff development.

Systems change

Understandings of systems change

As reported in previous waves, several ABS delivery staff were unfamiliar with or had no understanding of the term 'systems change'. Other ABS respondents' understanding generally **aligned with our definition of systems change:** transforming how services work and are delivered by changing ways of working.

Overall, ABS respondents described systems change in terms of relevant concepts, such as:

- **Test and learn approaches** and implementing learning of what worked well or less well.
- **Delivering prevention-focussed services** with a focus on early intervention.
- **Using partnership working and collaborative working** to implement changes across ABS and non-ABS services and organisations and to tackle societal inequalities like infant mortality.
- **Service design and delivery that is led by the parent voice.**

> If [services are] not working for the people they're designed for, then are you listening to the people that are using [them]... are you listening to people that you're aiming them at? If you are, then you've got an opportunity to change the system to work better. **Service Manager**

A few ABS respondents also understood systems change as **taking a proactive approach** through identifying what needs to be put in place to reach positive outcomes. This process involved understanding needs, looking at what support and services already exist and work well, and then devising solutions for the gaps.

Lastly, some ABS respondents outlined how they understood the aim of systems change to be to **embed learning** from ABS within existing services, future services, and the wider early years sector so that families continue to have better outcomes after ABS funding ends.

> It's understanding who your key partners are, who your influencers are. Making sure that everything is evidence-based and making sure that

that is given to the right people, that can influence system change. **Service Manager**

Partnership working and governance

In line with previous waves, **partnership working** was viewed as central to systems change and achieving positive outcomes. Respondents outlined five key aims of partnership working:

- **Providing holistic support.** ABS respondents described how their services provided holistic support to successfully deliver numerous activities, meet the high demand for support, and effectively signpost and refer families to the support they need.
- **Providing aligned support.** ABS and non-ABS services worked together to ensure that all services a family accesses are "on the same page" regarding what care is required and which service is providing what support.
- **Increasing channels for engagement.** Multiple ABS services aimed to increase the number of channels used to engage with families by utilising partner's resources, materials, contacts, and events, particularly to reach underrepresented or harder-to-engage communities.
- **Working together towards legacy and post-ABS arrangements.** This involves working to ensure that services supporting the same outcomes remain linked up after ABS funding ends, by focussing on embedding relationships between partners, such as the city council, heath services, and third-sector agencies.
- **Sharing learnings**. ABS services across child-level outcomes and partnerships were involved with sharing learnings, including learnings from collaborative working, with other ABS services, parent/carer mentor projects, and other external organisations like the NHS and the city council who want to learn from ABS's successes.

What worked well

What worked well overall

Similar to previous waves, ABS respondents cited four aspects of **the unique set-up of ABS** as an example of what worked well:

- **Emphasis on collaborative working.** ABS encouraged and supported ABS services to work collaboratively with other organisations and statutory services such as the NHS, Integrated Care System (ICS), and Integrated Care Board (ICB), as working collaboratively helps organisations to learn from one another and adopt a shared culture around ways of working.

- **Effective support from ABS core team.** One ABS respondent described how having an ABS project manager who supported connections and facilitated development across services was essential to their systems change success.

- **Long-term funding.** This was a change from standard practice and considered a luxury, which helped improve ABS staff buy-in as they were more optimistic about creating change given the long length of the programme and funding.

- **Approach to service design.** Respondents highlighted how ABS's approach to service design was centred around community and local knowledge and having decision-makers engage with service users and listen to their needs.

Partnership working and governance

According to ABS respondents, there were several aspects of partnership working that worked well.

Collective buy-in from ABS staff and from other partners and governance structures, such as a Health and Wellbeing Board, was one area that led to success. It was vital to have the "right people around the table" who were passionate and driven, who shared a desire to implement changes to improve outcomes for families, and who also respected and valued parent voices and feedback. ABS staff buy-in towards the importance of joined-up working in improving outcomes, helped increase recruitment, referrals, and signposting.

> I think we all understand the pros of multi-agency working [...] people have realised that… join-up just improves outcomes in the long-term all round for families. **Delivery partner**

Respondents viewed **establishing good communication and working relationships** with other ABS services, other non-ABS organisations, and statutory services such as hospitals, public health, and local authorities, as a vital element that made partnership working successful. Although ABS respondents reported that there was still some "siloed working", overall, everyone was better at connecting with others and aligning goals. This was

achieved by ABS respondents knowing who they could connect with and having opportunities to be introduced to those who work in non-ABS organisations, such as by attending the same partnership board. This resulted in "seamless" referrals between services and, for services like triage panels, the ability to easily coordinate joint visits between multiple services where appropriate.

This approach was echoed by respondents from non-ABS services; one respondent was part of an early help implementation board which regularly spotlights services so that staff can share successes and remind other providers about their service to strengthen referral pathways.

One positive impact of partnership working was that both **ABS and non-ABS services became aligned** on which areas needed addressing, in supporting the same objectives, and sharing the same messages with families. For example, one ABS respondent shared that their partnership held a workshop about priorities and legacy arrangements, where they discussed how ABS and non-ABS services should continue to work together to provide a "system response" that supports the same outcome, instead of each service taking responsibility for different aspects.

ABS respondents highlighted the positive impact of families and other non-ABS services and organisations being **more aware of ABS**, as ABS has become more established and a well-known name in the community. This improved awareness of ABS has been beneficial for referrals and building strong relationships between ABS and non-ABS services, expanding service engagement, and improving the ability of ABS services to reach local communities.

Another aspect of partnership working that ABS respondents thought worked well was **developing structures of continued care** through improving referral processes and signposting families to the right care that fit their needs. Respondents highlighted how collaborative working resulted in **quicker and more streamlined referral processes** that helped families to receive continued care and the right support for them outside of ABS services.

One ABS respondent identified **effective governance** as another aspect that worked well. This respondent reported how having a quarterly forum with partners working towards a local strategy to decrease poverty helped to identify what can be done to support residents from deprived communities and embed this into their work and their partners' work.

Tailoring services and activities

In line with previous waves, respondents reported the success of **tailoring services and activities** to better suit the needs or interests of parents and children.

This was done by designing service delivery to be **led by the needs or interests of parents and carers, and children**. This took many forms, including using detailed and in-depth assessments and discussions to identify what specific support children or parents and carers required from the service, and tailoring material and topics covered during a session in response to parent behaviour or concerns. For example, one ABS service invited speakers to talk to parents and carers about employment, skills, and work experience relevant to parents' and carers' interests.

Respondents also detailed how service delivery was tailored to **engage specific communities** who are underrepresented in ABS activities: dads, extended families, families that speak other languages, families with low or no literacy or internet access, families with learning needs or who are neurodivergent, and families where the child has (or is suspected to have) a disability or developmental delay. For example, one communication and language service advises parents or carers with autism to look at their baby's body language and gestures as they can have difficulty recognising facial cues. For families who speak other languages, multiple ABS services offered interpreters, delivered sessions in different languages, used live translation telephones, or provided resources and materials with information in languages other than English.

What worked less well/ challenges

Similar to previous waves, ABS respondents cited **staffing challenges** as an area of concern, including losing staff and their institutional knowledge, and existing staff operating at full capacity. One ABS respondent detailed how it had been difficult to design and transform services to work around the challenge of high workforce turnover and staff shortages in specialist roles, such as health visitors and midwives.

ABS respondents also discussed encountering **decreasing capacity for, and commitment from partners towards, partnership working**. ABS respondents described how they observed staff at partner organisations being stretched and at capacity and so their partners often do not have time to attend non-mandatory meetings and training. Furthermore, leadership turnover in other

organisations means that ABS staff must rebuild relationships each time, making it difficult to move forward with systems change work.

Other respondents emphasised how numerous factors must be present if partnership working is to be successful, which was often a challenge. These included:

- Trust, time, learning, and buy-in to adopt new policies and procedures, such as those about referrals, and align ways of working.
- Regular communication, effective navigation of all partner's agendas and priorities, and regular attendance of partners at meetings and other events.
- Internal processes and governance that are flexible so that partner organisations can successfully change their ways of working, even if they buy-in to the principles of systems change.

  So it's not that people don't want to do it or didn't want to do it. I think just some things are either too big to flex or just take so long for that process to happen. **Strategic Partner**

One ABS respondent felt that there is decreasing collaboration as the attendance of partners at meetings is not as strong as it used to be due to challenges such as staff turnover in partner organisations.

ABS respondents also saw **funding** as a challenge for systems change, for the following reasons:

- Implementing system changes is often expensive, which can make it difficult to find funding for this.
- A decrease in funding for other organisations who jointly deliver ABS activities can stall the planning and implementation of systems change.

Lastly, some ABS respondents were **unsure if there have been significant and long-lasting changes to the system**. For example, one ABS respondent noted that while their communication and language services have resulted in improved identification of speech, language, communication needs, the waiting list has not been reduced.

> We've increased the numbers of children that are being identified, [and] we are more knowledgeable and better at giving them the right

support at the right level, but we've not quelled the numbers. **Service Manager**

Mechanisms

This chapter outlines the mechanisms that ABS respondents described which contribute to reaching ABS outcomes. Mechanisms are defined as the guiding principles determining how the programme is implemented. For this wave, we asked ABS respondents about the following main themes related to ABS mechanisms: adaptive design, test and learn, upskilling workforce, sharing data and information, and using evidence to inform service design and delivery.

Adaptive design

ABS respondents identified two key themes related to adaptive design.

- **Adapting referral processes to increase engagement and take-up of support**. For example, a breastfeeding support service began accepting referrals for women earlier in the antenatal period to ensure they were seeing families when issues first arose and a social and emotional development service broadened their eligibility criteria for referrals to reach more families.

- It has evolved, because we identify different needs, different gaps, and also [we] wanted to make sure that as many clients as possible can actually access [ABS partnership] services, so we expanded on the referral pathways a little bit. **Service Manager**

- **Adapting service delivery to meet the needs of families**. For example, one service adapted by increasing the number of visits families received from five times to eight times. As a result, families received better support at the right time as there are visits from the antenatal period through to when children reached school age, in addition to young children undergoing more frequent checks as they reached developmental milestones.

Test and learn

ABS services across partnerships and child-level outcomes implemented test and learn approaches to test what worked well or less well in a variety of areas.

- **Where to deliver services**. Services had to work out which areas or venues it would be most beneficial to deliver activities in. For one partnership, this meant expanding service delivery from certain wards to the whole city. For a different partnership, this involved running activities in various venues that were not traditionally used to engage parents and carers or young children, such as parks, libraries, and local community halls which helped parents and carers to view the activities as less "formal" or "structured".

- **Engagement strategies**. Services tested various engagement strategies to determine how families best engaged with and access services. For example, learning from test and learn approaches showed that having refreshments at in person sessions made them more welcoming and increased engagement. One respondent describing the importance of advertising via multiple avenues, which helped engage families who might not speak English or who are from disadvantaged backgrounds.

- **During service delivery.** Services also used test and learn approaches during service delivery to see what works or does not work and what best suits the needs of local families. According to one ABS respondent, test and learn resulted in stay and play sessions being renamed to 'play and learn' with an emphasis on educating parents and carers about how their children can learn different skills through play, in response to parent feedback.

However, there were some **mixed views** regarding the feasibility of test and learn approaches. While test and learn was viewed as a key principle of ABS, respondents highlighted how it required extensive staff time and resources to implement and required building trust with families to get their feedback on what worked well or less well.

Additionally, multiple respondents shared the views that test and learn has not resulted in sustainable and whole systems change within their partnerships, as ABS services were only supporting specific wards. Furthermore, some services in their partnership did not start until later in the programme, which meant that these services had less time to set up, evaluate their impact and what worked well and less well, and use that learning and data to re-design the service accordingly.

> Some [services] are really, really good, but because they started in 2020 they still need time for implementation, learning, evaluation, and

> then [to] think about how we continue them. It's all been squeezed into these five years, so that's not really been helpful. **Service manager**

Upskilling workforce

ABS respondents understood the aim of upskilling to be **to increase workforce development and to share knowledge and skills,** so that staff can reach and support a wider audience.

Various services across child-level outcomes offered general upskilling opportunities for staff, such as webinars, workshops and sessions, and other training and support. One ABS respondent found that good working relationships with other organisations enabled external informal training opportunities to be easily organised.

> I think it's that joint learning thing that's amazing and I think because we know each other really well, it may well be that I would say to another project manager, can you come in and talk to my team about that? **Service Manager**

Services also offered **specific training for child-level outcomes**. Diet and nutrition-specific training included:

- Training on antenatal-onwards diet and nutrition related topics, including dental care, infant feeding, and the transition to solids.
- The UNICEF Baby Friendly programme.
- Informal training from a hospital Infant Feeding Coordinator on identifying tongue ties.
- Birth and infant feeding for LGBTQ+ families.
- A 12-week peer support training programme.

Communication and language-specific training included:

- Training for early years setting staff about identifying speech, language, and communication needs using WellComm assessment packs, Early Talk packs and boosters.
- A mentor service for settings that are struggling or having trouble engaging with the early years practitioner training because they have their own

system and language/communication strategies or have staffing issues including recruitment challenges, high turnover, or difficulty finding cover.

- Training for Family Hub staff in Early Talk strategies and partnership-specific communication and language strategies

Social and emotional development-specific training included:

- Training for early years practitioners about supporting parent-infant relationships
- Infant mental health awareness training for early years staff

Sharing data and information

In the last two waves, ABS respondents were specifically asked about the theme of sharing data and information. ABS services shared data with both ABS and non-ABS services for multiple purposes, including for the continuation of care and to share learnings.

Sharing data across ABS services. Clear guidelines for sharing data, as well as partnership working, have increased and streamlined data sharing across ABS services. However, not all ABS services had the same data tracking systems, which caused difficulties when transferring data across ABS services. Some services also faced challenges around GDPR and privacy, and one parental engagement service struggled with their staff not having enough capacity and time to collect and share registration and enrolment data with ABS and other partners.

Sharing data between ABS and non-ABS services. As with sharing data across ABS services, not having the same data tracking systems was also a problem when ABS services shared data with non-ABS services. Where shared data tracking systems existed, ABS services across child-level outcomes shared and received data from non-ABS services. Reasons for this included:

- **To identify eligible families.** One breastfeeding service saw an increase in engagement after hospitals set up a process to give Family Hubs live birth data, as they use this data to contact families who just had a baby that day to make them aware of available support, such as the breastfeeding service. Similarly, one another service received data monthly from the NHS about registered children who live in ABS wards that are eligible to be invited to language assessments for two-year-olds.

- **To enable partners to see updates about families' care.** One diet and nutrition service shared data with statutory services and used hospital clinical data and NHS records in their own assessments by creating a client pack for each family documenting any support given. The service now uses the NHS clinical records database, and has a hospital account so that they can send client data securely to the hospital trust. This also allowed the service to see clinical information that they use in their own assessments, such as birth weight and weight fluctuations.

Sharing data and learning across ABS and non-ABS services so that anyone interested can benefit from and use the learning from ABS. ABS services shared impact and evaluation reports widely and at various levels: local ABS and non-ABS services, statutory services, regional steering groups, and even nationally.

Sharing data to demonstrate the impact of ABS services. One ABS respondent described the value of data collection for demonstrating impact and to use as evidence for future funding bids. Another ABS respondent reported how sharing data with others helps them see the evidence of the impact of the ABS service and how it might work for them.

> …rather than an isolated programme or a project and then say, right, here you are, here is the evidence, now see how it can work for you. **Strategic Partner**

Sharing data through reports. Multiple ABS respondents described sharing data through internal or published ABS reports, such as the quarterly and annual reports that are a part of the ABS contract, to share evidence of outcomes and what worked well and less well. One ABS respondent mentioned external reports being shared with an external foundation, published on their website, and shared through social media with other local and regional ABS services.

Using evidence to inform service design and delivery

In the last two waves, ABS respondents were also asked about how they use evidence to inform service design and delivery. Some ABS respondents described how, instead looking for an existing evidence base to justify a programme, **the ABS evidence base was built gradually** which was viewed as good practice. A representative from The Fund highlighted the important role of evaluation teams at this stage of the programme and reflected that evaluation findings were showing strong evidence for the positive impact of ABS.

ABS services across partnerships reported **using evidence to inform their service design and delivery in various ways.** This evidence included assessment data and development outcomes collected directly from the children who access ABS services, such as:

- **Early Years Foundation Stage (EYFS) profile data and reception weight.** One respondent described how their support service extended access to families who have children older than 4 up until they are aged 11 as EYFS profile data and reception weight for children in their partnership showed that children's weight was not improving by the time they were in Year 6.

- **WellComm data.** One communication and language service evaluated WellComm data that is collected at three points across children's engagement with their targeted work and found that children's progress falls significantly if they only have six or less out of eight home visits. The service used this data to emphasise to families how important it is for them to attend all eight visits.

ABS services also use **parent and staff feedback** as evidence to inform service design and delivery.

- **Parent feedback.** Some ABS services use parent satisfaction or public opinion surveys and feedback help to understand who is using their services, what is in demand, what worked well and what did not work well. For one parenting service, there is evaluation of every programme a parent attends that happens at the beginning and the end of each programme. This evaluation used qualitative feedback questionnaires to understand the impact. ABS services also used other methods to gather parent feedback: for example, one diet and nutrition service used an app, while one partnership ran regular parent forums.

- **Staff feedback.** One social and emotional development service conducted interviews with staff to receive feedback on what worked well and less well. The respondent from this service discussed how they collected quantitative and qualitative data on feasibility, which they are planning to use to develop the service offer.

Parental engagement

Engagement strategies for services

Across partnerships, ABS services have implemented a variety of strategies to engage parents. Many focus on **improving accessibility**:

- **Increasing awareness through social media**: Respondents emphasised the importance of social media for raising awareness about available support.
- **Flexible services:** Many services offered flexibility, such as home visits, to accommodate parents' schedules.
- **Demand-based support:** Services operated in areas where there was a clear need for support, such as local high streets where parents were already engaging with other services, or in more isolated areas with limited transport links.
- **Minimising burden:** Providing a crèche for younger children allowed parents to attend without worrying about childcare. Offering food and drink, as well as inviting relevant providers to the same events, made it easier for parents to connect with multiple resources, whilst utilising various venues, such as libraries and children's centres, helped those with limited time to participate.

Many respondents noted the need to **be inclusive of all families** to foster engagement:

- **Engaging fathers:** Respondents recognised the historical challenge of engaging fathers. Examples of support included delivering classes from 7 to 9pm, after the workday, on Saturday mornings, or online. Services also held events such as visits to a local climbing gym and comedy nights focusing on men's mental health.
- **Language accessibility:** Multiple respondents used interpreters to facilitate communication with non-English speaking parents.
- **Community representation**: Ensuring events reflected the local community was crucial for inclusivity. This was achieved through accurate representation of service users at events, and hosting celebrations of diverse cultures, families, and heritage.

Efforts to **raise awareness of ABS services in communities** effectively increased engagement through:

- **Collaborative partnerships**: Respondents shared how their service worked with family centres, health visitors, and early years services to promote awareness of ABS services.
- **Early engagement**: Connecting with parents early on ensured they knew where to seek support when needed.
- **Parent training**: Services trained parents to raise awareness within the community
- **Community presence**: Several respondents described maintaining a presence at community events, including ABS-facilitated outreach events and local festivals such as Pride.

Respondents highlighted the effectiveness of **peer-led programmes** in engaging parents:

- **Lived experience**: Parents' experiences and understanding of local services enabled them to help others connect with the community.
- **Reducing power dynamics**: Peer support was seen to mitigate the power dynamic sometimes present between parents and professionals, enhancing engagement.

Non-ABS respondents also detailed how Family Hubs were employing similar peer-led approaches to engagement, training parents to engage with their communities and relay needs. Insights from the community led one service to deliver activities in the school holidays when other services paused, though this respondent described a smaller team of parent champions compared to those in ABS partnerships.

Challenges for implementing parental engagement

As reported in previous waves of fieldwork, respondents reported how **social stigma, and fear of being perceived as a 'bad' parent** created psychological and emotional barriers which prevented parental engagement with services. Some professionals observed parents who were reluctant to engage, viewing support as more common for parents who had previously received social care involvement. Other parents would not attend group sessions due to anxiety, and uncertainty over how their child would behave in public.

> I just think some families they're concerned about their child's behaviour, so they don't want to go to a group because they're not sure how they would cope with it, even though our session is to support that behaviour. **Delivery partner**

The level to which parents could engage with support was impacted by **socioeconomic challenges.** Some parents were experiencing housing issues or were homeless because of domestic abuse or poverty, which took priority. One ABS respondent noted the importance of signposting to other services to address these challenges separately, to ensure they have the capacity to meet their child's needs.

Catering to a wide range of diverse groups proved difficult across some of the ABS services. Respondents noted difficulties providing support to different family structures, such as single parents, those with school aged children who were unable to attend sessions unless they were in school hours, and parents who were pregnant. Challenges across the outcome areas included:

- One breastfeeding service had to stop offering breastfeeding support groups due to low uptake, as some cultures view support from outside of the family to be inappropriate.
- One domestic violence service experienced difficulty supporting the LGBTQ+ community, as their support programme was mainly designed for cisgender females in straight relationships.

Catering to different audience was also important for non-ABS services; one respondent described enlisting fathers and parents with SEND children to audit services via "mystery shopper-style" telephone calls and visits to ensure they are dad-friendly and appropriate for SEND children.

Co-production

Understanding of co-production

Although co-production was viewed by respondents as a "big word" which people had different understandings of, respondents were aligned in that their definitions involved collaborative work with parents, involving them in decision making, and being honest about how their input would be used. Working in partnership with parents throughout the life cycle of a project was seen as key to achieving a service offer that worked for its community, by harmonising parental experience with professional expertise.

A key distinction was that co-production was viewed as different from collaboration or co-design, which typically involved listening to parents' opinions but making decisions separately from them.

Parent involvement in co-production

Most respondents were able to give examples of co-production taking place in their service. Parents' **involvement in service delivery** was increasingly widespread, and included assisting with drop-in play groups, making referrals for other parents as part of their volunteering role, running their own sessions, conducting home visits, assisting with a staffing telephone hotline, or supporting with the triaging process.

Respondents from some services described specific **parent/carer mentoring projects**. Parents volunteered to assist with service delivery, provide support and advice to families, and attended workshops and courses alongside families to bolster confidence.

Multiple respondents spoke about the **upskilling opportunities** available for parents and carers in their partnership area. One diet and nutrition service introduced paid work opportunities once parents had volunteered for 30 hours with them. Other examples of upskilling parents included running training courses on topics such as LGBTQ+ awareness and IT skills building. One non-ABS service ran training for parents to become breastfeeding support volunteers. This included training specifically for minority groups (e.g. black and Asian parents) to ensure volunteers represented the wider community.

Multiple respondents described parental involvement in ABS **governance**. This ranged from attendance at steering groups, including the ABS partnership board when the parents' skills and interests aligned in doing so, to sitting on interview panels. The latter was described by staff as a hugely valuable opportunity in seeing how potential employees interacted with families.

Parents have also been involved in the **ongoing development of ABS services**. Multiple ABS respondents reported involving parents in producing promotional materials so that services reflect the experiences of those who live in the local area and use the services. One example included the development of an easy read leaflet with pictures and limited words, to ensure those with different literacy levels were not excluded.

Other services empowered parents to create and deliver their own projects. Some parents began to set up reading groups, or create book-sharing libraries, to help improve language and communication outcomes in their community.

Other parents volunteered to assist with service delivery, at times by running their own classes. Examples included Portuguese storytelling, and Spanish rhyme time, both celebrating children being bilingual.

Parents were also consulted on what has worked well or less well in the support that services offer. This took different forms: structured feedback forums, informal conversations, satisfaction surveys, in-person events, or the use of a suggestion box. One service held informal interviews and focus group sessions with local parents to identify the gaps in service delivery and access barriers in the area, and provided opportunities for these parents to design the programme. Another service consulted families with children who were born into care about their feedback on multiple factors, such as the referral process and the language used by services around babies born into care.

Respondents from non-ABS services generally appeared to have less focus on co-productive elements. Whilst collecting and implementing parent feedback was routine practice, respondents did not give examples of involving parents in governance or co-design of services. However, two respondents mentioned that they intended to build links with the Maternity Neo-Natal Voices Partnership, which works to bring together parents' voices to improve neonatal care.

Challenges to implementing co-production

Respondents noted how parents and local communities can be **distrustful of programmes promising huge investment**, especially when it is not transparent how the funds are being spent. Respondents described the importance of establishing a trusting relationship with parents when beginning co-production, including listening to their opinions on how the money should be allocated. This was viewed as a key factor in building a successful relationship.

An additional challenge to implementing successful co-production are the **extensive requirements** which come with it. These included demands on staff time, alongside the need for flexibility and ongoing refinement of co-production processes. Limited funding was cited as a barrier, preventing staff from delivering initiatives to the desired level. For co-production to be implemented at a high standard or on a larger scale, respondents emphasised that it would require additional time, commitment, and co-ordination. This challenge was viewed by respondents as even more pronounced in non-ABS services, and NHS services, where understanding of co-production is less developed.

Staff described how **navigating feedback processes** was challenging at times. Respondents recalled how managing opposing views between parents and professionals was difficult, meaning staff had to be upfront and honest with families if their suggestions were inappropriate. For example, during discussions about a peer support group, staff emphasised the need to have professionals present to address potential safeguarding concerns, whereas parents preferred for these groups to be represented by parents only. It took time and explanation for parents to understand that there may be situations where concerns were raised for a child in which specific experience and qualifications are needed.

Impact of co-production

Respondents detailed the impact of co-production on services and for those parents and carers who took part. They described how:

- **Service offers were enhanced**, partly as a result of developing more impactful, representative and effective resources.

- Families are telling us that there's been a culture change [...] just changing the language […] Things like 'cases' and 'case studies', that often people use within their daily work, and actually how much families hate to hear those words. **Delivery partner**

- **Communities achieved a sense of ownership** over activities due to their involvement with the design and development of them.

- **Parents and carers experienced personal development**, gaining confidence, experience and self-efficacy. Co-production was seen to empower them to take on new challenges and to go on and do "bigger and better things" outside of ABS, such as running their own sessions in the community.

> The individual journeys that the parents go through are all very different, but all hugely valuable to them. That varies from someone that's maybe never been in employment ending up finding a job to a mum that was so anxious she didn't want to leave her house, and now she's leading a governance meeting. **Delivery partner**

Respondents spoke about the impact of co-production equating to a change in culture. By reducing barriers to access for those who may typically struggle to

receive support, and listening to the needs of families, respondents felt better able to support those they were working with.

Sustainability of co-production beyond ABS

Co-production was viewed as important for the legacy of ABS. Respondents were clear about the benefits that co-production brought to services and communities, with some mentioning that their legacy arrangements already included plans for ongoing co-production.

ABS was seen to have raised the profile of parental engagement and co-production practices. One respondent emphasised how important it has been for parents from particular groups (e.g., SEND communities) to become involved in co-production, to allow for services to be truly informed. ABS has been seen by staff to do co-production well and was widely viewed as an example of good practice. Several respondents noted how co-production has been seen to take place more consistently in ABS services than elsewhere, such as in healthcare or education settings, and it has set a precedent for other local services to follow.

A representative from The Fund also described how ABS co-production had had an impact on the wider system. In one partnership, the council now had a lived experience team, which had been influenced by the ABS approach to co-production, which had 'revitalised' the commitment to working in partnership with service users.

Conversely, respondents explained how non-ABS co-production could often be perceived by parents as tokenistic, which gave them concerns that the high standards of current co-production may not be sustained without ABS. One respondent cited a lack of ownership among other partner organisations as a key factor.

It was also reported that some non-ABS services do not currently have the resource, namely staff or time, to engage in co-production in a way that is meaningful, despite recognising its importance.

> I think one of the biggest achievements for [ABS service] was the co-production, so the family mentors and parent champions. I think they are some of the most valuable assets which I am worried about losing because we haven't really found a home for them. **Public Health Consultant**

Legacy

Legacy is a new theme for 2024 reporting, and this chapter outlines arrangements that respondents described when exploring plans for their services after ABS funding ends. Whilst some services are being continued, a number of services are being discontinued due to a lack of other (non-ABS-related) means of financial support. Many of these services would end in March 2025 without additional funding. We explore these arrangements alongside the impacts, challenges and opportunities associated with this change.

Post ABS arrangements

Respondents across partnerships described different arrangements for services as ABS funding comes to an end. Some respondents highlighted that alternative funding has been acquired allowing services to sustain delivery independently of ABS funding. Whilst some services continue to rely on remaining ABS budgets, others are unlikely to continue, resulting in different conversations around legacy.

Continuation of services

In many cases, respondents described ABS services continuing to some extent through **alternative funding** (e.g. Start for Life, councils, libraries or local organisations). Various respondents highlighted plans for partners, such as children's centres and health visitors, to work together to continue delivering services. Respondents reflected how established relationships with organisations such as these made funding more likely.

Some respondents suggested that **certain services would be prioritised** over others. Respondents felt that services founded on a strong evidence base were more likely to receive additional funding. For example, a programme manager described a large-scale evaluation of a language and communication intervention which they hoped would help to secure longer-term funding. For services that had not collected data or done any formal evaluation work, this was thought to limit the likelihood of future funding. Relatedly, a representative from The Fund suggested that services with more evidence of impact, such as breastfeeding services that have shown increased initiation rates, were more likely to be recommissioned.

> Within the economic climate we're in at the moment, [commissioners] want hard evidence of what's going to work. **Representative from The Fund**

Under new funding arrangements, respondents anticipated that the **design of services would change,** or be run on a smaller scale. For example, by introducing stricter eligibility criteria, those deemed to be lower risk would no longer be able to access the service. Another respondent described the scaling down of programmes to a community-based model, which would allow services to continue without additional funding, and relying on volunteers.

Programme leads from multiple ABS partnerships mentioned collecting feedback from families to assist with redesign of services under new arrangements. In some cases, this feedback is collected through regular communication between delivery staff, commissioners and project managers to establish which services are needed.

Uncertainty around funding

Across partnerships, many respondents remained uncertain about future funding. There were a number of external factors that impacted how likely services were to be recommissioned.

<u>Government creating uncertainty around funding</u>

Respondents reflected on various reasons why government was causing uncertainty for the continuation of services:

- **Impact of government cuts:** Respondents referred to government cuts were causing uncertainty around funding. One respondent referenced previous government-imposed cuts which affected children's services and expressed concerns about the future of children's centres. Another suggested that charity organisations would find it hard due to reliance on government funding.

- It's a really challenging landscape to try and seek additional funds when funds are being cut left, right and centre to so many services. So, that's really hard. **Programme manager**

- **Shifts in political leadership:** One respondent from the first wave of fieldwork, suggested that recent changes to leadership created uncertainty around funding priorities which would make it difficult for staff to plan and could cause service delivery to stop. A non-ABS respondent echoed this sentiment as they saw the strong political buy-in in their area as key for sustaining investment into children's services and the reason for their well-resourced Family Hub and early years model.

- **Reduced likelihood of investment in long-term outcomes:** Others believed that governments were less likely to invest in long-term programmes, like ABS, because results often take decades to yield visible results. Therefore, making long-term investment unlikely within the five-year electoral cycle.

Uncertainty around funding for universal services

In cases where partnerships were delivering universal services, respondents were pessimistic about funding opportunities for several reasons:

- **Increasing costs of delivering services.** One respondent believed that rising costs made it unlikely that funding opportunities would match the amount ABS begun with. Another believed continued funding from public health was unlikely since Start for Life funding had ended.

- **Low turnout of service,** making funding or extensions to funding unlikely. One respondent suggested services are not sustainable in the long term.

- **Lower impact of services.** One respondent suggested that some supplementary services, such as taster sessions to improve individuals' confidence to join the workforce, were unlikely to get funding in the future. This is because supplementary services do not serve core functions of ABS and therefore, have a much lower impact.

In addition to these factors, a representative from The Fund explained that the services that had been recommissioned to date tended to be targeted services, or were recommissioned without the universal elements, as the funding often did not stretch to universal provision. However, some of the lower cost activities such as stay-and-play sessions, which still had strong social and emotional benefits, could continue to be run by volunteers with support from small grant funding.

Support during the transition

Respondents described **support for staff** during the transition where funding was ending. One respondent gave an example of a networking event which was focused on staff concerns regarding the end of services, although the participant did not cite examples. Meanwhile, another respondent highlighted pastoral support being offered to staff and a team away day to prioritise wellbeing. In one case where services were being discontinued, staff are being supported in finding other work due to limited job opportunities within ABS.

Multiple respondents from the same partnership highlighted **support for volunteers and parent champions** where funding was ending. Parent champions were being supported through a specialised programme which helps them identify professional development opportunities. This programme focuses on training, upskilling and mental health support to help parents move on after the end of ABS service provision.

> So, for our job is to make that transition as comfortable as possible, so between now and March, we will be in a supportive role with the parent champions, talking about their one-to-one capacity. Talking about what it is that they want, moving forward. **Service manager**

Respondents gave various examples of **support for families**. In some cases, staff are having conversations or holding workshops to inform families about new service arrangements. For one partnership, training is also being provided for staff and volunteers to help with communicating the end of service provision.

> They've all planned really, really well for that, but the challenge is, […] some of those services are stopping, and communicating that to parents who haven't been able to access those services but know people who have or may have had those services for their last one, two children but suddenly can't access those services now. **Representative from The Fund**

Challenges and opportunities post-ABS

Respondents reflected on challenges and opportunities post-ABS funding. Although respondents uncovered a handful of challenges, opportunities focused on continuing the legacy after ABS funding ends.

Opportunities to continue the legacy

Sharing learning with partners was considered key to sustaining the legacy of ABS for services which were ending as well as continuing. Respondents across partnerships described running webinars and meetings to ensure key learnings from ABS are taken into account by new providers. Respondents from one partnership were confident that ABS learning and delivery models would be incorporated into new services under alternative funding. In one case, the respondent described sharing evaluation data with new commissioners to show important aspects of ABS services. Respondents also suggested the licensing of training, resources and mentoring would be passed on.

Some respondents referred to a "legacy budget" when talking about grant funding that had not been spent, which could be repurposed by partnerships for specific purposes, as agreed by The Fund. In some cases, these funds would be used in the hopes of creating long-lasting impacts for staff and families, for example, the purchase of breastfeeding equipment or sensory toys.

> We would like to use our legacy budget […] to purchase things that will have a positive, lasting effect, so things like more breastfeeding support equipment, so teaching aids and breast pump sets, supplementary nursing systems. **Delivery partner**

Many respondents mentioned how services were upskilling staff and volunteers with the intention of continuing the legacy after ABS funding ends. Specifically, respondents from the same partnership described a 'train-the-trainer' model to begin in 2025 which enables expansion of services with less reliance on coaches from other organisations to help with training.

Challenges post-ABS

Respondents were asked about challenges for services post-ABS funding, which prompted various discussions:

- **Staffing challenges.** Respondents highlighted loss of trained staff and difficulty recruiting new staff where the structure of the organisation is changing under new funding. Some respondents suggested that recruitment challenges to continue due to a reduction in salary and benefits under new funding. Respondents also mentioned the increasing workload for staff continuing to work in ABS services, as other team members leave. One respondent suggested this loss of staff reduced the viability of the service.

- **Partnership challenges.** Respondents agreed that work is needed to maintain productive partnerships with other local services, such as children's centres, to make sure a variety of people are benefitting from support. However, some respondents suggested difficulties linking up recommissioned services. For example, communication with partners may be slower with the loss of core ABS team members, where remaining staff may not know the answers to questions or have the same relationships with partners.

- **Engagement challenges.** One respondent described their service's limited ability to maintain engagement in first months under the new arrangements, due to the time it takes for staff to give inductions or update processes. Respondents also reflected on changing approaches to delivery, such as: reduced ability to provide refreshments, resources, reduced use of social media or reduced space to deliver services which may discourage parents. Some respondents also suggested the de-prioritisation of co-productive elements such as parent champions would affect engagement.

- **Continuing to operate to a high standard.** Respondents suggested alternative funding may result in lower standards of delivery. One respondent suggested this was because of high costs associated with ABS approaches of individualised care and delivery by highly trained staff. Another respondent expressed concern that focus could shift away from meeting the needs of the community to more alignment with government spending priorities.

> So, what worries me about external funding from national sources is that it will be something that has to be endorsed... And will be very much prescribed, whereas we're used to understanding our communities and meeting the needs of our communities and our parents won't buy it now. **Service manager**

8.4 Next steps

In 2025, Objective 2 will conduct one final wave of data collection with ABS respondents. Findings from this and previous waves will be combined in the final evaluation report.

Mapping of activities and interventions across all five partnership areas will be carried out slightly earlier in spring 2025, when partnership leads are still in post.

9 Experiences of families through ABS systems (Objective 3)

9.1 Aims of the Objective

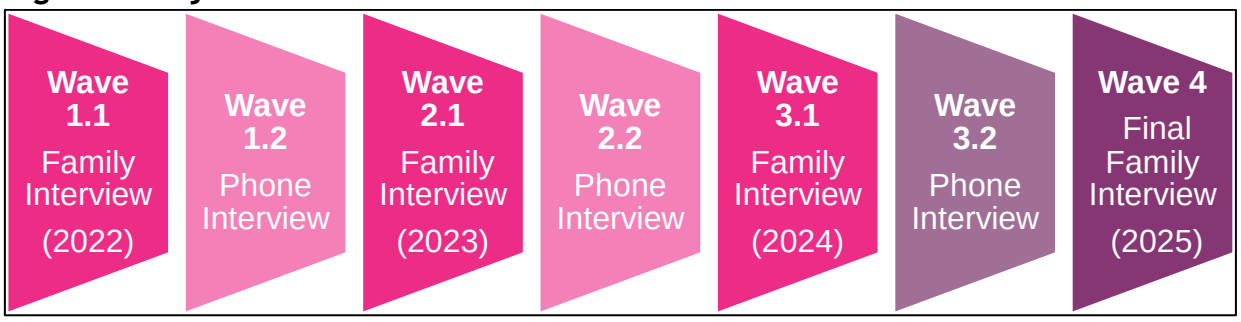
Objective 3 uses collective journey mapping to evidence the experience of families from diverse backgrounds through ABS systems, building a contextually situated understanding of the contribution of ABS to diverse family lives, including the identification of barriers/facilitators to engagement and impact in relation to the four core outcome domains. This is achieved through qualitative longitudinal analysis of twice-yearly interviews with families about their lived experiences over time, examining:

- how ABS activities and interventions concerned with child outcomes can become embedded and sustained in family lives and practices;
- the implications for families of ABS systems change; and
- families' contributions to systems change associated with involvement in ABS.

Full answers to the focused evaluation questions underpinning Objective 3 (see Appendix 3) will be established over time, as interviews with families are conducted at regular intervals over a four-year period (see Figure 2 below). For details of the sample and methods, please refer to Appendix 3. At this interim stage of the third annual report, we present analysis based on data collected between 2022 and 2024, which includes 25 families:

- 21 families from the original sample; and
- four interviewed for the first time in the summer of 2024.

Figure 2: Objective 3 interviews with families



9.2 Findings to date

Interviews conducted since 2022 build a consistent picture of the contribution of ABS. A high proportion of families in all five ABS partnership areas live with complex and challenging circumstances, including significant housing and/or economic insecurity, limited informal and/or extended family support, parents/carers with significant physical or mental health difficulties, language barriers, child SEND and parental neurodivergence or learning difficulty. This remains a dynamic picture: new challenges may emerge over time, and while difficulties reported in previous years persist for some families, circumstances have improved for others. The second annual report documented the contribution of ABS in helping families through difficult times, while revealing how family characteristics and circumstances shape the nature of their engagement with ABS provision over time. These findings are reinforced by the most recent interviews, but rather than repeating earlier findings, we focus on new analysis that illuminates the relationship between family involvement with ABS and evidence of benefits for children and families over time.

Objective 3 was designed to include families who had varying levels and forms of engagement and involvement with ABS (see Appendix 3). Involvement has also varied over time, for example, as family circumstances and/or service structures have changed. Interviews conducted to date provide clear evidence that families who have sustained involvement with ABS report significant positive contributions in child and family lives over time; this is apparent across all five ABS partnership areas and includes those who are navigating significant intersectional needs and challenges. Among families who have been less involved with ABS or whose involvement has been less stable during the evaluation period, evidence of positive contributions is more limited.

Forms of engagement with ABS

Qualitative longitudinal analysis has particular value for shining light on complex causal processes[10]. By analysing the nature of families' journeys of involvement with ABS provision, it is possible to understand the mechanisms through which ABS as a holistic and adaptable place-based approach can make a positive difference for children and families – as well as the factors that may pose barriers to engagement and positive change. In this section, we document different forms of engagement with ABS that are evident in family data over time, moving beyond a simple conceptualisation of levels of involvement to consider intersecting facets of engagement. Following from this analysis, the next section examines what involvement makes possible in terms of a contribution to family lives and child outcomes.

The analysis distinguished different forms of engagement with ABS over time, all of which were evident in all five partnership areas and among families with varying levels of need, including those living with complex and challenging circumstances. These can be understood as **pathways through engagement** and are not static or exclusive categories to which families do or do not belong. Rather, the analysis illuminates ways in which families have engaged with ABS over time, so helping us to think through the implications of modes of engagement for sustained involvement and impact from ABS in family lives. At Wave 3.1, half (13/25) of families described engagement that was driven by the **parent/carer pro-actively seeking out ABS provision**. All gave accounts of how they had identified and engaged with ABS provision and wider support: in some cases, journeys with ABS began with the parent/carer pro-actively seeking out local provision; in other cases, initial engagement was scaffolded by ABS staff or volunteers and this laid the foundation for parent/carer-led engagement with a wider range of provision. Parents/carers gave examples of seeking out ABS and other provision and following up on signposting and other information (e.g., by searching online) to identify and access ABS provision and other relevant services or support. While experiences varied, these families described having the resources to engage pro-actively with ABS. Their engagement was facilitated by positive experiences, including with ABS staff, but they were not wholly dependent on that facilitation.

For nine families, active and sustained engagement with ABS provision had been **scaffolded through targeted and timely support** over time. Here,

[10] For a discussion, see Østergaard and Thomson (2020).

Vygotsky's (1978) metaphor of 'scaffolding' is used to highlight how the assistance of others underpins the development of new skills and capabilities. These families described a variety of barriers to access that had been overcome with active outreach and support from ABS staff – including one-to-one support (e.g., family mentors, outreach workers), encouragement and reassurance, directly inviting families into group-based provision and practical help, such as taking families to activities. As this list indicates, scaffolded engagement can take diverse forms. The common feature is pro-active professional activity – adapted to families' dynamic circumstances and support needs and enabling the development of their involvement with ABS and wider networks of support.

Journeys of engagement

Understanding families' journeys of engagement with ABS helps illuminate the nature of effective 'outreach and engagement', posited as a core mechanism in the Theory of Change, underpinning the wider principle of 'Inclusion, Engagement, Empowerment'. Here, we focus on experiences of scaffolded engagement to illuminate the causal sequence towards positive impact in family lives, a pathway that was evident among diverse families across all five areas.

We begin with the example of a family who joined the evaluation sample in 2024: a couple household, living with challenges that included developmental concerns about one of the three children. The oldest children (now above the ABS age range) were part of ABS provision previously; the mother has been actively involved with ABS for several years and is a parent volunteer. She described ABS as instrumental in enhancing her own mental wellbeing and in providing developmental opportunities for her children, improving her knowledge of local systems and forging a sense of community connectedness:

> So, it's like I say about ABS, they have literally helped me in every stage of my life with my children. Not just my kids but they've supported me mentally, emotionally, with knowledge as well.

Her reflections on her journey with ABS demonstrate how effective **scaffolding across diverse ABS services** can lead to sustained parent/carer led engagement that facilitates significant long-term change for the family. She explained that, following the birth of her four-year-old child, she became anxious about leaving her home, but was invited to join an ABS group outing to a local park. She was already familiar with ABS following a positive

experience with postnatal breastfeeding support and decided to attend the outing as a result of active encouragement from ABS staff. This included the offer of practical support, such as the provision of 'wellies and coats' to address her concerns about potential risks of her children falling or getting ill because they lacked suitable clothing. She framed this trip as a pivotal moment: helping her overcome her fear that 'I'm not going to be a good mum', taking her to places she had never been in her local area and instigating the subsequent development of her pro-active engagement with ABS over several years. As she summed up, 'it was not just for the children, but it was for me as well'.

Elsewhere in her interview, she framed active scaffolding by ABS as **'people communication'**, which she described in terms of direct relational engagement rather than informational signposting 'that sometimes will not make sense to me'. She contrasted this quality of ABS with her experiences of other services:

> You know what, everybody can give you a leaflet or give you website, and this is what happens nowadays. You go to the doctors … go now, and this is the thing, they'll give you a website and say find out from there. Go the pharmacy and the pharmacist will do this. This is what they all do. This is the fact, whether we like it or not, this is the reality. But ABS is something else. Like you know they've still – which I was shocked about, because in this day and age that it can happen. They give you people communication.

One noteworthy feature of this family's engagement is the way in which it has spanned support for children of different ages. Arguably, this reflects another distinctive feature of ABS, as a 10-year local programme which has become known and trusted by families over time. Across all five partnership areas, there is evidence of the value of **continuity of trust and knowledge about ABS**. A further example comes from a family living in a different area: a couple household, whose child was under 12 months at the start of the evaluation. The family had used universal ABS provision as well as targeted services that included support for the mother's mental health and through a challenging period in her and her partner's transition to parenthood. Her interviews over time highlight the value of 'just knowing' ABS provision is available:

> Oh 100%, yeah, I think it's made a massive difference. It makes you feel a bit more held. Even if, you know […] if you've got difficulties at

> home, like we've definitely had, just knowing it's there has been really wonderful and really … yeah, calming in a way, because you know that you can go and do something, even if it's not quite the right fit for what you were looking for, you can go out and see people, and that's been … yeah, really helpful. (Wave 3.1)

Consistent and reliable contact with specific services was a core feature of effective **scaffolding**. There was clear appreciation of continuity of relationships with the same workers, and some families where the spread of child ages meant that the same ABS worker (e.g., a family mentor) had been involved for several years. But it was equally apparent that trust in ABS was not isolated to individual relationships with a worker; changes in staffing were not necessarily disruptive to family engagement providing there was continuity in support. At the same time, when engagement was well-established – including when parents and carers are involved in volunteering roles – this could help if circumstances changed or became more precarious. This is illustrated in interviews over time with a mother who was a parent champion and had been supported by ABS to establish a women's group. In our Wave 2.2 telephone interview, dealing with a close relative's recent diagnosis of serious illness, she expressed uncertainty about whether she would be able to continue her involvement with ABS. But by Wave 3.1, she was still a parent champion and actively involved in running the group – reflecting with pride on how much it had grown, but also noting how her involvement had 'helped me a lot, a lot' during this difficult period in her life.

For many families, the **combination of targeted support and group activities** was pivotal in scaffolding and sustaining engagement. The mother quoted above detailed how, as a parent champion running an accessible group for women, she had helped families who were undocumented migrants to access much-needed specialist support – for example, in relation to domestic violence and for children with SEND – by seeking advice and fostering connections with the ABS professional team:

> And the thing is you know you have a child, and then you think it's going to be OK but then […] you need help. […] She [mother that our respondent was working with] was like, "I can't do anything". […] But at the same time, she didn't know … how to do it, and if she don't have papers, how she's going to do it? […] Yeah, and she couldn't pay any of this thing that's for the child. And she was really scared to do that. But at the same time, I say to her, "you have to do something". […]

> And then, do you know happened? She called me and I'm like […] in the meetings with the person who is in charge of [ABS partnership area] and I said "Please, we need help." […] Because it's not just one, it's a few mums they are in this situation.

The second Annual Report documented the experience of a mother with two children in the ABS range, the older of whom has significant SEND, who was supported to access universal ABS provision with the support of her family mentor. A year later, at Wave 3.1, she had maintained this involvement, now attending *without* the family mentor:

> At one stage I felt I couldn't take these out [two younger children] because I couldn't manage [older child with SEND] with [younger child] […] I felt if I went there, someone would look at me, like oh my God she can't cope with them kids kind of look. And [family mentor] was like, I'll come with you. (R: Yeah, I remember you saying.) I'll meet you down there. And I went down there, and you know what, it was the best thing I've ever done. (R: Really?) Is actually going down there and actually doing it, and all I needed was that little bit of support to say, you can do it, come on […] (R: And then since then you've been able to go?) Yeah, literally we just go.

Her account marks the significance of this development – 'the best thing I've ever done' – during a very challenging period for her and the children following the breakdown of the parents' longstanding relationship. In the same area, another mother highlighted the value of family mentors for supporting access to 'anything you might need':

> You get one-to-one sessions with your mentor and the parent and child. They also have group sessions. They can look into any other services or anything you might need in your area. And the areas they cover, to say, "Oh … did you know that you know [local venue is] having this big event going off in the summer holidays", sort of thing.

In this example, the mother draws attention to **fun, inclusive and non-instructional activities** as an important component of diverse provision. Across interviews to date, families – parents/carers and children – have highlighted their appreciation of support that can include the whole family, rather than exclusively focusing on the mother and ABS-aged child. A consistent theme over the years has been the importance of provision that includes older children, especially during school holidays. Family events and

outings were particularly valued for this reason. As with the example of the park outing at the beginning of this section, such activities were also evidently helpful in maintaining engagement when parents and carers might be anxious or simply lacking motivation to engage. In another ABS partnership area, this was evident in the experience of a mother with a three-year-old child, whose engagement with ABS included targeted support for speech and language development that had been scaffolded through her occasional attendance at local children's centres. Over the course of her interviews during the last two years, this mother has emphasised the ways in which the combination of her own health problems and learning difficulties has meant it can be challenging (and confusing) for her to access services. In her most recent interview, she reflected that family events such as 'fun days' have helped her to stay engaged with ABS when her motivation to go out with her child and to attend activities was low. For example, she described attending a family event with her child:

> And they had a bouncy castle, they had face painting. They had music, and [child] loves things like that, so s/he was happy, they had food. So, she was happy. So, I'll go to things like that.

Her account echoes the experiences of other parents and carers (also discussed in previous annual reports) for whom engagement with ABS was scaffolded by **non-judgmental, supportive and active encouragement** from ABS professionals and volunteers.

Longitudinal analysis of family interviews indicates that scaffolding has been most effective in securing sustained involvement when it is multi-faceted, offering **diverse opportunities for engagement and repeated approaches or invitations** – often through a range of ABS staff, volunteers and services. For some families (as with the first example shared in this section) initial scaffolding is sufficient to establish sustained parent/carer led engagement. For others, continuity and targeting of scaffolding has been crucial for enabling and sustaining involvement. This was most starkly evident among families who face particularly complex and entrenched barriers to engagement. But equally, the analysis shows how everyday challenges – including distance to services, and related considerations like the affordability and manageability of public transport – could have significant impact on families' engagement. **Practical support for participation in ABS** was often key to engagement, and clearly valuable in overcoming hesitancy about getting involved. For example, one mother said that her local ABS covered the

costs of taxis which made it easy for her to attend provision that was not within walking distance:

> There's always an excuse, you know to not go. So, when ABS started, they went, like literally there was always something … there was always a group that were available for me, they were like, "OK we've got this going on, do you want to come?" And I'm like, "Oh how am I going to go?" And they're like, "We'll provide you with taxi, and there's other mums … you already know from the group are going". I'm like "Who?", and they'd be like "So and so", and so I'm like, "I'm coming then".

Local accessibility was highlighted by another mother in the same area. With four children of varying ages, she discussed the practicalities of managing outings on a day-to-day basis:

> And if you're going with […] little children, then you know like it's very difficult […] for you to go there, and if it's not best weather. If it's just there, OK, I will say yeah, go to that park because you know like if it starts raining, two minutes and I can just run back home, so in five minutes I'll be home. But if I have to walk half an hour … or take two buses to get there, you know?

She went on to explain that the range of ABS services available in her area had enabled her to structure her children's everyday lives in their immediate community, especially 'after Covid happened':

> But, since I have known … in ABS, I am so happy, and I wouldn't have nothing to do. Because I don't have a car. If I go when they were little, the double pushchair, you know I? […] It's not ideal to walk up and down and, you know, and all that.

Precarious engagement?

Having considered how scaffolding facilitates engagement with ABS over time, we now turn to the experiences of those families where engagement with ABS was less well established and relatively more precarious, to examine the implications for family lives and access to support over time. The Objective 3 sample has purposely included families with relatively low levels of ABS involvement, and previous annual reports have documented the implications of complex and intersecting barriers to involvement (analysis that is not

repeated here). Rather, we consider the experiences of families whose support needs appeared to be less readily identifiable – or less readily expressed. Understanding their journeys can further illuminate key qualities of effective 'outreach and engagement' as described in the Theory of Change.

As discussed above, supportive encouragement helps overcome parents/carers' **hesitancy as a barrier to engagement**. Not all families had received this kind of encouragement – and it was not always needed, especially for those who had prior positive experiences with older children and/or who had the resources pro-actively to identify and engage with ABS provision. Moreover, local services work with finite resources, and even universal provision such as ABS must make judgements about how best to utilise capacity within their area. However, one consequence may be that outreach and engagement is more challenging when parents/carers are hesitant or do not pro-actively engage, especially if **barriers to engagement are less readily visible** to local providers. Box 1 presents an example of a family who at first appear to be living with fewer challenges than many in the Objective 3 sample. In sharing their experience, we do not imply they are typical of the wider Objective 3 sample, nor even of those who have low levels of engagement with ABS. Rather, their journey with ABS illustrates a pattern of involvement which indicates a need for scaffolding to identify and address their support needs.

Box 1. A need for scaffolding?

This two-parent bilingual family have one three-year-old child (aged six months at Wave 1); they are financially secure homeowners. Over two years of data collection, the mother's interviews highlight a shift in her perceived support needs. At Wave 1, she reported feeling happy to be at home with her baby, but subsequent interviews have highlighted concerns across all three of the ABS priority child development outcome domains – relating to restricted eating patterns, delayed speech and language development, and child behaviour and socialisation – as well as in relation to her own social isolation. In her most recent interview, this mother reflected 'And I feel like … I do feel sometimes bad about did I not take her out enough when she was younger'. The child had recently started nursery for a few hours a week, and the mother expressed hopes that this would help. She also reported some engagement with local services, including occasional visits to a local family centre, and following the child's 23-month speech and language assessment (reported at Wave 2) a targeted three-week group course from ABS. The following edited extract (Wave 3.1), indicates some reservations about this experience:

> It's basically … so we go to this place, it's a group session, which at first when I got there, I wasn't really prepared for. Because in my mind I was like, how are you going to help when s/he's got individual needs versus other kids … where their situation is completely different, right? So, there's a three-week thing, and it would be … each course, each week lasted maybe like 30 to 40 minutes […] And I just think … OK. So not very long, and the idea is that they kind of teach you games to entice them to speak, which I didn't think was very helpful, but I don't want to … I'm at the stage where I don't want to be refusing help because I also don't want it to go on my record that … we offered them these courses, but s/he didn't do anything, and now s/he's eighteen and s/he's not speaking! *(laughs) Do* you know what I mean?! So, I feel like I'm compelled to go to these things, and I feel like maybe I will get something from it, but the last one I didn't. And then they finished over the summer, and now in October, I've been put on the next set of courses, which I agreed to, and it's only three weeks … and I was like I can do three weeks […] Yeah, I don't think they do [help], but I just feel bad, because I feel like maybe I can get something out of them.

Over the course of her interviews, this mother has consistently referred to her lack of knowledge about local provision. For example:

> I don't know much about local services […] Maybe there needs to be more communication out there of what's on offer. But, like, it's one of those things. It's like, unless you're in the market for researching baby groups or I don't know … food bank centres or whatever it might be, then I feel like you're not going to be in the know…You have to be, like, in the market. (Wave 3.1)

Considered as a whole, the family's longitudinal account indicates that while they have engaged with local ABS provision to some extent, the mother continues to feel uncertain about what kind of support is available and about its suitability or accessibility for her family. The experiences of others in the Objective 3 sample – including in her local area – indicate that more tailored provision has been available that would meet her needs, implying that pro-active scaffolding of engagement with ABS could have benefited this family.

Objective 3 analysis is focused on families' own accounts of their experiences, and so, of course, it is not possible to know more about the reasons why the family discussed in Box 1 has not accessed the kinds of tailored and scaffolded

support of the kind reported by other families in her area. The mother's interviews regularly show her reflecting, often half-joking, on how she, and her child might be seen by others: 'because I'm like, why isn't s/he doing X, Y and Z, somebody's doing X, Y and Z'. Her hesitation to engage may partly reflect fear of being judged by others, as well as her sense that her family is perhaps not 'the market' for ABS support. For others in the Objective 3 sample, reassurance and active encouragement helped to overcome anxieties of this kind, but it may be that the family's support needs were less readily identifiable to ABS staff and volunteers because they are socio-economically secure[11] and had no obvious concerns when the child was first born.

The experience of two other mothers, each living in a different ABS area and both otherwise highly engaged with local ABS provision, further illuminates **the tensions of targeting support** to families judged to be in need (see also discussion of Objective 2). One discussed difficulty accessing a group because limited capacity was managed through targeting, so even though she had been pro-active in trying to join, 'when you go there, they're already full, or sorry they're meeting this criteria, that criteria'. Another expressed frustration that her family had not been allowed to join an ABS daytrip that was available 'only for certain families' who met pre-defined criteria[12]. She said she had been told, 'We'll contact those families', but cautioned:

> You [ABS professionals] might not know that someone like me meets that criteria. Just because I'm not displaying certain behaviours or my children aren't displaying certain behaviours, doesn't mean I don't need it any less.

Another facet of targeting is illustrated by the experience of a family where primary care of the child has shifted over the course of the evaluation. In previous waves of interviewing, the parents in this couple household shared care of the child; the father, who had given up work because of the mother's chronic health condition, was evidently actively involved in everyday care of the child at that time. The mother was highly involved with ABS, pro-actively engaging after finding information online when she was pregnant. The father had not actively participated in ABS activities, although was aware of the activities on offer, and the family had implemented learning from provision

[11] Parkes et al.'s (2015) analysis of the *Growing Up in Scotland* study highlights a distinctive relationship between parenting stress and lack of support in higher income families.
[12] While it is not possible to specify the criteria for the activity being discussed here, ABS partnerships do use prioritisation strategies in determining how to use available resources to support family involvement, and day trips may be targeted at families who are known to be on low incomes who would otherwise be unable to afford to participate.

such as the HENRY weaning course in their everyday practices. At the time of our Wave 3.1 family interview, their situation had changed significantly; the mother was not currently resident, and the father had sole responsibility for the child's care. He was not attending any of the groups that the child's mother had been involved with, and said he was not aware of any relevant support available for the family via ABS. His experience raises an important question about the precarious nature of family support when engagement has been focused on the mother as the primary carer, and aligns with research documenting the ways in which **fathers' pivotal role within vulnerable families** may be missed or under-estimated (see Tarrant 2021; Hughes and Tarrant 2023).

Scaffolding families beyond ABS provision

Reinforcing Objective 3 analysis in the second Annual Report, interviews with families again documented a key role for ABS provision in enabling families to access support beyond the scope of ABS. This included access to relevant linked services and systems, such as specialist speech and language or SEND provision – a finding that can be seen to correspond with the systems change outcome of enhanced joined up working in the ABS Theory of Change. Analysis over the years consistently documents a critical role for ABS provision in response to the challenges of family poverty. That support includes examples of ABS workers helping families to secure welfare entitlements[13]. ABS provision also acts directly to mitigate the impacts of poverty, for example, via book schemes, affordable healthy food schemes, and examples of direct resourcing such as the gift of an air fryer to a family in need. Considered as a whole, these features of ABS provision can also be understood as scaffolding for families – linking them into wider networks of support beyond ABS, and so addressing needs that extend beyond the remit and capacity of ABS provision. Yet analysis also shows the limits of this capacity for some families who are living with the most challenging external circumstances, even when they are pro-active in seeking out support. We consider this point by reflecting on the experience of a family with refugee status, presented in Box 2. The parents speak little English and interviews have been conducted via interpreters.

[13] For example, Personal Independence Payments (PIP), a benefit for people living with a long-term illness or disability that interferes with everyday life, see https://www.gov.uk/pip

Box 2. Access to wider support networks

At the time of the Wave 3.1 interview, the youngest child in the family – a young infant when the evaluation began – was 32 months of age. Analysis in previous years has documented the importance of support from an ABS worker in enabling family engagement with universally accessible group-based activities. This took the form of consistent encouragement and information sharing, as well as active practical support, for example providing transport to ABS activities. Trust in the ABS worker was clearly a critical enabling factor. But by the summer of 2024, the worker who had supported their engagement was no longer in post and the family no longer had any active involvement with ABS provision. In understanding their experiences, their refugee status and language barriers are important, as well as the wider context of their lives. Throughout interviews over time, they have highlighted an ongoing threat of eviction from their private landlord, uncertainty that has coincided with other challenges including health concerns and financial pressures. The family's most pressing support needs related to that wider context. While the youngest child is still in the ABS age range, it is perhaps understandable that participation in ABS provision was not a key priority amidst everything else, and so might diminish if no longer actively scaffolded by the ABS worker.

The parents had been pro-active in trying to access services that were relevant to their priorities, but these attempts had been frustrated by an overwhelming sense of uncertainty about how to navigate local systems successfully. Speaking via an interpreter, the mother detailed the challenges of accessing appropriate advice and support in an unfamiliar system:

> To be honest, I am lost. […] Unfortunately, the connection or understanding, helping each other with the something which we don't know what to do. They give you wrong opinion or they make you more confused. … Yes, for example, we will ask, they said go to the council. We will go council, council... don't understand it that much, give us the telephone number, call them. We will call. Again, we come to the point of nothing happened. Don't get the answer.

As her account indicates, lack of support does not reflect a lack of effort in seeking help. Indeed, she commented that 'there is a lot [of support] around' but it is not accessible to the family. This family relied on one of the older children in the household – not just for translation, but for understanding and navigating access to local systems. As her mother explained:

> Yes, [name of young person], at the moment s/he's not going, going to work, she's not in the college now. Everything – my house, housing, money, everything, bank, she can understand. Without her, I cannot do anything!

Reliance on children and young people for language brokering is a common experience for many families who face language barriers, but as Iqbal and Crafter (2023) note – and as appeared to be the case for this family – young people are often caught in the middle of tense dynamics between parents/carers and adult professionals that are exacerbated by families' lack of understanding of complex systems.

The challenges of navigating inaccessible and confusing systems were not only highlighted by families from international backgrounds, as was illustrated by the experience of a multi-generational English-speaking family who had long lived in their local area. In this family, both mother and grandmother describe themselves as having learning difficulties and the grandmother highlighted their shared difficulties with navigating incomprehensible systems:

> You know for people that have got learning difficulties, they [non-specific] make it very hard for people? […] Yeah. You know basically even [child's mother] yesterday, you know trying to do this thing, you know for [child's] nursery. (R: For the [nursery] funding, yeah?) She was getting frustrated, I was getting frustrated … (R: So, it's confusing?) Yeah. Because you know I can't help her, you know? And it's real frustrating.

Such experiences of uncertainty and confusion contrast sharply with a story told by a mother who was an ABS parent champion. Closely involved with local ABS provision, she had longstanding roots in the area where she lived and her own extended living family nearby. Her account of giving advice to a mother who was dealing with housing problems, shows she understands her rights and how to advocate on behalf of herself and others in her community:

> So, then she'd been having problems with housing and stuff like that … So just be able to support her and telling her about, like, you can go talk to this person, you can go talk to this person. And then she called me because they want to move her somewhere temporary, because of all the stuff that's going on. She's like, "What should I do? I'm stressed and da da, I've got to move". So just being able to have the confidence to talk to people like that, and going like "This is what you

> can do, this is your rights, make sure you talk to your advocate, talk to the MP, da da da" … So just having that knowledge to be able to share with other people has been amazing.

In this account of her parent champion role, our respondent evokes the earlier description of 'people communication', as distinct from mere signposting.

The second Annual Report documented the importance of pro-active professional activity in providing consistent and reliable information about local provision, systems and resources, particularly for families who – for whatever reason – have limited understanding of local systems or face multiple intersecting barriers. The experiences documented above describe a minority of families within the Objective 3 sample, but they reflect a critical challenge for services – especially given a wider context of extreme pressure on sector resources, with universal and non-statutory provision disproportionately affected by public spending cuts (e.g., Rehill and Oppenheim 2021). Even programmes with the holistic and systemic remit of ABS have inevitable limits on their resources and capacity to provide both universal and targeted support to families, including extended support to families with multiple complex needs in their engagement with complex wider systems. For most families in our analysis, 'people communication', signposting and scaffolding were sufficient to enable and sustain engagement with ABS and wider systems of support. Yet others are likely to face persistent and recurrent barriers without more targeted ongoing support. The analysis presented is consistent with a wider UK literature that documents the cumulative risks and precarities faced by families living with entrenched and intersecting forms of structural disadvantage[14]. When critical challenges overwhelm other priorities, it is likely to be very difficult for families to engage with anything other than the present crises they face and their most urgent concerns. In this way, precarity exacerbates precarity – and without active ongoing scaffolding, will undermine the possibilities for families to access and sustain engagement with the support they need.

Wider impacts of ABS engagement

Over two years (to date) of twice-yearly interviews, Objective 3 has accumulated consistent evidence that ABS has supported diverse families – many of whom have significant and complex needs – in relation to all four ABS priority outcome domains (discussed further below). The analysis also shows

[14] See for example Patrick 2017; Hall 2019; Millar and Ridge 2020.

how impacts for families go beyond specific outcome areas, making a wider difference in child and family lives over time. This section begins by considering the broader perceived impacts of ABS engagement, reflecting on links with systems change outcomes, before going on to focus more specifically on core child development outcome domains in the next section of the report. Once again, we do not detail findings that simply replicate evidence documented in previous annual reports; instead, we interrogate new insights from the most recent longitudinal analysis that illuminate **mechanisms for change**.

It is well established that supporting **parental (and especially maternal) mental health and wellbeing** is beneficial across a range of child outcomes (e.g., Al Sager et al. 2024). Given this, it is of note that parents/carers who are involved with ABS have consistently been overwhelmingly positive about the difference it has made to their mental health and wellbeing, in ways that are likely to enhance child outcomes across developmental domains.

Particularly striking in light of the examples of family precarity discussed above, several described **feeling better equipped to cope with challenging situations** as a direct consequence of their involvement with ABS. Earlier in this report, we quoted a parent champion discussing how her involvement with embedded informal networks – built up through her ongoing engagement with community activities in her area – had helped during a very difficult period. In another area, a mother with a new baby talked about having been worried during pregnancy that she would experience a decline in her post-natal mental health, as she had with her first child. She explained that this time 'it looks different' because of ABS support, including targeted and universal services:

> It's been different … it looks different, that's the only thing I can say is it looks different. Like I've still struggled with post-natal … mental health, not depression, like anxiety and mental health sort of stuff. But like it looks different this time because I have support in place already … I already have support, I'm not trying to seek it while struggling, I already have the support.

Earlier, we highlighted the value for families of knowing – and trusting – that ABS support networks are there. In effect, the mother quoted above is describing her confidence in a critical facet of ABS systems change, specified

in the programme's Theory of Change: that **ABS approaches should be embedded and sustained across areas**.

Previous annual reports have highlighted the high proportion of parents who have experience of poor mental health and of limited informal support and social networks. A consistent theme in interviews to date is the value families attach to **wider social connections** as a crucial facet of wellbeing, described by one mother as helping her not to lose herself in her own 'little world':

> We were, we were home almost all the time, you know.... But now we are going out more, I mean we are going to the shop and neighbours and all that. But when he was smaller, we couldn't go that much out, you know. […] Yeah, it's like you have your own little world, you know. And you think at some point that that's all there is. But again … when you have somebody [ABS worker] come up you know and speak to you from another perspective and … about everything that's going on, then you see the big picture! […] You don't lose yourself.

Across areas and over time, **reducing parental isolation** was highlighted as a particular benefit of ABS. One mother, now working and so less involved in ABS activities, reflected on the importance of enduring friendships made in the period after her child was born:

> I think it's essential, yeah, yeah. I feel like … I mean we've got lots of friends through nursery now, but that first year on maternity leave, they're the friends that I made that I'm still in touch with. Like I wouldn't have had them, you know like I would have been […] been lost.

Addressing isolation did not necessarily depend on developing close or established friendships. In another area, a mother highlighted the environment of ABS group activities as being structured in such a way that 'if I don't get on with anybody, it doesn't matter'. She explained:

> Because we can just enjoy what's here. And a lot of the time because they're engaged in an activity, then your conversation is orientated around that, so it's really easy to chat.

In previous reports we have given examples of how parent involvement in community-led volunteering and related activities (e.g., as parent champions or in running groups) has provided important **opportunities for**

empowerment and skills development, ranging from enhancing English to enabling work opportunities or return to study (as for a mother who gained new counselling qualifications). One mother reflected at Wave 3.1 on her increased confidence since volunteering with ABS:

> You know why, because like I told you before, I didn't feel that confident [as] I feel today. Like I can express myself, I can find the help I need, I can help the others … And even like, [I'm] going to find a way to improve my life that I was telling you […] I want to go to this job for me.

Importantly, the sense of giving back and of valued empowerment was evident among all the parents/carers who had engaged in volunteering, regardless of the complexity of their family lives. One parent/carer, with ongoing mental health and relationship difficulties, talked about the value of being involved in something positive in the context of challenging personal circumstances:

> … I love giving back to the community, me. So, it's nice to … because I know if it's a woman, I know being a woman we have struggles. But it's nice … it's reward … I find it rewarding.

Parents and carers also shared reflections on the positive differences they observe in **community networks and resources**, such as one who discussed the impact of ABS investment in parent-led groups and activities in her area:

> But what I'm saying is that the way ABS works […] I'm 37 years old, and I've never known anybody to work the way they do. So, there is community, we do have communities, we've always had community, but we've never had events going like that. So, I've seen communities that [in the past] they've been quiet.

Supporting child development

Underpinning Objective 3 is a concern with understanding the **mechanisms by which involvement with ABS provision contributes to core outcome domains**, including local systems, child diet and nutrition, language and communication, and social and emotional skills. Analysing family data over two years, we can generate 'more detailed understandings of the contexts in which particular mechanisms generate particular outcomes' (Marchal et al. 2013, p126) – showing how ABS involvement can shape everyday family practices in ways that support children's development in relation to the child

outcome domains, and highlighting the value of secure engagement with local provision. As the older children in the Objective 3 sample have aged out of ABS provision and into formal education, the most recent analysis also highlights the ways in which ABS involvement can support school readiness for children and families.

Diet and nutrition

The benefits of ABS support for children's diet and nutrition have been consistently documented across waves of data collection with families, indicating that this provision – ranging from universal services to targeted support and advice – has made **a positive contribution across critical stages in the development of feeding**, from establishing and maintaining breastfeeding, through weaning and beyond.

Breastfeeding support was particularly highlighted by several families, including three mothers who said that ABS had been instrumental in the early identification of tongue-tie that caused early feeding issues. International literature demonstrates that the nature and quality of support from community services and health care providers is critical in facilitating breastfeeding, as support which is 'inadequate, impractical, or infused with conflicting messaging' may undermine breastfeeding practices (Beggs et al. 2021: 8). It is a striking feature of family narratives across waves that perceptions of breastfeeding support have been consistently positive and enduring. Mothers overwhelmingly found ABS breastfeeding support to be relational, flexible, and responsive to individual family's needs, in several cases over prolonged periods of time. One mother, who has very limited extended family support, spoke at Wave 1 about having successfully breastfed her first child with the support of ABS; following the birth of her second child this year, she explained that the service had been equally helpful. Reflecting on potential changes to local provision following the end of ABS funding, she expressed concern about the potential impact on rates of breastfeeding in her area:

> [ABS breastfeeding service] is amazing as ever, and God knows what breastfeeding mums in the area are going to do without them. Loads of people will not be able to see it through. Without those services, you're going to see a drastic drop in breastfeeding. There is no doubt about it. There are some people, it just … they just take … it just works. But there are people, like me, who even second time around it wasn't easy. It didn't just work again, and I thought it would. Without

> all that support … we had that, me and [partner] had the conversation multiple times, do we just go and get formula, it's not the end of the world. And I was like, come on, let's keep trying!

As children grow through the early years, parents/carers have spoken about the ways in which ABS has influenced their **nutritional knowledge and cooking skills** by sharing healthy recipes and ideas. For example, a mother of four young children talked about being able to make healthy snacks and meals for the children when previously she might have resorted to convenience food:

> Because life happens, and then you just forget, and then you are there, like, wait a minute, I can do my own pizza.

Access to affordable healthy food continued to be a significant concern for many, and a critically important facet of ABS support, through schemes that gave families access to subsidised fruit and vegetables or supported access to food banks. Some relied regularly on this provision (as discussed in previous reports), while for others it helped at critical points. One mother explained:

> Through [ABS] … I have a couple of times used the food bank. Kind of like I've been … referred through them to get a food bag … a box, and they've referred me to this one that [local authority] do, I don't know what it's called. So, that has been very helpful, a couple of times.

In line with analysis reported in previous years, there was evidence that families preferred **interactive activities rather than instructional courses**. Activities such as cook-alongs and shared meals were also valued for fostering community connections and informal networks. One mother, using ABS provision less frequently since her child started nursery and she returned to work, reflected on her earlier experience:

> Yeah, I think actually the food side of stuff, now that I think about it, particularly in those early days, was really wonderful… You had, like, come and you can pick five vegetables and we'll have a cook up together which … show you how to do this thing […] I suppose that side of things really appeals to me because [child] can get involved. I would love to learn more about that stuff, and [partner] is hopeless when it comes to cooking, so it would be a nice kind of thing to be involved with.

Another mother, a parent champion, highlighted the value of these activities for refugee families living in temporary accommodation with no cooking facilities:

> Yeah, so we do cooking. And what happen is they just keep the session [ABS have continued the provision] and they say, you give the idea because now the ladies were the refugees. They come together and they cook. Because in there … in the hotels, they just give bread … *(R:* So, there's no cooking?) No cooking, so … (R: So, they're doing that in the [ABS] children's centre?) The positive thing is now they can cook.

Communication and language

Across all five areas and interviews to date, parents/carers who are engaged with ABS consistently document distinct benefits in support for children's language and communication. The impacts described are diverse, from enhancing the child's early language environment – for example through participation in book schemes and storytelling groups – to early identification of concerns and support needs, supporting multilingual children's language development, and facilitated access to specialist assessment and services. The value of universal provision for **supporting family practices in relation to language development** has been reported previously, and was equally apparent in the most recent interviews. Parents/carers who had used ABS activities and resources consistently described how these had supported their aspirations to support children's early language development and literacy.

The contribution of ABS in relation to **emerging concerns about speech and language** was highlighted by more than one third of families at Wave 3.1. Families with the most active involvement in ABS provision (whether parent-led, or professionally scaffolded, or a mix of both) were the most likely to describe how ABS provision had enabled early identification of language support needs. This finding aligns with wider evidence of the most effective approaches to developmental screening for early language delay, which highlights the relatively greater sensitivity of parent-reported methods compared with other approaches (Feltner et al. 2024), as well as the tendency for children to face long delays between screening and intervention (Julien 2021). It is perhaps not surprising if early identification and support are facilitated when consistent involvement means ABS professionals have got to know children and families.

In contrast to the mother quoted in Box 1, who expressed reservations about the value of a structured group course, several families commented positively on tailored and home-based approaches. For example, one mother gave a detailed account of a play-focused home-based ABS intervention[15], explaining how it enhanced her understanding of how best to support her child, and meant that 'everything changed' for the child:

> She came here [ABS speech and language worker] […] she was supposed to only be here with me for six weeks, she was here for nearly twelve weeks, continuously coming in, spending one to one time with my [child], you know playing toys with [him/her], blocks and letting [him/her] be [him/her]self. And even the speech therapist would not do that, you know, I was on the waiting list for two years. I spoke to other parents from schools, from community centres and stuff like that. […] When I spoke to the parents, they said "Well, what's going to happen is they are going to see you, it's like an hour or two session, they're going to speak to you and that's about it, and then you go away with information and leaflets" … how … what … how does that help my [child], you know? You know, you help me with information but I'm clueless, you've only given me two-hour session which has gone over my head. And I'm going to sit down and do that time. Whereas those, they came in, ABS, she came in, she sat down, you know, with blocks and toys, and she showed me, you know rather than telling me, that this is what needs to be done. She'd come for an hour session. Sit down with [child] every week … (R: And did it make a difference, do you think?) … [His/her] confidence, speech, one to one, and then pronunciation, everything changed, it's just lovely.

For children who subsequently moved onto more **specialist speech and language and SEND interventions**, ABS had played a pivotal role in facilitating timely referrals, as well as providing support during the uncertain 'limbo' (in the words of one mother) of waiting for specialist assessment. At the Wave 3.1 family interview, the parents in a couple household described having recently completed an Education, Health and Care Plan (EHCP) assessment for their three-year-old child, which they hoped would make it possible to secure a place at an oversubscribed special needs school in their area. The mother explained that it was unusual to get an EHCP in place at this age, but this was made possible by ABS facilitation of early referral to specialist services:

[15] Edited here for length and to protect confidentiality.

> Oh, a huge difference! Like [ABS worker name] … I think [ABS worker name] probably was the one who really got the ball rolling, wasn't she? And she … was a joy to be around. And you know she put us on to [specialist disability service], she … (R: Would you have got there anyway without her or …?) I don't know. I genuinely don't know. Because I don't think I'd have known to go there. (Father: Yeah).

Support for multi-lingualism in language development was an important consideration for all the multilingual families in the sample. Between them, these families spoke 13 different languages, including at least four families where more than one home language other than English was spoken. Families also varied in the extent of English spoken at home, with a minority using mainly English, and four families where parents/carers speak little English. Across this diversity, all the parents/carers interviewed were concerned to support children's home languages alongside their English language learning. Families appreciated reassurance from ABS workers about the implications of multi-lingualism for children's speech and language development, but the analysis also shows that multiple language development could pose distinct challenges, and corresponding concerns, for parents and carers[16].

The balance of maintaining home languages alongside English language development was discussed in several families. Parents who spoke little English expressed some concern about school readiness, in preparing children to speak English at school. In families where English is spoken, including by older children, some parents/carers commented that development of home languages requires more active effort because children will be exposed to English in other ways (at nursery or school, and via TV, radio and books). For example, a trilingual mother whose family included school-aged children explained:

> I mix it up. I force [child] to speak my language, when she's at home she speak my language. For the kids […] so they won't forget. Because automatically they understand English. They're used to it around in school and everything.

Multilingual families valued sensitive, family-focused advice and encouragement to maintain dual- or multiple language learning, and those who had most involvement with ABS clearly felt supported in this. This is

[16] This finding corresponds to international research on multi-lingualism (e.g., Zheng et al. 2021).

illustrated in the experience of another trilingual family who received ongoing support from a family mentor. Over the course of their interviews, the mother has consistently discussed how best to support the child learning two home languages as well as English. For example, in the first phone interview (Wave 1.2), when the child was approximately 12 months of age, she explained:

> I was asking [ABS worker] if that's OK that we are not bilingual, we are actually speaking three languages in our house. We were speaking about that and, yeah, she said that's fine. It's just I should use my mother tongue with [child] as much as I can, and then my husband [speak his language of origin] as well.

At Wave 3.1, this family was being supported by a mentor from the mother's country of origin. While she did not think that it was essential to have a linguistic match between mentors and families, she had found the mentor's encouragement and understanding of multilingualism to be very helpful. For example:

> Well, she can understand actually. Until you go through it, you can't quite understand what's the problem, you know! ... It was good to feel encouraged to teach [child] my first language.

Her account over time illuminates the importance of encouragement and reassurance within a flexible approach that aligns with family priorities. The experiences over time of another family indicate that a tailored approach has particular value when multilingualism may coincide with parent/carer or professional concerns about potential speech and language delay, enabling early help. The mother in this family spoke English as well as her home language; the father also spoke English at home, but by Wave 2 he was no longer resident. In the first family interview, when the child was nine months old, the mother described her family mentor's support for child development:

> So now I have this [ABS] family mentor, she is nice, she is very nice. […] She ask me questions like how is [baby] doing, how is [his/her] development? […] And it depends on the score, she will say, OK maybe you need to try to play with [him/her] more or buy some white and black toys […] Like some advice to help [him/her] develop. But s/he always passed the test like with high score, so…

Interviewed 12 months later, she explained that the mentor had identified, and advised on, the child's developing communication:

> There was a bit of like a low score on the communication. […] So, she said to talk to him more without distractions. […] And I also say maybe he doesn't really talk much because he still didn't choose which language to communicate with. […] [ABS worker] was saying […] the next month or two months to try like that and if next time we meet he still doesn't have any, you know, speech improvement, she can refer me to [speech and language service for children <2.5y]. Yeah, I don't know exactly what they do. But I don't think it will be necessary to be honest.

By Wave 3.1, plans were in place for the child's referral to speech therapy:

> Yeah, she referred me to this [speech and language service for children <2.5y]. And they did a few sessions and […] she spoke with nursery and nursery feels like, obviously s/he's not going to go from three words to 200 words in three months, so they already started the referral for speech therapy, which is for [children over 2.5y].

These examples over time show how early support has transitioned into early identification of need and subsequently into specialist referral. Also noteworthy, in the context of the family's multi-lingualism, the mother did not appear to be wholly convinced at Wave 3.1 that her child had communication difficulties. But she evidently trusted in the guidance she had received, and was confident that the referral would benefit her child:

> He understands everything, and he makes himself understood as well and he's active. I can't see any signs of communication difficulties. But it is just about the speech. So, I think it's just going to do him good, you know.

Social and emotional skills

Wave 3 data reinforce findings presented in previous annual reports, showing consistently the value of affordable and inclusive opportunities for supporting children's social and emotional development, both directly impacting the child – for example, through provision that supports **socialisation and peer relationships** – and indirectly, by supporting parents/carers in their **caregiving practices and relationships with children.** In addition, family

narratives highlight important indirect influences on children's development through **improved maternal mental health and wellbeing** as well as **intersecting pathways to influence** (for example, as improved maternal wellbeing shapes caregiving practices and socialisation opportunities). Reflecting these diverse pathways to impact, a wide variety of ABS provision was seen to support children's social and emotional development – including services and activities which are primarily focused on the other core developmental outcome domains. Again, the most positive benefits were reported by families with higher levels of sustained involvement with ABS, a finding that was evident across partnership areas and diverse family characteristics, including those living with complex intersectional challenges. The implication is that ABS provision makes a positive contribution, but engagement is key to effectiveness.

Parents/carers have spoken positively and consistently over time about children's enjoyment of **ABS activities and groups** and the corresponding impact on their developing social skills. Fourteen families (spanning all five partnership areas) described regular use of activities accessed via children's centres. Consistently, their accounts highlighted how the quality and accessibility (cost and proximity) of these opportunities meant they were embedded into regular routines for children. For example:

> Yeah, it has because there was a lot of like activities they'd send through and you know they had sessions that they ran different days in the week and different areas where we live, for her to partake and meet other children. So, there was that building relationships with other younger children, and … or children similar to her age.

Interviews over the course of the evaluation repeatedly document the ways in which participation in activities can support parent/carer-child relationships, fostering mutual engagement and enjoyment by reducing stress and creating opportunities for positive joint interactions. This is illustrated in interviews with a mother of three children (one in the ABS age range). Reflecting that being at home together all day could feel overwhelming, increasing family tension and the frequency of shouting, she valued ABS sessions at the children's centre as a way she could 'just do something with [child] for an hour […] and take her somewhere'. In a different area, another mother highlighted the benefits for her child of embedding this kind of joint engagement into the family routine:

> So now I try to change my routine to take them out to do things. […] Now is, like, he more listen to me, you know, talking about things we're doing.

Parents/carers also talked about the value of ABS for **supporting positive parenting approaches**, through parenting courses as well as via ongoing access to trusted and tailored advice and support (e.g., through family mentors). Several specifically highlighted their appreciation of practical strategies for managing challenging behaviour in early childhood – for example, by praising positive behaviours rather than punishing negative behaviours – quoting advice that they had incorporated into their everyday parenting practices:

> She [ABS professional] goes "No, no", she goes "You do not punish your child". She goes, "If your child … if your two children are together, and one does something wrong, which is dangerous or not appropriate and the other one is doing something fine, ignore that the bad is happening, because we always address the wrong first, don't we?"

The second annual report included the example of a mother who benefitted from a parenting course that enabled her to be 'stronger, wiser, kinder' in helping her – and other adults in the family – in responding to the child's behaviour. Illustrating the value of **continuity through complementary forms of support**, this mother spoke at Wave 3.1 about the benefits of group settings – including the crèche her child had attended during the parenting course – in supporting the child's subsequent transition to nursery. She explained:

> You know before nursery everyone kept saying, oh she really needs to go nursery because she needs the social side of life. And I'm like no, actually we go to so many baby groups, you know … the social side of things, she's not deprived of that at all.

Her reflections are particularly striking given the family's experience over time. At Wave 1.1, she described very poor postnatal mental health, explaining that she rarely left her home. Her reflections two years later illuminate the lasting benefits of ABS involvement, as her confidence in her parenting choices is indicated by her casual rebuttal of unwanted advice: 'she's not deprived at all'. Her experience highlights, again, the value of multiple points of support.

A Better Start was established ten years ago, in 2015. While our Objective 3 analysis has focused primarily on children born later in the programme period, the family-centred approach means that respondents occasionally reflect on experiences with older children in the family. Box 3 presents an example of a mother looking back on an ABS parenting course she took eight years ago. Her vivid detail and repetition – 'this is how you do it' – indicates the enduring significance of the course for her family and her parenting practices over time.

Box 3. A long view

Over the course of her interviews, the mother in this large family has spoken in detail about the value of ABS in supporting multiple facets of her parenting and family life. Dealing with complex challenges including a young child with significant SEND, she had a close extended family network living nearby. In the family's most recent interview, she recalled an ABS parenting course that she had attended with her sister eight years previously. At the time, she said, her sister's child – then two years old – was 'one of them that did tantrums every two minutes, hit people, run off in stores and everything'. The course specifically addressed strategies for managing challenging behaviours, and she explained that as she also had young children at the time, 'we took it [the ABS course] on just to see then what would it bring to us as our family'. The relevance of the course to her and her sister's experience had immediately resonated, to the extent that they were 'both sat there crying because it was like proper in deep like' [resonated deeply with their experience]. She explained:

> I think it was just the fact that you can actually deal with the behaviour in a certain way … It was like, we was all sat round and […] the children weren't there, because they put like a little crèche on as well […] I can't remember who did it, who did the session. And then it's like a board and you write down on a piece of paper, and say that he was running off in a store, then how would you deal with it? If he was doing this, how would you deal with it? So, it actually shows you … how to come across the challenging behaviours without shouting and expressing that you're fed up and showing your kid that you're fed up, how to come across that. […] It's instead of them running off, they're now helping you do that [shopping]. There was a few times my sister just wouldn't, you could see that she was fed up, repeating the same thing, and it was like … this is how you do it.

> This is how you do it. Because then we both stuck together doing it, it's like this is how we do it.

Endings and transitions

As discussed earlier in this report, the five partnership areas have been working towards transition arrangements in anticipation of the ending of ABS funding, and this work was ongoing at the time of Wave 3.1 family visits in the summer of 2024. At the same time, the oldest children in the Objective 3 sample are now over four years old, and these families have been through their own transitions as children age out of the ABS target age range and into formal education provision. As appropriate for individual families, these transitions were addressed explicitly in our interviews, prompting parents and carers to reflect on the contribution of ABS over time for their families and their communities.

Positive endings

Families' involvement with ABS is, of course, dynamic, and several families across areas had ended involvement with local provision – as children turned four and grew out of the ABS target age range, or as family circumstances changed, with mothers returning to the workplace and/or children starting to attend early childhood settings, school reception classes, or occasionally, other specialist provision. Parents and carers were consistently positive about **ABS support for school readiness and transitions into early years education.** This finding relates to the discussion of core outcome areas, above. Parents and carers highlighted key features of ABS provision – including support for language learning and children's socialisation in peer relationships – as valuable in preparing for the transition to formal group settings.

A related consideration is **parents' and carers' experiences of endings**, especially when they have been highly involved – and heavily reliant on – support from ABS. Previous research has reported that endings within long-term family support can provoke uncertainty and concern, and – especially when volunteers are involved – this can be exacerbated by potential ambiguity about the nature of relationships, as professional or friend (Fisher et al. 2019). By contrast, our analysis has not identified such challenges, indicating that planned transitions from ABS support have been experienced positively, even when families' involvement has spanned several years. This is illustrated in the experiences of a multi-generational single mother household, where

the child is now almost five years old and was starting school in the autumn after our interview. Over time, this mother has provided a consistent account of ABS support across different stages of child development, giving examples of practical support with aspects of everyday parenting, such as weaning practices, reading with her child, and building relationships with other children. At Wave 3.1, she summed up her experience with ABS as follows:

> Oh, it's been amazing, she's [family mentor] gone through so much with me, and I feel like I've had extra support, whereas other people haven't had any extra support and have just … well "I have this child now, what do I do with this child? How do I help bring this child up?" And I feel extremely lucky that I've had [name] as a mentor and all this extra support from her and [ABS] service that they offer. Whereas other people, they may have just got the midwife for a few weeks or … like my friend did, she only got the midwife a couple of times and that was it.

By the time of this interview, the family were no longer involved with ABS, and the mother explained that she felt 'fine' about ABS support ending – with a graduation ceremony from the mentoring scheme – even though it has evidently been a significant part of her life since the child's birth. Reflecting on her child's enjoyment of nursery, she anticipated a smooth transition into school:

> She's really excited. She's got a couple of friends there from nursery who are going to the same school, so she knows a couple of people in her class. And she also knows a couple of people from the last year's lot of nursery, who left the year before.

In her description of a problem-free transition out of ABS support, this mother's experience has much in common with other families whose **support needs had been met by well-established involvement with ABS**. Equally, endings were facilitated when families were engaged with other forms of provision or networks of support, including through onward referral when appropriate.

Distinctive features of ABS provision

Earlier in this chapter, we quoted a mother highlighting the focus on **'people communication'** as a key feature of ABS in a wider service context where resource constraints increasingly restrict support to signposting and online

information. The capacity of ABS to provide flexible, relational support – and the affordances of this for effective work with families – was a consistent theme in interviews across partnership areas and over time. **Flexible, relational work** facilitates the engagement of families and sustains involvement in the context of persistent challenges and precarity and appears to be a critical mechanism in enabling benefits across outcome areas in family lives.

Partnership with parents and carers is embedded in key principles within the ABS Theory of Change – including emphasis on **inclusion, engagement and empowerment** of families as a key mechanism. Our analysis indicates that parents and carers recognise these qualities as distinctive – 'uniquely ABS' in the words of one mother. Another highlighted her sense that ABS in her community is like 'a village'. Characterisations of ABS as inclusive, relational and connected were framed by some respondents in contrast to their perception of (and in some instances, relative lack of trust for) statutory and local authority services. For some parents and carers, perceptions of the distinctive qualities of ABS informed their hopes and concerns about the nature of future service commissioning – for example, through the development of Family Hubs. Many families understood that key services were likely to be retained following the end of ABS funding, but several were concerned that the distinctive qualities of ABS might be lost through this transition. For example, one mother commented:

> I mean I know they've got the Family Hubs […] I just think ABS has got like … Like, they [Hubs] do it and they are good, but I feel like it's like they have to do it kind of thing. It's the council. […] But ABS felt like more enthusiastic…Like for more … thinking about why they're doing it. Very passionate about that, do you know what I mean?

She emphasised the passion of ABS staff for families and the local community, commenting that, 'they really want to help the area, they really want to help people with kids to have a better life'. Similar reflections were shared by a mother in a different area, highlighting the distinctive strengths of ABS in its focus on building relationships with families over time:

> I mean I know there's obviously the family centres, but it's not the same. Like the family centres is not the same, it's a council run thing, you know, you don't get to have a cup of tea when you arrive […] you know, it's not the same, you know, you're just a person accessing a

> service. […] I have recently, you know gone back and been like, oh I'll try the family centre baby group and see if it's any different to before. But it's not, it's just the same, you're just the service user, you're not like a regular mum attending a regular group, and you're not recognised in that way either.

In the same area, another mother highlighted the challenges of maintaining key facets of the ABS approach in a context of highly constrained local authority funding, commenting[17]:

> I know that the funding will be prioritised elsewhere, you know that that funding won't be there, and the council will not find funding for that. […] If they're [local authority] even just funding the parks out of education budget, where are they going to find that additional money from?

Her observations raise a challenging question for local authorities in developing provision that builds on learning from the evaluation of ABS. The Objective 3 analysis to date indicates that ABS has the potential to be highly effective for families when their engagement with diverse provision is enabled and sustained. Conversely, the weakest evidence of benefits – and greatest extent of unmet support needs – is found among the small minority of families in the Objective 3 sample who have limited or precarious engagement with ABS provision. Scaffolded engagement through continuity of flexible, responsive and relational support is evidently key to effective provision, allowing diverse families to access support and develop family practices in ways that accommodate complex circumstances and align with their aspirations for child development and wellbeing. In contexts of constrained public finance, Objective 3 analysis highlights the importance for the sector of sustaining the reported benefits of the approach beyond the end of ABS programme funding.

[17] Edited for confidentiality.

9.3 Next steps

The next phase of work for Objective 3, Wave 3.2 interim telephone interviews with parents/carers, began in January 2025 and are now complete. The final stage of in-person data collection will take place in the summer of 2025, approximately 12 months after Wave 2 in-person interviews. For a more detailed overview of plans for this work, please refer to the National Evaluation Protocol.

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

10.1 Aims of the Objective

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

- The costs associated with delivering the programme.
- What outputs have been delivered (e.g. beneficiaries reached).
- Any change in child and parent level outcomes as a result of their involvement in ABS activities (Objective 1).
- What public sector activities will change if the ABS programme causes a change in the above outcomes.
- Any change in public sector spend as a result of that change in public sector activity.

10.2 Methods used

In 2024 Objective 4 focused on:

- Identifying and describing the costs of the ABS programme to 31st March 2024;
- Further developing our costing model to estimate potential cost savings; and
- Updating analysis of cost per primary beneficiary and reach to 31st March 2024.

In 2022 we worked with the five ABS partnerships to agree a consistent approach to reporting their leverage funding[18] and mapping spend data to selected ABS Common Outcome Framework measures, as far as possible. In 2024 we continued to work with each partnership to update their mapped spend to 31st March 2024.

In 2023 we undertook a review of existing research from cohort studies[19] to establish the conceptual links (or 'causal chains') between the short-term parental and Early Years outcomes observed within the timeframe of the evaluation, and the longer-term outcomes that these are thought to influence, specifically the outcomes for children during their primary school years. This work was reviewed by the evaluation's academic partners at the University of Sussex, who sense-checked the assumptions, fed into our approach for reducing double-counting, and helped identify sources to fill some of the gaps identified. We have used the conceptual links that we have found to develop a model, which describes how a percentage point difference in a given ABS outcome (measured through Objective 1), is likely to impact public sector spending on primary school aged children. The model compares this difference with an estimate of the counterfactual (that is, how the outcome would be impacted without an ABS intervention). In 2024, this model has been reviewed by the evaluation's academic partners at the University of Sussex and the Evaluation Advisory Panel. It is currently being refined based on their guidance. We will also supplement the secondary evidence with qualitative data collated through Objective 2 on the impact of the ABS programme on 'Systems change'. This will be used to provide qualitative evidence of the consequences of the partnerships' expenditure on 'Systems change'. Outputs from the modelling work will be presented in the final evaluation report.

We have analysed output data from each of the partnerships, collated and validated by The Fund, for the period 1st April 2015 to 31st March 2024. It is important to note that data submissions for the period 1st April 2015 to 31st March 2018 predate the agreement of a consistent template and definitions.

[18] Funding or non-monetary (in-kind) commitments from partners to support the delivery of the ABS programme in their area (e.g., non-ABS grants, funding and donations or provision of services or facilities to ABS services and/or beneficiaries on a free or reduced fee basis).

[19] Such as:

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

Therefore, due to a lack of agreement on definitions, reporting structure, and validation, beneficiary numbers reported for this period may be less accurate, with a high likelihood of double counting due to uncertainty about which beneficiaries attended more than one project. Therefore, data should be treated with caution for this period.

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

While we considered conducting an analysis of uptake by service, the heightened risk of double-counting unique primary beneficiaries (UPBs) across years and different services, meant this analysis could not be relied on.

10.3 Findings to date

Inputs

ABS funding commitments

The Fund has committed a total of £216.3m in grant funding to the five partnerships to deliver the ABS programme (from 1st April 2012 to 31st March 2025). A further £17.8m grant funding was allocated for 'support and delivery activity' (e.g., the learning and development contract and national evaluation activity). Central programme costs, incurred by The Fund directly, for the management, administration and oversight of the programme are estimated to be £3.4m for the duration of the programme.[20]

In addition to ABS grant funding, the five partnerships have also secured an estimated £29m in leverage funding or non-monetary (in-kind) commitments from partners (from 1st April 2014 to 31st March 2025) to support ABS activities.[21]

[20] These costs include pre-programme spend associated with design, assessment and set up (i.e. from 2012/13). They are based on actual spend to 31st March 2023 and spend forecast or committed to 31st March 2026.
[21] Note: Leverage figures for Southend primarily relate to partner time associated with ABS governance activities. While these are expected to continue for the remainder of the programme period, forecast figures for leverage have not been provided by the partnership.

Central management expenditure

The Fund spent **£2.9m on central programme costs** relating to the ABS programme between 1st April 2012 and 31st March 2024. This includes time and expenses for the staff responsible for the management and oversight of the programme at The Fund. This is equivalent to 1.6% of ABS grant spend during this time or roughly £238,000 per year, on average.

The Fund has spent **£16.1m on support and delivery costs** from 1st April 2013 to 31st March 2024. This includes development grants, contracts for communication campaigns, evaluation, and learning. This is equivalent to 9% of ABS grant spend during this time or an average of £1.5m per year. It equates to 90% of the £17.8m budget for capacity building and development support. Nearly half of this spend (£7.8m) occurred during the set-up / mobilisation period (pre-1st April 2015).[22]

This 'central management expenditure' (or central programme costs and support and delivery costs) is outside of the partnerships' control and some of it occurred before the programme began. Therefore, in the analysis presented later in this report we have apportioned it evenly across the partnerships assuming equal distribution across the programme period to date (1st April 2015 to 31st March 2024).

Spend by partnership

As of 31st March 2024, the five partnerships had spent a combined **£182.9m, or 85%, of their £216.3m 10-year ABS grant** (i.e. up to the 9th year of the programme). Analysis indicates considerable variation by partnership.

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

Partnerships divide grant spend into:

- **Portfolio management costs**, which include all costs and expenses incurred in the conduct, management and administration of the portfolio of ABS services, e.g.., staff salaries, recruitment, training, and travel expenses).

[22] This includes £5.5m of development grants paid to the initial 15 sites to develop their ABS proposals.

- **Revenue projects**, which include all commissioned services delivered as part of the ABS programme, (i.e.., breastfeeding support programmes, community-based nutrition projects, and doorstep libraries).

- **Capital projects**, which include all capital expenditure or money spent to create or maintain infrastructure used for delivering ABS services such as hubs or community centres.

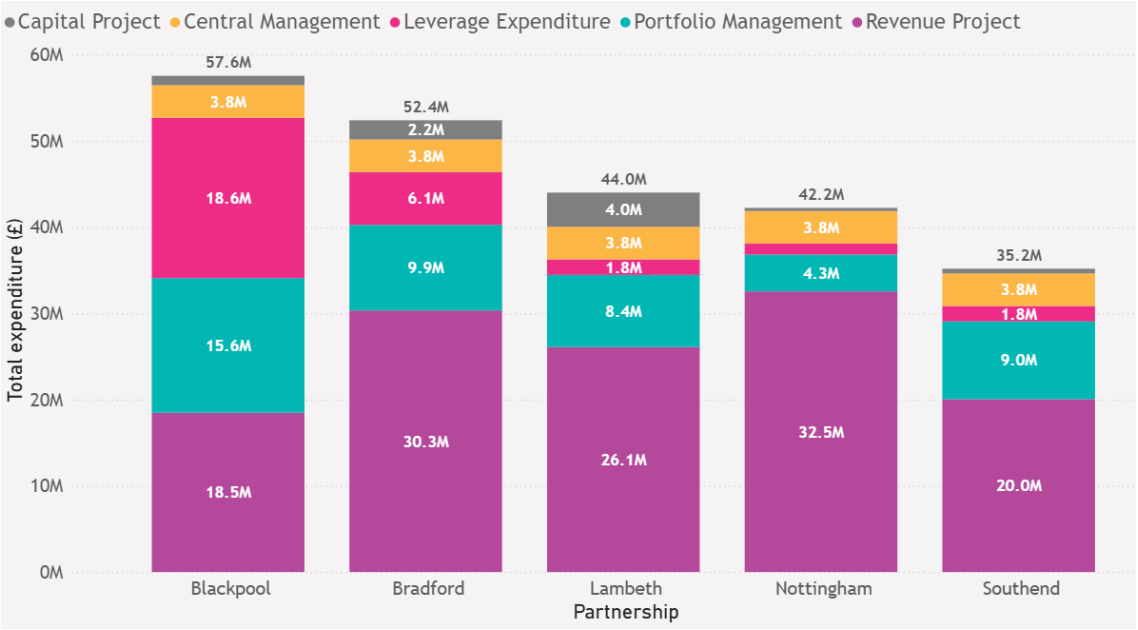
Analysis of spend to 31st March 2024 shows that the **majority of grant spend was on revenue projects**, which account for **£127.5m or 70%** of total grant spend. Portfolio management costs account for £47.2m or 26% of total grant spend to 31st March 2024, while capital projects account for just £8.2m or 4% of total grant spend. This is broadly in line with the overall 10-year budgets for the partnerships. However, there is considerable variation in the distribution of spend across these areas at partnership level (as shown below). This is due to the differing spend profile of each partnership. The variation in portfolio management costs across the partnerships results from individual decisions of the partnerships in relation to sourcing staff to deliver services. For instance, some partnerships commissioned services externally, while others delivered services with their own programme staff. This led to differences as some wages for programme staff were then included in commissioned services (revenue project spend) rather than calculated under portfolio management costs.

In addition to ABS grant funding the five partnerships also secured **leverage funding**, or non-monetary commitments from partners to support the delivery of the ABS programme. A total of **£29.6m** leverage funding was reported between 1st April 2015 and 31st March 2024. This is equivalent to 16% of ABS grant spend to 31st March 2024. This is substantially lower than the leverage forecasts originally submitted by partnerships, which projected leverage to match ABS grant funding. Figure 3 shows that leverage funding varies relative to grant spend in each partnership. In Blackpool, leverage expenditure was 53% of ABS grant expenditure, whilst it was 14% in Bradford, 5% in Lambeth, 3% in Nottingham and 6% in Southend. This demonstrates the significant differences between the partnerships when it came to securing additional funding and non-monetary commitments. An annual breakdown for each partnership is presented in Appendix 4.

Total programme spend to 31st March 2024

The total programme expenditure to 31st March 2024 is **£231.4m**. Figure 7 gives an overview of expenditure across all five partnerships. Blackpool had the highest total expenditure (£57.6m), despite its total ABS grant expenditure being one of the lowest (£35.2m). The reason for this is a much higher leverage expenditure compared to other partnerships (£18.6m), which roughly matched its revenue project expenditure. Southend was the partnership with the lowest ABS grant award and also the lowest total expenditure to date (£35.2m).

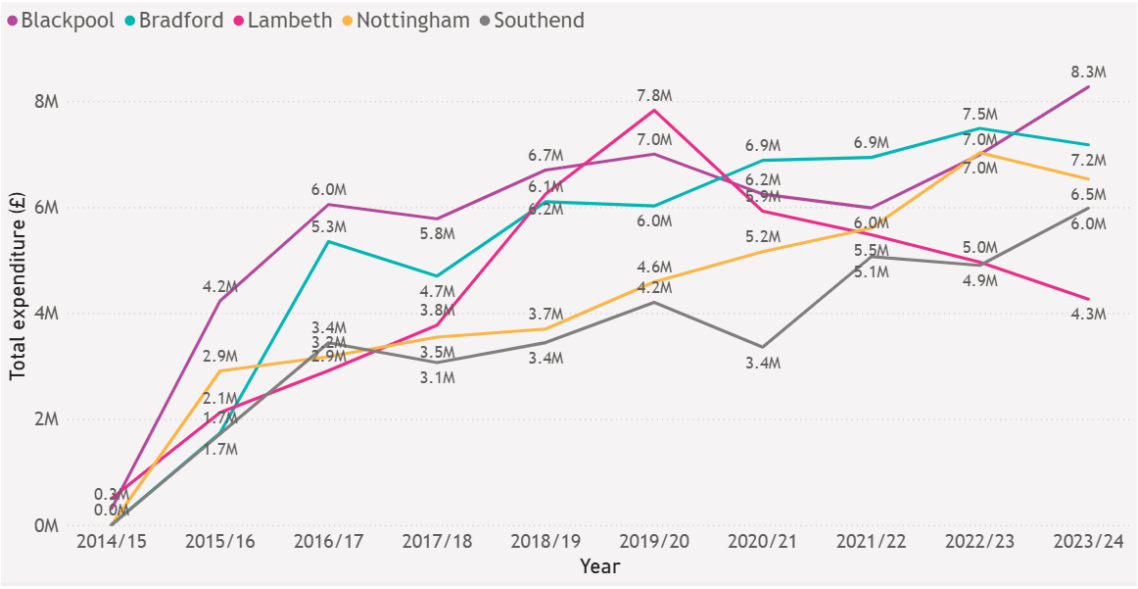
Figure 3: ABS programme expenditure by partnership and type



Source: ABS grant claims returns, leverage tables and central expenditure data provided by The Fund.
Note: Support and delivery costs are included within the central management total, which was divided evenly between the ABS partnerships.

Expenditure over time is shown in Figure 4. Overall, spending has increased over time as the programme has become more established within each area, particularly since the test and learn cycle (1st April 2015 – 31st March 2018). Total annual spend rose to £32.2 million in 2023/24. This was predominately driven by Blackpool (£8.3m), which has reported a substantial increase in annual expenditure since 2021/22. While an upward trend is generally observed across the entire time period, Lambeth's total annual spend peaked at £7.8m in 2019/20 and has consistently decreased since then. The initial drop coincides with the beginning of the COVID-19 pandemic.

Figure 4: ABS programme expenditure over time



Source: ABS grant claims returns, leverage tables and central expenditure data provided by The Fund.

Mapping spend to outcome area at partnership level

In 2024, we worked alongside the five partnerships to map their spend to outcomes up to 31st March 2024. This included the National Evaluation outcome measures as well as an additional category of 'Other outcomes'. 'Other outcomes' included some of the ABS Common Outcome Framework measures not selected for the National Evaluation, as well as partnership specific outcomes related to children and maternal health and well-being. An overview of each partnership's spending mapped to outcome measures is shown in the bubble diagrams below. Any remaining unmapped spend for each partnership has been allocated to outcomes on a pro-rata basis in line with their mapped spend. This includes project or leverage spend, portfolio management spend, central programme spend and support and delivery spend. A breakdown of this spend for each partnership is included in Appendix 4.

The largest proportion of **Blackpool's** project spend was allocated to achieving 'System change' (61%). At least some of the spend from 29 different projects was mapped to this outcome (see Figure 5).

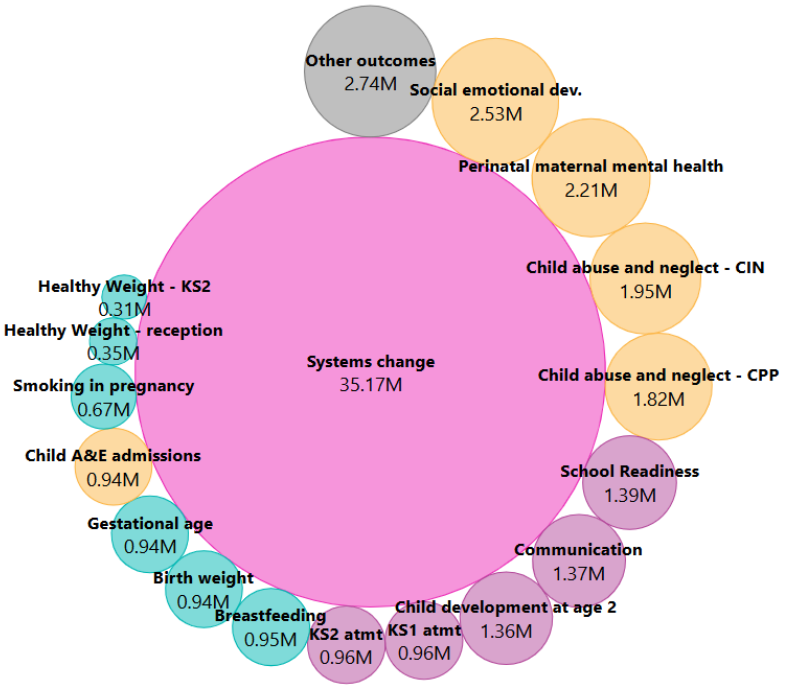
The largest proportions of **Bradford's** project spend were allocated to 'Perinatal maternal mental health – depression and anxiety' (30%) and 'Communication' (22%) (see Figure 6).

Lambeth allocated most of their project spend to 'Other outcomes' (63%). This included social capital (12% of total allocated spend), breastfeeding initiation, pre-term birth (3% each) and Hospital admissions due to unintentional and deliberate injuries of children 0-4 (0.4%). The remaining £10m of the total project spend allocated to 'Other outcomes' was allocated to six different parent or child level outcomes, including 'Improved parental mental health and wellbeing', 'Secure attachment to a trusted caregiver', 'Improved maternal physical health and nutrition', 'More families have strong support networks', 'Children have a BMI that's neither high or low' and 'More survivors of domestic abuse are accessing appropriate specialist support' (see Appendix 4). The second largest proportion of spend was allocated to 'Child development at age 2 – 21/2 (ASQ)' (10%) (see Figure 7).

The largest proportions of **Nottingham's** project spend were allocated to achieving 'System change' (32%) and 'School Readiness' (18%) (see Figure 8).

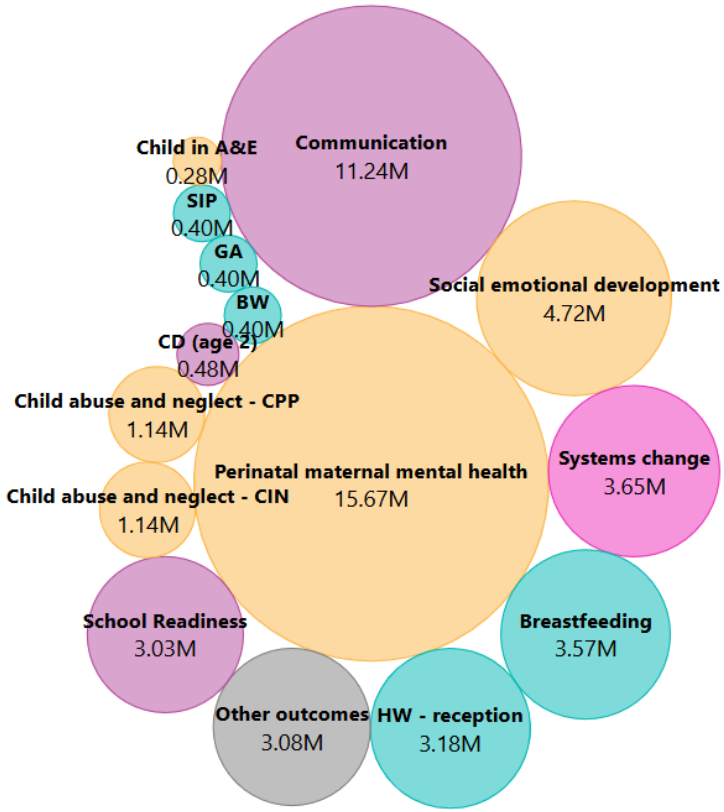
The largest proportions of **Southend's** project spend were allocated to 'Perinatal maternal mental health – depression and anxiety' (24%) and 'Communication (ASQ)' (20%). Substantial proportions of spend were also allocated to 'Systems change' (15%) and 'Breastfeeding 6-8 weeks' (13%) (see Figure 9).

Figure 5: Blackpool spend by outcome (£)



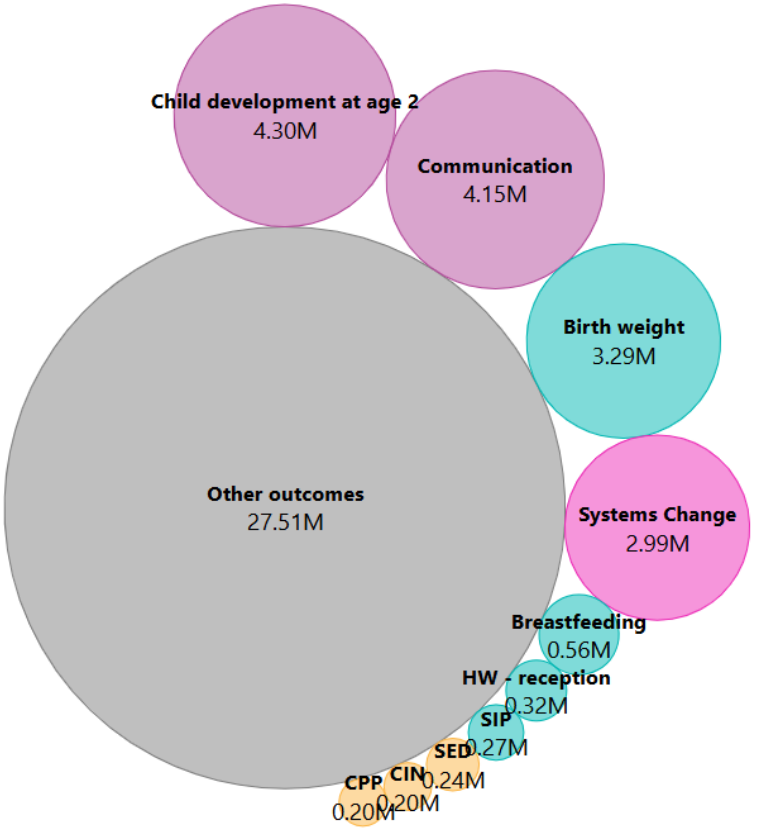
Note: HW = Healthy weight, GA = Gestation age, BW = Birth weight, CIN = Children in Need (Child abuse and neglect), CPP = Child Protection Plan (Child abuse and neglect).

Figure 6: Bradford spend by outcome (£)



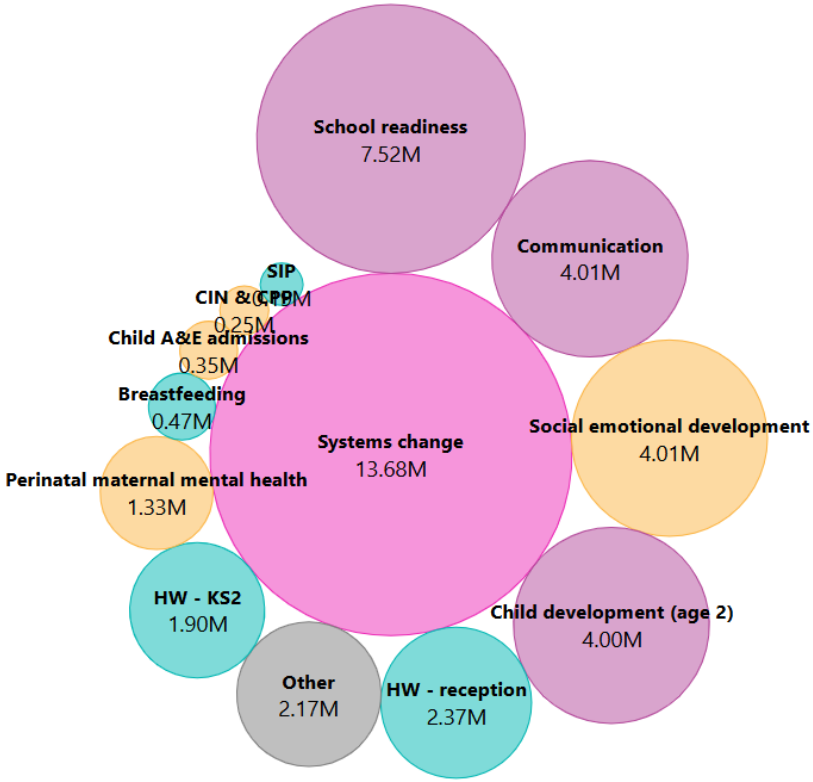
Note: SIP = Smoking in pregnancy, GA = Gestation age, BW = Birth weight, CD = Child development, CIN = Children in Need (Child abuse and neglect), CPP = Child Protection Plan (Child abuse and neglect, HW = Healthy weight.

Figure 7: Lambeth spend by outcome (£)



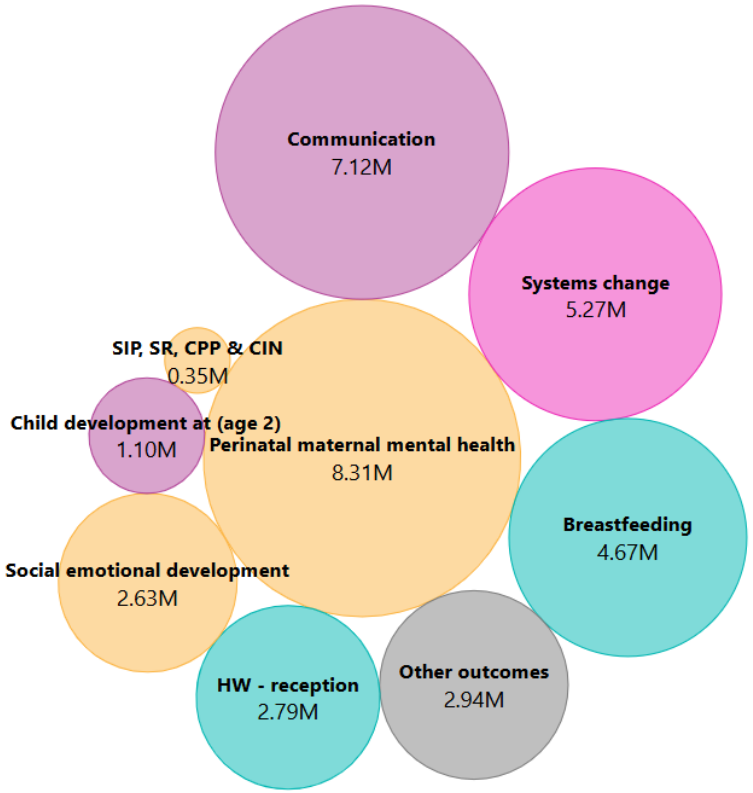
Note: SED = Social emotional development, SIP = Smoking in pregnancy, CIN = Children in Need (Child abuse and neglect), CPP = Child Protection Plan (Child abuse and neglect).

Figure 8: Nottingham spend by outcome (£)



Note: SIP = Smoking in pregnancy, CIN = Children in Need (Child abuse and neglect), CPP = Child Protection Plan (Child abuse and neglect, HW = Healthy weight.

Figure 9: Southend spend by outcome (£)



Note: SIP = Smoking in pregnancy, SR = School readiness CIN = Children in Need (Child abuse and neglect), CPP = Child Protection Plan (Child abuse and neglect, HW = Healthy weight

Beneficiaries

Participation in the ABS programme

This section shows our analysis of monitoring data on unique primary beneficiary (UPB) figures reported by each partnership. It is worth noting some limitations in interpreting the findings.

- Firstly, the methods used by partnerships, and the local services within them, may differ. This means that differences in UPB figures across services and partnerships may not be entirely attributed to uptake. Comparisons of UPB figures between partnerships must bear this in mind.

- Secondly, UPB figures do not capture the total impact of services, since the degree of resource requirement, engagement, quality, and experience differ across services. For example, some ABS funded services offer intensive, bespoke support to a small number of families with acute needs, whereas other ABS funded services offer less resource intensive, universal provision to the entire eligible population. This nuance is lost in the partnership-level UPB data analysis, where any participant from any ABS service is counted as one UPB.

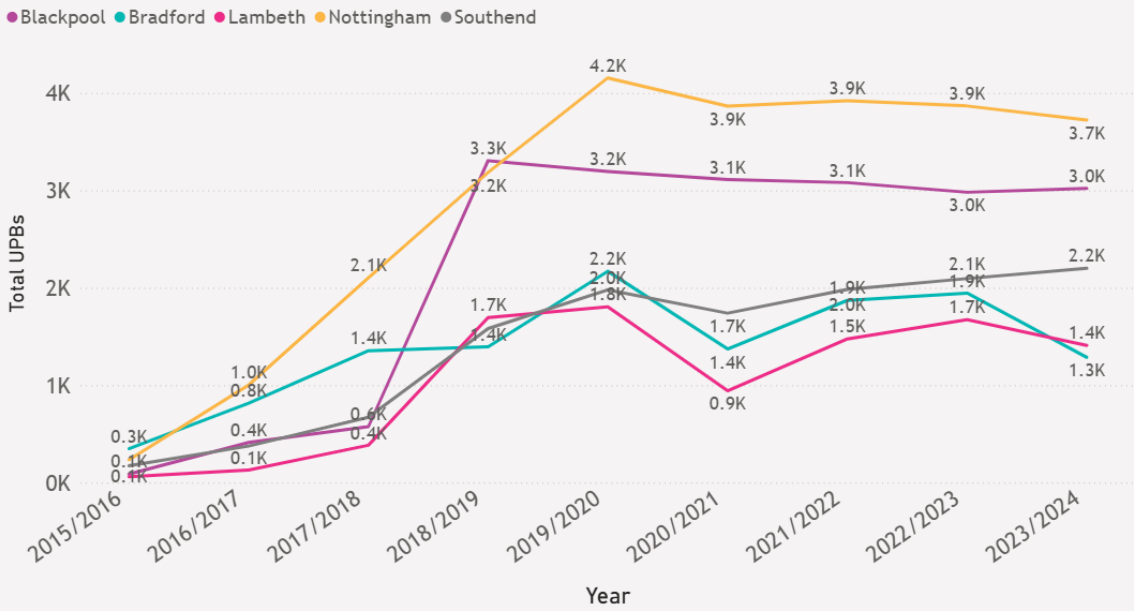
- Thirdly, any beneficiaries who accessed more than one service within the same year will only be counted once, whereas beneficiaries who accessed support in more than one year will be counted once in each year they accessed support, regardless of how many services they used. This means that the cost per beneficiary analysis presented below should be used to inform the overall picture of implementation rather than for assessing the performance of the ABS programme or individual partnerships.

Figure 10 shows that UPB figures were lower during the Test and Learn phase of ABS delivery, from 1st April 2015 to 31st March 2018. After this, uptake increased considerably between 1st April 2018 and 31st March 2019, particularly for Blackpool, and has remained relatively stable thereafter. Since then, the ABS programme has supported **11,000 to 13,300 UPBs per year**. The majority of UPBs were children between the ages of 0-3 (92%); the other 8% were pregnant people. Blackpool and Nottingham consistently reported the highest annual UPB figures of all ABS partnerships.

Error! Reference source not found. 10 also shows the impact of COVID-19 on uptake. Across all ABS partnership sites, UPB figures dropped 17% from

2019/20 to 2020/21, when the first lockdowns occurred. UPB figures recovered in the years following. This indicates that partnerships were able to adapt to public health guidance and continue service delivery during this time.

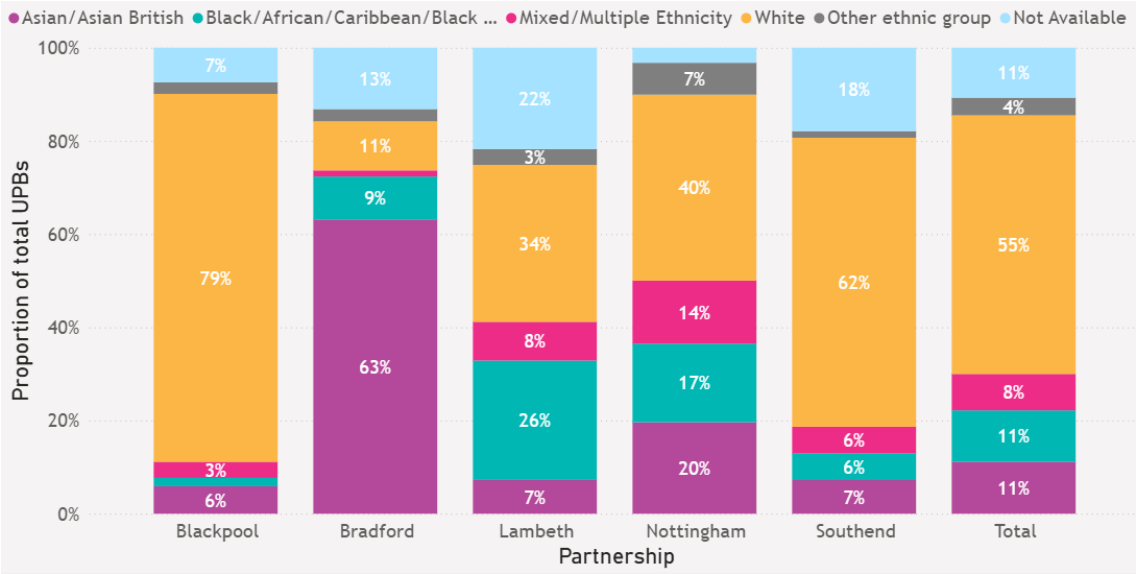
Figure 10: Total unique primary beneficiaries of the ABS programme by year and partnership



Source: ABS programme monitoring data
Note: The Fund has informed us that some ABS partnerships have recently changed their approach to measuring UPB data. This change has been retrospectively applied to previous years, which means that some of the data differs to what was presented in the second Annual Report for the ABS National Evaluation.

The high-level ethnic profile of UPBs varied across the different partnerships from 1st April 2023 to 31st March 2024. As shown in Figure 11, 55% of all UPBs were White, 11% Asian/Asian British, 11% Black/African/Caribbean/Black British, 8% Mixed/Multiple Ethnicity, and 4% were from other ethnic groups. Data was not available for the remaining 11%. The partnerships with the largest concentrations of a single ethnicity were Bradford, where 63% of UPBs were Asian/Asian British, and Southend, where 62% of UPBs were White. There was no significant difference in the ethnicity profiles of pregnant UPBs compared to 0-3 year olds.

Figure 11: Ethnicity distributions of UPBs within each partnership in 2023/24

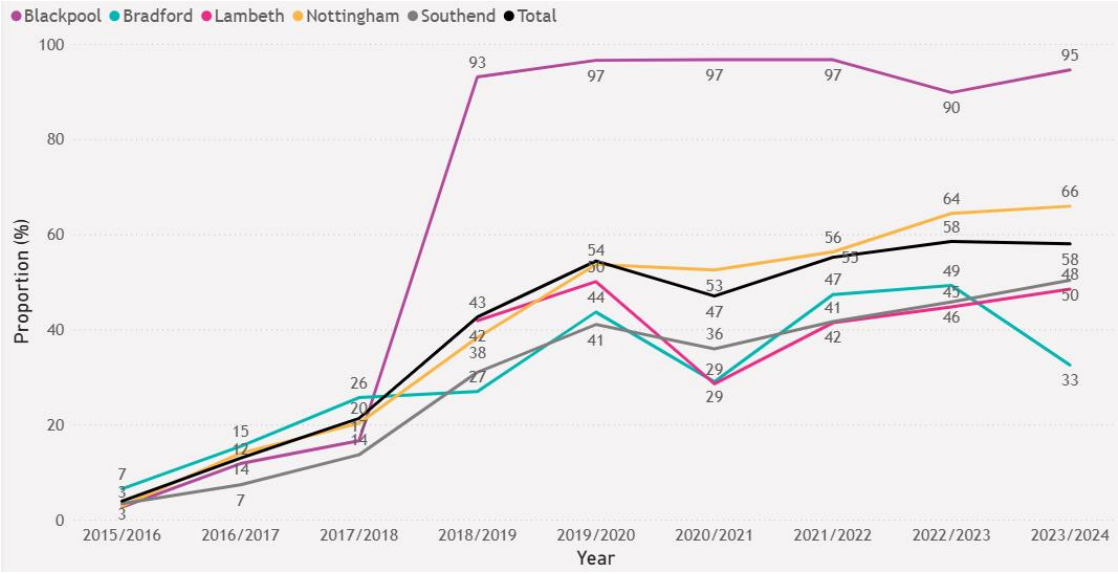


Source: ABS programme monitoring data.

Reach

The total proportion of the eligible population participating in ABS services, otherwise known as reach, is shown in Figure 12. All partnerships increased their reach over time. This increase was particularly concentrated in the fourth year of the programme, following the initial Test and Learn cycle. From 1st April 2018 to 31st March 2024, almost half (49%) of the eligible populations (pregnant women and 0-3 year olds in ABS wards) were reached on average by the ABS programme. This ranges from an average of 38% in Bradford to 95% in Blackpool. Blackpool sustained a high reach because the partnership invested in the transformation of the Health Visiting Service. This is a universal intervention for 0-3 year olds.

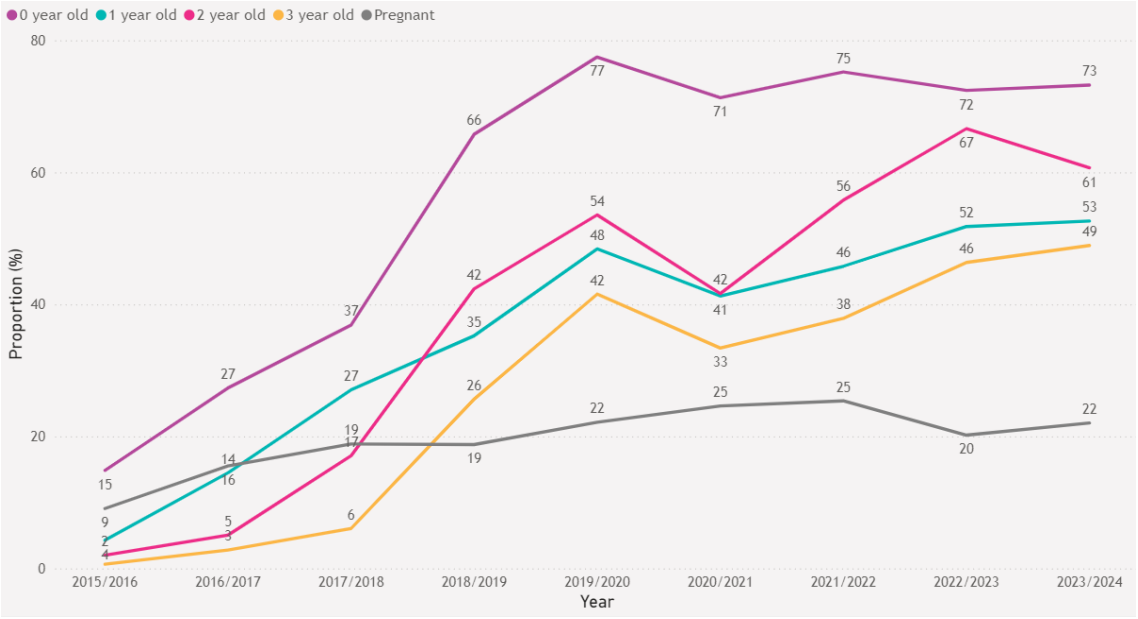
Figure 12: Total proportion of eligible population reached by partnership and year



Source: ABS programme monitoring data

However, the data also shows that reach differs substantially by user type. Figure 12 shows that, overall, the programme reached a greater proportion of eligible children and babies than pregnant women. This is true for all partnerships (see Figure 13).

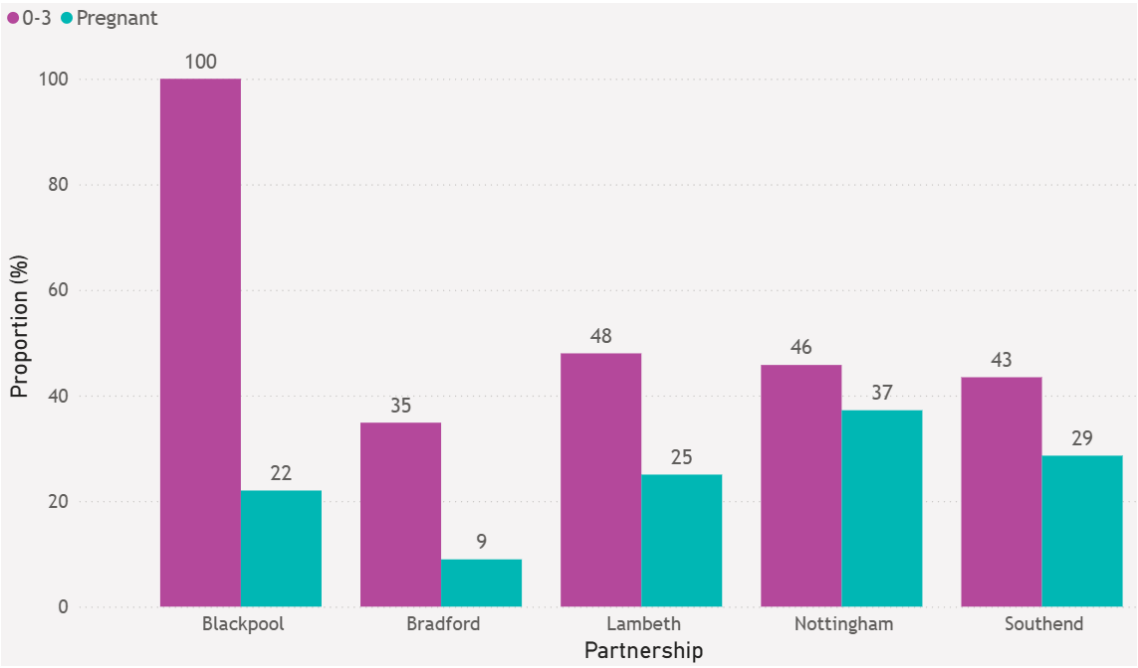
Figure 13: Total proportion of eligible population reached, by user type and year



Source: ABS programme monitoring data

On average from 1st April 2018 to 31st March 2024, **20%** of the eligible pregnant population was reached, compared **43%** of eligible 0-3 year olds.

Figure 14: Percentage of eligible population reached, by user type and partnership (from 1st April 2018 to 31st March 2024)

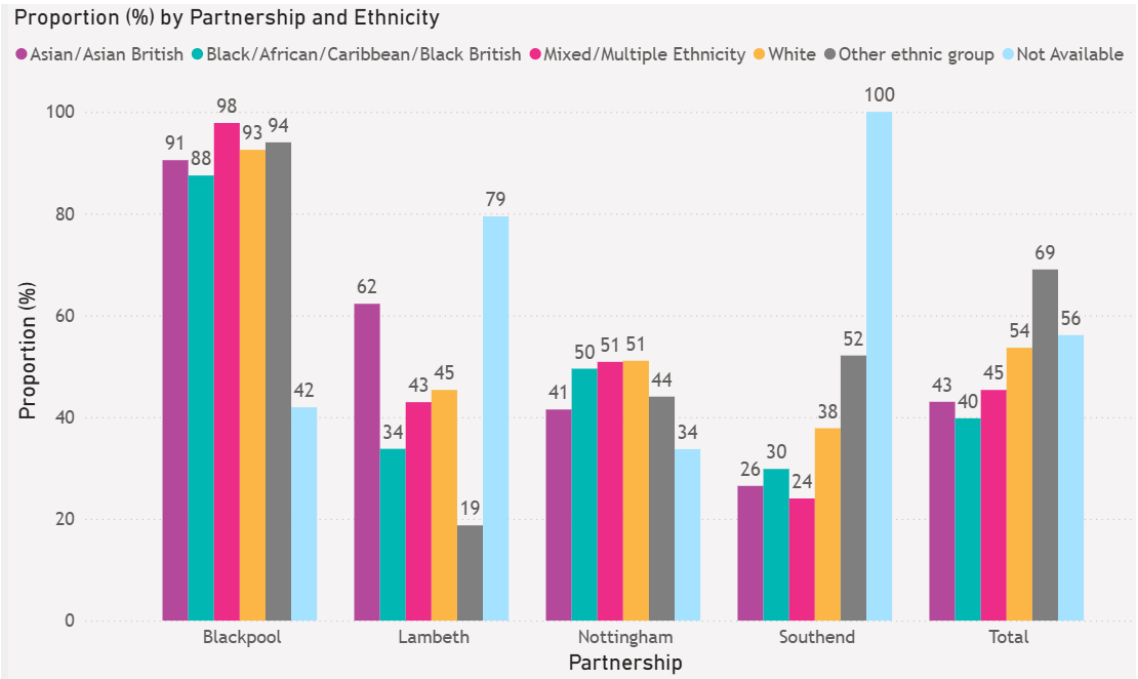


Source: ABS programme monitoring data.

Note: Blackpool's total reach of the 0-3 year old population can be attributed to its investment in the universal Health Visitor Service.

Error! Reference source not found.15 shows the reach of the ABS programme across different ethnic categories within each partnership. This analysis was limited as ethnicity data was 'Not available' for a substantial portion of the UPBs (57%). The available data shows that Blackpool had a high reach across all ethnic groups. Nottingham reached smaller proportions of its eligible population compared to Blackpool. However, reach was fairly consistent across all ethnic categories. In contrast, Lambeth and Southend had more varied reach across ethnic categories.

Figure 15. Proportion of eligible population reached by ethnicity and partnership (from 1st April 2018 to 31st March 2024)



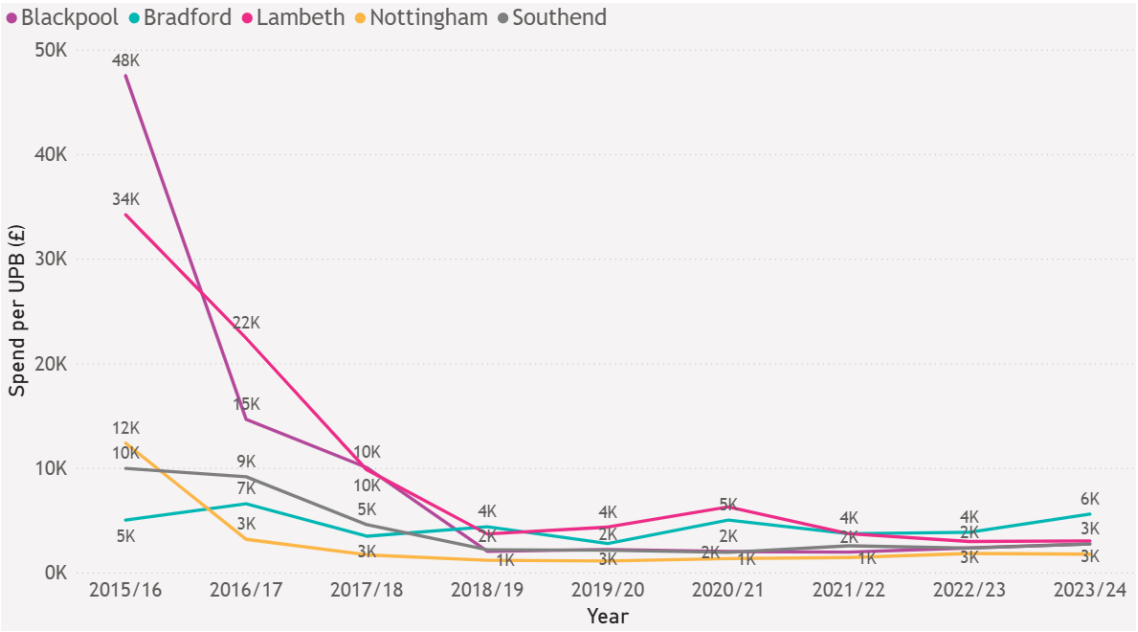
Source: ABS programme monitoring data.
Notes: Total UPBs within this time range was: 18,693 for Blackpool; 8,653 for Lambeth; 18,164 for Nottingham and 11,580 for Southend. Bradford data has been excluded from the figure because its data collection methods were not directly comparable to the other partnerships. The Fund is working with Bradford to resolve this issue for the next, and final, data submission.

Cost per beneficiary

Figure 16 shows that average spending per UPB has decreased over time. The average cost per UPB was highest in the first three years of the programme, during the set-up and Test and Learn cycle. This was particularly the case for Blackpool, where there was substantial spending on portfolio management, and Lambeth, where spending on capital projects exceeded that of other

partnerships at the time. However, as the programme developed and became more established, participant numbers increased. Consequently, average spending per UPB has dropped considerably. From 1st April 2019 onwards, average spend per UPB has been relatively stable, ranging from £1,100 to £5,600 per UPB per year for each partnership.

Figure 16: Spending per unique primary beneficiary, by partnership and year



Source: ABS programme monitoring data

Whilst the overall trend has been decreasing spend per user, in four of the five partnerships spend per user increased in the 2023/24 financial year. This was either due to a reduced UPB total and relatively stable spending (Bradford and Lambeth), or relatively stable UPB totals and higher spending (Blackpool and Nottingham).

10.4 Next steps

Next steps in this section relate to the immediate next steps for Objective 4 that will be delivered in 2025.

Calculating costs

We will update the analysis of costs above to the end of the ABS funded period. We will collect final spend data to 31st March 2025 from The Fund in June 2025.

Many ABS interventions will continue to be delivered through other funding sources. However, the end of the ABS programme period means reduced staffing levels in each partnership. Therefore, to minimise the burden on the partnerships, we will use the spend-to-outcome mapping presented in this report to estimate the final spend per outcome figures for each partnership.

Calculating short-term effects

In this chapter, data has been presented to demonstrate the reach of the ABS programme by partnership area, ethnicity, beneficiary age and proportion of eligible population. This analysis will be updated to 31st March 2025 based on programme monitoring data shared by The Fund (in June 2025). This will provide a picture of the reach of the five partnerships throughout the life of the programme.

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

We will continue to refine and strengthen the draft Cost Consequence Analysis model based on the guidance provided by our academic partners and the Advisory Panel. The next step will be to incorporate findings from Objectives 1 and 2 so that we can use the model to describe how a unit change in ABS outcomes is likely to impact public sector activity and spend on primary school aged children

11 Conclusion and next steps

The findings in this annual report represent the third and final annual report from the national evaluation team before the publication of the overall evaluation report in Spring 2026. The report presents emerging findings on child development outcomes and ways of supporting families with children aged 0-4 in the areas of diet and nutrition, communication and language, and social and emotional development. It also reports on how ABS is achieving systems change across the early years sector. It starts to explore the contribution that ABS has made to children's life chances, how that contribution has been achieved and how it has been experienced by a diverse range of families.

While the findings from the quantitative impact data on child-level outcomes are not yet available, the qualitative findings presented in this report show that ABS practitioners and families perceive that the ABS approach has positively influenced outcomes for children and families. Across the child-level outcome areas, there was an appreciation for the flexibility of ABS delivery and tailored approach to services on offer. Within the social and emotional development outcome area, there was a particular appreciation for the peer support element within services.

These findings support contribution claims about systems change and suggest that early years provision delivered by ABS is done differently, and that difference is received positively by parents and children. Alongside praise for ABS, limited capacity within the early years sector was highlighted by both practitioners and parents and the negative impacts that this can have on families' experiences and outcomes was recognised. Examples of mechanisms in practice demonstrate collections of step changes within the domains of adapting services to families' needs, test and learn, sharing data and information, and evidence-informed service design and delivery.

Sharing learning with partners was considered key to sustaining the legacy of ABS for services. There is the potential for ABS mechanisms to be integrated more widely across the early years eco-system with the potential to have a positive impact on outcomes.

The final waves of data collection for the national evaluation are taking place in Spring 2025. As an evaluation team, we will be spending 2025 synthesising data from across the four evaluation objectives to form our mosaic of evidence and assess how ABS has addressed each of the contribution claims.

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Appendix 1: Six steps of Contribution Analysis and contribution claims

The draft contribution claims presented in this chapter were developed collaboratively in 2023 by evaluation partners based on the existing ABS ToC and evidence presented in the first Annual Report. They will guide ongoing data collection and analysis across the evaluation with the aim of finding conclusive evidence (either confirmatory or dis-confirmatory) for the ABS ToC.

This convergence of evidence will be used to iteratively build a credible contribution narrative. Through the contribution narrative we will seek to provide a robust account of the link between programme implementation processes, intended and unintended intermediary and later stage outcomes, independent contextual features, and the development of causal mechanisms that can explain how and why outcomes have (or have not) been achieved.

For each contribution claim, we will seek evidence to support or challenge:

- The chain of results and assumptions underpinning it are plausible and supported by stakeholders (Plausibility)
- The ToC (the "final" version) is verified by evidence (Verified ToC)
- Other contributory factors have been accounted for (i.e. contextual factors are considered).

As with the theory of change, in the claims outcomes, causal pathways and assumptions are written as if they have already been achieved. At this stage, however, the draft claims should not be considered as confirmatory evidence of impact. These claims represent a first iteration of the contribution story that we will continue to expand and refine as our understanding of the impact of ABS becomes more complete. Importantly, the findings from Objective 1's QED are required for the full contribution analysis.

Child-level outcome: diet and nutrition

(ToC outcome) Children whose families are accessing ABS services have improved diet and nutrition / ABS services are preventing negative health impacts of poor nutrition on infants whose families engage with their services.

(Causal pathway) ABS-funded projects achieved this through working together across services to ensure that messaging on pregnant mother and child nutrition was consistent and countered harmful messaging; messaging outreach was effectively targeted at parents and other family members or adults who may have influenced children's diet and nutrition, empowering them to make positive choices which led to improved diet and nutrition for intended beneficiaries.

(Pre-conditions and assumptions) Families have sufficient exposure to ABS messaging and consider it relevant to them (e.g. formula feeders), families have sufficient financial resources or access to other appropriate resources to implement positive choices about child nutrition.

Child-level outcome: communication and language

(ToC outcome) Children whose families are accessing ABS services have improved communication and language development/ ABS services are preventing poor communication and language skills in children whose families engage with their service.

(Causal pathway) ABS-funded projects achieved this through: developing relationships with, and providing evidence-based training to, early years provider staff which led to: the creation of more language-rich early years environments, which enabled children to develop their communication and language skills; awareness raising amongst parents about how they can support children in the home environment which led to behaviour change amongst parents, enabling children to develop their communication and language skills; and better identification of communication and language needs and referral to appropriate specialist services.

(Pre-conditions and assumptions) Early years managers buy-in to the ABS approach; training is appropriate for, and accessible to, early years staff who engage with it fully and are open to adapting their practice; families and children have sufficient exposure to, and are included in, service initiatives and are open to diagnosis to benefit; specialist services have capacity or can adapt to meet the increased demand.

Child-level outcome: social and emotional development

(ToC outcome) Children whose families are accessing ABS services have improved social and emotional development / build strong relationships and resilience

(Causal pathway) ABS funded projects achieve this through the development of streamlined and effective referral routes for families to access the support they need. This has helped families to build strong relationships and resilience which reduces parental stress and anxiety. This can prevent potential detrimental impacts of this on and improving children's social and emotional development.

(Pre-conditions and assumptions) Referring agencies understand and implement referral criteria for ABS services; services are effective and able to meet different levels of need including complex needs; families do not feel stigmatised by accessing services and have sufficient access and exposure to ABS services.

Systems change: joined up working (upskilling)

(ToC outcome) ABS services have increased joined-up working between services which helps create new ways of working that allow for services to better meet the needs of children aged 0-4 and their families.

(Causal pathway) Successful implementation of the ABS approach demanded the upskilling of multidisciplinary, strategic and frontline staff. ABS provided the funding to train programme delivery staff for both pre-existing and ABS-specific programmes. Training offered to staff was connected to wider ABS strategies and priorities across different partnerships. This led to upskilling the workforce in a way that created a shared vision, culture and understanding of the ABS approach. Higher levels of staff skills and knowledge led to the implementation of working strategies to enhance service provision and child development outcome realisation.

(Pre-conditions and assumptions) For this to occur there must be sufficient personnel to develop and deliver training, staff receiving training must engage with the training and achieve intended learning outcomes. There must be collective buy-in to the shared vision for working culture so that staff enrol on training and implement the learning in their work.

Systems change: joined-up working (partnerships)

(ToC outcome) ABS services have increased joined-up working between services which helps create new ways of working that allow for services that better meet the needs of children aged 0-4 and their families.

(Causal pathway) This is achieved through collaborative working activities that facilitate strong relationships and improved information sharing pathways

between local services. These activities have directly led to the creation and strengthening of partnerships between ABS-funded activities and existing local service delivery, which has resulted in better integration in planning and delivery, leading to more holistic approaches to supporting ABS families.

(Pre-conditions and assumptions) For this to occur there must be collaborative working opportunities, shared understanding of the value of preventative approaches and collective buy-in to the shared vision for working culture.

Systems change: increased parental engagement

(ToC outcome) The design of interventions funded through ABS has led to better parental engagement with services and parental behaviour change which will positively impact child outcomes both directly and indirectly.

(Causal pathway) The emphasis of ABS programmes on co-production has led to more inclusive delivery techniques that help increase trust in services from recipient parents, leading to their better engagement with services. These positive experiences encourage peer-to-peer support which encourages more families to engage with services and will ultimately benefit them and improve outcomes for their children.

(Pre-conditions and assumptions) For this to occur, it is assumed that families are consistently supported by the same delivery staff member (as far as possible); that delivery staff have capacity and competency to consistently deliver an inclusive approach; parents themselves have the capability and opportunity to participate in services and social networks to recommend services to eligible peers.

Systems change: demand-led services

(ToC outcome) Early years services are more demand-led.

(Causal pathway) Service providers engage in co-design with parents and adapt to fit the pressures and circumstances faced by recipient families, which reduces barriers to engagement leading to better access and inclusion and families feel like their priorities and needs are well considered and accommodated.

(Pre-conditions and assumptions) Adaptations are appropriate and proportionate to the issues faced by recipient families at the local level. Greater engagement with ABS services from parents/carers leads to improved outcomes for the child.

Systems change: shift in resources

(ToC outcome) ABS has resulted in a shift in investment from acute services towards prevention-focused services for children aged 0-4 and their families (leading to improved chance of improved outcomes for children and families)

(Causal pathway) ABS partnerships achieve this by developing strong relationships between ABS and existing local delivery and planning partners (including parent/community representatives). This facilitates joint working towards creating, adapting and promoting evidence-based and co-produced preventative approaches, and the generation of impact evidence. This contributes to a common understanding and acknowledgement of the importance of early years and child development. This shared understanding directly influences decision making about future local early years service planning, resulting in a shift in ABS local authority spending and resource reallocation from acute to preventative services.

(Pre-conditions and assumptions) Evidence of positive impact of ABS preventative approaches is good quality, compelling and effectively disseminated, and partnerships are able to leverage buy-in from local authority senior management. There is sustained engagement and commitment from services, ABS partnerships and community members.

Systems change: adoption of ABS approach beyond ABS local authorities

(ToC outcome) ABS approaches of co-production, joined-up working and increased prevention-focused and demand-led services are adopted beyond ABS local authorities.

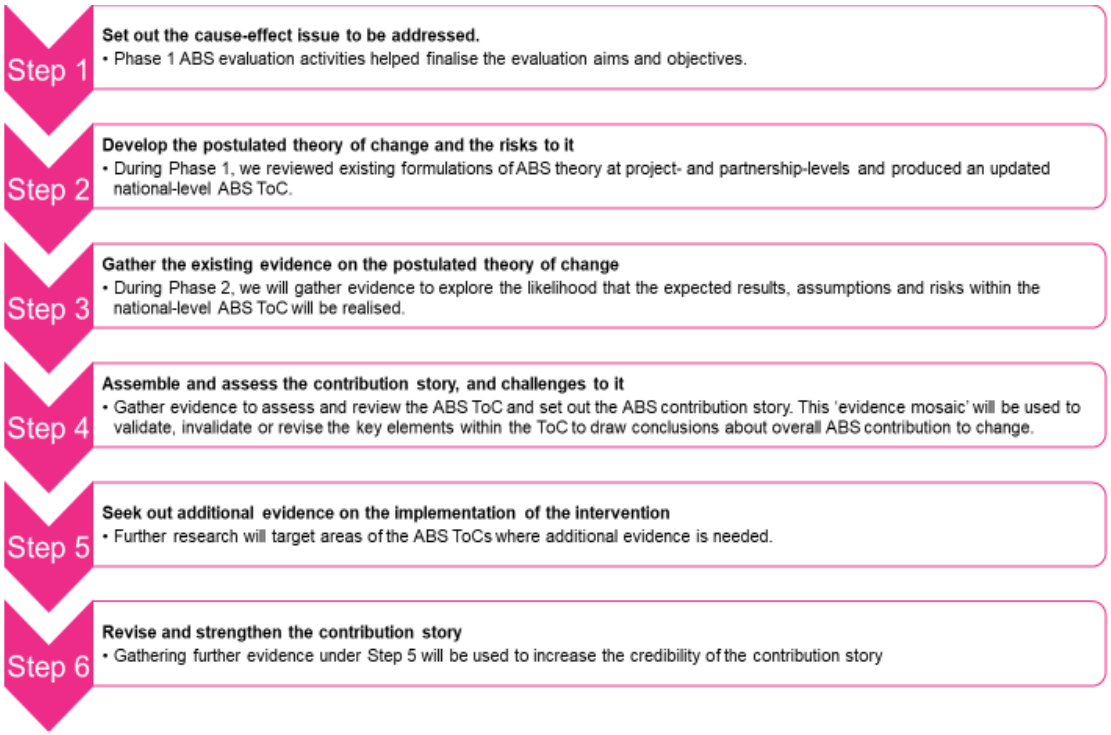
(Causal pathway) ABS achieves this through influencing key players in the early years' sector in non-ABS local authorities through test and learn, i.e. the dissemination and promotion of research and evaluation learning about the projects funded by ABS to non-ABS local authorities, national government and other stakeholders. These stakeholders are then motivated and informed by that learning to make evidence-based decisions to support and allocate resources to implementing ABS approaches in non-ABS early years settings through replication and adaptation to meet local or national needs.

Early years sector staff in ABS who have benefitted from upskilling will apply their skills in non-ABS local authorities they work in and influence the adoption of ABS approaches.

(Pre-conditions and assumptions) Research and evaluation undertaken by ABS-funded projects is of high-quality and relevance to non-ABS local authorities, evidence generated includes sufficient detail (e.g. on design and costs) to enable scrutiny and replication, non-ABS local authorities have the opportunity and willingness to engage with ABS evidence and learning, and are open to new ways of working.

The figure below sets out the six steps of the contribution analysis approach.

Figure 17: Contribution analysis six steps



Appendix 2: Objective 1 technical detail

Data cohorts requested from NHS England

Table 4 below describes the data request for each cohort submitted to NHS England as agreed after discussions regarding data minimisation and consent.[23]

Table 4: Datasets requested from NHS England for Objective 1 analysis

Year	Cohort A - consented	Cohort B - pseudonymised
Apr 2018 - Mar 2019		MSDS – v1.5
Apr 2019 - Mar 2020		MSDS - v2
Apr 2020 - Mar 2021		MSDS - v2
Apr 2021 - Mar 2022		MSDS - v2
Apr 2022 - Mar 2023		CSDS, ECDS, MSDS – v2
Apr 2023 - Mar 2024	CSDS, ECDS, MSDS – v2	CSDS, ECDS, MSDS – v2
Latest available		*CSDS, ECDS, MSDS - v2*

The DARS team underwent restructuring from late 2023, however, which resulted in resource and capacity constraints within the team. Processing of our application therefore did not start until July 2024, nine months after the initial submission. The expected time for processing at the time of application was six months.

Summary of pseudonymised data received from sites

Blackpool

For Blackpool, requesting pseudonymised data was motivated by the limited sample sizes available for consented beneficiaries. This limitation meant that analyses based solely on consented beneficiaries would only provide imprecise estimation of causal impact. We requested pseudonymised data on outcomes and characteristics of all ABS beneficiaries that was available.

The outcome data shared by Blackpool between May and November 2024 included breastfeeding status at 6-8 weeks, ASQ-3 assessment scores across all five domains, child birthweight, ASQ-SE scores, child's gestational age at birth (in days), maternal mental health, mother's smoking status at delivery and

[23] Data for the second cohort is requested from April 2022 onwards. This will allow for analysis to cover the period from June 2022 to June 2024, as the latest available data has been requested for this cohort. Additional years of MSDS data have been requested for this cohort to enable us to construct a dataset of 0- to 4-year-olds born in the wards of interest.

A&E attendances. The table below summarises the outcome data provided. It presents the total number of individuals included in each outcome dataset (the whole LA sample), which compromises ABS beneficiaries of both ABS and non-ABS wards. It also outlines the ABS analysis sample, representing the number and percentage of individuals within the whole LA sample who were residents of ABS wards and had outcome data available for the specified period of analysis, June 2022-2024.

Table 5: Blackpool pseudonymised outcome data

Outcome	Whole LA sample (N)	ABS analysis sample (N, %)
ASQ-3	2,430	824 (34%)
Breastfeeding status at 6-8 weeks	2,132	833 (39%)
ASQ-SE	2,325	45 (2%)
A&E attendances	8,712	- [24]
Gestational age at birth (in days)	2,640	1,120 (42%)
Maternal mental health	43	20 (47%)
Child birthweight	2,640	1,120 (42%)
Mother smoking status at delivery	2,061	797 (39%)

Approximately 40% of individuals in ABS wards have records available across most outcomes. This is expected to be sufficient for detecting meaningful impacts. However, the ASQ-SE scores provided for the socio-emotional development outcome exhibited high levels of missingness. This was anticipated as ASQ-SE assessments are not administered universally to all children and is only administered after the ASQ-3 indicates a potential problem. Furthermore, for the maternal mental health outcome, the data provided included scores from the PHQ-9, GAD-7 and the Whooley screening

[24] The A&E outcome data shared by Blackpool did not include information on whether individuals were residents of ABS or non-ABS wards. However, LSOA codes for each individual were provided. Further data management would be required to finalise the ABS analysis sample.

questions. Further inspection revealed that data was only provided for women who passed the initial Whooley screening questions. We are currently exploring whether it is feasible to obtain data on all women, including those who did not answer "yes" to the Whooley screening questions, or whether it can be assumed that those for whom data is missing, the screening would have been negative if it was carried out. This would enable us to measure incidence of anxiety/depression and conduct the individual level weighting analysis.

To support individual level weighting analyses, we requested available covariate data across the outcomes provided. The availability of covariate data varied across the outcomes. Levels of missingness varied across outcomes, with data on mother employment status and accommodation status having high levels of missingness for most outcomes. Several requested covariates, such as benefits eligibility status, the type of school the child attended, and early years pupil premium were not available, as they were not recorded by the site.

Nottingham

In Nottingham, data on breastfeeding status at 6-8 weeks and children's ASQ outcomes are not available through NHS England. We therefore requested pseudonymised data on these outcomes and characteristics of all ABS beneficiaries that was available.

The outcome data shared by Nottingham between July and October 2024 included breastfeeding status at 6-8 weeks and ASQ-3 assessment scores across the five domains: personal-social, problem-solving, communication, fine motor skills, and gross motor skills. The table below summarises the outcome data shared by Nottingham.

Table 6: Nottingham pseudonymised outcome data

Outcome	Whole LA sample (N)	ABS analysis sample (N, %)
ASQ-3 [25]	301	- [26]
Breastfeeding status at 6-8 weeks	301	-

Levels of missingness in covariate data were higher for benefits eligibility status and whether the child's first language is English. Additionally, some requested covariates such as mother's employment status, accommodation status, disability status and early years pupil premium eligibility were not available, as they were not recorded by the site.

Lambeth

Using pseudonymised data is the only analysis approach planned for Lambeth, where a consent process was not run as existing data systems within the partnership allowed for pseudonymised data to be shared.

The outcome data shared by Lambeth between May and September 2024 included breastfeeding status at 6-8 weeks, ASQ-3 assessment scores across all five domains, ASQ-SE scores, gestational age at birth (in days), child birthweight and mother's smoking status at delivery. The table below summarises the outcome data shared by Lambeth.

[25] In addition to the outcomes outlined above, the site also shared raw ASQ-SE scores for the socio-emotional development outcome. However, these scores were only available for assessments conducted at the 8-week mark. As the focus of this analysis is on children's socio-emotional development at the 2.5-year mark, this data will not be considered for analysis.
[26] Information on whether individuals were residents of ABS or non-ABS wards was not shared for all Nottingham data. However, LSOA codes for each individual were provided. Further data management will be carried out to obtain the ABS analysis sample.

Table 7: Lambeth pseudonymised outcome data

Outcome	Whole LA sample (N)	ABS analysis sample (N, %)
ASQ-3	17,270	487 (8%)
Breastfeeding status at 6-8 weeks	19,062	513 (3%)
ASQ-SE	672	<10 (1%)
Gestational age at birth (in days)	10,152	351 (3%)
Child birthweight	10,152	351 (3%)
Mother smoking status at delivery	6,711	378 (6%)

Across the outcomes, the ABS analysis sample sizes are limited, which may impact the ability to detect meaningful effects. In addition to the outcomes, we also requested available covariate data to support individual level weighting analyses. Levels of missingness varied with ethnicity, country of birth and disability status having higher levels of missingness.

Analysis of education outcomes to date

Analysis of education outcomes has been progressing in the ONS SRS. All outputs produced during this analysis will only be exported from the SRS after the ONS checks them for the risk of statistical disclosure.[27] The statistical disclosure control process is applied to minimise the risk of individuals being identified from any published materials. This may affect reporting on the descriptive analysis of CIN data where low counts are expected for children aged 0 to 4 years, even at the local authority level.

[27] Statistics are checked as to whether they are either 'safe' (low risk of statistical disclosure) or where 'unsafe', are derived from groups containing at least 10 data subjects.

Appendix 3: Objective 3 technical detail

Objective 3 detailed evaluation questions

The focused evaluation questions underpinning Objective 3 are as follows:

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

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

Objective 3 interview methodology

Families are interviewed twice a year over a four-year period[28]: four rounds of annual in-person data collection with each family/household, complemented by three rounds of interim telephone interviews with the primary caregiver, conducted approximately six months after the in-person interview. As was the case during Wave 1, Wave 2 in-person interviews involved all members of the household who wished to take part[29]. In one family the grandmother was the primary respondent, and in all other families the mother was the primary respondent; in two families a maternal aunt also participated. Five fathers participated in the family interviews, and supplementary telephone interviews were carried out with three resident fathers who were unable to take part in the home-based interview[30]. Children were present for 18 interviews.

Objective 3 analytical approach

Analysis of family interviews is conducted via a staged approach, as follows: within the family dataset, to identify key and recurrent themes and narratives within timepoints and over time, and to consider how individual family experiences relate to the broader context of the ABS partnership area and activities and local area; across families within an ABS partnership area, to identify common themes and points of difference (e.g., in relation to barriers or facilitators or systems change), taking account of the broader context of the ABS partnership area and activities and local area; across partnership areas to build a national picture in relation to themes and characteristics of interest, taking into account local variations in ABS activities and wider contextual

[28] In accordance with the Objective 3 research ethics approvals, where family interviews identify significant cause for concern about parent/carer or child welfare, the research team utilise an agreed protocol to activate/signpost to further support or service involvement, with the parent/carer's knowledge and agreement wherever possible. We note this here because the protocol was used with one of the families discussed in the pages that follow, not identified to protect their anonymity.

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

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

[30] To enable fathers' participation, we offered a separate phone interview for resident fathers who wanted to take part. We did not seek interviews with non-resident fathers because of potential ethics tensions for several families (including in relation to domestic violence, maternal concerns about paternal involvement, and contexts of recent separation).

factors. Within this annual report, we provide an overview of initial findings across areas. Given the underpinning aim of Objective 3 – to understand families' journeys with ABS over time – the presentation of findings is focused particularly on understanding experiences over time, beginning with families' experiences of working with ABS before turning to focus on the four core outcome domains. To avoid repetition (where themes arise across different research questions), findings are organised thematically, and discussed in relation to key relevant components of the ABS Theory of Change.

Appendix 4: Objective 4 technical detail

ABS grant spend by partnership

Blackpool[31]

Blackpool spent £35.2m (or 78%) of its total ABS grant allocation by 31st March 2024. The partnership has spent all of its original 10-year budget for capital projects and almost three quarters of its revenue project budget (74%). Blackpool reported the highest proportion of grant spend on portfolio management costs (45% of spend to 31st March 2024). This is due to having a considerable number of seconded or co-funded posts within the organisations that form part of the partnership, as well as posts designed to support systems change across the partnership, to ensure sustainability of all activity.

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

Table 8: Blackpool grant allocation by 31st March 2024

Type of Expenditure	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Portfolio Management	£284,821	£955,718	£1,359,034	£1,556,306	£1,978,920	£2,113,821	£1,912,130	£1,643,404	£1,874,938	£1,942,293	**£15,621,386**
Revenue Project	£25,938	£402,279	£1,647,393	£1,503,965	£1,733,278	£2,383,228	£2,267,351	£2,554,455	£2,944,346	£3,009,234	**£18,471,467**
Capital Project	£0	£0	£225,183	£0	£368,107	£62,077	£438,319	£0	£0	£0	**£1,093,686**
Annual Total	**£310,759**	**£1,357,997**	**£3,231,610**	**£3,060,272**	**£4,080,305**	**£4,559,126**	**£4,617,800**	**£4,197,859**	**£4,819,284**	**£4,951,528**	**£35,186,539**

Bradford

Bradford spent £42.5m (or 86%) of its total ABS grant allocation by 31st March 2024. This was largely driven by the £9.9m portfolio management costs which were equivalent to 123% of their original 10-year budget for portfolio management costs. A revised 10-year budget, shared with the evaluation team in May 2023, indicated a reallocation of revenue project funding to cover portfolio management costs for the remaining three years of the programme.

Table 9: Bradford grant allocation by 31st March 2024

Type of Expenditure	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Portfolio Management	£934,172	£882,874	£1,140,252	£1,137,474	£1,153,325	£1,167,007	£1,137,906	£1,239,538	£1,131,855	**£9,924,403**
Revenue Project	£0	£3,646,295	£2,702,013	£3,697,795	£3,982,254	£4,288,739	£4,225,362	£4,668,124	£3,131,095	**£30,341,678**
Capital Project	£242,576	£107,682	£7,609	£0	£10,231	£550,481	£561,835	£466,741	£276,005	**£2,223,160**
Annual total	**£1,176,748**	**£4,636,851**	**£3,849,874**	**£4,835,269**	**£5,145,810**	**£6,006,228**	**£5,925,104**	**£6,374,403**	**£4,538,955**	**£42,489,241**

Lambeth

Lambeth spent £38.4m (or 96%) of its total ABS grant allocation by 31st March 2024. The profile of Lambeth's spend across the three categories of expenditure is broadly in line with its 10-year budget.

Table 10: Lambeth grant allocation by 31st March 2024

Type of Expenditure	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Portfolio Management	£498,567	£469,110	£534,814	£638,623	£767,270	£1,012,821	£1,150,446	£1,205,951	£1,119,968	£965,494	**£8,363,064**
Revenue Project[32]	£0	£541,037	£1,040,885	£2,093,202	£3,805,057	£4,704,547	£3,833,943	£3,815,722	£3,400,655	£2,816,438	**£26,097,638**
Capital Project	£0	£278,047	£240,575	£321,092	£984,258	£1,609,888	£475,374	£38,837	£11,704	£2,077	**£3,961,853**
Annual total	£498,567	£1,288,194	£1,816,273	£3,052,917	£5,556,585	£7,327,257	£5,459,762	£5,060,510	£4,535,647	£3,826,840	**£38,422,554**

[32] Additional funding of £40,100 through the "Building Capabilities Fund" and additional funding of £6,052 through the "Local Celebration Events" has been added in with Revenue Projects expenditure A breakdown of total spend from "Building Capabilities Fund": £3,320 (2022/23 FY) and £36,780 (2023/24 FY), and total spend from "Local Celebration Events": £6,052 (2023/24 FY).

Nottingham

Nottingham spent £37.2m (or 82%) of its total ABS grant allocation by 31st March 2024. This included 100% of its original 10-year budget for capital projects and, 83% of its 10-year budget for both revenue projects and portfolio management costs.

Table 11: Nottingham grant allocation by 31st March 2024

Type of Expenditure	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Portfolio Management	£403,152	£449,135	£476,541	£412,744	£493,275	£482,437	£471,859	£571,299	£513,255	**£4,273,699**
Revenue Project	£1,570,588	£2,201,060	£2,462,639	£2,635,597	£3,538,229	£4,054,035	£4,618,634	£5,859,535	£5,608,265	**£32,548,582**
Capital Project	£363,759	-£17,126	£17,210	£0	£0	£0	£0	£0	£0	**£363,844**
Annual Total	**£2,337,499**	**£2,633,070**	**£2,956,390**	**£3,048,341**	**£4,031,504**	**£4,536,472**	**£5,090,493**	**£6,430,834**	**£6,121,521**	**£37,186,124**

Southend

Southend spent £29.6m (or 80%) of its total ABS grant allocation by 31st March 2024. The profile of Southend's portfolio management expenditure is broadly in line with its 10-year budget (around 30% spend to date). The proportion of total spend devoted to revenue projects is similarly in line with its original budget (68% of spend to date, compared to 66% of the 10-year budget). Meanwhile, the site devoted a smaller proportion of its total spend to capital projects (2% of spend to date, compared to 5% of its 10-year budget devoted to capital project).

Table 12: Southend grant allocation by 31st March 2024

Type of expenditure	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Portfolio Management	£893,994	£1,816,753	£716,043	£664,548	£1,095,747	£797,577	£858,525	£815,149	£1,361,341	**£9,019,677**
Revenue Project	£199,599	£1,064,655	£1,280,677	£2,090,477	£2,381,851	£1,876,642	£3,450,514	£3,493,316	£4,212,032	**£20,049,765**
Capital Project	£86,191	£0	£456,277	£0	£14,065	-£22,192	£8,127	£0	£0	**£542,468**
Annual Total	**£1,179,784**	**£2,881,408**	**£2,452,997**	**£2,755,025**	**£3,491,663**	**£2,652,027**	**£4,317,167**	**£4,308,465**	**£5,573,373**	**£29,611,910**

Leverage secured to 31st March 2024

In addition to ABS grant funding, the five partnerships secured leverage funding and non-monetary commitments from partners to support the delivery of the ABS programme in their area (e.g., non-ABS grants, funding and donations or provision of services or facilities to ABS beneficiaries or services on a free or reduced fee basis). Together the ABS partnerships secured £29.6m in leverage between 1st April 2015 and 31st March 2024. This is equivalent to 16% of ABS grant spend to 31st March 2024. This is substantially lower than the leverage forecasts submitted by partnerships as part of their original applications, which indicated that leverage funding would almost equal the value of ABS grant funding. However, The Fund has confirmed that it is aware that many of the partnerships' proposed leverage funding plans have not materialised, and leverage funding has become less of a focus from The Fund's perspective.

Among the five partnerships, Blackpool secured the largest amount of leverage funding (£18.6m leverage funding or 53% of their total grant spend to 31st March 2024). Bradford's leverage funding of £6.1m, accounts for 14% of their ABS grant spend to 31st March 2024. This is broadly in line with Bradford's original application. The leverage funding secured by Southend, Lambeth and Nottingham account for 6%, 5% and 3% of their total ABS grant spend to 31st March 2024 respectively. These are all substantially lower than proposed in their original applications.

Table 13: Leverage funding secured to 31st March 2024

Partnership	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Blackpool	£2,447,000	£2,392,000	£2,301,000	£2,187,909	£2,018,857	£1,216,943	£1,367,693	£1,744,962	£2,911,974	**£18,588,338**
Bradford	£141,102	£287,005	£430,717	£834,847	£452,986	£466,251	£592,347	£684,422	£2,231,373	**£6,121,049**
Lambeth	£409,498	£670,502	£300,076	£258,347	£78,439	£53,000	£0	£0	£30,477	**£1,800,339**
Nottingham	£147,026	£118,362	£170,008	£219,810	£132,539	£214,156	£92,760	£169,060	£0	**£1,263,722**

Partnership	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Southend	£118,000	£134,607	£192,143	£257,350	£289,593	£294,894	£328,318	£165,547	£0	**£1,780,451**
Total	**£3,262,626**	**£3,602,476**	**£3,393,943**	**£3,758,263**	**£2,972,413**	**£2,245,244**	**£2,381,119**	**£2,763,991**	**£5,173,824**	**£29,553,899**

Mapping spend to outcome area at partnership level

The following ABS COF measures were selected to align with the outcomes being measured through Objectives 1 and 2 of the evaluation: Perinatal maternal mental health – depression and anxiety; Smoking in pregnancy - smoking status at delivery; Birth weight; Gestational age at birth; Breastfeeding 6-8 weeks; School Readiness; Key Stage 1 attainment; Key Stage 2 attainment; Healthy weight – reception; Healthy weight - end of Key Stage 2; Communication (ASQ); Social emotional development (ASQ); Child development at age 2 - 21/2 (ASQ); Child abuse and neglect - Children aged 0-4 CIN due to abuse or neglect; Child abuse and neglect - Children aged 0-4 on Child Protection Plan; A&E attendances and any emergency hospital admissions due to unintentional and deliberate injuries of children 0-4; and Systems change.

'Other outcomes' included: Smoking in pregnancy – smoking status at booking; Smoking in pregnancy – cigarettes smoked per day; Alcohol use in pregnancy – weekly alcohol units; Other substance use in pregnancy; Low birth weight; Pre-term birth; Breastfeeding initiation; Children free from oral decay at age 5; Child abuse and neglect - Children under 5 Looked after; Hospital admissions due to unintentional and deliberate injuries of children 0-4; Social capital; Improved parental mental health and wellbeing; Secure attachment to a trusted caregiver; Improved maternal physical health and nutrition; More families have strong support networks; Children have a BMI that's neither high or low; and More survivors of domestic abuse are accessing appropriate specialist support.

Blackpool

The largest proportion of Blackpool's project spend was allocated to achieving 'System change' (61%). At least some of the spend from 29 different projects was mapped to this outcome. The projects contributing the largest amount of spend towards this outcome for Blackpool were 'Family HUB Funding' (all of the project's £17.1m spend was allocated to Systems change), followed by 'CAP Community Connector Team' (all of the project's £1.4m spend). Other projects that allocated large amounts to this outcome included 'Early Years Volunteering and Representative Voice' (all of the project's £0.9m spend), ' Early Help – Outsourced' (all of the project's £0.7m spend), 'Capital Parks Development' (£0.5m or 50% of the total spend on this project) and 'Workforce Development' (all £0.5m of the total spend on this project).

Bradford

The largest proportion of Bradford's project spend was allocated to 'Perinatal maternal mental health – depression and anxiety' (30%). In particular, spend from nine projects was mapped to this outcome. The project contributing the largest amount of spend to this outcome was 'SLA Family Action Perinatal Support', with £3.2m or 100% of the total spend on this project. The projects 'SLA Baby Steps' (£1.9m, 100%) and 'SLA Little Minds Matter' (£1.4m, 50%) also allocated a large amount of their spend toward this outcome.

The second largest proportion of Bradford's project spend was allocated to the outcome, 'Communication (ASQ)' (21%). Seven projects contributed to this outcome. The project contributing most spend to this outcome was 'SLA Talking Together' with an allocated spend of £3.5m (or 100% of the total spend on this project). The projects 'SLA Incredible Years Parenting Programme' (£0.8, 50%) and 'SLA BSB Imagine' (£0.5m, 50%) also allocated a considerable amount of spend towards the outcome 'Communication (ASQ)'.

Lambeth

Lambeth allocated most of their project spend to 'Other outcomes' (63%). These included:

- 'Social capital', which accounted for £2.7m or 12% of the total project spend allocated to 'Other outcomes'.
- As well as ABS COF measures such as:
- 'Breastfeeding initiation,' which accounted for £0.7 or 3% of the total project spend allocated to 'Other outcomes'.
- 'Pre-term birth' which accounted for £0.6m or 3% of the total project spend allocated to 'Other outcomes'.
- 'Hospital admissions due to unintentional and deliberate injuries of children 0-4', which accounted for £100,995 or 0.4% of the total project spend allocated to 'Other outcomes'.

The remaining £10.0m or 71% of the total project spend allocated to 'Other outcomes' was allocated to six different parent or child level outcomes, including 'Improved parental mental health and wellbeing', 'Secure attachment to a trusted caregiver', 'Improved maternal physical health and nutrition', 'More families have strong support networks', 'Children have a BMI that's neither high or low' and 'More survivors of domestic abuse are accessing appropriate specialist support'. However, in many cases the totals were

combined so it was not possible to disaggregate spend across these remaining 'Other outcomes'.

At least some of the spend from seven different projects was mapped to 'Social capital'. The projects contributing the most to this outcome were 'Community Engagement', 'Parent Champions' and 'Incredible Edible LEAP' contributing £1.0m, £0.7m and £0.7m respectively (or 50%, 50% and 65% of total spend for each project respectively).

The second largest proportion of Lambeth's project spend was allocated to the outcome, 'Child development at age 2 - 21/2 (ASQ)' (10%). Five projects contributed spend towards this outcome. The project contributing the most towards this outcome was 'Making It REAL/ Sharing REAL with Parents' with an allocated spend of £1.0m (100% of the total spend on this project), followed by 'Overcrowded Housing' (all £0.5m of this project's spend was allocated to this outcome).

Nottingham

The largest proportion of Nottingham's project spend was allocated to achieving 'Systems change' (32%). In particular,16 projects allocated spend to this outcome. The projects contributing the largest amounts to this outcome were 'Specialist Delivery and Supervision Team' with an allocated spend of £5.7m (or 100% of the total spend on this project), followed by 'Programme Evaluation & Learning' (£1.3m, 98%). Other projects that allocated a large amount of spend towards this outcome included 'Community Voice, Community Connections' (£0.6m, 100%), 'Partnership Workforce Engagement & Development' (£0.5m, 100%) and 'Programme Communications & Marketing' (£0.5m, 92%).

The second largest proportion of Nottingham's project spend was allocated to 'School Readiness' (18%). Among the 13 projects that contributed to this outcome, the 'Family Mentoring' project contributed the most (£3.7m or 25% of the total spend on this project). Other projects that allocated a large amount of their spend towards 'School Readiness' included 'Book Gifting' (£0.8m, 100%) and the 'Innovation Fund' (£0.7m, 91%).

Southend

The largest proportion of Southend's project spend was allocated to 'Perinatal maternal mental health – depression and anxiety' (24%). In particular, 20 projects mapped their spend towards this outcome. The project contributing the largest amount to 'Perinatal maternal mental health – depression and anxiety' was 'Family Nurse Partnership' with an allocated spend of £1.4m

(56% of the total spend on this project). The projects 'Perinatal Mental Health' (£0.6m, 100%) and 'Your Family' (£0.3m, 26%) were also substantial contributors to this outcome.

A substantial proportion of Southend's project spend was also allocated to 'Communication (ASQ)' (20%). Among the 21 projects that contributed to this outcome, the project 'Let's talk' contributed the largest amount (£2.3m, or 87% of the total spend on this project). The projects, 'Your Family' contributed £0.1m or 11% of its total spend and 'Fathers Reading Every Day' allocated £0.1m (57%) to this outcome.

A considerable proportion of Southend's project spend was also allocated to 'Systems change' (15%). In total, 21 projects contributed to this outcome. The project contributing the most was 'SAVS Engagement' with an allocated spend of £0.4 or 44% of the total spend and 'Co-production champion' with an allocated spend of £0.4m (75%). The projects 'Work skills' (£0.3m, 55%) and 'Let's talk' (£0.3m, 10%) and also allocated a large amount of their spend toward this outcome.

The outcome 'Breastfeeding 6-8 weeks' was allocated 13% of the total project spend in Southend. Among the 15 projects that mapped their spend to this outcome, the project 'Family nurse partnership' contributed the most spend (£0.8m, 34% of the total spend on this project), followed by '121 Breastfeeding' (£0.5m, 67%) and 'Group Breastfeeding' (£0.3m, 58%).

Appendix 5: Role of panels and advisory group

Parent panel

NCB facilitates a Parent Panel on behalf of the ABS Strategic Evaluation Consortium partners. The panel includes a commitment to co-production and embedding service user voices throughout ABS work.

The panel aims to:

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

Each partnership was allocated five places for the parent panel, and while there has been some turnover, in 2024 there were 22 panel members, representing Blackpool, Bradford, Lambeth and Southend. While all receive meeting invitations and notes, nine members are most active in attending & contributing to meetings.

Two Parent Panel Meetings were held in 2024. The first focused on managing the interaction with families involved with the University of Sussex team, as some of their children 'age out' of the ABS programme. It was acknowledged that this needed to be carefully and sensitively managed but that it was also important to capture the lasting legacy of ABS as the children grow older.

Parents at this meeting also heard an update on the various outputs from the evaluation team, such as the annual report, the report on Parental Engagement and Evidence Synthesis, the podcast, which gave a flavour of the findings to date, and an online webinar that was being planned for spring 2024, which provided highlights of the Annual Report.

The panel members appreciated getting the outputs, and some commented that they particularly liked 'hands free' outputs (e.g. the podcast) as they could listen when they were busy with their children:

> I like the idea of a podcast and the newsletter as it makes me feel more involved (Parent Panel Member)

The second meeting focused on the final family visits by the University of Sussex researchers, and the considerations that the researchers should be thinking about. The research team wanted to find out if there are ways that the ending of the research process can be handled sensitively and in a way that ensures the families feel valued for the time they have given. The research team shared an idea they had to create books for the families that include quotes, pictures, and information about the impact of their data on the national evaluation.

The parent panel agreed that a gesture like this would be a nice idea and that if the books could be personalised for each family that would make the gift more meaningful. Other suggestions by the parents included:

- Scrapbooking or creating a story book that represents families' journeys
- Getting people together in their areas to make connections with other families
- A video presenting the information that would be included in the books
- An area-specific resource about where families can go for alternative sources of support
- Presenting research findings in a simplified way for parents to demonstrate the impact that they have had on the research and beyond.

As the evaluation moves into its last year, the Parent Panel will continue to support the evaluation team as they bring their research activities to a close with each family, feeding into draft research findings. NCB will ensure an orderly and smooth closure to the Parent Panel as the evaluation comes to an end.

Practitioner panel

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

- To act as a critical friend and sounding board for the ABS national evaluation.

- To help us ensure that the evaluation and its outputs are as useful as possible to those involved in the work.
- To ensure that the evaluation reflects the current practice context.
- The panel meets virtually three times per year where they:
- Provide scrutiny, feedback, advice and constructive challenge to the ABS National Evaluation team so that the work and outputs are informed by local practice knowledge.
- Share insights/perspectives about new and emerging practice issues in the five ABS partnerships.
- Act as a sounding board and a critical friend to sense-check and contextualise findings as they emerge.
- Contribute to dissemination and product development. For example, reviewing evaluation outputs, submitting case studies or supplementary insights to help other local areas benefit from their learning.

In 2024, Research in Practice worked in collaboration with the practitioner panel to produce an illustrated briefing report[33] of the findings presented in the second ABS annual report for practitioners. This work helps enhance the impact of learning from the ABS evaluation on Early Years practice.

Advisory Group

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

Members have been invited to participate in the ABS Advisory Group because they have expert knowledge in complex evaluation approaches or specific knowledge and expertise in key areas relevant to the evaluation, such as

[33] https://natcen.ac.uk/publications/national-evaluation-better-start

systems change, family lives, engagement of parents and communities, early childhood development, early support and intervention, diet and nutrition, and/or Early Years outcomes and measures.

In 2024, the advisory group have reviewed the cost consequence modelling work as part of Objective 4.