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National evaluation of A Better Start: final report

Prepared for: The National Lottery Community Fund

By: The National Centre for Social Research, University of Sussex, Fortia Insight, Research in Practice, and the National Children's Bureau

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Contents

Glossary	3
Executive summary	4
1 Introduction	7
2 Theory of change.....	11
3 Evaluation methodology	14
4 Partnership area context, 2015-2025.....	24
5 Contribution analysis	31
Child-level outcome: diet and nutrition	32
Child-level outcome: communication and language.....	40
Child-level outcome: social and emotional development.....	46
Systems change: joined-up working	54
Systems change: increasing parental engagement	59
Systems change: adaptive and evidence-informed services.....	65
Systems change: shift to preventative services	69
Systems change: adoption of ABS approach beyond ABS areas	73
6 Conclusion	76
7 References	79
Appendix A: Theory of change detail	87
Appendix B: Contribution Analysis technical appendix	97
Appendix C: Objective 2 technical appendix	106
Appendix D: Objective 3 technical appendix.....	110
Appendix E: Objectives 1 and 4 methodological appendix.....	124
Appendix F: List of national evaluation outputs.....	141

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.

ABS partnership area: We refer to a geographical location where ABS is delivered as a partnership area. ABS is delivered in five areas in England. They are: Blackpool, Bradford, Lambeth, Nottingham, and Southend-on-Sea. 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.

Child-level outcomes: We refer to child-level outcomes throughout the report to mean the outcomes, for children, that ABS aimed to achieve. These included a range of outcomes under the three domains of diet and nutrition, communication and language, and social and emotional development.

Common Outcomes Framework: A Common Outcomes Framework was developed for ABS in 2016 to provide the programme with a shared approach to outcome measurement, across the partnerships, that leveraged the use of routinely collected health and education data.

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 generated by the national evaluation as the ‘mosaic of evidence’. Through the four evaluation objectives, we gathered different types of data to evaluate the elements of the ABS theory of change. That evidence was synthesised by way of the contribution analysis to enable a holistic evaluation of the impact of ABS.

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

Systems change: In the context of ABS, systems change is defined as improving the way that organisations work together and with families to shift attitudes and spending towards preventing problems that can start in early life.

Executive summary

This final report presents the findings of the national evaluation of A Better Start (ABS), a ten-year place-based programme that aimed to improve early childhood outcomes and Early Years systems in five partnership areas in England. The national evaluation used an approach aligned with the principles of contribution analysis to understand whether, how, and why ABS contributed to change for children, families and local Early Years systems. It aimed to draw on administrative data from NHS England and the Department for Education, qualitative research with families and practitioners, a cost-consequence analysis, and synthesis of local evaluation evidence to build a 'mosaic of evidence' about the contribution of ABS.

The ABS programme aimed to improve outcomes for children's diet and nutrition, communication and language, and social and emotional development. It also aimed to achieve systems change - that is, to improve how Early Years services are delivered. The ABS theory of change described a set of mechanisms that were intended to be part of programmes in order to create the conditions for change in outcomes. The three domains of mechanism were: adaptive design; inclusion, engagement and empowerment; and collaborative working, effective governance, and capacity.

Over the lifetime of the programme, ABS achieved considerable reach across the five partnership areas, supporting 194,677 people in total. This comprised:

- 88,737 primary beneficiaries (9,665 pregnant women and 79,072 children aged 0-3);
- 78,758 secondary beneficiaries; and
- 24,517 unique workforce attendees and 2,665 volunteers.

Partnerships delivered 253 services, alongside 5,380 workforce development sessions and 1,314 volunteer development sessions, reflecting substantial investment in building the capacity of the local Early Years workforce and volunteer base.¹

Across ABS partnership areas, the strongest evidence relates to the mechanisms that support change for families with young children.

Qualitative data collection with the ABS workforce and longitudinal qualitative evidence from families show that ABS improved access to tailored and culturally relevant support, helped families build confidence in supporting child development, and fostered collaborative relationships between services and communities. These mechanisms were seen across the three key child-level outcome domains of diet and nutrition, communication and language, and social and emotional development. Families described how ABS helped them establish positive routines, navigate local services, implement and

¹ A Better Start programme statistics

sustain breastfeeding and healthy eating in their family routines, support children's communication, and strengthen social and emotional wellbeing. Practitioners similarly described ABS as enabling relational practice, better early identification of needs, and more coordinated working across the local Early Years system.

For **diet and nutrition**, ABS supported many families to initiate and sustain breastfeeding, understand healthy feeding, and access practical support. Qualitative data show parents valued ABS's non-judgemental help, peer-support models and accessible group and home-based activities.

For **communication and language development**, qualitative and local evaluation evidence showed that ABS strengthened home learning environments, improved practitioner confidence in identifying speech and language needs, and supported families awaiting specialist assessments. Families described meaningful progress in children's vocabulary, communication confidence, and readiness for nursery.

For **social and emotional development**, qualitative evidence indicated improved parent-child relationships, increased confidence among children, and a reduction in isolation for parents. ABS created environments that supported emotional wellbeing through inclusive play, peer networks, and trusted relationships with staff. Families with additional needs particularly valued the continuity ABS provided.

At a systems level, the evaluation found clearer evidence of ABS's contribution to **Early Years systems change**. The ABS workforce described improvements in joined-up working, stronger referral pathways, and more coherent local offers for families. ABS also contributed to increased parental engagement, including through co-production, peer-led roles and activities designed to reduce barriers to participation. Partnerships reported that ABS supported the development of adaptive, evidence-informed approaches, including test-and-learn models, use of feedback, and local learning networks. While these strengths were evident across multiple partnerships, the extent to which they were embedded or sustained across wider Early Years systems varied, and ABS practitioners reported that longer-term system change was constrained by resource pressures and differing local priorities.

Findings from the quasi-experimental design (QED) and cost-consequence analysis are not reported here, because the available data did not support sufficiently robust conclusions. NatCen and The Fund jointly agreed that these findings should not be published. This decision followed careful consideration of the evidence and methodological limitations by NatCen and an independent peer review commissioned by The Fund. It reflected an assessment that a number of interlocking constraints limited the analysis. The most consequential of these was that very few consented beneficiaries' records could be located and linked to administrative data. Even before linkage, the consented samples in three of the four areas were too small to detect the

small effects the analysis was designed to find, and linkage reduced them further, so the intended primary analysis was not viable across most of the programme. Further challenges with the quality and completeness of administrative data limited confidence in the remaining analysis and the conclusions that could reasonably be drawn from it.

A full account of the methodological journey, including the challenges encountered and the decisions taken, is set out in Appendix E.

The findings show that ABS made a positive contribution to many of the processes and relationships that underpin long-term improvements in child and family outcomes.

The overall conclusion is therefore that ABS strengthened important foundations for long-term change in Early Years systems, and that many families experienced clear and meaningful benefits from ABS services. Future Early Years policy will be strengthened by long-term investment in relational, adaptive and preventative approaches, alongside continued improvement in data infrastructure to support robust evaluation of complex, place-based programmes.

1 Introduction

This is the final report of the national evaluation of A Better Start (ABS), commissioned by The National Lottery Community Fund (The Fund). It tells the story of the contribution that ABS has made to the lives of families with young children and the Early Years sector in the UK.

The ABS programme was delivered over ten years: 2015-2025. This national evaluation was delivered in two phases. During Phase 1 (April-October 2021), the evaluation team explored different options for data collection and analysis, developed the overall evaluation design, and produced an evaluation plan. The evaluation's main phase (Phase 2) then began in late 2021 and data collection spanned from 2022 until mid-2025.

The purpose of this report is to share the final results of the national evaluation of ABS and discuss conclusions so that insights from this evaluation can be used to inform how Early Years services are commissioned, delivered and evaluated. Interim findings have been shared throughout the evaluation in three annual reports, two themed reports, and a local evidence synthesis on implementation. A further local evidence synthesis on implementation and impact accompanies this report. All outputs can be found on [NatCen's website](https://natcen.ac.uk/ABS-national-evaluation).²

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

- **For ABS partnerships**, this report can help inform the legacy of A Better Start.
- **For practitioners, service commissioners, and policy makers** in the Early Years sector, this report provides information about the outcomes of ABS services and how the ways of working across ABS contributed to how stakeholders (families, practitioners and volunteers) experienced ABS.
- **For parents and carers**, this report shares the evidence of differences that ABS services made to the lives of families with young children, and how their voice and input impacted the delivery of ABS and reached 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 analysis and lessons learnt that can mitigate these challenges.

² <https://natcen.ac.uk/ABS-national-evaluation>

About A Better Start

A Better Start (ABS) was a ten-year (2015-2025), £215m programme set up by The National Lottery Community Fund (The Fund), the largest funder of community activity in the UK. ABS partnerships based in Blackpool, Bradford, Lambeth, Nottingham, and Southend-on-Sea supported families to give their babies and very young children the best possible start in life. Working with local parents, ABS partnerships developed and tested ways to improve their children's diet and nutrition, social and emotional development, and speech, language, and communication. The work of the programme was grounded in scientific evidence and research. It involved delivering evidence-based interventions and test-and-learn cycles to allow partnerships to make evidence-informed decisions about what was working in their local areas and what needed to be done differently.

ABS was also place-based and worked to enable systems change. It aimed to improve the way that organisations worked together and with families to shift attitudes and spending towards preventing problems that can start in early life. ABS was one of five major programmes set up by The Fund to test and learn from new approaches to designing services which aimed to make people's lives healthier and happier.

Learning and evidence from ABS have enabled The Fund to inform local and national policy and practice initiatives addressing early childhood development.

Context³

The Fund set up ABS to test and learn about what works to best support families throughout pregnancy and children's early years.

The importance of pregnancy and the first 1,001 days of a child's life for long-term development is well evidenced. These years are considered critical to building the foundations for cognitive, social and physical wellbeing throughout childhood, and into adolescence and adulthood. Poverty and socio-economic disadvantage can negatively affect early childhood development. For this reason, ABS was delivered in areas with high levels of need and aimed not only to achieve positive outcomes for children and families, but also lasting systems change (The Fund, 2025).

Over the ten years that ABS was delivered, the UK experienced two significant events which impacted delivery. These were the Covid-19 pandemic and, following shortly after, the 'cost-of-living crisis'. ABS partnerships were agile and adapted to meet the changing needs of families in their areas.

³ Further detail on the context in which the programme was operating is included in Partnership area context, 2015-2025

The national evaluation of ABS required a methodology that could both reflect and work with the complexities of the programme to tell a robust, yet highly nuanced, story of the impact of ABS.

The national evaluation

The national evaluation of ABS ran from April 2021 to March 2026. The evaluation was led by The National Centre for Social Research (NatCen) and delivered in partnership with the University of Sussex, Fortia Insight (formerly RSM), Research in Practice, and the National Children's Bureau.

The national evaluation had four 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 partnerships to improve delivery outcomes throughout the lifetime of the programme.
3. To enable The Fund confidently to 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 were 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.

Objective 1 was explored through a quasi-experimental design that compared outcomes at beneficiary and ward level between ABS areas and non-ABS areas. Objective 2 involved qualitative research that focused on implementation with ABS practitioners and service managers. Research through this objective also included fieldwork with Early Years practitioners who were not involved in delivering ABS services, and with The Fund. Objective 3 involved longitudinal qualitative research with families who had varying levels of involvement with ABS services, examining experiences with

ABS and wider local systems and implications for family practices over time. Finally, Objective 4 involved a cost-consequence analysis of ABS spending and outcomes to consider the extent to which it resulted in savings to the public purse. Findings from the quasi-experimental design (QED) and cost-consequence analysis are not reported here. NatCen and The Fund jointly agreed not to publish them, principally because very few consented beneficiaries' records could be located and linked to administrative data (in most areas, too few to detect the small effects the analysis was designed to find), and because wider challenges with the quality and completeness of the administrative data meant the analysis could not support sufficiently robust conclusions. Appendix E gives a full account of the challenges encountered and the decisions taken.

Table 1. Evaluation partner roles and responsibilities

Partner	Role
National Centre for Social Research	• Lead contractor • Led evaluation Objectives 1 and 2
University of Sussex	• Led evaluation Objective 3 • Convened the Advisory Group • Provided specific expertise to Objectives 1 and 4 in relation to child developmental outcome indicators.
Fortia Insight	• Led evaluation Objective 4
National Children's Bureau	• Convened the Parent Panel
Research in Practice	• Convened the Practitioner Panel

About this report

This report presents the results of the national evaluation of A Better Start. The remainder of the report is structured as follows:

- **Chapter 2: Theory of change.** This chapter presents the ABS theory of change diagram and detail of activities, mechanisms and intended outcomes of the programme.
- **Chapter 3: Evaluation methodology.** This chapter provides an overview of the methodology of the national evaluation, including the approach for synthesising evidence from the four evaluation objectives using contribution analysis.

- **Chapter 4: Partnership area context.** This chapter describes the five ABS partnership areas, how they differed from one another and how their local context changed between 2015 and 2025, to support interpretation of the contribution analysis.
- **Chapter 5: Contribution analysis.** This chapter presents evidence for each of the contribution claims that formed our hypothesis for how ABS could contribute to child-level and systems change outcomes.
- **Chapter 6: Conclusion.** We close the report by summarising the findings as they emerged over the evaluation and draw conclusions about the contribution that ABS has made.

This report also includes appendices on the methods used for each of the evaluation objectives (including Objectives 1 and 4 where there are no published findings).

Considerations for reading this report

We refer to the team members collating and analysing data for this report as ‘we’ throughout: researchers and analysts from NatCen, the University of Sussex, and Fortia Insight.

This report presents synthesised evidence from across the four evaluation objectives. Detailed interim findings were presented in three preceding annual reports and two themed reports. Those can be found in [The Fund’s evidence library](#)⁴ or on [NatCen’s website](#)⁵.

2 Theory of change

The ABS theory of change (ToC) underpinned the evaluation, and the four evaluation objectives interacted with each other to deliver a comprehensive evaluation of ABS implementation and outcomes. The ToC was developed in Phase 1 of the evaluation in collaboration with The Fund and ABS partnerships. Each ABS partnership had its own ToC and the ToC for the national evaluation is a synthesis of those documents.

The ToC shows how inputs and activities were expected to lead to positive impact on short-, medium- and long-term outcomes. Our approach to developing the theory of change drew on literature about theory-based evaluation and the use of theories of change in evaluation (Mayne, 2012; Noble, 2019; Bunge, 2004).

We define each component of the ToC as follows:

- **Assumptions:** the external events and conditions that enable the achievement of ABS outcomes.
- **Inputs:** the resources required for ABS to be delivered.

⁴ <https://www.tnlcommunityfund.org.uk/insights/documents?q=&programme=a-better-start&portfolio=>

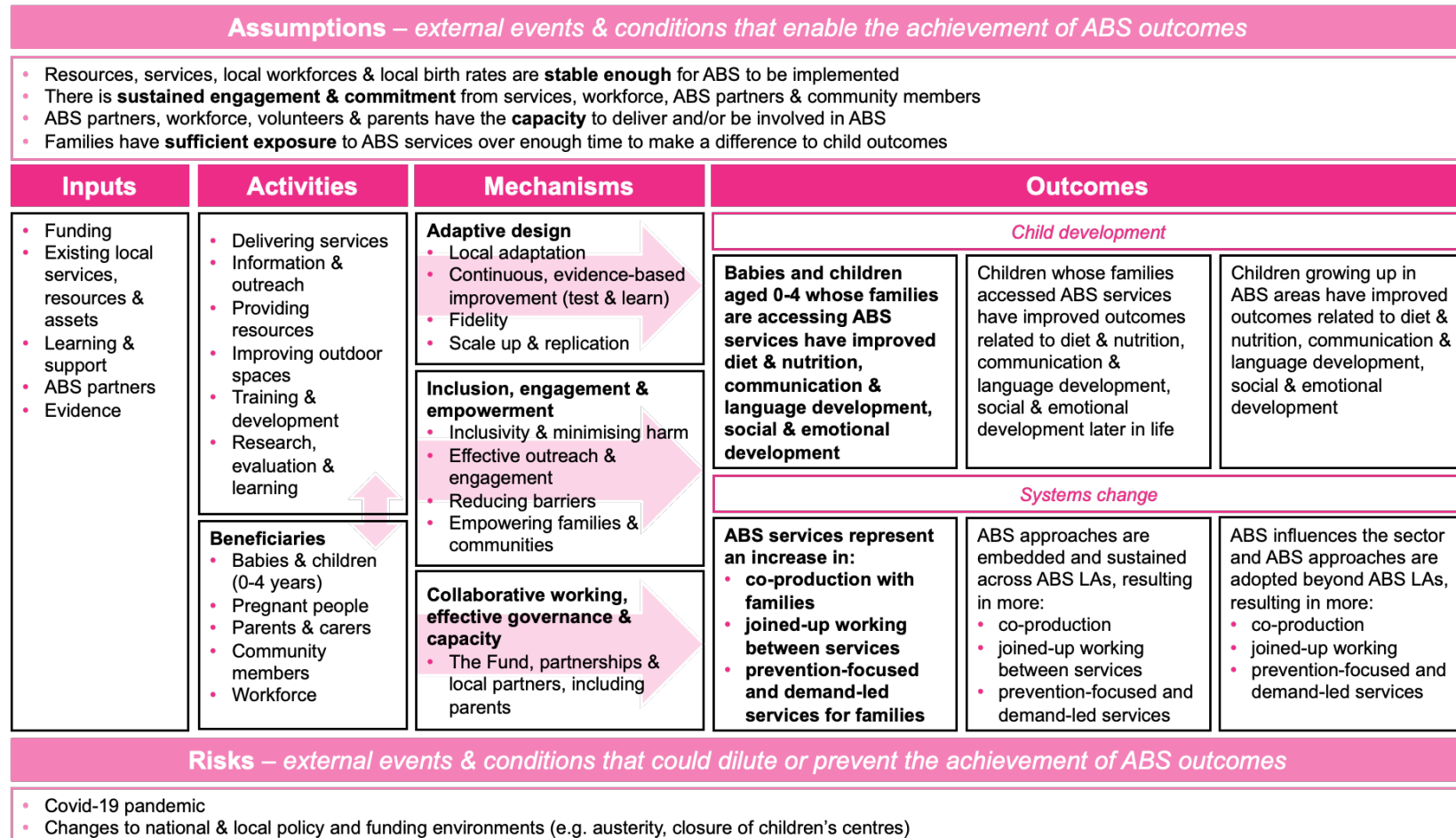
⁵ <https://natcen.ac.uk/ABS-national-evaluation>

- **Activities:** the services and other activities delivered by ABS.
- **Mechanisms:** processes within ABS delivery that act as triggers to achieve the intended outcomes.
- **Outcomes:** the benefits and changes expected as a result of ABS in the short, medium and long term.
- **Risks:** the external events and conditions that could dilute or prevent the achievement of ABS outcomes.

ABS inputs and activities varied across the partnership areas; however, it was essential that all ABS partnerships included the mechanisms on the ToC in their delivery and worked towards achieving the ToC outcomes.

Figure 1 presents the theory of change diagram. It is intentionally high level, reflecting the synthesis (from the partnership ToCs and Phase 1 fieldwork) of inputs, activities, mechanisms and outcomes as broad themes. The more granular detail of activities, mechanisms and outcomes is presented in Appendix A.

Figure 1. A Better Start theory of change



3 Evaluation methodology

In this chapter we provide an overview of the methods used in the ABS national evaluation and types of evidence generated through each objective and then synthesised through contribution analysis. For further methodological detail, refer to the [evaluation protocol](#) and appendices of this report.

The evaluation was delivered in two phases.

Phase 1 was delivered in 2021 and included three work packages that are described in Table 2.

Table 2. Phase 1 work packages

WP1. Situational analysis	WP2. Theory of change	WP3. Evaluation mapping
• Initial interviews with partnership areas and The Fund • Desk review • Workshops with partnership areas • Partnership area summaries	• Desk review • Workshops with partnership areas and The Fund • Synthesis and analysis	• Desk review • Workshops with partnership areas • Mapping external data sources • Conversations with local evaluators

Phase 1 began in April 2021 with a document review of outputs from the first national evaluation and local evaluations, and initial interviews with site directors and other key representatives from the core staff teams of each of the ABS partnerships. In June-July, a series of 30 workshops across the different partnership areas followed on the themes of introduction to our evaluation, ToC, mapping of services and stakeholders, and each site's approach to data collection, research and evaluation. This work resulted in the production of a site summary for each partnership. In July and August, we carried out mapping work of the partnership- and programme-level ToCs, which, combined with the site workshops and a ToC workshop with The Fund, helped us to clarify, understand and synthesise the different existing ToCs, in order to establish a cohesive overarching conceptualisation of the theory behind ABS.

As part of establishing feasibility related to the collection of child-level outcome data, we also carried out a mapping of external data sources. This helped us to determine which data sources we would be able to interrogate as part of the work under Objectives 1 and 4 in Phase 2. To minimise duplication with the work of local evaluation teams, we met with each site's local evaluators to map our proposed fieldwork and priorities for the first year of Phase 2 against their planned work.

The University of Sussex team consulted widely with families and parental engagement leads on the proposed methods and the best ways of engaging families to ensure a wide reach, build trust and maximise sustained participation over time.

During Phase 1, we also established governance processes and ways of working with the ABS partnerships, The Fund, and each other as consortium partners through regular meetings and two consortium away-days.

Phase 2 was delivered from 2022 to 2026.

Phase 2 involved conducting the main fieldwork and analysis for the evaluation and producing interim annual outputs. During Phase 2, we worked closely with ABS partnerships through regular meetings with site leads and attendance at partnership learning events and meetings.

We also held regular meetings and collaborated with members of the Parent Panel, Practitioner Panel and Advisory Group.

The National Children's Bureau (NCB) facilitated the **Parent Panel**. The panel reflected a commitment to co-production and embedding service user voices throughout ABS work. The panel aims were to:

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

Meetings were held 2-3 times per year over the course of the evaluation and members contributed to the design of research instruments and interpretation of interim findings.

Research in Practice convened the **Practitioner Panel**. The purpose of the Practitioner Panel was:

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

The panel met virtually three times per year at which members:

- Provided scrutiny, feedback, advice and constructive challenge to the ABS national evaluation team so that the work and outputs were informed by local practice knowledge.
- Shared insights/perspectives about new and emerging practice issues in the five ABS partnerships.
- Acted as a sounding board and a critical friend to sense-check and contextualise findings as they emerged.

- Contributed 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.

Research in Practice, in collaboration with members of the Practitioner Panel, produced annual illustrated briefing reports to present the findings from the annual reports that were most relevant to practitioners.

The **ABS Evaluation Advisory Group** was established to advise the ABS national evaluation team on the evaluation design and delivery. Members of the Advisory Group: supported the ABS national evaluation team to develop its approach to Phase 2 of the national evaluation; advised the ABS national evaluation team on the design of the evaluation to ensure that it had a rigorous and informed methodology; acted as a ‘critical friend’ providing support, check and challenge to the national evaluation team to help ensure that the national evaluation aims and objectives were met.

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

Methods

This section introduces the methodological approach to the national evaluation, including the overarching contribution analysis and each objective. Further detail about methods is provided, as relevant, throughout the report and full technical details are presented in the appendices.

The national evaluation used an approach aligned with the principles of contribution analysis as the overarching analytical framework to understand whether, how, and why A Better Start (ABS) contributed to change for children, families and local Early Years systems. ABS was a complex, multisite programme operating within dynamic local systems, where services, populations and delivery contexts varied substantially between areas. In such settings, outcomes are influenced by multiple interacting factors, and change typically occurs through non-linear, interdependent pathways rather than simple cause-and-effect chains.

Due to the complexity of ABS, traditional ‘gold-standard’ experimental approaches (such as randomised controlled trials (RCTs) or quasi-experimental designs alone) were insufficient for capturing how a programme of this kind could contribute to change across diverse contexts. These limitations are well-documented in evaluation literature, which shows that experimental and quasi-experimental designs alone often struggle in real-world, evolving programmes and shifting delivery environments (Abimbola, 2023; Rhodes & Lancaster, 2019; Fitzsimons & McCracken, 2020). Similar guidance from the UK Medical Research Council (MRC) emphasises the importance of using a wider range of methodological perspectives, beyond efficacy and effectiveness, to understand mechanisms, contextual influences and system dynamics in complex interventions (Skivington et al., 2021).

Considering these factors, a theory-based approach, such as contribution analysis, was the most appropriate choice for this evaluation. Contribution analysis does not seek to prove that a programme caused an outcome; instead, it examines whether the ToC is plausible, whether the expected mechanisms were present, and whether the overall body of evidence supported a credible case that the programme contributed to observed changes, while considering alternative explanations.

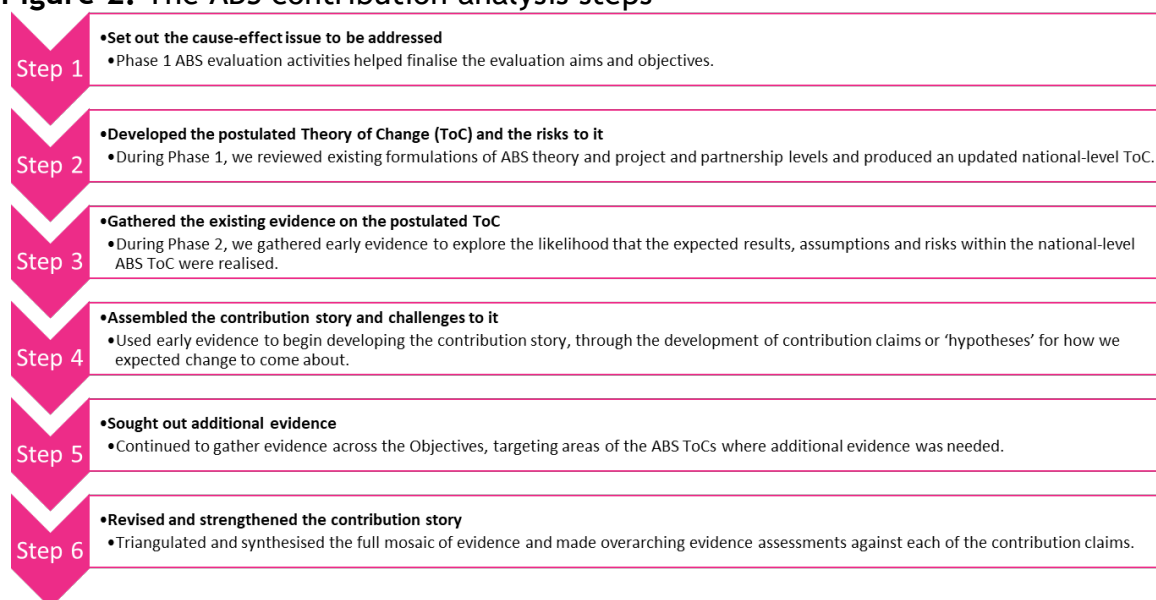
For ABS, contribution analysis was well-suited because:

- the programme operated across five areas with different local delivery approaches and contexts;
- outcomes were shaped by multiple service and system-level influences;
- causal chains involved multiple mechanisms and actors; and
- understanding contribution required integrating multiple forms of evidence, not relying on any single method.

Contribution analysis

We developed an approach adapted from Mayne's (2011, 2012) six-step model (see Figure 2). This adaptation retained the central principles of contribution analysis and applied them flexibly and iteratively to reflect the realities of ABS's design and delivery. At the heart of this approach was the assembly of a mosaic of evidence, bringing together different types and sources of data to explore causal chains, mechanisms and contextual factors in a systematic and transparent way.

Figure 2. The ABS contribution analysis steps



Our approach drew on the principles illustrated in Figure 2 but was adapted to reflect the scale and complexity of ABS, and the practical realities of synthesising evidence gathered over several years. Rather than following the steps as a strict sequence, we used them as a flexible structure to support an iterative process that unfolded across the two phases of the evaluation.

During the early part of the evaluation, the team focused on building a shared understanding of the ABS programme and refining the overarching ToC. This work provided the foundation for later stages of the contribution analysis by clarifying the intended causal pathways and the assumptions that underpinned them.

As evidence began to accumulate, we drew on these early insights to develop a set of contribution claims in 2023. These claims translated the ToC into a series of clear, testable causal hypotheses about how ABS activities and mechanisms were expected to contribute to key child-level and systems-level outcomes. They were grounded in the initial qualitative and contextual evidence gathered across the partnerships and refined through collaborative workshops with The Fund. As the evaluation progressed and further waves of qualitative, administrative and local evidence were collected in 2024 and 2025, the claims were revisited and updated to ensure they reflected the most plausible pathways indicated by the emerging data.

The contribution claims then provided the organising framework for the final synthesis. Evidence from Objectives 2 and 3 and the local evidence synthesis was systematically mapped against each claim, enabling us to examine whether the hypothesised pathways were supported, contradicted or left partially evidenced. This process also incorporated an assessment of plausible alternative explanations, both internal to ABS and arising from wider contextual changes, in order to judge the credibility of the claims as a whole. The resulting contribution narrative, presented in Chapter 5, draws together this triangulated evidence to provide a transparent assessment of the extent to which ABS plausibly contributed to change across the outcome domains.

Objective 1

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

Objective 1 conducted a quasi-experimental design to explore differences in outcomes at the beneficiary and ward-level. We assumed that the [Common Outcomes Framework \(COF\) indicators](#) agreed with ABS partnerships in 2016 articulated how ABS could have improved life chances and these were a core part of the ABS ToC and partnership management. The COF was used so that ABS partnerships had a consistent, rigorous approach to collecting data on key outcomes and indicators of child development that leveraged the use of data that was already routinely collected. It covered the three core outcome domains for ABS: social and emotional development, communication and language, and diet and nutrition.

Estimating the contribution of ABS required gathering evidence of relevance to the counterfactual: ‘If ABS had not been funded in this area, what would ABS beneficiary outcomes have been?’

Answering the counterfactual question required evidence about people who had not received (or been exposed to) ABS interventions. We used administrative data to form the counterfactual to carry out the impact analysis using a quasi-experimental design. Data on education outcomes came

from the National Pupil Database (NPD) and data on health outcomes came from NHS England. The whole-ward analysis included all the eligible individuals in an area, which included both people who engaged and people who did not engage with ABS services. The individual beneficiary analysis only considered data from those who took part in ABS services in ABS areas.

Findings from the quasi-experimental design (QED) and cost-consequence analysis are not reported here, as the available data did not support sufficiently robust conclusions. NatCen and the Fund jointly agreed that these findings should not be published. This decision followed careful consideration of the evidence and methodological limitations by NatCen and an independent peer review commissioned by The Fund. It reflected an assessment that a number of interlocking constraints limited the analysis, resulting in insufficient confidence in the results and the conclusions that could reasonably be drawn from them.

The single most consequential constraint was the very low volume of successfully linked consented records. Although a consent process was designed, approved by NHS Digital and run in four partnership areas, the number of consented beneficiaries whose records could be located and linked was far below what was needed, so the intended primary analysis was not viable across most of the programme. Other constraints included:

- wider challenges with the quality and completeness of administrative data
- inconsistent monitoring data on ABS participation, which was recorded differently across and within partnerships and did not capture the type, intensity or duration of support received. This made it difficult to define a consistent ‘treatment’ group or to distinguish families who received intensive targeted support from those with light-touch universal contact
- diversity of outcomes in ABS sites, meaning few common impact measures
- the design and timing of the evaluation, which was prospective because it was commissioned in 2021 and the scope was built around data collection from that point onwards
- a data window for consented records that was shorter than planned
- a move to ward-level analysis in response to the low number of linked records, which sought to match ABS wards to comparison areas on their propensity to receive ABS but ultimately was not robust
- a reliance on the covariates available to capture all relevant differences between the ABS and non-ABS groups, with only a small number of covariates available in the underlying datasets for several outcomes.

A full account of the methodological journey, including the challenges encountered and the decisions taken, is set out in Appendix E.

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 required us to investigate implementation of ABS at the national level. We generated evidence of what had happened and why, and identified internal and external factors that may have affected ABS's contribution to intended outcomes.

This was done through qualitative interviews in each ABS partnership and non-ABS areas. We spoke with 99 ABS practitioners and service managers, 22 Early Years practitioners who were not involved with ABS (these respondents included people both within and outside of ABS partnership areas) and conducted nine interviews with colleagues from The Fund.

Interviews explored the following topics:

- How ABS practitioners and service managers understood ABS's ambitions for child-level outcomes and systems change.
- The barriers and enablers to ABS delivery, mechanisms, and outcomes.
- ABS practitioners' and service managers' perceptions of whether and how ABS services were contributing to improved child-level outcomes and systems change.
- Similarities and differences between Early Years services delivered through ABS and those that were not delivered through ABS.
- The Fund's perceptions of ABS implementation and contribution towards improving child-level outcomes and systems change.

Objective 3

To evidence the experiences of families from diverse backgrounds through and beyond ABS systems to identify mechanisms of engagement and impact for intended service beneficiaries

Addressing Objective 3 required 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. In total, 29 families took part in Objective 3, representing diverse characteristics and experiences with ABS across the five partnership areas. We spoke to parents/carers twice a year over a four-year period, and children contributed their views using methods such as photography and map-making (199 interviews in total). In-depth analysis over time built a contextually situated understanding of variation in families' experiences of ABS in relation to the four core outcome domains for the programme. This included addressing what ABS systems change means for the lives of children and families, in relation to their experiences of professional support and involvement (e.g., interagency

working); and their experiences of contributing to ABS programme design or delivery (e.g., through consultation or volunteering).

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's focus on prevention, early intervention and systems change had the potential to create public benefit by avoiding costs at a later point in children's lives. To address this objective, we conducted a cost-consequence analysis that was intended to evidence the extent to which the ABS outcomes evidenced in response to Objective 1 contributed to reduced public sector costs relating to primary school aged children (5-11-year-olds). This would have allowed us 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). Findings from the cost-consequence analysis are not reported here. The analysis was designed to build directly on the quantitative impact estimates from Objective 1, which were needed to value any changes in child outcomes associated with ABS. Because the Objective 1 quasi-experimental analysis could not produce sufficiently robust impact estimates, principally owing to the very small number of consented records that could be linked, there was no reliable basis on which to estimate cost consequences. NatCen and The Fund therefore jointly agreed that these findings should not be published in this report. A full account of the methodological journey, including the challenges encountered and the decisions taken, is set out in Appendix E.

Local evidence synthesis

We conducted three syntheses of local ABS evaluation evidence. These included two syntheses of implementation evidence and one synthesis of impact evidence. The purpose of this was to allow us to incorporate insights from evaluation evidence produced at the ABS partnership level into our analysis and interpretation of the contribution that ABS has made to the lives of children and families and to systems. This work is presented [separately](#).

Caveats and limitations

Interpreting results of the national evaluation of ABS requires careful attention to the strengths and limitations of the evaluation objectives, which make up the mosaic of evidence.

Objectives 1 and 4 were designed to provide quantitative evidence of the contribution of ABS to child-level outcomes and to reducing costs to the public purse. However, the single most consequential constraint was that very few consented beneficiaries' records could be located and linked to administrative data - in most partnership areas, too few to detect the small effects the analysis was designed to find. This was compounded by wider challenges with the quality and completeness of administrative data, few common outcome measures across partnerships, monitoring data that

recorded participation inconsistently and could not distinguish intensive from light-touch support, a shorter-than-planned data window and a limited range of covariates. Together, these meant that the quasi-experimental analysis could not produce sufficiently robust impact estimates. Because the cost-consequence analysis depended on these estimates, there was no reliable basis on which to estimate cost consequences. NatCen and The Fund therefore jointly agreed that findings from Objectives 1 and 4 would not be published, and the contribution analysis in this report draws on Objectives 2 and 3 and the local evidence synthesis. A full account of these caveats and limitations, and the decisions taken in response, is set out in Appendix E.

Objectives 2 and 3 provide rich qualitative insight into families' and practitioners' experiences of ABS; however, work conducted for these objectives was not designed to be statistically representative. The approach taken - learning from diverse professional and family perspectives over time - was designed to illuminate complexity, change, and relations between variables. Hence these objectives have not assessed the frequency of reported improvements within the ABS population, nor have they sought any independent corroboration. For example, within Objective 3, analysis over time and across multiple methods in family interviews provides triangulation in qualitative data - 'combining knowledge and experiences [...] for a fuller picture of the issue under study', rather than seeking validation of an imagined 'master reality' (Flick, 2018, p. 21).

Qualitative methodology is designed to afford depth of understanding, and in the context of ABS's total scale and reach, we spoke to a relatively small number of families and professionals. Nonetheless, qualitative datasets have successfully captured a broad range of views and experiences with ABS, from a wide variety of stakeholders. While recognising that there will be other views and experiences that are not captured in this evaluation, this methodological approach provides social rather than statistical representativeness, which is critical in order to capture complex experiences and relations between variables, especially within populations that are known to be diverse (see Gobo, 2004).

Research ethics and data protection

Research Ethics Committees (REC) reviewed and approved all work that was conducted for the evaluation. NatCen's REC reviewed and approved Phase 1 fieldwork in June 2021 and Phase 2 work was reviewed and approved in November 2021. Phase 2 work on Objective 3 was additionally reviewed and approved by the University of Sussex and NSPCC-Blackpool RECs in autumn 2021, and these approvals were updated ahead of each annual wave of Objective 3 fieldwork.

Other work around the infrastructure of our evaluation included a Data Protection Impact Assessment (DPIA), agreeing our safeguarding protocol, detailed discussions of the implications of informed consent related to data collection in Phase 2, and regular monitoring and maintenance of our risk register.

The evaluation's [Participant Information](#)⁶ page on NatCen's website explained to respondents how their data was used for the evaluation and included a link to the Privacy Notice. In addition, a dedicated University of Sussex webpage provided information about Objective 3.⁷

All personal data was handled in accordance with the General Data Protection Regulation (GDPR).

⁶ <https://natcen.ac.uk/participant-contents/better-start-national-evaluation-participant-information>

⁷ <https://www.sussex.ac.uk/esw/circy/research/a-better-start>

4 Partnership area context, 2015-2025

ABS was delivered in five areas of England: Blackpool, Bradford, Lambeth, Nottingham and Southend-on-Sea. These areas were selected because of the level of need among families with young children, and in each case programme activity was concentrated in a small number of wards rather than across the whole local authority. The five areas were not, however, alike. They differed in size, population profile, local government and health system arrangements, and in the nature of the disadvantage experienced by families. They also changed over the ten years of the programme. This chapter describes the context in which each partnership operated, and how that context shifted between 2015 and 2025, to support interpretation of the contribution analysis presented in the following chapter.

Two caveats apply throughout. First, the figures cited are indicative rather than definitive. Definitions, geographies and data sources changed over the period: the English Indices of Deprivation were updated in 2015, 2019 and 2025 using different indicators and boundaries, and the 2025 outputs are explicitly described as less directly comparable to earlier releases (DCLG, 2015; MHCLG, 2019, 2025); ward boundaries were revised in several ABS areas; and measures of child poverty changed following the Welfare Reform and Work Act 2016. Comparisons over time therefore describe relative rather than absolute change. Second, local authority figures conceal considerable variation within areas. In every partnership, the ABS wards were substantially more deprived than the local authority average, and in some cases sat alongside neighbouring wards that were among the least deprived in the country.

Changes affecting all five areas

All five partnerships operated within a decade of sustained pressure on local public services. ABS began in 2015 during a prolonged period of reductions in local government funding, which coincided with the contraction of children's centre provision and of wider universal Early Years and family support in all five areas. Two national shocks followed: the Covid-19 pandemic, which suspended or moved online much face-to-face delivery from March 2020, and the subsequent rise in the cost of living, which increased food, fuel and housing pressures for families in every partnership area. The policy landscape also shifted repeatedly. Clinical Commissioning Groups were replaced by Integrated Care Systems in 2022 under the Health and Care Act 2022, altering the commissioning relationships on which ABS partnerships depended; the Start for Life and Family Hubs programme introduced a parallel national model for Early Years support from 2021-22 (DHSC, 2021); and the change of government in 2024 brought renewed national attention to child poverty and, subsequently, to Best Start Family Hubs. For partnerships, these changes created both opportunity (new routes for embedding ABS learning) and risk (competing priorities, repeated changes of local and national counterparts, and uncertainty about which services would be sustained).

The population ABS was designed to serve also changed. Between the 2011 and 2021 censuses the number of children aged four and under fell in all five areas, most sharply in Lambeth (a decrease of around 26%) and Bradford

(around 12%), reflecting falling birth rates and, in inner London, the movement of families out of high-cost housing (ONS, 2022). At the same time, the populations of the ABS wards became more ethnically and linguistically diverse, and several areas saw new arrivals through asylum dispersal and resettlement. Demand on services also changed in character rather than simply in volume: practitioners in all five areas reported rising need relating to speech, language and communication, SEND, perinatal and parental mental health, housing insecurity and food insecurity, particularly after the pandemic.

Table 3. Overview of the five ABS partnership areas

Partnership	Local context in brief
Blackpool Better Start (led by the NSPCC)	Small coastal unitary authority; ranked the most deprived local authority in England throughout the period; predominantly White British population; high population churn linked to the private rented sector
Better Start Bradford	Large, young metropolitan district (population around 546,000 in 2021); highly diverse ABS wards with substantial South Asian heritage communities; strong local research infrastructure through Born in Bradford
Lambeth Early Action Partnership (hosted by the National Children's Bureau)	Densely populated inner London borough; very diverse population; deprivation driven strongly by housing costs and insecurity; sharpest fall in the under-five population of the five areas
Small Steps Big Changes (hosted by Nottingham CityCare Partnership)	Core city with high child poverty; ABS wards span diverse inner-city and predominantly White British social housing estates; city council issued a section 114 notice ⁸ in 2023, with significant consequences for local services
A Better Start Southend	Seaside city with an older population overall but marked contrasts between central and coastal wards; council under no overall control since 2019; city status granted in 2022 and further local government reorganisation planned

⁸ A formal notice issued by a council when forecast income is expected not to cover forecast expenditure

Blackpool

Blackpool was the most deprived local authority in England throughout the lifetime of ABS. It held that position on the Indices of Multiple Deprivation in 2015, 2019 and 2025 (DCLG, 2015; MHCLG, 2019, 2025), with around two-fifths of its neighbourhoods among the most deprived tenth nationally and seven of the ten most deprived neighbourhoods in England located in the town (MHCLG, 2025; Blackpool Council, 2026a). Relative child poverty in Blackpool is substantially above the England average. Deprivation in the seven ABS wards is closely bound up with the town's housing market: a large, low-quality private rented sector concentrated in former holiday accommodation attracts households in crisis from outside the area, producing high levels of residential churn among families with young children. Employment is heavily seasonal and insecure. Over the ten years, Blackpool's relative position on the Indices barely moved, although the number of its neighbourhoods in the most deprived group fell slightly between 2019 and 2025 (Blackpool Council, 2026a).

Demographically, Blackpool is the smallest and least ethnically diverse of the five areas, with a predominantly White British and ageing population, a declining number of births, and high levels of transience among the families ABS sought to reach. Politically and institutionally, the partnership benefited from relative stability: a long-standing partnership between the council, the NSPCC, the hospital trust and the local NHS commissioner, hosted through the Blackpool Centre for Early Child Development. Local authority finances were nonetheless under sustained strain, and the town remained a focus of national political attention throughout the period. Unlike the other partnerships, Blackpool secured an extension to its funding beyond March 2025, using an underspend accumulated largely during the pandemic, which altered the timing of its transition and legacy planning relative to the other four areas.

Blackpool's health picture is among the poorest in England. Male life expectancy is the lowest of any local authority in England, at 73.7 years in 2022-24 compared with 79.5 years nationally (ONS, 2025; Blackpool Council, 2026b), and the town has persistently high rates of smoking in pregnancy, adult mental ill health, alcohol and drug-related harm, and domestic abuse. Support needs among local families therefore frequently extended well beyond child development, and the partnership's strategy explicitly targeted the pressures on parents that make it hard to parent well, including substance misuse, mental ill health, domestic abuse and social isolation, alongside its work on diet and nutrition, communication and language, and social and emotional development. These needs intensified during the pandemic and cost-of-living period, and were compounded by pressure on health visiting and mental health services.

Bradford

Better Start Bradford operated in three inner-city wards of one of the largest and youngest districts in England. Bradford district's population reached around 546,000 in 2021, an increase of nearly 5% since 2011 (ONS, 2022), and children and young people under 15 made up over a fifth of residents, the highest proportion in the region. The three ABS wards, Bowling and Barkerend, Bradford Moor and Little Horton, are among the most deprived

nationally (MHCLG, 2025) and are considerably more diverse than the district as a whole: while around a third of Bradford's population identified as Asian or Asian British in 2021, the proportion in the ABS wards was closer to four-fifths (ONS, 2022). A high proportion of families speak languages other than English at home, and the wards have received new arrivals through asylum dispersal and resettlement. Over the period, the district's overall population grew while the number of children aged four and under fell by around 12% (ONS, 2022).

Politically, Bradford was governed throughout by a Labour-led metropolitan district council facing severe budget pressures, particularly in children's services and home-to-school transport, alongside the establishment of the West Yorkshire Integrated Care Board and Combined Authority. Bradford's year as UK City of Culture in 2025 coincided with the closing phase of ABS and brought additional investment and attention to the district. The partnership's institutional context was distinctive in one further respect: its Innovation Hub, delivered with Born in Bradford, gave the area an unusually strong local evaluation infrastructure, including Born in Bradford's Better Start birth cohort, an interventional birth cohort designed to evaluate multiple early life interventions (Dickerson et al., 2016, 2022), which shaped how the partnership tested and refined its projects.

The local health picture is characterised by persistent inequalities in maternal and infant health, including relatively high rates of infant mortality, low birthweight and childhood illness, alongside high levels of child poverty, overcrowding and fuel poverty in the ABS wards. Support needs reported locally centred on early language development in multilingual households, maternal mental health, access to affordable and culturally appropriate food, and navigation of services for families with limited English or insecure immigration status. Rising demand for speech and language support and for SEND assessment was a consistent theme in the later years of the programme.

Lambeth

The Lambeth Early Action Partnership (LEAP) worked in four wards of a densely populated and highly diverse inner London borough. Lambeth's population reached around 318,000 in 2021, and it remains one of the most densely populated areas in England, with a young median age (ONS, 2022). Deprivation in the LEAP wards, Coldharbour, Stockwell, Tulse Hill and Vassall, sits alongside considerable affluence elsewhere in the borough, and is shaped above all by housing: high private rents, overcrowding, temporary accommodation and homelessness. Child poverty after housing costs in Lambeth is around 31%, well above the England average (Trust for London, 2026). The most significant demographic change of the period was the fall of around a quarter in the number of children aged four and under between 2011 and 2021, as families moved out of the borough in response to housing costs (ONS, 2022), which reduced the size of the population ABS was designed to serve.

Lambeth's political context was the most stable of the five areas, with continuous Labour control of the council throughout the programme, a long-standing local commitment to the Early Years and a well-developed voluntary and community sector. Institutional change was nonetheless significant: ward

boundaries were redrawn in 2022, so that the four original LEAP wards no longer exist in their earlier form, and health commissioning moved to the South East London Integrated Care Board alongside the development of local place-based arrangements. The boundary change is relevant to the analyses reported in this report, because it affects the comparability of ward-level administrative data over time. LEAP itself was hosted by the National Children's Bureau rather than by a statutory body, and closed as planned in March 2025.

The local health picture is dominated by inequalities associated with ethnicity, migration and housing. Lambeth has a large Black African and Black Caribbean population, and national evidence of markedly worse maternal and perinatal outcomes for Black women was a recurring focus of local work. Rates of common mental health problems are high, and a proportion of families in the LEAP wards have no recourse to public funds or insecure immigration status, limiting access to mainstream support. Reported support needs therefore included culturally competent maternity and perinatal mental health provision, interpreting and translation, help with housing and welfare, and early language support for children growing up in multilingual households.

Nottingham

Small Steps Big Changes worked in four of the most deprived parts of a core city with persistently high child poverty. Nottingham ranked among the ten most deprived local authorities in England on the 2019 Indices of Multiple Deprivation (MHCLG, 2019), and, while its relative position improved somewhat by 2025, it remains more deprived than the large majority of districts (MHCLG, 2025). Local analysis in 2019 estimated that well over half of the city's children lived in workless families or in families with incomes low enough to receive tax credits, a far higher proportion than nationally. The four ABS areas illustrate the diversity of need within a single city: Arboretum and Hyson Green are among the most ethnically diverse neighbourhoods in the East Midlands, with substantial minority ethnic and newly arrived communities, while Aspley, Bulwell and St Ann's are predominantly White British areas with large social housing estates and long-standing intergenerational disadvantage.

The most consequential contextual change in Nottingham was the deterioration of the city council's financial position. The council was subject to external improvement and assurance arrangements from 2021 and issued a section 114 report in November 2023, citing rising demand for children's and adults' social care, homelessness and inflation (Brown, 2023). This was followed by immediate spending controls and substantial reductions to non-statutory services, including community and early help provision, during precisely the period in which the partnership was seeking to secure the legacy of ABS. Delivery was hosted by Nottingham CityCare Partnership rather than the council, which gave the programme a degree of insulation, but the wider funding environment strongly shaped what local partners felt able to sustain, a theme reflected in the systems change findings in Chapter 5.

Local health needs reflect the city's deprivation profile, with relatively high rates of low birthweight, smoking in pregnancy, childhood obesity and poor

oral health, and significant levels of parental mental ill health. Support needs identified locally included accessible infant feeding support, help with the cost of food and essentials, father-inclusive practice, and early identification of speech, language and communication needs. The partnership's peer-led Family Mentor model, delivered through local community organisations, was developed in direct response to the strength of community networks and the mistrust of statutory services reported by some families in these neighbourhoods.

Southend-on-Sea

A Better Start Southend operated in six wards of a seaside city whose overall profile masks sharp local contrasts. Southend's population reached around 181,000 in 2021 and is older than the other four areas, with a median age of 41 (ONS, 2022). At the outset of the programme, however, the six ABS wards, Kursaal, Milton, Shoeburyness, Victoria, West Shoebury and Westborough, were home to around 44% of the city's children. Central wards such as Victoria, Kursaal and Milton are considerably more diverse and more deprived than the city as a whole, with higher proportions of private renting, transient households and residents born outside the UK, while the Shoebury wards combine coastal isolation with concentrated deprivation (MHCLG, 2025). As in Blackpool, deprivation is closely linked to a low-cost private rented sector and to seasonal and insecure employment.

Southend experienced the least stable political context of the five areas. The council has been under no overall control since 2019, with changes of administration and of political and corporate leadership during the programme, alongside significant financial pressure and a substantial medium-term budget gap. Southend was granted city status in 2022 in tribute to Sir David Amess, the local Member of Parliament who was murdered in 2021 (Royal Household, 2022), and the council is expected to be replaced by a larger unitary authority covering south east Essex as part of local government reorganisation. Health commissioning moved to the Mid and South Essex Integrated Care Board in 2022 under the Health and Care Act 2022. This combination of frequent changes of counterpart and impending structural reorganisation shaped the partnership's ability to plan for legacy, and forms important context for the findings on sustainability and adoption beyond ABS areas.

The local health picture combines relatively good average outcomes with steep inequalities between wards. Life expectancy, child development and school readiness outcomes in the ABS wards are markedly worse than in the west of the city. Locally identified support needs included infant feeding and breastfeeding continuation, perinatal and parental mental health, social isolation among new parents, and the effects of the cost-of-living crisis on families with young children, which local evaluation identified as a defining feature of the later years of the programme. Maternity transformation and the development of community-based family support were recurring priorities across the period.

Implications for interpreting the evaluation findings

This contextual variation matters for two main reasons.

- **It shaped what each partnership chose to deliver and why:** the emphasis on parental substance misuse and domestic abuse in Blackpool, on multilingual language development in Bradford and Lambeth, on peer-led community delivery in Nottingham, and on infant feeding and community resilience in Southend all reflect local need rather than differences in fidelity to a single model.
- **It affected the conditions for systems change and sustainability.** Partnerships working alongside financially distressed or politically unstable local authorities, or facing imminent structural reorganisation, had less scope to embed ABS approaches beyond the programme, irrespective of the perceived value of those approaches.

5 Contribution analysis

This chapter presents the contribution analysis for the outcome domains identified through the ABS ToC and early evaluation work. Three outcome domains relate to the child-level outcomes of diet and nutrition, communication and language, and social and emotional development. Five further outcomes relating specifically to systems change were also included in the ABS ToC and were evaluated through the contribution analysis. These include: joined-up working; parental engagement; adaptive and evidence-informed services; prevention and early intervention; and adoption of ABS approaches beyond ABS areas.

One contribution claim was developed for each outcome domain. The claims specify expected inputs/activities → mechanisms (pathways) → outcomes, along with key assumptions and potential enabling or constraining factors, and they are used to structure the analysis within this chapter.

For each claim, we synthesised and triangulated evidence from the qualitative data with practitioners and The Fund (Objective 2) and from the longitudinal qualitative research with families (Objective 3). Findings from the final local evidence synthesis, which reported synthesised findings on impact from a review of reports produced locally by ABS partnership areas, were also synthesised and triangulated as part of the contribution analysis.

We assessed the evidence we compiled for each claim using a contribution analysis framework developed for the national evaluation. The assessment framework considered the strength, completeness and plausibility of the evidence underpinning each causal pathway, alongside potential alternative explanations. Assessments were conducted across three components:

- pathway evidence: were the hypothesised inputs/activities and mechanisms present and plausible?
- outcome evidence: was there evidence the intended outcome was realised?
- alternative explanations: were there other plausible explanations for what we observed?

We then combined these assessments into an overall confidence rating to reflect how strongly the available evidence confirmed or challenged the claim. Importantly, these ratings assessed confidence in the *claim* (i.e., whether national evaluation evidence corroborated the hypothesised causal story), not the quality of individual data sources. The ratings rubric for the overarching assessments ranged from Low to High, where a lower rating indicated less confidence that national evaluation evidence showed ABS contributed to the outcome, and a higher rating indicated greater confidence. The overarching assessment ratings are:

- **Low:** Evidence is limited or contradictory across components. There is little/no evidence that outcomes were realised; coverage is weak and there is no corroboration across objectives. Pathway links are largely

unsupported or illogical, and there are multiple plausible alternative explanations that could account for observed changes.

- **Low-medium:** Mixed evidence with notable weaknesses. Some elements of either the outcome or pathway are evidenced, but coverage is patchy and triangulation is inconsistent. Logical sequencing of the pathway is only partially supported and/or there are unresolved alternative explanations. Overall, the claim has limited support but shows some promising signals.
- **Medium:** Reasonably consistent evidence with some gaps. There is some evidence that outcomes have been realised with moderate coverage and corroboration across objectives; the pathway is partly evidenced with a generally logical sequence, although not all links are well-substantiated. Alternative explanations have been considered, but a few remain plausible. On balance, the claim is supported but not conclusively.
- **Medium-high:** Strong evidence in key areas with only minor limitations. Outcomes are supported by good coverage and cross-objective corroboration; the pathway shows clear, well-explained links between inputs/activities and mechanisms, and the narrative holds together logically over time. Alternative explanations have been explored and largely ruled out, with only limited residual uncertainties.
- **High:** Strong, convergent evidence across all components. Outcomes are well-evidenced with good coverage and consistent corroboration; the causal pathway is robust, with clear links from inputs/activities through mechanisms to outcomes, and the explanation is logical and well-substantiated. No plausible alternative explanations remain. This represents a high level of confidence in the claim.

Across the eight outcome domains, most claims were rated **medium**, with two rated **low-medium**. The medium ratings signal that the contribution claims are plausible and supported but not conclusively demonstrated across all components of the evidence base. The low-medium ratings reflect more limited and uneven evidence for both pathways and outcomes. While some elements of the causal pathways were present, the evidence was patchy, sometimes contradictory, and less consistent across objectives. Outcome evidence similarly showed mixed or weak indications of change, with notable gaps in corroboration. Overall, these ratings suggest that, although there were promising signals, the evidence only partially supports the contribution claims and important uncertainties remain.

In each outcome section that follows, we begin by setting out the **hypothesis** for how ABS was expected to contribute to change (the contribution claim). We then summarise the **overall confidence rating** for that claim before presenting the underlying evidence. The **pathway evidence** describes whether the expected inputs, activities and mechanisms were evident and how strongly they were supported across the data. The **outcome evidence** draws together what the evidence suggests about whether intended outcomes were realised, noting both confirmatory and contradictory findings and any limitations. We also identify any **alternative explanations** and **unanticipated**

and/or unexpected outcomes that help to contextualise the strength of the claim. Unanticipated and/or unexpected outcomes were the additional outcomes identified through the data, which could be either positive or negative. This consistent structure provides a transparent account of whether, how and why ABS may have contributed to change in each outcome domain, grounded in the full set of available evidence.

Child-level outcome: diet and nutrition

Hypothesis

ABS was expected to contribute towards improved diet and nutrition outcomes (e.g., breastfeeding, child weight, oral health) among infants and young children whose families engaged with ABS services. Outcomes were expected to come about through two main pathways: (1) access to support and/or activities for parents/carers to enhance their knowledge, skills and confidence in relation to healthy feeding and nutrition; and (2) holistic, joined-up support across services to identify feeding issues early and facilitate access to appropriate advice and specialist support where needed.

Through pathway 1, ABS activities aimed to enable parents and carers to develop practical skills and confidence around healthy feeding practices, including through interactive community activities, targeted outreach and peer-led support. These activities were intended to support changes in family routines and help establish and maintain healthier feeding behaviours. Through pathway 2, ABS aimed to strengthen continuity of support by improving early identification of feeding-related issues and facilitating referrals and coordinated responses across services. Across both pathways, the support provided intended to help families overcome practical, financial and structural barriers to implementing healthy feeding practices, including supporting access to affordable and healthy food where relevant. Collectively, these mechanisms were expected to contribute to improvements in children's diet and nutrition outcomes, as well as to the prevention of poor or worsening outcomes associated with inadequate nutrition in early life.

Overarching assessment of confidence in the claim

Our overall confidence in the contribution claim for diet and nutrition is **medium**. Across the evidence sources, there is relatively strong and consistent evidence for the processes through which ABS was expected to contribute to better diet and nutrition (pathway mechanisms), and limited confidence in evidence of sustained, measurable child-level outcomes.

Confidence in pathway 1, focused on improving parents' and carers' knowledge, skills and confidence in relation to healthy feeding and nutrition, was relatively strong. There was consistent qualitative evidence that ABS delivered a wide range of practical, interactive activities such as breastfeeding support, weaning guidance and cooking sessions. Several parents/carers who had engaged in these activities reported improved confidence and engagement with healthy feeding practices. **Confidence in pathway 2, relating to holistic, joined-up support and early identification of feeding issues, was more limited.** It was most evident in relation to

breastfeeding, although there were some examples of support with broader diet and nutrition challenges among families.

Evidence of outcomes was limited. Qualitative primary data collection, as well as the local evidence synthesis, provided examples of positive changes for some families, including evidence of sustained breastfeeding and healthy feeding practices. Qualitative longitudinal evidence from families consistently indicates that family engagement with ABS support is a key mechanism in enabling and sustaining healthy feeding practices. However, the qualitative evidence relating to outcomes was relatively limited. This affects the extent to which we can confidently say that the national evaluation evidence supports the claim.

The presence of potential alternative explanations in the evidence, such as overlapping non-ABS activities and pre-existing parental understandings and motivation, further complicates the level of confidence in the claim, reflecting the dynamic and complex system which ABS operated within.

Evidence of pathways

Across both pathways, evidence suggests ABS delivered a wide range of services and resources intended to support families in enhancing diet and nutrition outcomes for their children.

Supporting parents to establish healthy feeding practices

There was strong evidence across pathway 1 that **ABS delivered a wide range of parent-focused activities aimed at improving knowledge, practical skills and confidence in relation to healthy feeding and nutrition.** Examples of these activities included cooking workshops and food projects focused on affordable, nutritious and culturally relevant meals; guidance on breastfeeding, weaning and portion sizes; and practical support delivered by family mentors, peer supporters and group facilitators. Activities were often designed to be interactive and practical, for example by involving children in cooking sessions or modelling feeding techniques, rather than relying solely on the provision of information.

Activities were described by practitioners as hands-on and designed to help families translate advice into their daily routines. Examples of topics covered through ABS activities included recognising readiness for solids, balancing milk with solids, and expanding variation within a child's diet. Parents in all five areas described learning practical skills through cooking sessions, receiving guidance on portion sizes and food variety, and gaining confidence in encouraging healthier eating for their children. In some cases, families concerned about their child's weight or feeding received additional home-based support via ABS, and parents said this had been helpful. Evidence from the local evidence synthesis corroborates these accounts, identifying increased parental confidence and practical skill building as consistent intermediate outcomes of diet and nutrition activities across partnership areas. These findings suggest that ABS activities were successful in creating spaces for knowledge exchange and skill-building.

Beyond the content of activities themselves, qualitative longitudinal evidence from families indicates that **group-based activities and peer-led support**

enabled some parents to learn from others' experiences, for example by sharing culturally specific food knowledge. Parents reported that this could also reduce isolation. Evidence from parents/carers indicated that these activities supported them to feel more confident and capable in relation to feeding practices, rather than simply increasing factual knowledge. For example, some parents reported that group-based breastfeeding sessions helped reduce isolation and support their motivation to sustain breastfeeding.

I needed to be in a roomful of breastfeeding people to feel like you know, hang on, I am still breastfeeding, this is normal...I feel like I would have really struggled if I didn't have that team of people around me [Parent/Carer]

Evidence from practitioners and families also indicated that **group activities facilitated informal networks for many parents, which enabled the sharing of advice and reinforced positive family practices.** Practitioners highlighted that food-based events and clubs acted as meaningful spaces for connection, reducing stigma that can be associated with accessing services and encouraging participation. One practitioner described how communal cooking sessions created 'safe, dedicated spaces' for families to learn together and discuss cultural food practices, which helped them embed healthy eating messages in ways that felt relevant and inclusive.

Peer-led breastfeeding support was another example of this mechanism, with trained mothers providing one-to-one and group support that parents valued for its relatability and appreciation of families' diverse needs and circumstances. **The relational aspects of ABS delivery, which were particularly present in group-based activities and peer-led support, were consistently identified as enablers of engagement** as they made families feel understood, welcome, and supported. Mechanisms of trust, relatability, accessibility and inclusivity were consistently described as enabling initial engagement and sustaining involvement, and so also increasing the likelihood of behaviour change around healthy feeding practices over time. This was particularly the case for some families living with complex challenges and/or those who might otherwise have felt isolated or excluded.

Box 1. Supporting Sustained Breastfeeding

The value of support for sustained breastfeeding is exemplified by the experience of one mother, who had little extended kin support and experienced significant challenges with perinatal mental health. At the first family interview, she described struggling despite early aspirations to breastfeed, especially as her baby lost weight postnatally. As 'the third generation [in the family] that's tried and almost didn't succeed' in breastfeeding, she was emphatic that ABS had played a crucial role in overcoming this challenge:

'Without all the support and help [from ABS], I would have stopped. We had endless nights where it was like, "Go and get the formula, no, don't do it!" It was just so, so hard. So, without that support, there was no way that we would have got there.'

By our third annual interview this mother had a second child, now almost six months old. Despite significant perinatal medical complications, and while noting that ‘even second time around it wasn’t easy’, she had successfully established and maintained breastfeeding. Once again ABS support had been key for her through this challenging time. The availability of ongoing support was emphasised by several participants, such as a mother in another area. Commenting that she experienced breastfeeding as very painful, she explained ‘And I need them [ABS], to be honest with you because even though I’ve established breastfeeding, but with each baby it’s been different.’

Evidence of changes in knowledge and confidence leading to sustained healthy feeding practices was mixed. Findings from the local evidence synthesis suggested that practical cooking and healthy-lifestyle sessions were associated with changes in families’ daily routines (e.g., more frequent preparation of balanced meals, improved portion control, and reductions in sugary snacks). This indicated that skill-building mechanisms sometimes translated into behaviour change at home.

Longitudinal data found that while several families described making changes to meals or daily routines, evidence was more mixed in two linked respects. First, **many families highlighted prior knowledge and aspirations around healthy eating or breastfeeding** and discussed ABS in terms of supporting their existing aspirations and practices rather than changing knowledge and behaviour. At the same time, structural constraints, particularly the **affordability of healthy food along with challenges of fuel poverty and housing issues, were frequently cited as limiting families’ ability to implement or sustain changes**, even where knowledge and motivation were strong and/or had increased. While corroboration across pathway 1 was generally strong across evidence sources, this finding slightly weakened confidence in the extent to which the pathway was achieved through ABS.

Box 2. Affordable healthy food

Across areas and over time, family interviews documented the ways in which wider pressures could interact with developmentally normative fussy eating.⁹ In these contexts, support for affordable healthy food was evidently a key facilitator for family feeding practices. These mechanisms are exemplified by interviews over the years with a mother who described how the challenges of preparing fresh healthy food on Universal Credit were exacerbated by the pressures of juggling cooking with caring for a young child as a single parent. In her first interview she took several photos of food accessed through an ABS scheme; a year later, she described these schemes as ‘lifesavers’ in enabling her to provide a range of nutritious food in a period when ‘[child] definitely seems to be getting more fussy over time’.

⁹ These findings accord with other studies showing the intersection between food insecurity, family feeding practices, and child eating behaviour (e.g., Hevesi et al. 2024).

She also highlighted the value of ABS services, such as cooking groups, in encouraging her child to try new things and in reducing pressure to cook at home.

By the third annual interview, she reported that her child's fussy eating was still a challenge, but she expressed clear understanding of their preferences, for example, that they would eat vegetables in soup.

'If [child] knows what it is and knows that it's something that [they are] much more likely to enjoy, then [they are] easier about it'.

By the time of the final interview in the summer of 2025, the child - who had recently started school - took several photos of meals that they enjoyed, and the mother reflected 'I feel like we're making a bit of progress' with eating.

Holistic support and early identification of feeding issues

Evidence for pathway 2, focused on holistic support and early identification of feeding issues, was more limited. There was evidence from practitioners and families that ABS provided holistic and relational support, particularly through family mentoring schemes and breastfeeding services, and that services worked together to offer continuity of support during critical periods such as the postnatal phase. This was most evident in relation to breastfeeding, where partnerships between ABS services, health visitors and maternity services enabled early engagement with families, consistent messaging, and smoother transitions between services. In some areas, breastfeeding support was embedded within existing health settings (e.g., postnatal wards, health visitor centres), which was perceived to improve reach and reduce the need for families to navigate multiple service entry points.

Families and practitioners described how this joined-up and sustained approach helped create a sense of continuity and reassurance. In some cases, ABS support facilitated referrals to additional help, such as specialist feeding advice or wider support for families experiencing complex circumstances. Evidence from families indicated that non-judgemental and sensitive support was a critical enabler of engagement and impact for parents; this is of particular importance because feeding issues can be emotionally charged.

Several families reported that their involvement with ABS had enabled timely identification of issues that affected breastfeeding (such as tongue tie), but there was less evidence of systematic early identification of feeding issues beyond breastfeeding. Some parents discussed broader diet and nutrition issues, for example, in relation to difficulties with termination of breastfeeding, or concerns about child overweight or obesity, and restricted food preferences or challenging behaviour at mealtimes. Beyond broader support as illustrated by the examples shared above, there was limited evidence that ABS involvement had contributed to early identification of or referral pathways related to these broader identified issues.

There was also relatively limited evidence that joined-up working was a key mechanism for the establishment of sustained healthy feeding practices through this pathway. While families highlighted the importance of continuity of care and emotional support, fewer examples demonstrated how referrals or coordinated support resulted in longer term changes to diet or nutrition. Very occasionally, families expressed criticisms of the advice they had received about diet and nutrition, questioning the accuracy of what they had been told, or reflecting on the negative impact of advice given at an overwhelming or poorly timed moment, reducing its usefulness or leading to disengagement. While these experiences were not typical, they weakened confidence in the extent to which this claim pathway was achieved through ABS.

Improving access to affordable healthy food

Across both pathways, ABS aimed to improve access to affordable and healthy food through food clubs, pantries, vouchers and referrals to charitable provision (e.g., for cooking appliances). Evidence from families consistently documented that these initiatives were important for alleviating immediate financial pressure and, in several cases, played a critical role in enabling families to access healthier foods or reallocate household resources to support children's diet and nutrition. Findings from the local evidence synthesis similarly added that affordability-focused schemes were deliberately designed to be stigma-reducing (e.g., community membership models rather than crisis provision) and that low-cost, predictable access to fresh items sometimes prompted families to try healthier recipes more often. However, where benefits were reported by families and from local evidence, they were (by their very nature) often small scale, short term or highly context dependent, with impact limited by wider economic constraints, and this in turn limited the scope for improved access to contribute to sustained changes in feeding practices.

Evidence of outcomes

Evidence of outcomes related to children's diet and nutrition was found across three key themes: **breastfeeding, diet and weight, and oral health**. Evidence and coverage across these themes, however, was mixed.

Breastfeeding and transitioning to solid food

Qualitative evidence from practitioners and families indicates that **breastfeeding support delivered through ABS had been important for many families; several parents clearly delineated how support had contributed to positive outcomes over time**. Breastfeeding support was said to build confidence, strengthen socio-emotional bonds with the baby, and alleviate anxieties about early infant growth. There was clear evidence from families that ABS support had helped some families initiate or continue breastfeeding, and several mothers described a sense of pride and achievement associated with these experiences. Some also indicated that **ABS support had been critical in enabling them to overcome barriers that might have led to early cessation of breastfeeding**.

I got a lot of breastfeeding support from [ABS service]...which was...I wouldn't have carried on breastfeeding if it hadn't been for that.
[Parent/Carer]

Support for weaning and transitioning to healthy solids was generally well received, particularly among families who found this stage challenging. For example, one family reported early weaning challenges, which they felt were addressed by ongoing help from ABS services, particularly around establishing regular meal patterns. However, some families reported ongoing issues with weaning, particularly around breastfeeding cessation. For parents/carers of children with complex additional needs, such as SEND, challenges linked to highly restricted eating and food preferences for some children had not been a focus of ABS support or needed further specialist intervention.

Practitioners in some areas reported increases in breastfeeding rates, often citing hospital or area-specific data. Similarly, interview evidence from The Fund indicated general improvements in breastfeeding rates across all ABS partnership areas, particularly those where breastfeeding rates were previously low. However, these claims were not consistently substantiated with evidence available to the national evaluation, so cannot be corroborated. The local evidence synthesis similarly noted that while breastfeeding support was frequently reported as beneficial, evidence linking activities to sustained, measurable improvements in breastfeeding rates was limited.

Diet, nutrition and weight

Evidence related to other **child diet and nutrition** outcomes is more limited. Qualitative evidence from practitioners and families indicated that **ABS was beneficial in supporting healthy family food practices, but overall, there is very little evidence available of demonstrable changes.** Practitioners reported some promising examples, including pre- and post-questionnaire findings from specific programmes (such as HENRY) that suggested positive changes in parental behaviours around diet and nutrition. In one example, a family who were concerned about their child's restricted eating habits and growth faltering reported resolution of these issues over time, and they attributed this positive change in part to timely advice and support from ABS. However, longitudinal data from all five ABS areas also highlight that family poverty, and corresponding impacts encompassing housing issues, food and fuel insecurity, constrained the potential to fulfil knowledge and aspirations for healthy child eating practices. This finding is consistent with other research highlighting that individual family interventions may not address the cumulative impacts of household and neighbourhood deprivation as drivers of childhood obesity (e.g. Smith et al., 2025).

The local evidence synthesis similarly **concluded that while programmes appeared to support parental behaviour change around healthy eating, there was relatively little evidence available linking these changes to specific child-level diet and nutrition outcomes.** Where child outcomes were reported, they were often anecdotal, based on practitioner observation, or drawn from small samples, limiting generalisability. A small number of intervention level evaluations reported improvements in children's fruit and vegetable consumption and reductions in sugary snacks, but these findings

were not linked to specific child diet and nutrition indicators (e.g., child obesity rates).

Oral health

Evidence on **oral health** outcomes was also limited. **Some practitioners and representatives from The Fund reported improvements in oral health over longer timeframes, citing reductions in visible decay among five-year-olds in two ABS partnership areas.** The local evidence synthesis similarly noted a longer-term reduction in dental decay among five-year-olds in one of the same areas during the ABS funding period; however, this was based on population-level data across the area (not just ABS wards) and could not be directly attributed to ABS activities. Families who discussed oral health reported that their family practices had benefited from ABS activities such as supervised toothbrushing sessions, provision of toothpaste, and dental advice delivered through group sessions or family mentors. While these findings were positive, other evidence linking ABS activities specifically to sustained child-level oral health outcomes was limited.

Unanticipated outcomes

Through qualitative evidence, several unanticipated and/or unintended outcomes associated with ABS diet and nutrition related activities were identified. Some families reported that changes in diet and nutrition practices spilled over to benefit other members of the household, including older children and adults in the family. There were also indications that food-based group activities sometimes produced additional social connection, reducing isolation and building informal support that families valued. Service delivery was also linked with increased practitioner confidence and capability in having sensitive feeding conversations and providing practical, non-judgemental advice. There was evidence from families that this was critical for effective breastfeeding support. These findings represent secondary outcomes that may enable longer term change, even if not captured by child-level measures.

Alternative explanations

Several influencing factors additional to ABS intervention may help explain improvements in diet and nutrition outcomes. Families often accessed multiple services simultaneously, including health visitor support, community food schemes, and non-ABS programmes focused on healthy eating. These overlapping interventions make it difficult to isolate ABS's contribution, whilst recognising of course that ABS was always designed to be part of a causal package within local systems. Similarly, many parents were already motivated to adopt healthy feeding practices, such as breastfeeding or introducing balanced meals, before engaging with ABS services. In these cases, ABS often reinforced existing knowledge and skills and provided resources that enabled them to fulfil their aspirations for child diet and nutrition, and these were clearly mechanisms through which parents/carers could implement healthy feeding practices.

Child-level outcome: communication and language

Hypothesis

ABS was expected to contribute towards improved communication and language development among children whose families engaged with ABS services. Outcomes were expected to come about through two main pathways: (1) support and/or resources provided to parents/carers to enhance knowledge, skills and confidence to facilitate child communication and language development in the home environment; and (2) supporting and providing evidence-based training and tools to practitioners, particularly those in Early Years settings.

Through both pathways, support provided through ABS aimed to contribute to the creation or enhancement of language-rich environments children are exposed to, in the home (pathway 1) and/or in Early Years settings (pathway 2). Through pathway 1, participation in ABS activities was expected to facilitate improvements in parent/carer knowledge, skills and/or confidence with literacy and how they can engage with and support child development at home, while pathway 2 was more focused on training and support for practitioners to facilitate improvements in Early Years services environments. Across both pathways, activities also aimed to enhance parents' and/or practitioners' ability to identify emerging needs and help to facilitate timely access to appropriate specialist support where needed. Collectively, these mechanisms were expected to contribute to improved communication and language development, and/or the prevention of poor and/or worsening communication and language development.

Overarching assessment of confidence in the claim

Our overall confidence in the contribution claim for communication and language is **medium**. Across the available evidence sources, there is stronger and more consistent evidence for the processes and mechanisms through which ABS was expected to contribute to communication and language than there was for sustained, measurable child-level outcomes.

Confidence in the parent-focused pathway 1 was relatively strong, particularly around improvements to the home-learning environment. Evidence describes practical, home- and group-based support, coupled with resources and modelling, that parents said helped them build language-rich routines with their children (e.g., everyday talking, songs and rhymes, shared reading, managing screentime). **Confidence in pathway 2 was moderate, but not as strong as pathway 1.** Training and tools were linked to earlier recognition, clearer triage and referral routes, and better continuity across services; however, there was less consistent evidence of sustained 'language-rich' setting environments, so confidence in this pathway was more limited.

Evidence of outcomes was limited and mixed across evidence sources. Families and practitioners who reported benefits for children discussed improvements in wider vocabulary, greater confidence in speaking, enjoyment of books and rhymes, enabling English language in multilingual families and children 'passing' communication elements of developmental reviews. Practitioner accounts also describe changes consistent with improved outcomes (e.g., discharge from one-to-one support; assessment

improvements). For children with identified or emerging needs (including SEND), longitudinal family narratives documented evidence of meaningful progress, particularly through interim support measures. We also note plausible alternative explanations, including overlapping non-ABS provision and pre-existing home learning practices, which further complicate the confidence in contribution to this outcome domain.

Evidence of pathways

Across both pathways, there was clear evidence that ABS delivered a wide range of services and resources designed to support communication and language development.

Supporting parents to build language-rich home environments

For **pathway 1**, the parent-focused pathway, strong evidence from practitioners and families indicated **ABS delivered a blend of home based, one-to-one, and community/group activities designed to help parents and carers support children's communication and language at home**. These activities were often complemented by practical resources (e.g., books, activity ideas) and consistent messaging designed to normalise everyday language rich interactions.

Through families' evidence, several parents described how **practical modelling ('show, not tell'), reassurance through developmental checks, and/or light touch follow-up helped them to weave talking, reading and play into daily routines** (e.g., narrating the day; face-to-face interaction; naming objects). Parents valued strategies they could replicate and highlighted the importance of support that was enabling and culturally sensitive, attuned to family needs and supportive of their priorities, rather than corrective or simply instructive. Similarly, evidence from both parents and practitioners highlighted the value of **play-based approaches over more formal instruction**. Evidence of these mechanisms was especially visible through home-based support and structured group courses that paired demonstration with take home resources. As for other child outcome domains, the provision of resources, such as books for children, could be a critical enabler of family practices for those who faced poverty and economic constraints.

Through families' evidence, parents reported that participation in ABS activities contributed to **embedding reading with their children into routines, creating book corners/baskets in the home, integrating songs/rhymes into everyday activities, managing screentime and maintaining book sharing habits over time**.

Box 3. Supporting early reading practices

The experience of one family - a couple household with several older children - exemplifies the ways in which ABS support and provision of resources enabled sustained change in early reading practices. When first interviewed, the mother expressed concern that at 16 months her youngest child 'wasn't really talking much' and was spending too much time on a tablet, because 'I had my hands full' with older children and work.

Feedback from two separate ABS interactions - a group activity and a home visit - encouraged her to establish space for reading with her youngest child at home, while providing reassurance about developmental milestones. By the second annual family group interview, the mother explained her child was now 'more into books', following the implementation of a book basket, including books from ABS home deliveries. At the final family interview, she reflected on this period, saying 'Yeah so I reduced that screen time and then all [child's] vocabulary came out.'

In this same interview, the sustained impact on reading practices was also illuminated by a photograph taken by the child of one of their favourite books, prompting the following explanation from mother and child:

Mother: Oh yeah, we read it at bedtime.

Researcher: So where did you get that book from?

Child: From the basket.

Mother: Oh, we've got a basket ... yeah. We've got one upstairs, you know for bedtime.

Some parents reported cascading reading and literacy practices to younger siblings, and interviews over time demonstrated sustained influence beyond initial ABS interventions.

For many families who already prioritised and/or had knowledge or experience of literacy and/or child development, ABS resources and reassurance made it **easier to implement existing aspirations** (e.g., regular reading practices).

I might have talked to [child] around the house, but I think I might have felt a bit awkward being out and about, whereas the encouragement ... the fact that they kind of normalised it I just assumed people would just know that I was just chatting to my baby! (Parent/Carer)

Evidence from the local evidence synthesis supported these findings. Local evaluation reports also indicated ABS services, such as **home visiting, structured group support and resources (e.g., books/activity packs), were linked to more frequent language rich interactions and home environments**. For example, in one study, Dolly Parton Imagination Library (DPIL) participation was associated with more frequent reading and improved parent-child interaction during reading sessions, when compared to non-participants. Overall, these findings, corroborated across sources, indicated movement toward language-rich home environments, providing confidence in the extent to which these pathway 1 mechanisms were achieved through ABS.

Early identification of needs through family support

There was also some evidence that the parent-focused pathway (1) **supported early identification of needs and referrals and/or provision of specialist support**. Practitioners reported using routine screening and check-ins to validate concerns with parents/carers, signpost referral routes and offer interim support where needed. Families similarly described ABS checks and conversations that helped them recognise issues and, in some cases, secure

more timely access to speech and language therapy or other specialist services. For families of children with identified or suspected SEND, including those on waiting lists for assessment or specialist support, the provision of interim support through ABS was highlighted as beneficial for parents/carers and children. For example, families documented the value of ABS opportunities to attend SEND inclusive groups, in enabling them to meet other families and share experiences and advice about how to navigate systems, and access support during highly challenging periods that could often feel overwhelming.

Improving practitioner identification and referral processes

For **pathway 2**, the provider-focused pathway, confidence was strongest for pathway activities and mechanisms surrounding improved identification and referral processes. Practitioner evidence indicated **training programmes for Early Years practitioners were widely implemented and perceived as useful, equipping staff with training on tools such as WellComm screening assessments and clear referral routes**. In some settings, this support included coaching in interpreting screening data, new communication and language specific roles, and the introduction of multi-agency triage panels to streamline decision-making.

Some practitioners reported that the **use of structured screening tools supported earlier recognition of potential speech, language and communication needs, as well as greater confidence in deciding when and where to refer**. Triage and clear referral routes also reportedly helped to arrange timely and better matched referrals, while data sharing practices supported continuity between practitioners and/or settings. Some practitioners also described knowing when not to refer, using assessments, professional judgement and contextual factors to avoid over identification. In these instances, practitioners aimed to redirect families to other targeted and/or universal provision. Interim support was also used in some settings to maintain progress while awaiting specialist input. These findings were largely corroborated by the local evidence synthesis, where the combination of training and useful tools had reportedly contributed to improved practitioners' confidence, screening coverage and accuracy, and referral quality.

These mechanisms appear to have strengthened early identification and improved coordination between services in some settings, strengthening confidence in the extent to which this element of the pathway was achieved through ABS. However, evidence of changes specifically to make Early Years environments more 'language-rich' was limited. While some evidence documented initiatives to promote communication-friendly practices, such as audit and award schemes, these were not consistently linked to observable changes in settings. **This suggests that training and upskilling may have been more focused on identification and referrals than on creating language-rich environments**. These findings weakened our confidence in the extent to which this pathway was achieved through ABS.

Evidence of outcomes

Evidence on outcomes relating to children's communication and language development is mixed across evidence sources.

Communication and language development

Practitioners and parents reported improvements in children's development such as wider vocabulary, greater confidence in speaking, enjoyment of books/rhymes/phonics, school readiness, and children 'passing' communication elements of developmental reviews after participating in ABS activities. **These accounts often attributed progress (fully or partly) to ABS** and are consistent over time and across multiple narratives and sources.

Box 4. Supporting communication and language

As with the example of the book basket, above, several parents/carers attributed positive impacts on children's communication and language development to the benefits of incorporating ideas from ABS into regular family practices.

For example, one mother documented practices over time that included 'story sacks' (activities linked to books) in her first interview, to using resources like 'nature trays' and 'flash books' (in year 2 of the evaluation), along with regularly attending ABS group activities.

In the third family interview, with the child now attending nursery, the mother commented that 'lots of people keep saying to me, "God she's got a big vocabulary"' - and she repeatedly emphasised the positive impact of ABS in supporting her child's social and communication skills.

Findings from the local evidence synthesis support many of the national evaluation findings and highlighted a small number of strong evaluations at programme level. A feasibility study of a speech and language intervention found children in the intervention group made more progress on measured scales (e.g., Oxford CDI; WellComm) than the control group. In another setting, an evaluation of a language intervention reported statistically significant improvements in the home learning environment for children, indicating that structured parental engagement can translate into measurable change. Together with the qualitative evidence from Objectives 2 and 3, these findings provide some support for pathway-to-outcome links for this outcome domain in specific contexts. However, evidence of outcomes remains relatively limited, relates to a few specific interventions and is not generalisable across ABS activities, and/or is not always clearly attributable to ABS.

Progress for children with additional needs

Practitioners in some areas also reported that ABS participation sometimes **led to children being discharged from one-to-one specialist speech and language support, and that demand for more intensive services had reduced in ABS wards.** Practitioners also reported improvements in assessments over time, such as WellComm scores and BPVS in ABS areas. These findings, however, were often observation-based and/or unsubstantiated claims which lacked detail on how improvements were

measured or whether findings were statistically significant. These findings therefore supported suggestions of ABS contribution towards outcomes but were not definitive, influencing our assessment for this outcome area.

Practitioners emphasised that ABS services were able to support children with identified delays to make progress in their communication and language development. While these children may often still not be expected to meet age-related milestones, due to the extent of delays and remaining requirement for specialist support, this was still considered progress as ABS support helped to prevent delays from worsening, helped families manage in the interim (see above) and allowed children to enter specialist support in a better position than before ABS intervention. For children with SEND or emerging delays, families documented meaningful change (e.g., a nonverbal child repeating words and communicating in other nonverbal forms; improved tolerance for interaction) with ABS providing important pre-specialist support and continuity while families waited for services.

Yeah, I mean it was fantastic [ABS home-based speech and language support]...But that fleeting interaction [between child and others] wasn't there at all before, [child] wouldn't even acknowledge that someone was in the room...Whereas now, [ABS worker's name] who did our speech and language therapy, [child] actually goes looking for [worker] as soon as we get to playgroup. (Parent/Carer)

These findings support confidence that **ABS could contribute to mitigating the adverse impact of delayed access to specialist support for children with complex needs.**

Unanticipated outcomes

Qualitative evidence also revealed several **unanticipated and/or unintended outcomes** of ABS communication and language support, both positive and negative. Some families described cascading benefits, for example as parents re-used ABS strategies with younger siblings, suggesting a sustained influence on family practices beyond initial ABS interventions. Among multilingual families, some parents reported improvements in their own English proficiency as a by-product of engaging with their child's language support. However, support for multilingualism is complex and the balance of maintaining home languages alongside English language development was discussed by several families over time. ABS encouraged multiple language learning, and this was important because some parents highlighted their concern to maintain home languages alongside supporting English language development. Additionally, both parents and practitioners raised concerns about potential over-identification of delay where screening tools were not adjusted for multilingual development.

Alternative explanations

A number of potential **alternative explanations** were also identified. As with diet and nutrition above, families frequently engaged with multiple non-ABS sources of support or community venues (e.g., libraries) making it difficult to disaggregate the impact of ABS activities specifically, and it is important to recognise that these were designed to be part of the wider causal package

operating within local systems. Several parents indicated that they already had strong home learning practices or prior knowledge/interest in child development; in these cases, ABS typically acted as a facilitator or amplifier rather than the primary driver, especially in low-income families who may otherwise struggle to provide resources in line with their aspirations and priorities. This is not a limitation of ABS but suggests a more complex causal pathway, such that ABS is not the sole driver of improvements in child outcomes in this domain. The influence of starting nursery and/or school, and the presence of older siblings in the home were also external influences often credited with language development. In one area, ABS activity also coincided with a city-wide literacy push, making it difficult to distinguish improvements related to ABS vs this larger campaign.

Child-level outcome: social and emotional development

Hypothesis

ABS was expected to contribute towards improved social and emotional development among young children whose families engaged with ABS services. Outcomes were expected to come about through two main pathways: (1) the provision of enriched environments and activities that supported children's social interaction and emotional development, alongside opportunities to strengthen parental networks, wellbeing and resilience; and (2) tailored, relationship-based support for parents and families, including early identification of need and access to appropriate support and specialist services.

Through the first pathway, ABS activities aimed to provide regular opportunities for children and families to engage in safe, inclusive and stimulating environments for play, interaction and social participation. These activities were intended to support the development of early social skills, confidence and emotional regulation, while also reducing isolation and strengthening parents' social networks and wellbeing. Through the second pathway, ABS aimed to support parents and carers through trusted, non-judgemental and relationship-based approaches, helping to build parental knowledge, skills and confidence in supporting children's social and emotional development. Activities also aimed to improve early identification of emerging needs and facilitate timely referrals to tailored or specialist support where appropriate, particularly for families experiencing additional challenges. Collectively, these mechanisms were expected to contribute to improvements in children's social and emotional development, as well as the prevention of poor or worsening outcomes in early childhood.

Overarching assessment of confidence in the claim

Our overall confidence in the contribution claim for social and emotional development is **medium**. Across the evidence sources, there is relatively strong and consistent evidence for the mechanisms through which ABS was expected to contribute to children's social and emotional development, particularly in relation to enriched play environments, relational support, and

strengthened parental wellbeing. However, as with the other child outcome domains, there is more limited evidence of sustained, measurable child-level outcomes in available administrative data across ABS areas.

Confidence in the pathway evidence is strongest for pathway 1, which focused on enriched environments for social interaction. There was clear and consistent qualitative evidence that - over time and across areas - ABS activities supported children's confidence, social interaction and emotional regulation, alongside improvements in parental wellbeing and the creation of support networks. **Confidence in the second pathway, focused on tailored support and early identification, was moderate.** Trusted relationships and early guidance were reported to help some families identify emerging needs and access support sooner, including where children had additional or developing needs, though experiences varied and consistency across areas was more mixed.

Evidence of outcomes was limited. Families and practitioners frequently documented improvements in children's confidence, social interaction, emotional regulation and readiness for nursery, and longitudinal qualitative data showed that several families indicated benefits that were sustained over time. Of note is that longitudinal analysis indicates that the strongest evidence of benefits came from families with higher levels of sustained engagement with ABS provision. As noted above, ABS is part of a complex causal package, and the presence of alternative explanations, including overlapping non-ABS services, varying levels of parental motivation, and differences in local system context makes it difficult to isolate the ABS contribution to positive outcomes. Taken together, contribution analysis suggests clear indications of positive change for some families, particularly those who were closely engaged with ABS provision, but not consistent, generalisable evidence of sustained child-level impact across populations in ABS areas.

Evidence of pathways

ABS activities aimed to support children's social and emotional development through several connected pathways, designed to provide opportunities for social interaction, embed play into routines, and provide sensitive, non-judgemental support for families during key transitions (e.g., settling into nursery/school) and/or challenging times (e.g., financial struggles).

Enriched environments for social interaction

For pathway 1, there was strong evidence from practitioners and families that **ABS delivered a range of safe, inclusive, and stimulating activities where children could interact with others, explore new settings, practise early social skills and build confidence.** Group-based play sessions, and outdoor and sensory activities were described as giving children regular opportunities to explore new environments, engage with peers, and develop skills in emotional regulation. Parents and practitioners both highlighted how children became more confident, began playing alongside and with others, and were more willing to try new experiences following participation in these activities. These findings are consistent with findings from the local evidence synthesis,

which reported improved confidence, cooperation, involvement and wellbeing, albeit from small, localised studies.

Similarly, evidence from families and the local evidence synthesis suggested that **parent/carer participation in these activities often created a pathway to improved parental wellbeing and resilience**. Parents consistently described increased confidence, improved mood, reduced isolation, greater enjoyment in parenting and strengthened parent-child relationships arising from regular participation in ABS groups and supportive spaces. Many families emphasised that having predictable, supportive spaces each week benefited both parents and children, with some describing how these routines helped parents manage in their home environment and eased transitions into Early Years settings.

Social connectedness was identified as a key mechanism of change, as friendships established through ABS often continued after services ended. This often contributed to resilient and meaningful networks of support between parents/carers, which were particularly important for those who were socially isolated. In accordance with a significant international evidence base (e.g., Smith et al., 2022), longitudinal analysis of family data evidenced that parental benefits were often important pre-conditions for observed changes in children's confidence, social interaction and emotional regulation.

The amount of learning I had is because of them [ABS services], you know [the] relaxation and the calm that I have now is because of them, every group has helped, not even one I would say ... 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 [Parent/Carer]

Over time, some parents moved from attending sessions to taking on peer roles delivering ABS services. These parents often described feeling more confident and connected and described how ABS opportunities supported their sense of agency (as a parent and more generally) and skill development. Practitioners emphasised that peer-led services often helped ease anxieties that some parents and carers felt when accessing support. The involvement of peers with lived experience reduced feelings of stigma and made families more receptive to engaging with ABS services.

I think people can be worried about what that means for them or their family going forward if they do access that support. I think that peer-led model really goes some way to helping to reduce a lot of the anxieties that can be associated with that for some families [ABS practitioner]

Taken together, these findings provided relatively strong evidence of pathway 1, indicating confidence in the extent to which evidence from the national evaluation supports the mechanisms within this claim pathway.

Relational support and specialist pathways

Evidence from practitioners and families also supported pathway 2, as **ABS provided trusted, relationship-based support aimed at helping parents understand their child's cues, respond sensitively, and manage moments of**

stress or challenge. Examples of activities included infant mental health/attachment programmes, targeted home visiting, and group-based guidance. Parents described learning strategies such as slowing down, naming feelings, and maintaining calm interactions during difficult moments, with several reporting that routines at home became easier as a result and documenting changed practices over time in the longitudinal analysis. Practitioners viewed this work as ‘laying the groundwork’ for secure attachment and improved emotional wellbeing. These mechanisms align with the pathway’s emphasis on strengthening parenting capacity as the route to child-level development. Additionally, evidence from the local synthesis indicated that direct support for parents helped to reduce stress and strengthen parental wellbeing. Services expected these improvements to enhance the emotional climate at home and, in turn, support children’s developing social and emotional skills.

A further mechanism within this pathway was early identification of support needs and referral to specialist services. Practitioners stressed the importance of acting quickly, particularly for infants. Evidence from practitioners and families suggested that early contact with families, often beginning in pregnancy or the early months, sometimes enabled concerns to be recognised sooner and helped families feel more prepared to access additional support when needed. Some practitioners also indicated that parents were more likely to accept referrals from staff they trusted, such as health visitors or group facilitators. Evidence from practitioners suggests some services embedded identification within universal or non-stigmatising activities, like craft or play sessions, so that needs could be recognised discreetly. Similarly, parents described sensitive identification of needs through general group sessions.

There were compelling examples of joined-up ABS support enabling earlier or smoother access to help, particularly for those with SEND trajectories. Among families of children with SEND, several described how ABS support initiated early referral processes culminating in EHCP approvals and/or placements in sought after specialist schools. ABS support could also help families manage the long and complex journey typical of specialist provision. Families waiting for specialist support and/or referrals also described the facilitation of peer support as essential for navigating complex referral systems. These networks helped parents feel less isolated and provided resilient support structures during times of perceived overwhelming parenting demands.

Box 5. Supporting social and emotional wellbeing

The value of support for families of children with SEND is exemplified by the experience of a family that was initially referred to a SEND-focused ABS group by the Health Visitor when the child was 10 months old. By the time of our final interview, the mother still had strong connections with other families they met there. Reflecting back in her final interview, she explained:

Whether it was having someone to cry at, someone to laugh with ... I think it was the fact of those were the first ones [groups] I was introduced to, where I stood and looked around at these children and went, yeah, he fits here.

The importance of having a space where mother and child were accepted and would feel comfortable was a recurrent theme in the family's interviews over time. ABS had also proved a key route to accessing support and entitlements to meet her child's needs, from Disability Living Allowance benefits to facilitated referrals to paediatric specialists and portage, and an appropriate specialist school.

In understanding the long-term benefits of ABS on children and families' socio-emotional wellbeing, there is clear evidence of the value of a **holistic approach in supporting families who were navigating multiple intersecting challenges over time**. This was a strong feature of accounts of the value of home-based tailored support - such as family mentoring - and is exemplified in interviews over time in another large family with a child with significant SEND. In her final interview, the mother emphasised the critical role her ABS family mentor had played in providing 'whole family' support that has 'literally helped me right through' - ranging from focused support through crisis points including the breakdown of the parents' longstanding relationship to scaffolded engagement with the universal ABS offer in her local area.

While evidence from both practitioners and families suggested that relational support and early identification were meaningful mechanisms for many families, **experiences of these mechanisms differed**. Practitioners described instances where referral routes felt unclear or eligibility boundaries created uncertainty and noted that some families had needs that required support beyond what ABS services were designed to provide. Families likewise reported varying experiences, with some receiving timely guidance or reassurance while others were already linked into different services or navigating more complex circumstances that created barriers to support and shaped how, when, or whether early identification occurred. It was clear from family interviews that these experiences also depended on the wider availability of SEND support within their local area. This variation was also reflected in the findings from the local evidence synthesis. Taken together these factors influence the extent to which the pathway can be considered consistently supported by the evidence, slightly weakening our confidence in ABS's contribution through pathway 2.

Evidence of outcomes

Evidence on outcomes relating to children's social and emotional development is mixed and uneven across evidence sources.

Social and emotional development and family functioning

Parents and practitioners frequently reported perceived **improvements in children's confidence, social interaction, emotional regulation, and readiness for nursery/school following engagement with ABS activities**.

These findings were corroborated by the local evidence synthesis.

Longitudinal family narratives described children becoming more confident and socially able over time, settling well in nursery, and being seen as 'school ready'. Some parents explicitly linked these changes (in whole or in part) to participation in ABS groups and play based activities. These accounts were consistent across areas and multiple waves of fieldwork with families,

strengthening confidence that ABS mechanisms contributed to perceived change for some children.

She's [...] so confident in class, she's a really confident child... I used to take her to the [ABS] playgroups... the book ones as well, so it really helps social development (Parent/Carer)

Practitioners also reported improvements in family functioning closely linked to children's social and emotional development. Relationship-based support (e.g., parent-infant psychotherapy, attachment focused work, peer led groups) was frequently described as helping parents read children's cues and respond more calmly and consistently to their developmental needs. These practitioner observations align with the hypothesised pathways for ABS's contribution, although they were not substantiated by additional data in most cases.

Findings from the local evidence synthesis also reinforced these patterns of evidence, providing additional examples of improved confidence, cooperation and social interaction. **A small number of evaluations also indicated measurable progress in social and emotional development,** though these were typically based on limited samples and non-experimental designs. Taken together, these findings signal ABS contribution towards improvements in social and emotional development but remain limited to specific interventions.

Earlier engagement with specialist support

Through family data, in several SEND or complex needs cases, **ABS support was said to enable earlier engagement with appropriate services (e.g., EHCP processes, specialist placements) and help children enter specialist support in a more stable position.** The consistency of examples across families' data, spanning all five partnership areas and longitudinal data, indicates that ABS support may have mitigated the potential negative impacts of waiting lists and delays for young children with significant emerging needs, though it was not possible to corroborate this point through evidence from other objectives or evidence sources. Local evidence similarly highlighted that ABS support sometimes prevented difficulties from escalating for children with emerging or additional needs, particularly where families received timely guidance from ABS staff while awaiting specialist input.

Unanticipated outcomes

Qualitative evidence revealed a few **unanticipated and/or unintended outcomes.** Some parents reported becoming more comfortable discussing their own and their child's mental health following participation in ABS activities. At the same time, some complex or negative consequences were highlighted. For a few families, expectations for early diagnosis of SEN as a route to support could be a source of tension or ambiguity in a wider context of complex family needs. Meanwhile, in a small number of families, parents/carers reported increased anxiety about their parenting linked to the

framing of advice in some ABS interventions¹⁰. These are important considerations but sit adjacent to measured child outcomes.

As for other outcome domains, the clearest evidence of benefits was reported among families with higher levels of engagement with ABS. However, some specific examples from families raise questions about the level of family reliance on individual support through ABS, especially for those living with chronic challenges. There is debate in the literature about the risks of over-dependency in parenting support (e.g., Sanders, 2023; Devaney and Crosse, 2023) and so families' long-term reliance on ABS could be seen as an unintended or adverse outcome. Nonetheless, it is clear that these examples involve families where the level and continuity of ABS support had helped vulnerable parents/carers cope with caregiving in the years until the child starts nursery and/or school, as illustrated in Box 6.

Box 6. Sustained support for vulnerable families

The mother in this multi-generational household spoke in each of her interviews about her struggles with her own mental health and SEND. For example, she spoke of having 'a lot of good days, a lot of bad days... And it can get in the way of parenting'. Over time, this mother had expressed concerns about her child's SEN, and there had been referral for formal assessment with the support of ABS.

As well as a range of targeted support from ABS, she was also supported to access universal ABS provision through her local children's centres, and she said this helped her and her child 'because it means I can get out and talk to people. And I'm not so isolated indoors all the time'. Meanwhile, she explained that her child was able to do things that she would not manage to provide at home:

'[Child] plays with water... sand, kicks balls, plays with dolls' houses, kitchen, everything. They do ... sing songs like nursery rhymes, it's good.'

By the time of the third family interview, the child was attending nursery, and both mother and grandmother reflected that nursery did not report the challenges they experience at home:

Mother: They say when [child's] at nursery, [their] behaviour's completely different. [Child's] well behaved, well mannered, here it's a different story.

Grandmother: We noticed that yesterday when [child] was at sports day, that you know [child] listens to them [Mother: Yeah] more than she listens to us here.

Alternative explanations

As with the other child outcome domains, it is likely that some social and emotional development outcomes reported by parents and practitioners **have been influenced by factors outside ABS services**. Families often accessed

¹⁰ For example, content on the risks of parental non-responsiveness prompted anxiety for some whose reported practices were already highly responsive to child needs.

multiple programmes at the same time, including non-ABS initiatives and specialist intervention/support (where applicable), which could have contributed to improvements in children's social and emotional development and must be considered as part of the causal package. Parents who attended ABS play sessions also suggested local nursery provision and community-led activities may have contributed to outcomes, making it difficult to separate the effect of ABS from other sources of support. Other contextual factors, such as informal networks of extended family or faith-based groups, also helped reduce isolation and provide emotional support. In addition, some practitioners noted that wider system changes, such as increased awareness of infant mental health among health professionals, may have improved referral pathways independently of ABS.

Systems change: joined-up working

Hypothesis

ABS was expected to contribute towards increased and sustained joined-up working between services to better meet the needs of children aged 0 to 4 and their families. Outcomes were expected to come about through two main pathways: (1) the creation of collaborative working opportunities across local services to strengthen relationships, shared understanding and coordination; and (2) upskilling multidisciplinary, strategic and frontline staff across ABS-funded and non-ABS services through shared learning, training and joint working.

Through the first pathway, ABS activities aimed to increase awareness of the range of services available locally and to strengthen partnerships between ABS-funded and existing services. This included developing shared ways of working, improving communication and referral pathways, and supporting joint planning and problem-solving across organisations. These mechanisms were intended to reduce siloed working and enable more coordinated, holistic responses to families' needs. Through the second pathway, ABS sought to support joined-up working by developing a shared vision, culture and understanding of the ABS approach across the Early Years system. Training, shared tools and opportunities for joint reflection were intended to strengthen staff capability and confidence, reinforce collaborative practice, and support the implementation of integrated working strategies across services. Collectively, these mechanisms were expected to contribute to more coherent, coordinated and responsive Early Years systems, enabling services to work together more effectively to support families and improve access to appropriate support.

Overarching assessment of confidence in the claim

Our overall confidence in the contribution claim for joined-up working is **medium**. Across the evidence sources, there is clearer and more consistent evidence that ABS contributed to collaboration across services, particularly across mechanisms within pathway 1, than there is for sustained, measurable system-level outcomes.

Confidence is stronger for pathway 1 than for pathway 2. For pathway 1, practitioner accounts and local evidence consistently describe joint delivery, shared planning structures, and more coherent referral processes; these mechanisms were seen to reduce duplication and support more holistic responses for families. There was good coverage and corroboration across sources and mixed family experiences on the visibility of local offers.¹¹ In contrast, confidence in evidence for pathway 2 was more limited, with fewer examples of workforce development translating into sustained changes in joint practice, and concerns about the impact of staff turnover on continuity.

Evidence of outcomes was limited, with families and practitioners reporting perceived improvements in access, coordination and continuity, but with few substantiated examples and notable variation in family experiences. Similarly, evidence of sustained joined-up working, while present, was limited and difficult to substantiate. Some potential alternative explanations were also identified, including pre-existing partnerships and wider local initiatives that may have contributed to improvements independently of ABS. Overall, while some mechanisms associated with joined up working were consistently described, the limited outcome evidence, uneven coverage and difficulty isolating ABS's unique contribution weakened the assessment.

Evidence of pathways

Evidence from practitioners and the local evidence synthesis indicated that ABS contributed to more integrated and collaborative working across local services, though progress varied by pathway.

Collaborative working across services

There was relatively strong evidence from practitioners and the local evidence synthesis in support of pathway 1. Partnerships implemented **joint delivery models, shared planning structures, partnership working between ABS-funded and non-ABS services, and collaborative decision-making processes that aimed to reduce siloed working and improve continuity of care for families.** Practitioners and programme staff described working groups, shared planning meetings, and processes that supported coordinated responses, joint solutions to local challenges, and greater awareness of each other's service offers and gaps. **Some accounts highlighted holistic support, where multiple services contributed to a more integrated response around families.** For example, partnerships with health visitors and schools improved identification of speech and language needs and facilitated referrals to specialist support. One practitioner explained:

We sit down together, and referrals come in where parents are requesting support... we all talk about it together, and we think about ensuring that the family gets the right service at the right time. (ABS practitioner)

The local evidence synthesis echoed these themes. The synthesis found that these mechanisms were often **supported by governance boards and strategic**

¹¹ Families in Objective 3 were sampled to include varying levels of engagement with ABS, and this is reflected in findings in relation to systems level outcomes.

groups, which brought together statutory, voluntary, and community organisations to align priorities and share resources. For example, practitioners described triage panels that combined health visiting, midwifery, and early help services to coordinate timely support for families. The synthesis noted that integrated referral systems were widely valued across partnership areas.

Collaborative working was strengthened through practical enablers such as co-location of services, shared measurement systems, and integrated referral pathways. Practitioners reported that shared data platforms enabled partners to monitor outcomes collectively and adapt delivery based on evidence. The local evidence synthesis supported this finding, highlighting that shared measurement systems and co-location were key drivers of integration, though these were not consistently implemented across all partnership areas. There were, however, mixed experiences among families. While some felt that services joined up effectively, others reported feeling under-informed about the breadth of support available or found the landscape confusing. Overall, the evidence across sources suggests this pathway operated as intended in many places, but with variability in user experience and coverage across areas.

Upskilling of multidisciplinary staff

Evidence for pathway 2, upskilling of multidisciplinary staff to achieve joined-up working, was more limited. Practitioners described **workforce development initiatives such as structured training, cascade models, and competency frameworks designed to promote a shared vision and consistent practice across services.** Practitioners also referred to consistent messaging, which helped embed elements of shared practice. Some respondents reported that this upskilling contributed to a shared vision of Early Years delivery, more confidence among practitioners, and stronger relationships between organisations. There were also perceptions of enhanced service provision resulting from shared learning. For example, one practitioner noted that training delivered as part of a local breastfeeding campaign helped strengthen joined-up working by enabling a wider range of partners, including local businesses, to promote consistent breastfeeding messages.

The local evidence synthesis also found that **these initiatives were widely implemented but questioned their sustainability, noting that high staff turnover often undermined training efforts, with skills lost when trained staff left their roles.** These challenges were reflected in qualitative data as well, as high staff turnover and frequent handovers weakened continuity and limited the lasting impact of training. **There were also challenges engaging certain groups,** for example, some services reported limited resource or structures for effectively involving fathers, which constrained how far joint working could be inclusive of all family members. The limited coverage of this pathway, and the challenges around sustainability and staff turnover, constrains confidence in its strength and the extent to which ABS contributed to this pathway.

Evidence of outcomes

Evidence from parents and practitioners indicates that some families in ABS areas, and particularly those with higher levels of involvement with ABS over time, experienced improved access to a wider range of services and, in some cases, more timely support.

Reducing duplication and improving access to support

Parents reported that collaborative working between services reduced duplication and created clearer referral routes, enabling them to receive help when needed. One mother described ABS as her ‘village’, explaining that the engagement team ‘got me involved with all the right people’ and provided support while she was waiting for specialist help. Similarly, parents valued the continuity offered through integrated approaches. These findings are consistent with the intended outcomes for this domain.

Practitioners echoed these views, noting that **joined-up working allowed for wraparound support, with families able to benefit from multiple types of support within a single setting.** Examples included combining stay-and-play sessions with oral health and infant feeding advice. Additionally, there was some evidence that joined-up Early Years offers meant children could receive support from before birth through early childhood, enabled through closer alignment of Early Years partners. One practitioner described continuity as:

Support that sticks with the family... so they’re not having to change over from different services, but they’ve got one constant link. (ABS practitioner)

Variation in access and experiences of joined-up services

These positive views of joined up working and the impact it had on families’ experiences with services **were not consistent across the different evaluation objectives and local evidence synthesis.** Some families were clearly highly motivated to get involved with local provision, and had the necessary resources to make the most of what was offered, as illustrated by one mother in an extended reflection on the importance of ABS for her family:

So I, what did I do? ... Children’s Centre, I will go Monday to Friday if I could, like literally every day, just to get out, get the kids out and get myself out and thinking of things to do, especially if it’s raining, they’ve still like got lovely indoor spaces... [ABS has had] a massive impact. I think I’m much more happier for it. And then ... it’s given me ways to teach playing with the children as well and learning through play, learning how they teach kind of ... well not teach, but certain activities they may have out in the stay and play session or songs that they sing or ... You know knowing ... then bringing that home as well. Also just also to cut down screen time for the kids is always a good thing. And yeah, I think once ... I remember seeing this ... I think it was social media, like the biggest impact on children is having a happy mum. So yeah, I think that is ... has been a big motivator for me. (Parent/carer)

Families such as this, with higher levels of involvement with ABS, often reported that identification of support options and access to services felt easier. Those who were less involved - including families who faced complex and intersectional barriers to engagement - could feel overwhelmed by the number of options or were unclear about what was available.¹² Across areas and over time, families' data consistently highlighted the importance of scaffolded engagement - including through home visits, targeted outreach activities and pro-active invitations and facilitated engagement (e.g., help with transport or other barriers to participation). This is illustrated by the experience of a mother who described becoming involved with ABS after being invited to join an ABS walk in the park, at a time when she was struggling with significant anxiety and a young baby. In the final family interview, she reflected on the difference this made:

As a woman, you go through so much at home with kids, the worries, like I said, the anxiety, the stress ... There's a lot that goes in your head. But when somebody says to you, we're here for you ... You know when somebody says to you, come out, we missed you, we need you coming. You're like, oh you know what? ... I matter, you know what I mean? (Parent/carer)

Overall, practitioners and families indicate that while structural integration improved, families' experiences with services varied¹³, which limited our confidence in the extent to which ABS contributed to more effective and accessible support for families.

Evidence of sustained joined-up working

There was some evidence of **sustained, system-level joined-up working, with partners in some partnerships reporting that multi-agency collaboration had become embedded in local practice** and was expected to continue beyond the ABS funding period. In one partnership, stakeholders described partners being 'all around the same table' and working collectively on shared priorities, an indication that collaboration was operating at both board and grassroots levels. However, this evidence was limited and is difficult to corroborate without additional evidence following the end of the ABS funding period, further limiting our confidence in this claim.

Unanticipated outcomes

In addition to these intended outcomes, the evidence showed that joined-up working sometimes produced additional benefits. In several areas, collaboration helped strengthen local capacity, for example by spreading effective models to new settings or deepening practitioners' shared understanding of Early Years priorities outside of ABS services. At the same time, some unintended challenges emerged. Differences in how partnerships operated meant that families did not always experience services consistently, and the ending of time-limited programmes occasionally left parents feeling the loss of trusted support. Families' evidence showed that weaker

¹² For a more detailed discussion of families' experiences of engagement with ABS, please refer to the [Third Annual Report of the National Evaluation](#).

¹³ Discussed further below, in relation to parental engagement.

coordination sometimes left families unclear about what support was available, creating confusion and the potential for duplicated effort, while practitioners described safeguarding-related situations where inconsistent or poorly aligned approaches could feel overly intensive or intrusive for families.

Alternative explanations

Evidence from the qualitative data and local evidence synthesis suggests that while ABS enhanced joined-up working in some local Early Years systems, there are **alternative explanations that should be considered**. Some partnerships and collaborative practices may have emerged independently of ABS or would have been introduced through other initiatives. Practitioners also noted that pre-existing networks and funding streams in some areas already promoted joint working, making it difficult to isolate ABS's unique contribution. In areas with substantial non-ABS provision, it was also harder for families to distinguish which coordinated elements were driven by ABS.

Systems change: increasing parental engagement

Hypothesis

ABS was expected to contribute towards increased parental engagement with Early Years services, strengthening the role of parents within local Early Years systems. Outcomes were expected to come about through two main pathways: (1) the provision of holistic, tailored and accessible support that reduced barriers to engagement and improved parents' experiences of services; and (2) the creation of opportunities for parents/carers to contribute to service design and delivery through co-production and peer-led approaches.

Through the first pathway, ABS activities aimed to address practical, emotional and cultural barriers to engagement by offering flexible, family-centred and non-judgemental support. By improving experiences of Early Years services and enabling continuity of care, these activities were intended to increase parents' trust in services and willingness to engage over time. Through the second pathway, ABS sought to strengthen parental engagement by enabling parents to share their knowledge, skills and lived experience through co-production and peer-led roles. These activities were intended to improve the relevance, inclusivity and accessibility of services, as well as to foster peer-to-peer networks that reinforced engagement and confidence among families. Collectively, these mechanisms were expected to contribute to stronger parental engagement within Early Years systems, embedding collaborative and relational approaches to service design and delivery and supporting a shift towards more responsive, demand-led provision.

Overarching assessment of confidence in the claim

Our overall confidence in the contribution claim for parental engagement is **medium**. This assessment reflects relatively consistent qualitative evidence that ABS strengthened parental engagement through its tailored and

relational approaches, alongside more limited evidence for the embedding of co-production and peer-led practice as sustained system-level outcomes.

Confidence in pathway evidence is strongest for pathway 1, with multiple sources indicating that holistic, accessible and culturally responsive delivery helped reduce barriers and supported more comfortable and confident engagement for many families. **Confidence in the second pathway was moderate**. Evidence for pathway 2 indicates that parent/carer involvement through co-production and/or peer-led approaches often added value, although the extent to which these contributions became consistently embedded in service design or wider practice varied across partnership areas, with some concerns about depth, coverage and sustainability over time.

Evidence of outcomes was present but more limited, with families and practitioners describing perceived improvements in the relevance and accessibility of services, as well as benefits such as increased confidence and reduced isolation. However, more substantiated or sustained examples were limited and varied across partnerships, and evidence of deeper, embedded change was uneven and difficult to verify. While only a small number of alternative explanations were identified, some improvements may also reflect wider local provision or pre-existing parental motivations.

Evidence of pathways

Across both pathways, qualitative evidence from families and practitioners and the local evidence synthesis suggests that ABS delivered a range of activities designed to strengthen parental engagement by reducing barriers to participation and supporting collaboration.

Supporting parental access and engagement

There is relatively strong evidence for pathway 1. Evidence from longitudinal family data shows consistently, over time and across areas, that **ABS addressed barriers to engagement by offering flexible, tailored and/or inclusive delivery**. Parents gave multiple examples of staff adapting services to meet individual needs, using home-based support, varying session times and embedding SEND inclusive and culturally sensitive approaches. These findings are supported by qualitative evidence from practitioners and the local evidence synthesis, which indicated that ABS delivery was deliberately holistic, tailored and accessible. For example, some services adapted when and where support was offered and provided multiple modes of contact, including in-person, telephone and/or online support (the latter being particularly important during the Covid-19 pandemic). These adaptations were consistently described as making engagement feasible and helped to sustain attendance over time among families who often faced multiple barriers, including financial constraints and time poverty.

Practitioners also reported a **strong emphasis on culturally and linguistically responsive delivery**, for example, using interpreters, translated or plain language materials and visual aids, and involving staff or volunteers who speak community languages, **to increase relevance and comfort for families who might otherwise disengage**. Findings from the local evidence synthesis support these findings, as flexible formats (including home visits and catch-up

sessions), multilingual offers, and continuity-of-care pathways were frequently associated with improved accessibility and trust. Practical enablers such as creche provision, assistance with transport and central community venues were also seen as particularly helpful for families facing certain barriers.

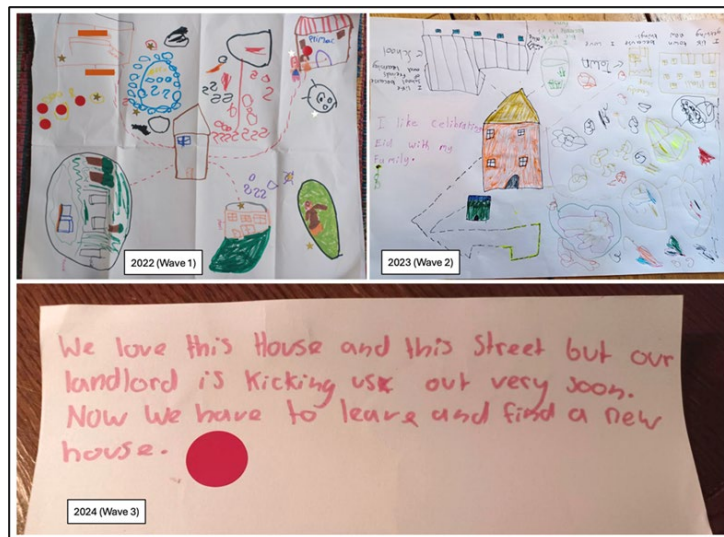
Evidence from families indicated that **relational, targeted support played an important role in sustaining parental engagement with Early Years services.** Families who remained engaged over time often described the value of one to one, scaffolded support from staff or peer workers. This support particularly helped families navigate services, reduced anxiety about participation, and, in some cases, enabled movement from more intensive or home-based contact into wider group or universal provision. **However, the evidence also shows that this was not experienced equally by all families.** Some families reported that they did not consistently receive tailored or scaffolded input, and others continued to face barriers related to language, timing, location, or the format of provision. Engagement was particularly challenging for families when complex intersectional barriers were exacerbated by critical factors such as housing insecurity.

Box 7. Complex barriers

Figure 3 shows maps created over three years by school-aged children in one large family (with children ranging from three years old to early adulthood) who arrived in the UK as refugees several years ago. The first two maps show the family actively involved with ABS and the local community; their interviews and photographs documented their appreciation of ABS as well as local parks, school and the family allotment (which appears on both maps - the small, repeated shapes are vegetables).

The third map symbolises how threat of eviction has overwhelmed family life, and involvement with other networks and activities had fallen away. At this time, the family no longer had access to ABS support because their youngest child was now outside the age range (0-4 years). The mother still attended a local women's group, which she described as 'the only time of my happiness'. But she explained that the family could not afford to contest the landlord's plans for eviction nor to pay the rent required for local authority housing for a family of their size. She reflected that 'We [are] going round with our mind all over the place'. Their experience shows how difficult it was for them to sustain any benefits from ABS associated with community engagement, given the extent of precarity in their lives at this time.

Figure 3. Children's mapping over three years, showing changing engagement with ABS and local services



The local evidence synthesis similarly reported that scaffolded support and extended pathways can enable continuity and referrals, while noting that benefits were not uniform across activities or partnership areas. These findings slightly weaken our confidence in the extent to which this pathway was achieved.

Qualitative longitudinal evidence from families also indicated that **ABS could help parents build peer networks that reduced isolation and created informal support systems**. Families reported forming friendships through ABS groups and volunteering roles, which provided emotional support and practical advice. One parent referred to the ‘treasured friends’ she had made through ABS and described how one person went on to be her birthing partner. This illustrates the depth of relationships fostered. These networks often developed through peer-led activities, such as breastfeeding support or parent champion schemes, and were valued for their relatability and trust.

I’ve got a few friends, and I’ve said to all of them, like if you can go to the SEND group, you will meet other mums and you’ll...and they will share experiences with you, and it makes you...it teaches you things that you wouldn’t have known. (Parent/Carer)

Opportunities for co-production and peer-led activities

ABS created opportunities for parents to add value to services by sharing their knowledge and lived experience, as hypothesised through pathway 2. Qualitative evidence from practitioners indicates that **ABS created structured opportunities for parents to help shape and, in some cases, deliver services**. Practitioners reported that parent contributions, drawing on language skills, lived experience and local knowledge, were used to simplify materials and tone, tailor content to different cultural contexts, and refine practical details such as timing, childcare and venue selection so provision better matched how families use services. These inputs were perceived to **improve the ‘fit’ between offers and local need and, where peers were involved alongside professionals, to make services feel more relatable and approachable for families who might otherwise hesitate to engage**. The local evidence synthesis supports these points, adding that peer roles (e.g.,

Parent Champions, Family Mentors, Community Connectors) were widely used to build trust and encourage participation, and co-produced resources and peer-led models commonly enhanced relevance and approachability for families.

Parents involved in co-production reported influencing service design, shaping activities and contributing to culturally relevant resources. For example, one parent described contributing to a healthy eating course by offering insight about the realities of managing healthy eating with a limited budget. Parents similarly described peer-involved offers as less judgemental and more welcoming, with some reporting that seeing peers in visible roles increased their willingness to take part. Findings from the local evidence synthesis provide parallel examples of co-produced campaigns and materials that were perceived to be better aligned to community needs.

At the same time, qualitative accounts caution that the depth and coverage of co-production was uneven, and that its sustainability varied over time. In some settings, activity labelled as co-production resembled enhanced consultation rather than shared decision making. Additionally, representation could narrow if the same parents were repeatedly involved in co-production activities. Finally, maintaining parent-led roles required ongoing support and clear boundaries, particularly as funding tapered and some volunteers reported feeling less valued. The local evidence synthesis reflects the same variation. These findings limit our overall confidence in the extent to which ABS has contributed to pathway 2, although the corroborated evidence from practitioners and families, and the local evidence synthesis are strong.

Evidence of trust in services as part of these pathways was limited but positive where reported. Parents said they trusted peer-led services and valued seeing volunteers with similar experiences, which made them feel supported. ABS practitioners shared these views and felt that messaging was more powerful and engaging when it came from peer-led services.

I think that's a really good model because for a professional to go in and tell a woman how she should be doing it is very different from somebody going in who lives in the area, and has been there and done it and has lived through that experience, and has possibly felt some of the same things themselves, and is able to stand alongside somebody and help them. (ABS practitioner)

Evidence of outcomes

Variation in levels of engagement

Across the longitudinal family dataset, a number of families demonstrated sustained participation in ABS offers over time, often linked to scaffolded routes into universal provision. A few families indicated mixed or weak engagement, typically those who faced **complex intersectional barriers to engagement, and where targeted support did not align with barriers such as language, timing, or confidence.** This pattern is echoed in the local evidence synthesis, which reports qualitative links between tailored formats

and increased attendance in some settings, while noting that quantified increases and long-term sustained engagement were rarely evidenced.

It is important to note that through the evidence available to the national evaluation, **it was not possible to determine whether engagement ‘increased’ over time** because this was not systematically measured as part of the national evaluation. Qualitative longitudinal data from families commonly document sustained and, in some cases, increased engagement over time, but in a few instances, engagement was disrupted in the face of other factors (including staffing changes or families’ changing circumstances). It is also important to consider that due to the flexible and place-based design of ABS, **services were designed to support families during specific elements of childhood**, and therefore families may have engaged at the most useful and/or relevant times depending on support needed, and not throughout the length of the programme. For example, involvement often shifted after children started nursery or childcare and/or mothers returned to work after maternity leave.

Engagement and systems change through co-production and peer-led activities

Practitioner and stakeholder accounts describe parents contributing to service design and delivery through co-production and peer-led services, and ABS practitioners felt that it was a particularly powerful aspect of the ABS approach. This was because they perceived it as leading to **increased engagement with services and also, in some examples, triggering positive steps towards systems change**. In several settings, parent voice was reported in governance and commissioning forums, and peer-led roles were perceived to increase approachability and trust for some families. The local evidence synthesis similarly records peer-led and co-produced activity contributing to engagement and relevance, while emphasising variation in strength of evidence across activities and partnership areas. These signals suggest that principles of co-production and peer leadership were being integrated into elements of local practice, even though depth and coverage varied across partnership areas and over time.

ABS staff across several partnerships described a **shift towards co-produced design and delivery, and some organisations outside the programme reported drawing on this learning in their own work**. In some areas, new roles and initiatives were created to promote coproduction beyond the life of the programme, and parents were involved in award schemes, peer led groups and advisory panels. Those who had positive views and experiences felt that these were powerful aspects of systems change. Consistent with this, the local evidence synthesis highlights a small number of local examples where tailored engagement mechanisms or practices were carried forward, while noting that evidence of broader, systemwide embedding remains limited.

ABS practitioners perceived a link between improved systems and improved engagement outcomes. They felt that improved systems increased the likelihood of parents engaging in services, and then the quality of those services. Co-production was considered a key mechanism for removing barriers to engagement and ensuring that services were demand-led. There were cases where ABS practitioners felt positive about the potential for co-production to continue after ABS funding ended.

After A Better Start finishes, they still want to be out in the communities and in strategic meetings, having those conversations, and broadening it out to not just parents of nought-to-four-year-olds, but parents of older children being involved in whatever, if it impacts on them. (ABS practitioner)

Unanticipated outcomes

Qualitative evidence also pointed to potential **unanticipated and/or unexpected outcomes for parents/carers**. Practitioners reported that co-production and peer-led roles often built parent confidence, skills and self-efficacy, with some parents progressing into employment, leadership or further volunteering. These positive spill-overs (confidence, ownership, progression) were documented by some parents, and are also reflected in the local evidence synthesis. Parents and staff also described a stronger sense of ownership and belonging when families helped shape offers or acted as connectors, which, in turn, supported more authentic engagement within local communities.

And it [ABS volunteering role] just gave me a real sense of like a bit of pride that I'm not just being a stay-at-home mum doing nothing with myself. I'm still building my CV while not actively working, because I'm doing all this volunteering and work skill stuff (Parent/Carer)

Alternative explanations

Evidence of **alternative explanations** was more limited for this outcome domain. However, in several cases, progress in parental engagement and/or co-production was not seen as solely down to ABS, as it often aligned with pre-existing practice, parallel local initiatives or national programmes. ABS contributions should therefore be interpreted as one component of a wider focus on increasing parental involvement in Early Years services.

Systems change: adaptive and evidence-informed services

Hypothesis

ABS was expected to contribute towards Early Years services becoming more adaptive and informed by evidence, so that services were better able to respond to families' needs and circumstances. Outcomes were expected to come about through two main pathways: (1) the collection and use of data and feedback from services, parents and practitioners to inform understanding of what was working and where adaptation was needed; and (2) the use of test-and-learn approaches to trial, refine and improve services and delivery models over time.

Through the first pathway, ABS activities aimed to strengthen the use of administrative data, monitoring information and feedback from families and staff to build understanding of need and service effectiveness. This evidence was intended to support learning within and across services, informing decisions about how services could be adapted to improve relevance,

accessibility and responsiveness for families. Through the second pathway, ABS sought to embed a test-and-learn approach by encouraging services to pilot new or adapted ways of working on a small scale, review learning, and refine delivery based on evidence and experience. Where approaches were perceived to work well, learning was expected to be shared across ABS and non-ABS services, informing wider decision-making about future delivery and sustainability. Collectively, these mechanisms were expected to contribute to the development of more adaptive and evidence-informed Early Years services, supporting continuous learning, informed decision-making and improvements in how services respond to families' changing needs.

Overarching assessment of confidence in the claim

Our overall confidence in the contribution claim for adaptive and evidence-informed services is **medium**. This assessment reflects evidence that partnerships used some data, feedback and test-and-learn approaches to adapt delivery and improve responsiveness, but more limited evidence of sustainability of these approaches.

Confidence in pathway 1 is the strongest, as multiple qualitative sources indicated partnerships collected and used administrative/assessment data, routine monitoring and structured feedback loops to tailor delivery and improve responsiveness. Evidence for pathway 2 shows that small-scale trials and iterative reviews sometimes informed service refinement, scaling decisions or de-commissioning where fit was poor. However, **across both pathways, practices were not applied consistently across or within partnership areas** and were often informal rather than systematic.

Outcome evidence was limited and weighted toward changes in engagement rather than longer-term durability. While there were examples of services adapting delivery in response to monitoring data or feedback, these were often localised or short-term, and evidence of wider or sustained embedding of adaptive and evidence-informed practice was mixed. System-wide embedding beyond ABS remained unclear amid data-sharing barriers, capacity constraints and programme timing as funding tapered, and it was difficult to verify the extent to which these practices were maintained across partnerships.

Evidence of pathways

Evidence on whether ABS contributed to adaptive and evidence-informed services through the pathways described in the claim was mixed.

Collecting information and data from services and families

Through pathway 1, qualitative evidence indicated partnerships collected and used multiple types of data throughout the programme, including administrative/assessment data (e.g., immunisations, maternity/early years records), routine engagement/monitoring data, and structured and informal feedback from parents and staff. Some partners also introduced basic evaluation tools and processes (e.g., logic models, monitoring templates) to support more consistent reflection and use of evidence. Findings from the local evidence synthesis reported that partnerships similarly used integrated

data solutions, routine monitoring and feedback loops to tailor delivery and target priority populations.

Practitioners described using system-level and project-level data to tailor services and improve responsiveness, such as engagement data informing referrals and feedback forms shaping delivery. Some practitioners reported that bringing together activity data and feedback **improved understanding of who was being reached, what was working/not working, and where to adjust offers** (e.g., timing, content, mode of delivery). Findings from the local evidence synthesis added that screening tools and staff training were sometimes revised in response to monitoring and practitioner feedback to improve identification and referral consistency.

Families often reported that services adapted in response to their feedback (e.g., adjusting formats, extending provision, or refining the offer), which felt more relevant and accessible. However, the formality and coverage of these practices varied, and evidence of consistent application across settings was limited. Similarly, the local evidence synthesis found that while ABS demonstrated adaptive principles, they were inconsistently applied and not always embedded into routine practice.

ABS practitioners recognised that the process of being adaptive was continuous, as families' needs regularly changed. This was particularly pertinent during periods such as the Covid-19 pandemic and the 'cost-of-living crisis', which required services to adapt in response to emergent needs. Even outside of these significant events, families' needs evolve over time.

It is about, again, that holistic view and that culture of being flexible and moving with the community, because the only constant thing really about systems or communities, is change. (ABS practitioner)

However, practitioners also reported tensions when parents and professionals had opposing views about how services should be delivered. In one example, parents wanted a peer support group to only have peers present; however, professionals were required to be present in case safeguarding concerns arose which required a professional response. These examples illustrate that while ABS partnerships sought to embed feedback into service design, with the aim of better understanding and meeting families' needs, this was not always straightforward.

Adopting test-and-learn approaches

Partnerships described testing services on a small scale and using iterative monitoring (e.g., learning logs, quarterly reviews, formal/informal reflections) to refine approaches during delivery. Some practitioners reported scaling up perceived successes or stopping/decommissioning offers that did not fit the local context, with evidence used to support those decisions. **Practitioners also indicated partnerships used test-and-learn approaches to enable flexibility and innovation to pilot interventions before wider rollout.** Where monitoring was more routine, teams described clearer decision points (continue, adapt, scale, or stop), and some reported feeding learning into wider service planning or commissioning. Findings from the local evidence synthesis support this, noting that pilot activity and test-and-learn

cycles enabled adaptation and occasional scaling, and in some cases contributed evidence for commissioning or workforce decisions.

Local Better Start services are used as little guinea pigs sometimes to see what works, what doesn't work, and then looking at outcomes. If there's things that are particularly significant, that can then be distributed and implemented on a wider scale. (ABS practitioner)

One practitioner described a feeling of enhanced trust between partners **knowing that a degree of 'failure' could be accepted if there can be learning from that experience that leads to improvement.** Conversely, some perceived a drift towards 'data over needs' when measurement requirements dominated delivery priorities. A few narratives suggested short term workload pressures where adapting/monitoring increased staff burden without additional capacity.

ABS practitioners described internal learning and evaluation practices that supported their test-and-learn work. These included formal processes, such as completing regular progress reports and holding quarterly reviews to capture lessons learned. Practitioners also shared, however, examples of test-and-learn evaluation work being informal rather than systematic. This suggests that across ABS partnerships, there was a range of test-and-learn practices within adaptive and evidence-informed service delivery.

Evidence of outcomes

Adapting delivery based on feedback and/or evidence

Across sources, there are localised, short-term examples of **services adapting delivery based on user feedback or monitoring data, and accounts of improved evaluation processes** (e.g., clearer project theories, basic data capture) supporting more informed decision making. A few accounts suggest improvements in identification criteria and tools, with perceived links to earlier support or increased uptake (e.g., immunisations, maternal vulnerability screening).

However, evidence of outcomes is limited and largely uncorroborated. **There is mixed evidence about the sustainability and legacy of ABS and its services beyond ABS funding.** While some respondents were optimistic about the longer-term sustainability of more adaptive and evidence-informed services, others were cautious about its potential. The local evidence synthesis similarly concluded that while mechanisms (data use, feedback loops, pilots) strengthened responsiveness and sometimes informed commissioning or continuation, the evidence base largely focused on engagement and process change, with limited substantiation of longer-term outcomes or durability beyond the funding period.

Sustainability of adaptive and evidence-informed approaches

Evidence of sustainability of adaptive and evidence-informed practices within services and ABS's legacy was limited. Practitioners reflected that while test-and-learn approaches were useful for innovation, they were not consistently embedded into routine practice. There was also a view that

effective test-and-learn became more challenging over time as ABS funding came close to completion.

One of the problems has been they've been running long enough to see the impact, but not long enough to see the impact and then plan where do we go next. So that's been one of the issues. (ABS practitioner)

Others felt more positively about the legacy of ABS and how adaptive and evidence-informed services would continue after funding.

Having the privilege of having such an amount of time to work in this way has given them such a lot to say, has really generated huge expertise, and you can see that translating into policy and practice at all levels. (ABS practitioner)

Overall, sustainability and legacy were not consistently realised within the available timeframe and resources.

Overall, some evidence suggested ABS supported adaptive and evidence-informed practice, notably through user informed adjustments, basic evaluation processes, and test-and-learn cycles. In some places, this appeared to make services feel more relevant and accessible for families. However, the breadth, depth and durability of these changes are limited in the available data, and sustainability was often constrained by funding, timing and data sharing challenges. Confidence in a system wide, sustained shift to adaptive and evidence-informed services is limited, though ABS appears to have strengthened enabling conditions and practical know how for adaptation in several contexts. We did not identify any clear evidence of plausible **alternative explanations** for this claim.

Systems change: shift to preventative services

Hypothesis

ABS was expected to contribute towards a shift in planning, decision-making and service delivery towards prevention, early identification and early intervention within local Early Years systems. Outcomes were expected to come about through two main pathways: (1) upskilling Early Years practitioners, service providers and parents to strengthen shared understanding of the importance of prevention and early intervention in the early years; and (2) collaborative working between services and co-production with parents and carers to design, adapt and promote preventative approaches.

Through the first pathway, ABS activities aimed to build awareness, knowledge and confidence around preventative practice, early identification of need and timely intervention. This included supporting practitioners and parents to recognise emerging issues earlier and to take action before needs escalated, with the intention of enabling more targeted and timely support for families. Through the second pathway, ABS sought to strengthen collaborative approaches across services by supporting joint planning, shared learning and co-produced service responses. These mechanisms were intended to support the development and implementation of evidence-based

preventative approaches that were more accessible, relevant and responsive to families' needs. Collectively, these mechanisms were expected to contribute to a systems-level shift towards prevention and early intervention in Early Years services, with the potential to reduce escalation of need and lessen future demand on more intensive statutory services over time.

Overarching assessment of confidence in the claim

Our overall confidence in the contribution claim for shift to preventative services is **low-medium**. This reflects limited and often inconsistent evidence that ABS activities contributed to increased focus on prevention and early intervention within local service planning. While evidence indicated ABS delivered preventative approaches within its own programme, evidence that these approaches were embedded across wider systems, sustained over time, or translated into reduced demand on statutory services was limited, mixed and constrained by financial pressures.

Confidence in pathway 1 was the strongest, but moderate, with some examples indicating that upskilling, learning and practitioner understanding around prevention improved, and that families welcomed and described benefits arising from early help approaches. **Evidence for pathway 2 was weaker**, with only isolated accounts of collaborative working or co-production contributing to earlier identification or culture change.

Evidence of outcomes was limited and at times contradictory. There were isolated examples suggesting that preventative and early-intervention approaches supported earlier help for some families and helped to prevent escalation in specific contexts. However, these were typically small-scale, localised or short-term, and evidence of wider or sustained system-level impact remained mixed. In a few cases, services that appeared to have preventative benefit were discontinued due to funding pressures, underlining the role of wider system constraints in what could be sustained. Although some practitioners described a stronger emphasis on early identification and preventative thinking locally, broader embedding was uneven and difficult to substantiate and reported reductions in demand for statutory services were service-level and not consistently sustained.

Evidence of pathways

Development activities to build skills and understanding

There was moderate confidence in pathway 1 evidence. Qualitative evidence from practitioners indicated that **partnerships delivered a range of workforce development and parent-facing activities designed to build skills and understanding around early identification and early intervention**. Examples included practitioner training on identifying developmental needs, and parent-focused sessions raising awareness of early help, child development, and preventative practices. In one example, an ABS practitioner described training for the Early Years workforce around the early identification of speech and language delays, which in turn improved their understanding of the importance of such early screening.

Practitioners in several locations reported that **training improved confidence in identifying emerging needs, strengthened understanding of the value of early screening, and supported more timely referral decisions.** Some parents also reported learning about the importance of early intervention through ABS, however there was limited detail on the specific service or initiative through which they would have gained this understanding.

Longitudinal family data consistently documented that most parents/carers understood and appreciated the importance of early help and preventative support. In these instances, ABS was valued for providing resources and strategies that enabled parents/carers - many of whom were navigating complex structural disadvantage - to achieve their aspirations for children and family lives. This is an important finding in light of longstanding evidence of the problems with deficit-based approaches to parent/family intervention and the need for poverty-aware family-centred support (e.g., Featherstone et al., 2014). The local evidence synthesis supports these findings, showing that training paired with practical tools (e.g., screening tools, assessments and coaching) improved early identification and practitioner confidence across several ABS programmes.

Collaborative working to adapt and promote preventative approaches

Confidence in pathway 2 was more limited. Evidence suggests that ABS activities also aimed to support forms of multi-agency collaboration, joint delivery, and peer and parent led involvement that were **intended to strengthen early identification and embed preventative ways of working.** These included community-based support, shared spaces for coordinated decision making, and peer support models that aimed to reduce stigma and encourage families to seek help earlier.

There was some, though limited, evidence from practitioners that **co-production and collaborative working supported preventative and early-intervention approaches.** A few participants described peer support as helpful for delivering early-intervention activities in the home, though these examples were not widespread. One participant also noted that collaboration between services had, in at least one instance, enabled earlier support for children awaiting specialist speech and language services, which they felt helped prevent escalation, though this account was isolated and not corroborated elsewhere.

Some partnerships also adapted elements of their Early Years offer, such as adding early intervention components to universal services, based on learning shared through ABS collaboration. There were also examples of learning from ABS contributing to local shifts in emphasis towards prevention and early identification. For example, in one area, understanding of the importance of prevention and early intervention was reported as being embedded into the City Council's strategy for public health. However, this influence was typically described as one contributing factor alongside broader local strategies, priorities and existing commitments. Findings from the local evidence synthesis similarly highlight individual programmes, such as parent-infant mental health services and oral health initiatives, that embedded preventative principles, while emphasising that wider system-level adoption remained uncertain.

Evidence of outcomes

Mixed evidence on sustainability of prevention-focused approaches

While evidence across the evaluation indicated that ABS delivered services that had a particular focus on early intervention and prevention, **the extent to which these approaches were sustained and led to reductions in demands on statutory services is not well evidenced.** Across the partnerships, there were isolated examples of prevention and early intervention principles being integrated into aspects of local delivery or planning. Practitioners described instances where Early Years learning contributed to enhanced focus on the first 1,001 days, strengthened early help pathways, or prompted revisions to certain service models so that prevention was given greater prominence.

What's great about [ABS] is it brings us right back to, actually, why aren't we trying to fix it before they're five? Why are we waiting for it to go wrong at five and then frantically trying to halt its rise? (ABS practitioner)

Practitioners described examples of preventative approaches of ABS delivery being integrated into wider services. These included introducing roles designed to prevent escalation of need and embedding early intervention into local provision. One practitioner explained that ABS had renewed attention on preventative action and described how this focus was consolidated in a new programme using a preventative model. Another practitioner reported that ABS helped embed early intervention within a service supporting families affected by domestic abuse, ensuring children were included in the remit and that the service worked to prevent cases reaching crisis point.

Limited evidence of reduced demand on statutory services

There was some, though limited, qualitative evidence that preventative services reduced demand on statutory provision. Some practitioners reported that referrals to intensive support were lower in areas where early intervention programmes operated and described how positive results led to wider adoption of these approaches. **However, these findings were typically service-level, qualitative, and localised, and in some cases the preventative effect was not sustained because services were discontinued.** As a result, while there are indications of short-term reductions in demand in certain contexts, evidence of consistent or long-term system-level impact remains limited. Findings from the local evidence synthesis support these points, adding that some evaluated programmes demonstrated positive wellbeing and economic outcomes, but links to reduced statutory demand were not robustly evidenced.

Barriers to sustaining preventative approaches

There were several examples where **prevention-focused services were withdrawn or not sustained, primarily due to financial constraints, despite positive feedback or promising early data.** Participants frequently reflected that limited funding and competing priorities hindered the embedding of preventative approaches, even where understanding and support for such

approaches had increased. **The evaluation found challenges in sustaining preventative approaches and early intervention.** Local evidence synthesis findings highlight this challenge, noting that while programmes demonstrated promise, there was no clear evidence they would be sustained or embedded post-ABS. There was also a perception amongst some practitioners that more funding was available to support families in crisis situations and that the nature of preventative care being difficult to evidence made it less attractive to commissioners.

Unfortunately, there's no money for [intervention] to continue, so the fact that it saves money and improves things in the long term makes no difference...There's no money for it, so that's going to mean that there will be children who end up with worse outcomes and who will need intensive services in the future because that service has been taken away. (ABS practitioner)

Alternative explanations

Evidence suggests that wider contextual factors including local authority strategies, individual leadership, and existing practitioner beliefs also shaped any shifts towards prevention, indicating potential **alternative explanations**. Additionally, many families already held strong views on the importance of early support, meaning ABS often played a role in enabling access rather than driving attitudinal change towards early intervention.

Systems change: adoption of ABS approach beyond ABS areas

Hypothesis

ABS was expected to contribute towards the adoption of elements of the ABS approach to service design and delivery beyond the wards and areas that directly received ABS funding, supporting the programme's longer-term sustainability and legacy. Outcomes were expected to come about through two main pathways: (1) capacity-building for parents, practitioners and service providers involved in ABS, enabling them to apply ABS principles in other settings; and (2) the collation and dissemination of learning from ABS to inform practice, commissioning and decision-making within the wider Early Years system.

Through the first pathway, ABS activities aimed to build skills, confidence and shared understanding among parents and practitioners, enabling them to carry forward relational, preventative and family-centred approaches beyond ABS-funded services. These included parents applying learning through peer-led or community-based activity, and practitioners embedding elements of the ABS approach into wider service delivery or organisational practice. Through the second pathway, ABS sought to support the wider adoption of its approach by generating and sharing learning through evaluation, test-and-learn activity, reports, events and engagement with Early Years networks and policy stakeholders. These mechanisms were intended to increase awareness of the ABS approach and support evidence-informed

decision-making about future service design and commissioning, both locally and, in some cases, beyond participating areas. Collectively, these mechanisms were expected to contribute to the spread and uptake of selected ABS principles and practices beyond ABS areas, supporting aspects of the programme's legacy even where services themselves were not sustained in their original form.

Overarching assessment of confidence in the claim

Our overall confidence in the contribution claim for adoption beyond ABS areas is **low-medium**. While there were examples of ABS-aligned practices and services continuing beyond the funded areas, evidence of broader or sustained adoption was limited, uneven, and often based on isolated practitioner accounts. Little evidence came from non-ABS services, restricting our ability to assess wider system-level influence.

Confidence in both pathways was relatively limited. Evidence for capacity-building and upskilling (pathway 1) was limited, with isolated examples of parents and practitioners applying skills or approaches beyond ABS-funded services, including taking on wider community roles or contributing to boards and forums in their local areas. However, these instances were uneven and often depended on individual enthusiasm rather than embedded structures. Evidence for dissemination and system-level uptake (pathway 2) was also limited, characterised by descriptive accounts of sharing learning through reports, events and partnership forums, but with few clear examples of this activity influencing strategic decision-making or shaping practice outside ABS areas in a sustained way.

Evidence of outcomes similarly indicates only limited and uneven continuation of ABS-aligned practices beyond funded areas. Where continuation occurred, it tended to be confined to specific services or roles rather than broader system-level adoption, and there were mixed views about the sustainability and value placed on parent involvement as funding tapered. Overall, while mechanisms associated with adoption were present and sometimes valued, the breadth, durability and verifiability of system-level uptake remained low, and it was difficult to isolate ABS's specific contribution beyond participating areas.

Evidence of pathways

Across both pathways, evidence indicated that ABS delivered a range of activities intended to support sustainability and adoption of its approaches beyond ABS areas.

Capacity building and workforce development

For pathway 1, **parents and practitioners described opportunities for development and upskilling, and in some cases reported applying learning in roles outside ABS-funded provision.**

We've seen the power that our voice has done in our own wards and we now want to push that out into everything and not just under-fives [...] with the confidence and the training and the experience we've received [from ABS], we're now pushing that into other boards and into

other areas of [area] to get that voice forward as well. (ABS practitioner/volunteer)

However, there was little evidence that this translated into consistent adoption of ABS approaches more broadly, and some parents reported feeling less valued as funding tapered off. There were mixed views about the extent that co-production with parents would be embedded into Early Years services after ABS funding ended.

Practitioners also reported capacity building efforts, including ‘train the trainer’ models designed to maintain approaches after ABS funding ended. These examples suggest ABS influenced capability and commitment within specific settings, however, examples were limited and tended to reflect individual experiences rather than system-wide shifts.

Collation and dissemination of learning

For pathway 2, both the qualitative evidence and local evidence synthesis indicated **dissemination activities had taken place and that partnerships invested in sharing ABS learning through evaluations, reports, data insights, toolkits, and events.** Practitioners described sharing learning from ABS through webinars and knowledge-exchange sessions, and some stakeholders described presenting at national forums and parliamentary briefings. Some practitioners described engaging with wider stakeholders, including policy and commissioning audiences, to share learning from ABS.

However, there was little evidence about how this dissemination was received or used by organisations outside ABS areas. Examples of perceived influence on local or national strategy were anecdotal and lacked detail on process or impact. **Similarly, network-building efforts were seen as difficult to sustain once ABS staffing and resources were reduced.** Given the evidence available to the evaluation, it is not possible to suggest exactly what influence the information disseminated has had on broader Early Years policy or decision-making.

Evidence of outcomes

Variation in evidence of broader adoption of ABS approaches

There were some examples of ABS-funded services or approaches being continued, expanded, or incorporated into local Early Years offers. These included services being recommissioned by local partners, elements of practice adopted in other settings, or programme learning contributing to aspects of local strategic planning. These services covered early health, communication and parental wellbeing. Some organisations also secured co-funding from statutory partners.

Furthermore, some practitioners said the programme influenced the design of other activities in their area. Public health teams adopted campaign materials, government protocols were changed in specific service areas and voluntary sector organisations committed resources to sustain Early Years support. **These examples suggested that partners saw value in approaches that offered clear tools or materials that could be embedded in**

existing work. Relatedly, practitioners also felt that the programme contributed to wider strategic thinking, although the extent of this influence was difficult to evidence. Some practitioners believed that the programme's focus on Early Years outcomes supported broader planning, while others described links to emerging national strategies.

You can genuinely hear in conversations and see in approaches how, whether directly or indirectly, because of A Better Start actually, everyone is doing things differently. I think that's reflected across the city and across the partners. (ABS practitioner)

However, evidence of sustained or system-wide adoption was limited. Several examples of service continuation were highly context-specific, reliant on temporary funding, or not clearly linked to broader structural change. Where participants described influence on strategies or wider systems, these accounts were descriptive and unsubstantiated. The evaluation did not find clear evidence that ABS approaches were embedded at scale across non-ABS areas after funding ended.

Unanticipated outcomes

Qualitative evidence also suggested a series of **unanticipated and/or unintended outcomes**, both in positive and negative directions. There was a suggestion that ABS principles were being applied to future healthcare strategies, not just Early Years care, such as the NHS ten-year plan for mental health access. This suggestion was not substantiated through additional evidence however, so the extent to which ABS influenced this strategy is unclear. Conversely, other evidence suggested parents who were involved in ABS services had felt 'let down' once ABS began decommissioning their services. After the investment of ABS into upskilling parents to run services (often voluntarily), some parents felt undervalued and discouraged once those services were no longer available.

Alternative explanations

Evidence for **alternative explanations** was limited for this outcome domain. Some evidence indicated that funding availability was the most significant driver of sustainability. Where new funding was available, services continued; where it was not, they ceased, regardless of perceived value. Similarly, there were suggestions from the qualitative evidence of a general decline in statutory services, thus creating greater demand for ABS services to replace them. This evidence points to external contextual influences on the continuation or adaptation of ABS services, outside of the perceived success or value of the services.

6 Conclusion

This report concludes the national evaluation of A Better Start. Through our five-year evaluation, we have built a body of evidence that includes: three

annual reports of interim findings; two themed reports (place-based approaches and parental engagement); three practitioner briefings; three local evidence syntheses; three podcasts; and three webinars. Additionally, an open access academic paper was published about the Objective 3 approach in 2025 (Boddy et al., 2025). Appendix F presents a list of all the outputs produced through the national evaluation.

This national evaluation shows that A Better Start (ABS) made a meaningful contribution to how Early Years services support families. Across the qualitative evidence and local evaluation evidence, families and practitioners described clear benefits from ABS activities, including more confidence in parenting, stronger relationships with staff, and easier access to support. These reported experiences indicate that ABS strengthened important foundations for positive child and family outcomes, particularly for those who had more engagement with ABS services and engaged with them over time. Taken together, however, the contribution analysis provides clear indications of positive change for some families, rather than consistent, generalisable evidence of sustained child-level impact across populations in ABS areas.

These findings show that ABS delivered progress in the mechanisms known to support long-term change. Families benefited from approaches that were relational, inclusive and responsive to their needs. Parents described accessible support that helped them establish family practices, understand their children's development and feel more confident navigating services. Practitioners reported clearer referral routes, stronger links between organisations and more consistent messages across services. These insights point to the programme's success in shaping the conditions that enable positive child development over time, even if these conditions were not always detectable in available population-level indicators.

Similarly, ABS made positive contributions to local Early Years systems. Partnerships reported more joint planning, better coordination between statutory and voluntary organisations and greater focus on prevention. Parents also played a more active role in shaping and delivering services, which helped create a stronger sense of trust and ownership. These developments were supported by test-and-learn approaches, flexible delivery and a commitment to adapting services in response to local needs. While some of these changes were not sustained at scale, they demonstrated what is possible when local areas have time, resources and stability to work in early and preventative ways. This suggests that achieving a broader shift towards prevention requires long-term resourcing, stable delivery conditions and stronger alignment across local agencies.

More broadly, the evaluation shows the importance of long-term, relational and preventative approaches in the Early Years. Families consistently valued support that was non-judgemental, culturally relevant and tailored to their circumstances and priorities. Practitioners emphasised the need for capacity, time and continuity to build effective relationships with families. These

lessons highlight the benefits of investing in workforce development, local coordination and flexible delivery models that can respond to families' priorities as they change over time.

The national evaluation concludes that ABS strengthened key foundations for longer-term improvements in Early Years systems. It did so by building trusted relationships, increasing engagement, improving coordination and supporting families to take small but meaningful steps that promote children's development. The programme created the enabling conditions that future Early Years interventions can build on.

The evaluation suggests that future policy will be strongest when it combines long-term investment, relational practice and high-quality data infrastructure. In this evaluation, the very small number of consented records that could be linked meant the intended impact analysis was not viable. Strengthening administrative datasets, improving local data sharing and aligning measures more closely with families' lived experiences would support clearer assessment of impact in the future. The learning from ABS offers a valuable platform for shaping early help and prevention across the Early Years system, and points to the potential of place-based approaches when delivered with consistency, flexibility and close partnership with families.

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Appendix A: Theory of change detail

Activities

In August 2021, ABS activities were mapped as part of the work delivered in Phase 1. That process found approximately 160 ABS activities being delivered across the partnerships. These were categorised into six broad activity types for five beneficiary groups. Table 4 presents this typology.

Table 4. Typology of ABS activities and beneficiaries

Type of activity	Examples	Beneficiary groups
Services	• Communication, language and literacy programmes • Enhanced health visiting • Family home visits • Forest schools • Health-related interventions and support - Breastfeeding - Mental health - Nutrition - Oral health • Parenting courses and interventions - Antenatal support - Improving parent-baby interactions - Relationship support	• Babies and children (0-4) • Pregnant people • Parents and carers
Information and outreach	• Community-facing campaigns • Digital campaigns • Educational mobile apps • Educational programmes • Health promotion • Signposting to services and activities	• Babies and children (0-4) • Pregnant people • Parents and carers • Community members
Resources	• Books • Clothing banks • Learning aids	• Babies and children (0-4) • Pregnant people • Parents and carers
Outdoor spaces and community buildings	• Physical improvements to buildings and outdoor spaces • Access to and use of parks and outdoor spaces	• Babies and children (0-4) • Pregnant people • Parents and carers • Community members
Training and development	• Workforce - Language assessment toolkits	• Workforce • Community members • Parents and carers

Type of activity	Examples	Beneficiary groups
	- Messaging around Early Child Development outcomes - Trauma-informed approaches • Community member volunteers - Community champions - Family engagement workers - Family mentors - Literacy champions • Parent and carer volunteers - Parent ambassadors - Parent champions - Career guidance and employment skills	
Research, evaluation and learning	• Local formative and summative evaluation work • National formative and summative evaluation work • Research projects with communities • Conferences to share latest evidence and findings from implementation	• Babies and children (0-4) • Pregnant people • Parents and carers • Community members • Workforce

Mechanisms

We understand mechanisms as the processes triggered by the ABS programme, which lead to the achievement of ABS outcomes. While activities are *what* ABS does; mechanisms are how activities are done, or the guiding principles determining how the programme is implemented.

We have organised identified mechanisms under three ‘types’:

- Adaptive design;
- Inclusion, engagement and empowerment; and
- Collaborative working, effective governance and capacity.

However, this is not to suggest that each group of mechanisms worked independently. When the ToC was developed, the assumption was that mechanisms would trigger processes that should (in theory) complement each other - for example, test and learn principles informing better understandings of local needs; workforce capacity improving the effectiveness of outreach activities, and so on.

The ToC was developed in 2021 and was built on the following premises (as outlined under each type of mechanism).

Adaptive design

Local adaptation

- Local needs are understood, including through:
 - Use of current data on early childhood development outcomes and inequalities in ABS wards; and
 - Use of a systemic, ecological approach to understand and change the barriers faced by children in ABS wards.
- Approaches and services are adapted to local contexts and are appropriate and acceptable to local families. This included:
 - Offering services that fit with families' life pressures and circumstances.
 - Designing and implementing a programme of needs- and demand-led projects using service design methodologies which wrap around and enhance existing statutory services.
 - Providing services and projects that offer the capability, opportunity and motivation for behaviour change at the individual, family, community and organisational levels.

Continuous, evidence-based quality improvement

- Service design and delivery are informed by existing evidence, including:
 - data, evidence, learning and the science of 'what works', including looking at areas similar to ABS in terms of demographics and context to understand where the best outcomes have been achieved
 - evidence on delivering high quality services for babies and very young children
- Test and learn principles are followed, including:
 - trying approaches on a smaller scale to learn from them
 - pathways and approaches are refined and improved over time based on data, evidence and learning (including stopping what doesn't work)
 - monitoring and evaluating projects to ensure provision remains appropriate, that necessary changes and adaptations are made in a timely way
 - evaluation capturing accurate and relevant evidence and learning, and learning being fed back to improve future services and project design
 - partnerships valuing evidence from local evaluations and supporting the use of this evidence to shape services for babies and young children
- Improving data infrastructure, including:
 - working to improve data collection processes and data quality
 - facilitating data access and consolidating multiple data sources
 - maximising current opportunities for effective and robust data sharing

Fidelity

- Services that are implemented are carried out as designed and in adherence with ABS delivery principles, including test and learn.

Scale up and replication

- Learning and evidence from ABS is used to scale-up and replicate useful services and practices. This includes:
 - maximising replication from ABS partnership areas to other ABS partnership areas (e.g. something that was useful in Bradford is adapted for and rolled out in Lambeth)
 - ABS approaches and/or services being embedded and scaled up within their local areas (e.g. local system leaders decide to replicate aspects of ABS that have been successful across their local authority)
 - evidence and learning from ABS influencing policy and practice beyond the five ABS areas (e.g. The Fund making use of learning on other place-based initiatives, local commissioners in other areas adopting ABS approaches)

Inclusion, engagement and empowerment

Inclusivity and minimising harm

- ‘Do no harm’ principles are followed, including:
 - use of evidence, science-based services and approaches
 - innovation only where gaps are verified
 - safeguarding policies and procedures are in place and owned by partnerships
- Inclusive practices are followed so that all families in ABS wards are reached, including:
 - ensuring families from all backgrounds and circumstances feel understood by services and staff, feel represented, respected and that ABS is ‘for them’
 - ensuring families from all backgrounds and circumstances have a positive experience of ABS services from the start, including being made to feel welcome, safe, secure and positive, that they can trust and are confident in the knowledge and skills of ABS staff and organisations
 - ensuring services are accessible, so that families can access services which meet their needs (e.g. in terms of affordability, opening times)
 - adopting a trauma-informed approach to ABS services
- The needs of particular vulnerable groups are considered and understood and services are adapted and improved in recognition of these needs.

Effective outreach and active Outreach: ABS provides target groups with information about services and how to access them, and consistent, positive messaging to support ECD outcomes.

Reducing barriers to engagement

- Local system leaders are committed to the ABS strategy and approach, and are willing to engage and support success practically and financially. Local authorities, VCSE, communities and parents remain actively engaged. and constraints are identified and overcome so parents can make positive choices.
- ABS activities reduce stressors on families and the community. Examples of stressors include issues related to drugs and alcohol, mental ill-health, relationships and domestic abuse and isolation.

Empowering families and communities

- Co-production involves parents and professionals equally in identifying needs, solutions and how these are developed, which:¹⁴
 - empowers parents and community members to shape services delivered in their communities, driving service improvement and system change as equal partners
 - supports better design, delivery and services
- ABS activities empower families and communities by building their capabilities. Examples of capabilities include parenting knowledge and skills, attachment and attunement in the parent-child relationship, self-efficacy and social cohesion.

Collaborative working, effective governance and capacity

Collaborative working and effective governance

- Local authorities, health, VCSE, communities and parents form local partnerships and have formal roles and responsibilities set out in governance arrangements.
- ABS partners work together on a shared vision, priorities, language and outcomes. This includes working with all key agencies to support a common understanding of and approach to identifying and supporting vulnerable families at an earlier stage.
- Regular, open and transparent communication between The Fund Programme team, partnerships and contractors:
 - builds mutual trust
 - facilitates the Programme Team's understandings of grant progress

¹⁴ Note: co-production is framed as an outcome related to system-level change rather than a mechanism in one ToC: SSBC Theory of Change [draft] (2021).

- enables partnerships and contractors to feel confident discussing challenges
- involves the Programme Team and contractors listening to each other to improve understandings of the challenges and being flexible to meet programme needs
- Effective governance arrangements:
 - facilitate effective spending of funds, effective leadership and accountability
 - mean that service users, practitioners, commissioners and local leaders have sufficient understanding and confidence to challenge, for example when ABS management and/or delivery does not feel right, and are confident that their contributions will be fully considered
 - include commitments to promote equity, justice, impartiality and fairness within ABS procedures, processes and distribution of resources, based on an understanding that parents and carers have different starting points, needs, beliefs and values
- Parents and carers are involved as equal partners. This is facilitated by:
 - mutual trust and valuing of contributions
 - training and mentoring for parents and carers
 - practical provision such as providing childcare and considering parent and carer needs in selecting timings and locations for meetings

Capacity

- Contractors are able to deliver agreed outputs.
- The local workforce develops the capacity and skills to implement ABS, including:
 - feeling confident about the data they are collecting and how to evidence the difference they are making
 - being equipped with knowledge and confidence to deliver consistent key messages across services, agencies and communities
 - being empowered to engage in new ways of working and to make relationships central
 - viewing ABS as a trusted and valued source of learning, training and development

Outcomes

Table 5 maps the outcomes as short-, medium-, and long-term outcomes that align with the outcome domains on the ToC. They include child-level outcomes, many of which are reflected in the Common Outcomes Framework

and administrative data used for Objective 1, and systems change. The table mirrors the outcomes that were in the original ABS Stage 2 application form for the programme. It was not meant to be a prescriptive, or exhaustive, list of outcomes, but rather examples of short-, medium- and long-term outcomes. The application form acknowledged that the long-term outcomes may not be achieved within the 10-year programme period.

Table 5. ABS outcomes

	Short-term	Medium-term	Long-term
	<i>During the lifetime of ABS</i>		<i>After ABS grant funding ends</i>
Diet and Nutrition	• Fewer women are overweight or obese during pregnancy and at the time of delivery • Increased breastfeeding at initiation, six weeks and six months • More parents introduce solid foods to their child after six months • Parents have improved confidence and understanding of nutrition issues	• Birth outcomes for children are improved, with a reduced risk of complications in pregnancy • Fewer children are overweight or obese at school entry age • Fewer children have diabetes • Fewer children are bullied as a result of being overweight • Children have a more positive attitude towards physical exercise • Children have improved self-esteem • Fewer children have dental decay	• Children have improved health and well-being into adulthood • Breastfeeding has a positive impact on the health of the mother and child, and adults who were breastfed as children have lower blood pressure, lower levels of cholesterol and lower frequency of diabetes • The NHS costs of dealing with life-long obesity health risks are reduced • Children have improved dental and general health into adulthood <i>Short- and medium-term outcomes achieved across children growing up in ABS areas</i>
Communication and Language Development	• Children have increased verbal and non-verbal communication skills • Children have an increased vocabulary • Children are empowered by the ability to express themselves	• Children start to talk earlier, and by age three are more able to express themselves and interact easily with adults and other children through their use of language. • Children have age-appropriate vocabulary and are more able use language to express their physical needs and have positive social interaction. • Children are more able to resolve conflict and understand the consequences of actions, through verbal communication.	Later in childhood and adolescence, ABS children have: • Better literacy and language skills, better social skills and better school achievement As young adults and into adulthood, ABS children: • Have improved educational attainment, which positively impacts on their children • Develop improved social and emotional adjustment and cognitive skills, which improves long- term success in career and in relationships

	Short-term	Medium-term	Long-term
	<i>During the lifetime of ABS</i>		<i>After ABS grant funding ends</i>
		- Children use physical contact less in response to frustration. - Children make better progress through pre-school and are more school-ready.	<i>Short- and medium-term outcomes achieved across children growing up in ABS areas</i>
Social and Emotional Development	- Fewer pre-natal families experience domestic violence - More infant and primary carer or parent relationships have good quality attunement - More 15-month-olds have secure attachment - Fewer children are hospitalised for non-accidental injuries and accidental injuries - Fewer children experience abuse or neglect - Improved parent-child interactions	- More toddlers have good social and emotional development, with lower levels of high aggression in pre-schoolers. - Children have greater empathy. - Children have higher levels of key soft skills: conscientiousness, perseverance, self-esteem, motivation, ability to pay attention, self-regulation, self-esteem, ability to defer gratification, sociability. - More children arrive at school 'school-ready'. - Pre-schoolers are more able to socialise. - Parent-child relationships are improved. - Children have an improved ability to handle stress.	Later in childhood and adolescence, ABS children have: - Improved school behaviour and engage positively with their peers and teachers - Lower levels of aggression, crime, antisocial behaviour and violence in adulthood - Higher emotional intelligence and empathy and improved mental health As young adults and into adulthood, ABS children have: - Improved educational performance and better career outcomes, which leads to a higher proportion of tax contributing citizens - Lower long-term levels of heart, liver and lung disease, diabetes, alcoholism, tobacco and drug consumption, depression, suicide and mental illness <i>Short- and medium-term outcomes achieved across children growing up in ABS areas</i>
Systems Change	ABS services represent an increase in: - co-production with families - joined-up working between services	ABS approaches are embedded and sustained across ABS LAs, resulting in:	Learning from ABS influences the wider sector, resulting in:

	Short-term	Medium-term	Long-term
	<i>During the lifetime of ABS</i>		<i>After ABS grant funding ends</i>
	• prevention-focused, demand-led and evidence-informed services for families	• a shift in culture and spending across children and family agencies towards prevention • local health, public services, the social sector and the wider community working together to coproduce and deliver less bureaucratic • services are more prevention-focused, demand-led and evidence-informed	• a shift in culture and spending across children and family agencies towards prevention • local health, public services, the social sector and the wider community working together to coproduce and deliver less bureaucratic • services are more prevention-focused, demand-led and evidence-informed • continuous reflection and improvement

Appendix B: Contribution Analysis

Technical Appendix

Contribution analysis approach

Contribution analysis is an established theory-based evaluation method that provides a systematic way to assess whether an intervention has plausibly contributed to observed outcomes. It is especially suited to complex systems, where interventions interact with multiple contextual factors and where there is equifinality (similar outcomes achieved through multiple activities) and multifinality (similar activities or one activity can contribute to multiple outcomes).

For the national ABS evaluation, we developed an approach adapted from the key principles of contribution analysis, recognising the complexity of ABS and the need for a flexible, iterative analytical process. Central to this approach was assembling a mosaic of evidence, bringing together multiple types and sources of data to explore causal chains, mechanisms and contextual factors in a structured and transparent way.

The national ABS evaluation adopted an adaptation of contribution analysis principles as the core analytical framework because:

- ABS operates across multiple sites with varied delivery models
- outcomes are influenced by a mix of service and system-based activities and contextual factors
- causal chains involve multiple mechanisms and actors
- different forms of evidence are required to rigorously assess contribution

Drawing on principles of Mayne's six step model,¹⁵ we followed an iterative process that incorporated early scoping, theory development, multi-strand evidence collection, triangulation, refinement and assessment of claims, and development of a credible contribution narrative.

Step 1: Understanding ABS and the Problem Context

During the first phase of the evaluation (2021), the team undertook extensive scoping to develop a shared understanding of the ABS programme, its design, context, delivery structures and intended outcomes. This involved:

- reviewing programme documentation
- engaging with ABS partnerships
- reviewing evidence from the first national evaluation

¹⁵ Step 1) Set out the attribution problem, Step 2) Develop a theory of change and identify its risks, Step 3) Gather existing evidence on the theory of change, Step 4) Assemble the 'contribution story' as assess its challenges, Step 5) Seek additional evidence to fill gaps, Step 6) Revise and strengthen the contribution story, 7) Return to Steps 2, 3 and 4 if needed. (See Mayne (2019) Revisiting Contribution Analysis, Canadian Journal of Program Evaluation).

- agreeing evaluation aims and objectives

This scoping provided clarity on the challenges ABS seeks to address, from inequalities in early childhood development to variations in local systems capacity and established the analytical foundation for developing the Theory of Change.

Step 2: Developing and Refining the ABS Theory of Change

A high-level Theory of Change (ToC) was developed to articulate the intended causal pathways through which ABS inputs and activities were expected to contribute to outcomes. To develop the ToC, we mapped and synthesised information from the existing national-level and partnership-level ToCs. We also drew on information from a range of Phase 1 scoping activities conducted in 2021 including consultations with The Fund, interviews with ABS site leads, workshops conducted with the ABS sites (core ABS staff and local evaluators), activity mapping and a review of key documentation. The ToC defined:

- key inputs (e.g., services, workforce development, systems-level activities)
- activities delivered by ABS partnerships
- mechanisms (e.g., improved parent knowledge, strengthened early-years workforce)
- short- and medium-term outcomes for systems and children
- assumptions and enabling conditions

The ToC provided the overarching analytical framework for the evaluation and the structure against which evidence was gathered in later steps.

Step 3: Evidence Collection Across Multiple Objectives

In 2022, evidence was collected across the qualitative strands of the evaluation, including qualitative research with ABS and non-ABS stakeholders (Objective 2) and longitudinal qualitative research with families (Objective 3). Early waves of qualitative fieldwork formed part of evidence collection under Step 3, while later waves informed iterative refinement in subsequent steps. This evidence was complemented by local monitoring and evaluation evidence brought together through the local evidence synthesis. Together, these sources provided the mosaic of evidence used in the contribution analysis.

Step 4: Assembling Evidence and Developing Contribution Claims

In early 2023, we then assembled the initial body of evidence and began mapping it against the ToC, to support the development of detailed claims based in evidence. This process involved:

- identifying emerging causal links and hypotheses
- synthesising early findings from Objectives 2 and 3 and
- refining the initial hypothesised pathways
- assessing which ToC assumptions were holding or required revision or where additional assumptions were needed

Using this initial evidence review, the team developed a set of testable contribution claims for eight key ABS outcome areas (see ‘Developing Contribution Claims’ section below for more detail). These claims set out:

- the causal chain from inputs and activities to mechanisms, outcomes and impacts
- the assumptions underpinning each chain
- the factors that may enable or inhibit progress

Claims were discussed and validated in workshops with The Fund in May 2023. The claims were then carried forward for testing through further evidence gathering across the four evaluation objectives.

Step 5: Gathering Additional Evidence to Test and Strengthen Claims

Following the claims development, the evaluation team continued to collect evidence (in 2023, 2024 and into 2025) through:

- further waves of Objective 2 qualitative research with professionals
- further waves of Objective 3 longitudinal qualitative research with families

local evaluation reports and monitoring data brought together through the local evidence synthesis. This additional evidence was used to test the claims, identify gaps in evidence and strengthen the narratives for each outcome area.

Step 6: Triangulating Evidence and Finalising the Contribution Story

In 2025, the team undertook a full synthesis and triangulation of qualitative evidence from professionals and families (Objectives 2 and 3) and local monitoring and evaluation evidence. The evaluators identified both confirmatory and contradictory evidence to assess confidence in each contribution claim. This process included formal evidence assessments, which informed the final contribution narratives presented in the main report.

Developing Contribution Claims

We developed eight contribution claims, focused on the key outcomes areas across the evaluation. This included **three child outcomes** (communication and language; diet and nutrition; social and emotional development) and **five systems change outcomes** (joined up working; parental engagement; adaptive and evidence informed services; early intervention; adoption beyond ABS).

The contribution claims were narrative descriptions of how ABS was hypothesised to contribute to specific child and systems-change related outcomes. They represent chains of cause and effect, designed to explain whether and how impact is brought about by a programme. For ABS, the claims allowed us to test whether, how and why ABS may have contributed to child-level and systems change outcomes, and better understand the mechanisms of change associated with these outcomes.

Early evidence generated through Step 3 indicated several possible pathways for how ABS might lead to intended outcomes. To manage this, we focused on developing a set of contribution claims that were: closely linked to the Theory of Change, reflected the most common and important mechanisms hypothesised to contribute to change, and aligned with the evidence available through evaluation Objectives (Step 4).

For each of these outcome areas, the contribution claims specified:

- Inputs/activities: the types of activities/support ABS funded or convened related to the outcome area; these were the start of the causal chain pathways illustrated by the claims.
- Mechanisms: the underlying factors contributing to the process by which change was expected to occur; leading on from inputs and activities, the mechanisms formed 'pathways' of different, but sometimes interlinking factors; and
- Outcomes/impacts: what change would we plausibly expect to observe.

Alongside these key components, we identified likely assumptions/pre-conditions related to the outcome area, and likely enabling factors and/or barriers to outcome achievement.

We organised evidence across Objectives 2 and 3 by developing evidence-mapping templates structured around the logic of the contribution claims (inputs/activities → mechanisms/pathways → outcomes, as well as dependencies, alternative explanations and unintended consequences). We also applied similar charting tools in the local evidence synthesis so that local evaluation findings could be incorporated directly and consistently into the national analysis.

As further waves of qualitative and administrative data were collected (Step 5), the claims were updated to ensure they were supported by the available evidence and accurately reflected the most plausible causal pathways. Using these refined claims, in the final evaluation year we created a framework for Objectives 2 and 3 to extract and organise their evidence consistently. This structured and transparent approach enabled systematic triangulation and synthesis across evidence sources for the various elements of each claim.

Evidence Triangulation and Claim Assessment

In 2025, we undertook the final stage (Step 6) of the contribution analysis. This involved a structured process of triangulating the relevant qualitative and local evaluation evidence and assessing confidence in the plausibility of the claims. We brought together the full mosaic of evidence from Objectives 2 and 3 and the local evidence synthesis. The aim was to assess whether the contribution claims were supported, not supported or challenged by the available evidence, and the extent to which we could identify a plausible contribution from ABS to the observed outcomes. .

Evidence was organised under the contribution claims using the evidence-mapping templates, enabling Objectives 2 and 3 to map data systematically across pathways, outcomes, and alternative explanations. This process helped

organise the data in a way that supported systematic analysis and perform the evidence assessments against the claims.

Our assessments were guided by three overarching principles designed to ensure consistency and transparency across outcome areas¹⁶:

- **Plausibility:** whether the causal chain remained logical, feasible, and aligned with the emerging evidence.
- **Completeness:** whether the available evidence was sufficient to speak to the full claim narrative, including mechanisms, contextual influences, and potential alternative explanations.
- **Strength of evidence:** the robustness, credibility, and coverage of the evidence base supporting (or challenging) the claim. This included the extent of corroboration/contradictions across Objectives and types and sources of data.

The strength of this approach is that we were able to build confidence and credibility by seeking corroboration between evidence sources. These principles helped ensure that assessments were grounded in a balanced reading of the available data and not driven by any single evidence source.

Assessment components

Each contribution claim was assessed across key areas: pathways (mechanisms), outcomes and alternative explanations. These assessments were informed by the structured data extraction templates and the systematic triangulation process.

Our assessments focused on what the evidence showed in relation to the elements of each contribution claim, rather than on judging the quality of the underlying data. In assessing pathways, outcomes and alternative explanations, we examined the presence, consistency and triangulation of evidence across Objectives and sources. The ratings therefore relate to the strength and completeness of the evidence in relation to the claim, not the robustness of the evidence itself. A low or mixed assessment does not reflect poor-quality data; rather, it reflects the extent to which the available evidence corroborated, contradicted, or did not speak directly to the claim.

Outcome assessment: We examined evidence on whether the intended outcome had been realised, drawing on qualitative insights from professionals and families (Objectives 2 and 3) and relevant findings from the local evidence synthesis. We considered:

- realisation of the outcome;
- coverage and representativeness across sites and data sources;
- consistency and triangulation across evidence sources.

The strength of evidence for each outcome was rated **low**, **medium**, or **high** based on the criteria used across all outcome areas (and intermediary ratings,

¹⁶ Befani, B., & Mayne, J. (2014). *Process Tracing and Contribution Analysis: A Combined Approach to Generative Causal Inference for Impact Evaluation*. IDS Bulletin, 45(6). Available at: <https://www.betterevaluation.org/sites/default/files/idsb12110.pdf>

e.g., low-medium, were applied where the assessment fell between to ratings).

- **Low:** There is little or no evidence that the outcome has been realised; coverage/representativeness is limited and there is no clear corroboration across evidence sources and/or there is strong contradictory evidence. Reported changes are not substantiated by reliable evidence.
- **Low-medium:** There is some evidence that the outcome has been realised, but coverage is limited and corroboration across evidence sources is partial or inconsistent, and/or there is some contradictory evidence. The evidence suggests emerging signals of change, but it is not strong or comprehensive enough for a full medium rating.
- **Medium:** There is some clear evidence that the outcome has been realised, with moderate coverage and some corroboration between evidence sources. However, parts of the evidence base remain incomplete, and not all reported changes are well-substantiated.
- **Medium-high:** There is strong evidence in most areas that the outcome has been realised, with good coverage and clear triangulation, though a small number of gaps or inconsistencies remain. The evidence is robust overall, but not fully comprehensive enough for a high rating.
- **High:** There is strong evidence that the outcome has been realised, supported by good coverage, representativeness and clear corroboration across evidence sources. Most reported changes are backed by reliable, well-explained evidence.

Pathways assessment: We assessed the extent to which evidence supported the hypothesised causal pathways, including the presence of key inputs, activities, and mechanisms (pathway 1/pathway 2). Evidence was synthesised across mainly Objectives 2 and 3, supported by relevant findings from the local evidence synthesis. We considered:

- whether inputs/activities and mechanisms were evidenced;
- whether mechanisms between pathway elements held;
- the logic and sequence of the causal chain;
- areas where evidence was strong or weak; considering completeness or presence/absence of factors within the pathways and whether evidence was confirmatory and/or contradictory between sources.

Each pathway assessment was also rated **low**, **medium**, or **high**.

- **Low:** Limited/no evidence of key factors within the pathway and/or weak or illogical links between them. The pathway is not convincingly supported by the available data.
- **Low-medium:** There is some evidence linking inputs/activities and mechanisms, but it is uneven, limited, or inconsistently demonstrated. Parts of the pathway appear plausible, but several links remain weak, unclear or insufficiently evidenced, preventing it from reaching a full medium rating.
- **Medium:** Some/mixed evidence linking inputs/activities and mechanisms, with a pathway that is broadly logical and reasonably

sequenced, though not all links are well-evidenced. Coverage is uneven and some gaps remain.

- **Medium-high:** There is strong evidence for most pathway elements, with a clear and coherent sequence, though a small number of links are less well-evidenced or show minor gaps. Overall, the pathway is well supported, but not fully robust enough for a high rating.
- **High:** Strong evidence linking the pathway elements (inputs/activities through pathway mechanisms), with a clear, coherent sequence and well-supported explanations of how change occurs.

Assessment of alternative explanations: For this assessment we focused specifically on both internal (factors missing from the claim) and external (other programmes or contextual developments that may explain changes) alternative explanations. We considered:

- whether there was evidence of other plausible explanations, internal to ABS, for the outcomes observed (alternative causal pathways);
- the prevalence of external initiatives or contextual changes which also may have explained outcomes observed;
- whether alternative explanations have been ruled out or whether they remain part of the plausible explanation for the observed outcomes.

Each alternative explanation assessment was also rated low, medium, or high.

- **Low:** There are clear internal gaps in the claim and/or multiple plausible external programmes or contextual factors that could explain the observed changes.
- **Low-medium:** There is some evidence of alternative explanations, but it is not extensive or strongly substantiated. Plausible alternatives remain, and some cannot be ruled out due to insufficient evidence.
- **Medium:** There is limited evidence of internal or external alternative explanations; a few remain plausible but are not widespread or strongly evidenced; Or sufficient evidence was not available to rule out alternative explanations.
- **Medium-high:** Most alternative explanations have been addressed or partly ruled out, with only minor residual uncertainties. The evidence base is strong overall, though not complete enough for a full high rating.
- **High:** Alternative explanations have been explored and largely ruled out; the claim covers the relevant pathway factors and no plausible external explanations remain.

Overarching assessment of confidence in the claim

For each contribution claim, the final step involved bringing together the assessments of pathways, outcomes, and alternative explanations to form an overall conclusion of our confidence in the claim. The overarching assessments were driven primarily by the pathway and outcome assessments, as these form the core components of each contribution claim. The assessment of alternative explanations did not automatically raise or lower the overall rating, but it provided important supporting evidence, particularly when the pathway and outcome assessments diverged and a clear judgement

was harder to reach. For example, if the pathway assessment was medium and the outcome assessment was low-medium, an alternative explanation rating of low-medium would help confirm an overall judgement of low-medium.

Claims were rated on a five-point scale:

- **Low:** Evidence is limited or contradictory across components. There is little/no evidence that outcomes were realised; coverage is weak and there is no corroboration across Objectives. Pathway links are largely unsupported or illogical, and there are multiple plausible alternative explanations that could account for observed changes.
- **Low-medium:** Mixed evidence with notable weaknesses. Some elements of either the outcome or pathway are evidenced, but coverage is patchy and triangulation is inconsistent. Logical sequencing of the pathway is only partially supported and/or there are unresolved alternative explanations. Overall, the claim has limited support but shows some promising signals.
- **Medium:** Reasonably consistent evidence with some gaps. There is some evidence that outcomes have been realised with moderate coverage and corroboration across Objectives; the pathway is partly evidenced with a generally logical sequence, although not all links are well-substantiated. Alternative explanations have been considered, but a few remain plausible. On balance, the claim is supported but not conclusively.
- **Medium-high:** Strong evidence in key areas with only minor limitations. Outcomes are supported by good coverage and cross-Objective corroboration; the pathway shows clear, well-explained links between inputs/activities and mechanisms (P1/P2), and the narrative holds together logically over time. Alternative explanations have been explored and largely ruled out, with only limited residual uncertainties.
- **High:** Strong, convergent evidence across all components. Outcomes are well-evidenced with good coverage and consistent corroboration; the causal pathway is robust, with clear links from inputs/activities through mechanisms to outcomes, and the explanation is logical and well-substantiated. No plausible alternative explanations remain. This represents a high level of confidence in the claim.

This assessment provided a transparent summary of how convincingly ABS was found to contribute to each outcome area and formed the basis for the contribution narrative presented in the main report.

Claim Assessment by Outcome Area

The table below summarises our assessment for each outcome area, bringing together the triangulated evidence across Objectives 2 and 3 and local evidence. Ratings reflect and combine the three component assessments of pathways, outcomes, and alternative explanations into an overarching assessment of confidence in the claim. .

Table 6. Summary of outcome area assessments

Outcome domain	Pathway Evidence Assessment	Outcome Evidence Assessment	Alternative Explanations Assessment	Overarching Assessment of Confidence
Diet and nutrition	Medium-high	Low-medium	Low-medium	Medium
Communication and language	Medium-high	Low-medium	Low-medium	Medium
Social and emotional development	Medium-high	Low-medium	Low-medium	Medium
Joined-up working	Medium	Low-medium	Medium	Medium
Parental engagement	Medium-high	Low-medium	Medium	Medium
Adaptive and evidence informed services	Medium	Low-medium	Medium	Medium
Prevention and early intervention	Low-medium	Low-medium	Medium	Low-medium
Adoption beyond ABS areas	Low-medium	Low-medium	Medium	Low-medium

Appendix C: Objective 2 technical appendix

Aims of Objective 2

The aim of Objective 2 of the National Evaluation of A Better Start was to identify the factors that contributed to improving children's diet and nutrition, social and emotional skills and language and communication skills through a suite of interventions, both targeted and universal, selected by ABS partnerships.

We used qualitative methods to investigate how ABS works at both partnership and national levels. This has included conducting in-depth interviews with:

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

Through these interviews, Objective 2 explored the successes and challenges of ABS activities and projects in working towards these aims and lessons learned about how best to achieve positive change in children's and families' lives.

Methods

Recruitment

Recruitment of ABS respondents

In-depth interviews took place across multiple waves of data collection every year between 2022 and 2025. In 2022, there were three waves of fieldwork, two waves in 2023 and 2024, and one wave in 2025. At the beginning of the first wave of fieldwork in 2022, NatCen contacted the ABS partnership leads from each of the five sites to request a list of potential respondents from within their partnerships from across the range of ABS services on offer in their areas. Out of this sample, we systematically selected a subset to contact, with the aim of interviewing up to four respondents in each partnership area per wave.

For subsequent waves of fieldwork, we contacted respondents who had not yet taken part in an interview, and respondents who had taken part previously to conduct a follow-up interview. This approach allowed us to capture changes in implementation between interviews during follow-up interviews, and speak to new respondents, ensuring a range of services, views and experiences were represented in the sample. Before the first wave of interviews each year, we asked ABS partnership leads to share a new list of respondents.

Over the course of the evaluation, we interviewed 99 ABS respondents, conducting a total of 139 interviews.

Table 7. Sample of ABS respondents by partnership and year

Partnership Area	2022	2023	2024	2025	All waves
Blackpool	11	8	7	2	28
Bradford	10	5	6	2	23
Lambeth	14	10	7	1	32
Nottingham	10	8	5	5	28
Southend	11	8	7	2	28
Total	56	39	32	12	139

Recruitment of non-ABS respondents

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

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

A list of non-ABS respondents working within ABS local authorities was then sent to the ABS partnership leads to ensure that there was no overlap with ABS respondents. After the partnership leads provided their input, we systematically contacted a subset of respondents for each wave, ensuring different areas were represented. After the original sample had been contacted a maximum of three times, additional contacts were found through an online scoping exercise. A total of 22 non-ABS respondents were interviewed over the course of the evaluation.

Recruitment / selection of The Fund respondents

We interviewed two representatives from The Fund in the first year of data collection and conducted follow up interviews each subsequent year of the evaluation. We conducted one additional interview with a different stakeholder from The Fund in 2025.

Data collection

ABS interviews

Our sample of ABS respondents included delivery staff, including qualified health and Early Years practitioners, and service managers. We chose to focus our interviews on the specific project(s) or service(s) that they were involved in rather than the ABS programme as a whole. This allowed us to explore their experiences of ABS in depth and understand how experiences differed between and within partnerships. This approach drew on respondents' expertise, eliciting nuanced findings rather than generalised statements.

We developed topic guides to be used in interviews which listed the key themes and sub-themes to be explored with respondents. Topics covered in ABS interviews are outlined in Table 8 below. Topic guides were tailored over the course of the evaluation to reflect particular themes of interest and the stage of the programme. However, the same core topics were explored throughout the evaluation, as shown in the table below. In 2022 and 2023, we explored the themes of 'place-based approaches' and 'parental engagement' respectively, which were reported on through standalone thematic reports.

Table 8. Topics covered in ABS interviews by data collection year

Partnership area	2022	2023	2024	2025
Child-level outcomes	X	X	X	X
Mechanisms	X	X	X	X
Systems change	X	X	X	X
Parental engagement	X	X (annual theme)	X	X
Place-based approaches	X (annual theme)			
Sustainability and legacy			X	X

Non-ABS interviews

Topic guides for non-ABS interviews were designed so that knowledge of the ABS programme was not assumed. Interviews explored respondents' involvement in the Early Years sector, key successes and challenges in the sector in their area, and what worked well and less well in achieving key child-level outcomes and systems change in their area, and any influence ABS had had on their service (if applicable).

The Fund

Interviews with The Fund explored the same topics as the ABS interviews above, providing a higher-level overview of progress towards child-level outcomes and systems change across the five partnerships. They also explored differences in implementation, successes and challenges between partnerships.

Analysis and reporting

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

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

For the final report, qualitative data collected from all waves was appraised and inputted to the contribution analysis framework and mapped against the contribution claims, according to the approach described in Chapters 3 and 4.

Appendix D: Objective 3 technical appendix

Overview

Objective 3 involved recursive, in-depth family interviews incorporating creative, participatory methods to evidence the experiences of families from diverse backgrounds through ABS systems over time. The aim was to build a nuanced understanding of family experiences with ABS, including barriers/facilitators of engagement and impact in relation to the four core outcome domains. We established qualitative evidence over seven waves of data collection conducted over four years , focusing on (1) how ABS activities and interventions related to child outcomes become embedded and sustained in family life (2) the implications of ABS systems change for families, including professional support and involvement and (3) families’ contributions to systems change through their engagement with ABS.

We used a family-focused approach because it is within child and family lives that any sustained learning or benefits from ABS activities and systems will be evident over time. We used qualitative longitudinal methods - interviewing families twice a year across seven waves (see Figure 4), combining parent/carer and family group interviews with creative and participatory methods to support the engagement of children. Methods were designed to enable a place-based understanding of the ‘big picture’ of the family life at the time of each interview and to show how ABS provision fits into that picture. Qualitative longitudinal data are particularly useful for understanding complex causal mechanisms: moving beyond linear models of cause and effect, to enable consideration of relational, inter-connected, and temporal processes that influence what works in real-life contexts. ¹⁷ Building in-depth understanding of family lives and experiences of ABS over time and across partnership areas provides evidence of the contribution of ABS to improving children’s lives and outcomes - helping to identify factors that contribute (or pose barriers to) benefits for children in key outcome domains (diet and nutrition, social and emotional skills, and language and communication skills) as well as illuminating patterns of engagement with local services.

Figure 4. Objective 3 interview waves



Longitudinal family interviews were designed to answer the following research questions:

¹⁷ For example, see: Treanor M. C., Patrick R., Wenham A. (2021). State of the art. Qualitative longitudinal research: From monochrome to technicolour. *Social Policy and Society*, 20(4), 635-651.

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?
 - b. Experiences of involvement in ABS work on systems change, and understandings of the implications for family lives and 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?

Methods

Protocol development and piloting

Consultation with families in phase 1 of the evaluation was used to inform the design of Objective 3 in relation to sampling and approach to interviewing. This entailed regular consultation with the parents' panel along with local consultation with practitioners and area leads and visits to ABS activities in one area to consult with parents. Subsequently, one-to-one consultations were held (in person and online) with parents' panel members across several ABS partnership areas to explore potential data gathering materials in depth and to discuss how best to manage potential ethics considerations. This consultative process underpinned the development of topic guides and sampling strategy and formed the basis of the protocol and materials

submitted for independent ethics review. The ethics procedure is detailed in a further section.

Sampling strategy

In total, 29 families contributed to Objective 3. For the evaluation of a programme such as ABS - designed with the understanding that one size does not fit all - the diversity of family characteristics and circumstances is important for understanding both the nature of their involvement with ABS, and the difference that ABS makes within their lives. At Wave 1, an initial sample of 25 families (five per ABS partnership area) was established using a quota sampling approach. The sampling strategy was designed to ensure that the sample as a whole would be emblematic¹⁸ of a variety of family characteristics and patterns of engagement with ABS.

After securing ethics clearance, we followed a staged sampling process in each area:

Stage 1:

Local practitioners shared information with parents/carers (leaflets in community languages and a project webpage with a short accessible video) and identified 10 families per area who consented to inclusion in a preliminary sampling frame:

- families with a child aged 0-12 months or 24-36 months;¹⁹
- diverse engagement with ABS provision; and
- variation in ethnicity, household structure and family characteristics.

Stage 2:

With families' consent, each partnership area provided an anonymised summary in relation to these criteria, and a potential national sample of 25 was selected by the Sussex team from the 50 families, encompassing diversity across the five ABS partnership areas. Families were then contacted again by ABS staff, and with their consent, contact details of the 25 selected families were shared by ABS staff with our team using secure online file transfer.

Stage 3:

Initial contact was made with families by text message to request contact by phone, to describe the study in more detail, and to seek preliminary consent to participate. For participants with interpreting needs, text messages were sent in the participants' main language using Google Translate, and initial

¹⁸ The aim in sampling was to achieve what Gobo (2004) describes as *social* rather than *statistical* representativeness, designed to capture complex experiences and relations between variables, especially within populations that are known to be diverse.

¹⁹ Sampling criteria specified that at least two families in each area should have a child aged 0-12 months, and two families should have a child aged 24-36 months at the time of initial recruitment. This was to ensure balance of child age across the sample, enabling focus on a broad range of ABS activities across the span of ABS beneficiary target ages. The strategy also meant that we were able to i) follow some families as their children aged out of ABS, helping to illuminate experiences around transition to school ii) include data relating to older pre-school children's experiences with ABS that pre-dated families' involvement in the evaluation.

phone conversations were conducted with support from a local interpreting service.

Of the original sample selection, 18 families agreed to participate at this stage. Existing long-lists were used to replace the seven families who declined to take part or were no longer eligible (e.g., child age, or area of residence). Replacements from the long list were like-for-like where possible, in terms of sampling characteristics such as level of engagement, child age group, and family size.

Baseline sample

The final sample of 25 families included varied family sizes (1-7 children) and structures (sole-parent, two-parent, and complex/multi-generational households); variation in ethnicity and home languages (14/25 identified as white British); and varying levels of involvement with ABS provision (low, medium, and high). ABS involvement was a diverse category, depending on the local context of provision and variations in patterns of use. For example, a family categorised as 'highly involved' could be working closely with one service, such as family mentoring, or participating in multiple activities, or roles such as volunteering.

Sample boost and replacement sampling

In total, four new families joined the sample mid-way through the evaluation:

- In March 2024, two additional families were recruited to the evaluation in one area to enhance the variety of experiences of ABS engagement in that area. This process followed the same recruitment and sampling protocol as for the main sample.
- Two other families were recruited (in two different areas) to replace two families who withdrew from the evaluation or were unreachable despite multiple attempts to make contact. In each case, replacement sampling was designed to be as close to 'like-for-like' as possible, in relation to key sampling characteristics such as child age and level of engagement with ABS. Both replacement families joined the sample at wave 3.1.

Retention & attrition

The generation of robust evidence within qualitative longitudinal research and evaluation designs depends on maintaining participants' engagement and ensuring the ongoing representativeness of diversity of experience, including maintaining the participation of families who had negative or limited experience of ABS.

Sample retention across waves was very strong. Of the original 25 families at Wave 1, 23 remained in the sample at Wave 4. Participant retention was supported by the explicitly family-centred, flexible approach to data collection. This included conducting interviews around the priorities and schedules of family lives.

See table 9 for participation by timepoint.

Table 9. Number of families participating in data collection at each time point, by area.

Partnership area	Wave 1.1	Wave 1.2	Wave 2.1	2 nd parent	Wave 2.2	Area boost	Wave 3.1	Wave 3.2	Wave 4.1
Blackpool	5	5	5	0	4	-	5*	5	5
Bradford	5	5	5	0	5	2	6	7	7
Nottingham	5	4	5	1	5	-	5	5	5
Lambeth	5	5	4	0	3	-	5*	5	5
Southend	5	5	5	2	5	-	4	5	5
Total	25	24	24	3	22	2	25	27	27

* indicates family replacement

Final analysis was based on transcripts of data generated from all 29 families. Of these families, 19 completed interviews at all seven waves of data collection. See table 10 for participation by family.

Table 10. Waves of data collection completed by family.

Number of interviews completed (excluding optional second parent phone interview)	Number of families
7	19
6	4
4	1
3	4
2	1

Participants

Key characteristics of the 29 families who took part were:

- 15 families with a child aged 0-12 months, and 14 with a child aged 24-36 months; family size ranged from 1-7 children.
- 6 sole-parent, 19 two-parent, and 4 complex/multi-generational households.
- 15 families where the main respondent identified as White British, and 14 families where the main respondent identified with one of a range of Black and Minoritised Ethnic Groups, including families of Black African, South Asian, and European origin.
- Four families had significant language barriers, of whom two had experienced insecure immigration status and two other families had settled refugee status. Of these, three families required interpreter support to take part.
- Across the sample, levels of involvement with ABS provision were described by partnerships as low (6 families); medium (7 families) or high (16 families), although it should be noted that 'high involvement' was a diverse category, depending on the local context of provision and variations in patterns of use.

- At the time of Wave 1 interviews, two families no longer met the initial sampling criteria: one of these families had received some outreach support but was living outside of the ABS ward boundary, and the other no longer had direct caring responsibilities for an ABS-eligible child. Both families were retained in the sample to illuminate experiences around engagement/inclusion of different family types.

Across the sample, a high proportion of families in all five areas were managing complex and often challenging circumstances. For example, almost half the sample (14/29) described significant economic and/or housing insecurity, including unpredictable or limited income. Economic insecurity spanned different family structures and circumstances (e.g., lone parent professional, working couple household, and families reliant on state benefits, including refugee families). Vulnerabilities relating to social isolation due to a lack of informal and/or extended family support were also common (16 families, including four parents with care experience and/or complex relationships with their families of origin).

A high number of parents/carers (17/29), including those living in economically secure circumstances) had significant past or ongoing issues with mental ill-health, most commonly anxiety or depression; three reported living with chronic illness or disability; and two discussed their own learning needs. The sample also included two families with a disabled child, and seven families with one or more children with special educational needs (SEND).

Primary respondents

Most primary respondents were mothers (27/29 families). In one family, the primary respondent was a grandmother, and in one family the primary respondent was a father.

Children's involvement

In-person interviews were designed to facilitate the inclusion of children (see above). ABS-aged children and/or siblings contributed to all, or the majority, of face-to-face contacts. In some families, children were involved less frequently: in 3/29 families, children took part once or twice due to maternal preference and/or nursery schedules; and in two families it was not possible to include children in data collection²⁰. Child contributions included taking part in (or leading) interview activities (e.g. map making and photo tasks) as well as talking about the most important things in their everyday lives.

Father/second parent involvement

Fathers/second parents in 11/29 families contributed to at least one face-to-face interview. Following consultation with the evaluation advisory group and the parents' panel, we included an optional second parent/carer phone interview at Wave 2 (see below). This interview was offered to all 15 families with a second resident parent/carer at Wave 2.1. Of these families, three fathers took part in a separate phone interview, and a further three fathers were substantively involved in the home visit.

²⁰ Reasons not given, to protect family confidentiality.

Other family members' involvement

Data from other family members included aunts/uncles (6/29 families); grandparents (4/29 families), and a cousin (1/29 families).

Recognition of families' contribution

All families received a thank you voucher of their choice at every time point in recognition of their time and commitment (sent to the primary respondent via post or email). Reflecting the long-term nature of families' commitment to the evaluation, the value of the vouchers increased following Wave 3.1, as follows:

- Family interviews: £30 (rising to £35)
- Interim phone interviews: £20 (rising to £25)

Families were provided with an annual newsletter about learning from Objective 3 (translated into family languages as appropriate) following the publication of each National Evaluation Annual Report.

As a final thank you and souvenir of their contribution to the evaluation, ABS index children were given a University of Sussex branded teddy bear at the Wave 4 interview, and an end of project souvenir book is planned for all families following publication of the final report.

Interviews

Data collection was conducted across seven waves. In-person family interviews took place during the summer months over four years (2022 - 2025), with interim telephone interviews conducted with the primary respondent (parent/carer) in each family approximately six months later. All interviews were conducted by the same researcher.

Initial family interviews

Family interviews were arranged via the primary respondent at a time and place convenient to them, usually in the family home²¹, and typically lasted between 90-120 minutes. Families were encouraged to include children where possible, although this was not a requirement. To scaffold children's participation, the researcher took a University of Sussex branded tote bag including washable pens, paper sketch pads and gold star/red spot stickers for use in the mapping task.

Semi-structured topic guides were used to guide interviews, ordered flexibly depending on each family's response and the flow of conversation. Initial Wave 1 interviews addressed the following:²²

- Family structure: household composition, ethnicity, home languages
- Mapping activity (see details below)
- Photography activity (see details below)
- Learning about the family: housing situation, views on the area/neighbourhood; paid/unpaid work, caring or voluntary

²¹ Other locations included community spaces e.g. children's centre or public venue

²² This topic guide was also used for families joining the sample partway through the evaluation.

commitments; financial circumstances, including any benefit entitlements

- Learning about the children (each child discussed in turn): perspectives on development and identification of any concerns/support needs
- Any professional support/involvement e.g. Health Visitor, GP; any perceived unmet support needs
- Learning about ABS:
 - Knowledge of ABS: awareness/sources/perspectives of local service offer
 - Initial experiences with ABS: probing timing; routes to engagement; barriers and facilitators; hopes and motivations
 - Journey with ABS: probing range of services used; retention in different services; patterns of service use
 - Hopes and plans for future service use
- Overall evaluation: extent to which ABS has helped with family priorities

Mapping

Using the pens/stickers provided, parents/carers and children were invited to create a map showing important places and people in their everyday lives. This activity facilitated discussion about aspects of family life that - individually or collectively - were considered to be important, as well as preferences and perspectives on the accessibility of places and people, capturing parent/carer and child/ren's likes and dislikes, and the implications for family practices. The inclusion/non-inclusion of ABS services and activities on family maps were probed by the researcher.

Photography

Families were asked to take photos of important things and places in their daily lives.

All families were provided with a child-friendly digital camera and SD card at the time of the first visit (replaced between visits if required) and an accessible explainer document describing the task, including what photos should not be shared (e.g. identifiable or sensitive images). At Wave 1, families were given approximately one week to take photos before the researcher returned for a short photo elicitation discussion about the meanings/significance of photos and reflections on their relevance to everyday family life. For subsequent in person interviews, families were asked to take photos prior to the home visit with photo elicitation discussions included within the main interview.

Interim phone interviews

Telephone interviews with the primary respondent took place approximately six months after the family interview.²³ Interviews were arranged at a time of the participant's choosing and typically lasted between 30-60 minutes. Each

²³ Three-way interviews with an interpreter were arranged for the three families with English language support needs.

Wave focused on key changes and emerging concerns and also helped to support sample retention over time.

All telephone interviews followed the same format:

- Update: most important things for the family at the moment?
- Any changes to household circumstances: housing; family member's health and well-being; employment; financial situation
- Everyday routines, including children's activities
- Changes to formal/informal family support
- Any changes to involvement with ABS: probing for activities under the three child outcome domains i) diet and nutrition ii) language and communication iii) social and emotional development
- Summing up: any other relevant/significant changes.

Wave 2 second parent/carer interview (via phone)

An optional second parent/carer phone interview was offered following Wave 2.1 data collection (only offered to resident second parent/carers). This short interview included the following areas of discussion:

- Changes and challenges
- Current family priorities
- Perspectives on child development (for each child)
- Awareness and involvement in ABS
- Hope and plans for future involvement
- Overall evaluation of ABS.

Subsequent family interviews

Key elements of the initial interview were retained across waves, including a central focus on family context (supported by mapping and photo activities) in order to build a nuanced picture of family life over time. Subsequent interviews also included questions relating to each of the three child outcome domains, as well as perspectives of systems change. Wave-specific adaptations as children aged out of ABS, and in relation to the end of the ABS funding period, were included as appropriate. See table 11 for an overview of interview topics across waves.

Table 11. Overview of in-person topic guides (Waves 2-4)

	Wave 2.1	Wave 3.1	Wave 4.1
Important changes since previous interview (incl. health and wellbeing; housing; finances; unpaid/paid work)	X	X	X
Mapping²⁴	X	X	X

²⁴ For subsequent waves this included comparative reflections with previous maps, facilitating discussion about change over time.

Photo activity²⁵	X	X	X
Exploring child outcome domains (diet & nutrition, communication & language; social & emotional development) <i>for each child in the family</i>	X	X	X
Involvement in local services (levels of engagement; volunteering)	X	X	X
Perceived changes in local service provision, including ABS		X	X
Hopes/plans for future service use	X	X	X
Transitions from ABS (for children aged 4+)		X	X
ABS legacy plans/post-ABS landscape		X	X
Reflective timeline²⁶			X
Overall evaluation of ABS	X	X	X

Ethics

Ethics approval was provided by the University of Sussex (ER/JMB55/11) for all work with families, with additional area-specific NSPCC ethical approval for work in Blackpool (R/22/220). All researchers involved in data collection or analysis had enhanced DBS clearance.

Prior to each data collection timepoint, the researcher discussed the interview process with opportunities for questions. Participants were also given copies of the study information sheet, with an adapted version for children. Informed consent was then confirmed for all contributing family members (with verbal assent recorded for young children).²⁷ The consent form included items relating to confidentiality, data protection, right to withdraw, and proposed use of research material.

The research design builds on an established body of work involving in-depth, participatory and QLR research with families, including families with young children and people living in vulnerable or disadvantaged circumstances.²⁸ Beyond the consultative approach to evaluation design involving parents/caregivers and ABS staff (see above), the overall approach to fieldwork was designed to be flexible, respectful of family lives and priorities, and engaging. Strong interpreting and translation support has also been critical in scaffolding respectful engagement of families who speak diverse

²⁵ To reflect children's increased capacity to generate their own data, this activity was adapted at Wave 4. Parents/carers were asked to support children to take photos showing the world through their own eyes, including likes and dislikes.

²⁶ The researcher prepared a simple visual timeline of all the services discussed over the course of the evaluation (ABS and non-ABS). Discussion focused on holistic reflections about the significance of specific services and impact on family life.

²⁷ Paper copies of consent forms were collected during each in-person interview with space for the names of all contributing family members. For telephone interviews, the researcher read consent items to participants and recorded their verbal consent. This recording was stored separately from interview data.

²⁸ For a detailed discussion, see: Boddy, J., Lacey, A. and Hampden-Thompson, G. (2025) [Supporting families in precarious times: A qualitative longitudinal approach to understanding 'what works'](#). *Journal of Family Issues*. Online first.

community languages. Clarity of roles was also a distinct ethical consideration, establishing a clear distinction between the researcher team and the work of local ABS partnership areas and local evaluators. We achieved this by using clear visual branding materials and by taking time at each contact to reiterate the researcher's role and remit.

Care was taken during family group interviews to respect potential tensions around confidentiality or managing children's involvement (e.g., following up sensitive questions when children were not present, pausing or rescheduling the interview if a child was clearly restless or wanted the research to stop). Objective 3 research also followed a clearly defined protocol for any instances when the fieldwork researcher had concerns about the situation or wellbeing of any family member, including: initial consultation with the Objective 3 leads and where appropriate and with family consent in all cases, follow up with ABS.

Throughout the evaluation, we were led by principles of respectful and responsive engagement.²⁹ To ensure that data collection did not feel extractive, we kept in touch with families in between data collection points in the following ways:

- Birthday cards for all children in the family
- Christmas/seasonal greetings cards
- Messages (via text or Whatsapp) in response to big occasions or at sensitive times, where relevant. (e.g. where a family had talked about a forthcoming significant event or challenge during their interview, the researcher would send a supportive message around that time)

Perhaps not unexpectedly for a long-term evaluation involving young families, five families welcomed new babies during the project, and each was sent a small newborn gift to mark the occasion.

Our very high retention rate, and comments from families throughout the evaluation indicate that the process was respectful of families' needs, preferences and priorities, and enjoyable for those taking part. For example, one parent who missed an interview due to a period of challenge and later rejoined, talked about feeling supported to continue:

I'm grateful for you for actually just ... you know, because when I spoke to you before, I was quite ready to ... not that I wanted to, but I felt so overwhelmed at the time that I was just like, can't do it, and I really appreciate you saying, yeah, let's just catch up later, and that was really ... I was grateful for that, so thank you. [Objective 3 participant, Wave 3.2]

Other families talked about enjoying 'chatting' and having an opportunity to build rapport with the same researcher. This explicitly relational approach involved ethical responsibilities: namely, the responsibility to manage expectations and to anticipate endings. The Wave 4 interview was designed to

²⁹ Thomson R., Lacey A., Nasrawy M., Boddy J., Morrice L., Brannen J. (2024). *Scoping longitudinal qualitative studies with seldom heard families: Knowledge synthesis: Literature and academic expert consultation*. University of Sussex.
<https://hdl.handle.net/10779/uos.25574778.v1>

allow time for a proper ending - with the gift to the index child of the teddy bear, and opportunities to talk to families about next steps.

The research literature is clear that participants want and expect to know how the information they provide is used.³⁰ Throughout the evaluation period, in addition to regular feedback to both the parents' and practitioner panels, we provided ongoing feedback to families. All families received annual newsletters aligned to the annual reports, highlighting key findings each year and linking to the main evaluation outputs. Newsletters were translated into community languages where appropriate (five languages in addition to English), and several families commented on their appreciation of this.

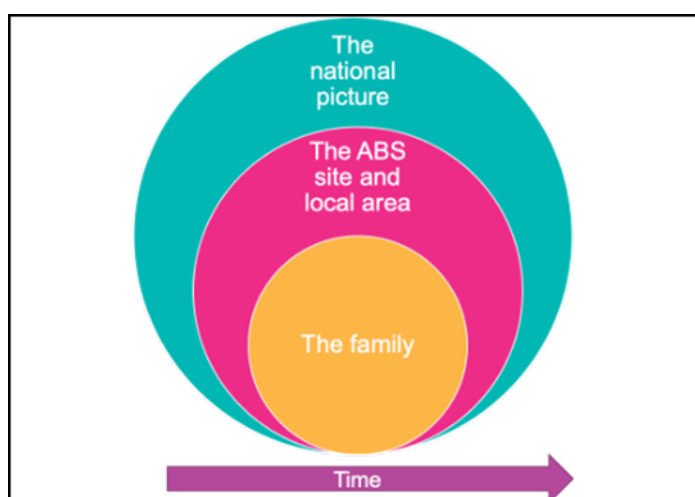
Data management

All interviews were digitally audio recorded and transcribed. In line with a detailed data protection protocol for Objective 3, all audio and visual files, transcripts, field notes, and other interview materials (e.g. maps, photographs, timelines) were stored in a secure password-protected folder, accessible only to named members of the Sussex research team who were identified to families on information sheets. Participants' data is anonymised (with removal or amendment of identifying details where necessary to protect confidentiality) in all reporting from the study. To mitigate potential risks of accumulating identifiable information about families across evaluation outputs and data points, reporting does not pseudonymise participants or routinely identify them by ABS area.

Analysis

As illustrated in Figure 5, Objective 3 analysis followed a staged and nested analytic approach to ensure that insights and findings were appropriately contextualised within family lives across place and time.

Figure 5. Objective 3 analytic approach



³⁰ See Thomson R., Lacey A., Nasrawy M., Boddy J., Morrice L., Brannen J. (2024). *Scoping longitudinal qualitative studies with seldom heard families: Knowledge synthesis: Literature and academic expert consultation*. University of Sussex.
<https://hdl.handle.net/10779/uos.25574778.v1>

Interviews over four years generated a rich and layered dataset, comprising approximately 245 hours of interviews; 6324 pages of transcripts; and maps, photos and timelines from interviews that included 99 participants across the 29 families.

Initially, we explored utilising computer-supported analysis with NVivo software and trialled this approach during Wave 1 data analysis. However, given the complexity of the dataset, it became apparent that thematic coding within Nvivo risked fragmentation of longitudinal narratives, obscuring evidence of families' journeys with ABS, and of complex intersecting influences in understanding the mechanisms through which ABS could contribute to family lives over time. Accordingly, the revised analytical process incorporated the following steps at each of the seven timepoints:

Family-specific summaries

Within 24 hours of each interview, an interviewer fieldnote was written, following the topic guide template. Following a process of data checking (transcript against audio recording) and familiarisation, thematic and narrative analysis of the data corpus (interview transcripts, family maps, and photographs,³¹ and fieldnotes), was used to create a family analytical summary for each time point. This included inductive and deductive analysis in relation to the focused research questions for Objective 3, including focus on the four ABS outcome domains, highlighting links with and questions for Objective 2 of the evaluation.

For all rounds of interviewing subsequent to Wave 1.1, cross-sectional analysis was followed by the preparation of a **longitudinal analytic summary** for each family, developed across waves. Longitudinal analysis focused on families' journeys over time with ABS, and on evidence of causal mechanisms in relation to the impact of ABS on family lives and practices, and outcome domains (child outcomes and systems change). This encompassed: evidence of change or continuity over time; maintenance/cessation of service involvement and the context in which this occurs; critical moments in family journeys, including key positive changes and periods of precarity, challenge or crisis.

An overarching longitudinal analysis was conducted for all families following the completion of Wave 4, reviewing data over time in relation to Objective 3 research questions and the causal claims of the contribution analysis, supported by the reflective timeline analytical tool.

Site-specific and cross-site analysis

Once preliminary analysis was complete for each round of interviews, site specific and cross-site analysis was conducted for each ABS partnership area, drawing on analytic summaries and the wider data corpus, to identify area-based and cross-cutting themes, with a focus on the Objective 3 research questions with a focus on the four outcome domains, barriers and facilitators of engagement and impact, and the nature and consequences of commonalities and differences in families' experience within and across areas. In line with the process outlined above, this analytic work was

³¹ At 4.1 this also included reflective timelines.

conducted cross-sectionally and longitudinally, following each round of data collection.

Following Wave 4 longitudinal analysis, Objective 3 data were incorporated into the overarching contribution analysis drawing on evidence synthesised within analytic summaries for each of the 29 families over time. For each contribution claim, Objective 3 data for each family was summarised to indicate: evidence in support of the claim (with cross-sectional and longitudinal framing); challenges or complexities highlighted by Objective 3 data in relation to the claim (supplemented by references); an anonymised overview of key contextual evidence for each family, to support interpretative insights.

Quality assurance and critical challenge

Analytical discussions

Preliminary data analysis was followed by extended discussions/workshops between the core research team at each wave. This included the review of draft analytical summaries for each family against interview transcripts, field notes, maps and photographs. Discussions were used to ensure analytic depth and rigour, developing and interrogating the definition of themes, narratives and analytic interpretations both cross-sectionally and longitudinally.

Internal quality assurance

Each year, sample data and analysis relating to three families (chosen in relation to analytic themes identified in the corpus for that year) was discussed with an internal QA team including colleagues with expertise in developmental psychology, early childhood services, and SEND. Feedback from the QA process was then incorporated into a subsequent review of the analysis by the core team.

External Quality Assurance

Draft copies of annual report contributions and other publications or presentations from the analysis were reviewed by colleagues at NatCen, NCB and The Fund prior to publication.

Appendix E: Objectives 1 and 4 methodological appendix

The national evaluation included a quasi-experimental design (QED) under Objective 1, intended to estimate the contribution of ABS to child-level and maternal outcomes, and a cost-consequence analysis (CCA) under Objective 4, intended to translate those estimates into implications for public spending. NatCen and The National Lottery Community Fund jointly agreed that the findings from Objectives 1 and 4 should not be published, because the available data did not support sufficiently robust conclusions. This decision followed careful consideration of the evidence and methodological limitations by NatCen and an independent peer review commissioned by The Fund. It reflected an assessment that a number of interlocking constraints limited the analysis, most notably significant challenges with the quality and completeness of administrative data, which resulted in very low numbers of linked consented records. Because the CCA depended on the impact estimates from the QED, there was no reliable basis on which to estimate cost consequences. The published evidence from the national evaluation therefore comprises the qualitative research conducted under Objectives 2 and 3, together with the local evidence synthesis and the contribution analysis that draws these strands together.

This appendix does not report any results from Objectives 1 or 4. Its purpose is to provide a transparent account of the methodological journey: what the evaluation team originally planned to do, as documented in the evaluation protocol and the study plan; how the approach had to be adapted during delivery; why the original design proved unfeasible; and what can be learned from this for future evaluations of complex, place-based programmes. This account is offered in the interests of methodological transparency and so that commissioners, evaluators and data controllers can benefit from the practical learning generated.

What we intended to do

Objective 1 aimed to identify the contribution made by the ABS programme to the life chances of children who received ABS interventions. The study plan set out a two-stage quasi-experimental design intended to estimate the average treatment effect on the treated (ATT): the average difference between the observed outcomes of ABS beneficiaries and what those outcomes would have been had ABS not been funded in their area. Estimates were to be produced separately for each partnership area and each outcome.

Evaluation timeline and agreed scope

The context in which this evaluation was commissioned is material to understanding the design that was adopted, and to interpreting questions that have subsequently been raised about it.

ABS was a ten-year programme, running from 2015 to 2025. An earlier national evaluation of the programme was undertaken by a separate team, and that contract came to an end before the work reported here began. The current evaluation was commissioned in 2021 and ran from April 2021 to March 2026. It therefore began six years into a ten-year programme, rather than alongside it, and picked up an evaluation function that had been interrupted.

The scope agreed at the point of commissioning in 2021 was prospective. It was established at the outset, and reflected in the evaluation plan developed during Phase 1, that the evaluation would be built around data generated from 2021 onwards rather than seeking to reconstruct a pre-programme position from retrospective sources. The evaluation's effective baseline was therefore 2021, six years after ABS funding began, and around the point at which the programme was considered to have reached full implementation across the partnership areas.

This shaped every subsequent design decision. In particular, it meant that designs relying on the comparison of outcomes before and after the introduction of the programme were outside the agreed scope of the work from the beginning, and the quasi-experimental design set out in the Study Plan was constructed accordingly, around matched contemporaneous comparison rather than temporal comparison.

In principle, the main route to an earlier, pre-programme baseline would have been through administrative data: historical health and education records held nationally by NHS England and the Department for Education, and locally by ABS partnerships and their statutory partners. In practice, this route proved unavailable. Throughout the evaluation, it was very challenging to source administrative data of adequate quality and completeness from either national or local data controllers. Data were not consistently compatible across health and education sources, across the five partnership areas or over time, and the outcome measures collected locally varied between partnerships, leaving few common measures that could be tracked consistently. Changes to ward boundaries during the programme period, including in Lambeth in 2022, further limited the comparability of ward-level data over time.

These challenges were not confined to retrospective data. They also affected the data available for the prospective design, resulting in very low numbers of linked consented records, a shorter data window than planned, and only a limited range of covariates. Taken together, they meant that neither a robust pre-programme baseline nor a sufficiently robust contemporaneous comparison could be achieved, and they were central to the joint decision by NatCen and The Fund not to publish the findings from Objectives 1 and 4.

Stage 1: Area-level matching

Each ABS electoral ward was to be matched to a statistically similar non-ABS ward in England using Mahalanobis distance matching, without replacement and using optimal pairwise matching. Matching was to draw on 24 publicly available local authority- and ward-level covariates covering deprivation, demographic structure, health, unemployment and local authority spend on

children's services, all measured prior to full programme implementation in 2020. This stage was intended to establish a pool of comparison areas from which a refined individual-level comparison group could subsequently be drawn.

Stage 2: Individual-level beneficiary analysis

The main analysis was to be an individual-level propensity score weighting model (inverse probability of treatment weighting, IPTW), followed by doubly robust outcome estimation. Critically, the intervention group was to comprise *identified ABS beneficiaries*. This depended on an opt-in consent process running in ABS areas for approximately one year between spring 2022 and spring 2023, through which families accessing ABS services would agree for their identifying details to be shared securely with NHS Digital (now NHS England) and the Department for Education (DfE) for linkage to routine health and education records. Comparison group records were to be supplied by the same data controllers for individuals living in the matched non-ABS wards. All data returned to the evaluation team would be pseudonymised.

Service use data collected by partnerships was to be linked to the pseudonymised records to describe reach and intensity of engagement and to enrich interpretation of the impact estimates.

Planned contingencies

Two contingencies were anticipated in the study plan. First, a modified group-level approach was planned for the Lambeth Early Action Partnership, whose data system had been deliberately designed to prevent the release of individual-level beneficiary details to third parties. Under this approach, aggregate characteristics and outcome means would be produced by site analysts and compared with an individual-level comparison group drawn from matched wards. Second, the same modified approach was to be applied in other sites if the volume of consents proved too low to sustain the main analysis.

A third, distinct strand, a 'whole-ward' analysis comparing all residents of ABS wards with residents of matched non-ABS wards, was planned *only* for Key Stage 1 and Key Stage 2 attainment. These were longer-term outcomes for which the evaluation timeframe was known to be too short to support beneficiary-level analysis.

Planned outcomes

Thirteen outcomes from the ABS Common Outcomes Framework were selected for the individual beneficiary analysis: perinatal maternal mental health; smoking status at delivery; birth weight; gestational age at birth; breastfeeding at 6-8 weeks; school readiness; healthy weight at reception; communication skills, social and emotional development and overall child development at age 2-2½ (Ages and Stages Questionnaire); children aged 0-4 who are Children in Need due to abuse or neglect; children aged 0-4 on a Child Protection Plan; and A&E attendances or emergency hospital admissions for children aged 0-4. Key Stage 1 and Key Stage 2 attainment were reserved

for whole-ward analysis. In total, the Study Plan anticipated fitting approximately 20 propensity score models and 52 outcome models.

Objective 4: the intended cost-consequence analysis

Objective 4 aimed to evidence the contribution the ABS programme had made to reducing costs to the public purse in relation to primary school aged children (5-11 year olds). The intended method was a cost-consequence analysis (CCA): a form of economic evaluation that presents a detailed, disaggregated comparison of costs and consequences, rather than combining them into a single metric such as a benefit-cost ratio. This approach was chosen because ABS was expected to influence a range of outcomes falling to different parts of the public sector (principally health and education) and because a disaggregated presentation allows decision-makers to interpret and weigh each component according to their own context.

The scope of the analysis was deliberately bounded. It was confined to public sector spending relating to children during their primary school years, and did not extend to economic productivity, quality of life, or costs and benefits relating to parents, to children under five, or to children over eleven. Longer-term and life-course savings, indirect and intergenerational effects, and impacts that could not be robustly quantified were also outside scope. This reflected both the resources available to the evaluation and the fact that the links between early years outcomes and subsequent public sector activity are most clearly evidenced for the primary school age group. It followed that any estimates produced would represent a partial rather than a complete account of the programme's cost consequences.

The analysis was designed to proceed in five steps:

- **Establish the inputs:** analyse expenditure on the programme (i.e. grant spend by the five partnerships, leverage and in-kind contributions, central programme costs, and support and delivery costs) and map that spend to the outcome domains it was intended to influence.
- **Take the estimated change in outcomes:** draw the estimated difference in each in-scope Common Outcomes Framework indicator from the Objective 1 analysis, applied to the same subset of indicators.
- **Identify the cost consequence pathways:** for each indicator, map the pathways linking the early years outcome to specific outcomes or interventions during the child's primary school years, recording the direction of the relationship and whether the underlying evidence indicated correlation or cause and effect.
- **Identify the cost components:** attach unit costs to each pathway, principally health, education and criminal justice costs, and derive a cost per defined outcome change for each year of primary school.
- **Present the cost consequences:** report the cost consequence for each outcome, specifying the sector and the age group affected, and whether the consequence was favourable or unfavourable.

All figures were to be adjusted for inflation using the HM Treasury GDP deflators, with 2025/26 as the base year, and discounted to present value using HM Treasury's social time preference rate of 3.5%. Where no suitable UK evidence existed for a given indicator, proxy measures drawn from closely related indicators or from reputable published sources were to be used in its place. Where cost consequence pathways overlapped, only one chain was to be counted, so that costs were not double counted. Evidence relating to systems change, which does not lend itself to this form of quantification, was to be drawn qualitatively from the Objective 2 interviews and presented alongside the partnerships' expenditure in that area.

The model itself was built from a review of existing research. This included cohort studies establishing the conceptual links between short-term parental and early years outcomes and longer-term outcomes for children during their primary school years, and economic studies of the effect of early years interventions on public sector spending for that age group. The conceptual links were then used to construct a model describing how a percentage-point difference in a given ABS outcome would be likely to affect public spending on primary school aged children, compared with an estimate of the counterfactual. The approach was reviewed by the evaluation's academic partners at the University of Sussex in 2023, who sense-checked the assumptions, advised on reducing double counting and suggested sources to fill identified gaps; in 2024 a paper setting out the conceptual links was shared with the ABS National Evaluation Advisory Group and the academic partners for further comment, and their feedback was used to refine the model.

Methods undertaken

The area-level matching stage was delivered broadly as planned. ABS wards were matched one-to-one to non-ABS wards across England using Mahalanobis distance matching on the intended covariate set. The closeness of matches varied between partnership areas, and residual imbalance remained on some individual covariates after matching, which would have needed to be reflected as a limitation in any reporting of results.

The second stage departed substantially from the plan. This was primarily because far fewer beneficiary records could be linked than anticipated: the individual-level analysis relied on opt-in consent, the number of consented, linked records was very low, and the data window for these records was shorter than planned. Combined with variation between partnerships in the outcomes measured and the data that could be supplied, this meant that a single analytical approach could not be applied consistently across sites. Rather than a single individual-linked beneficiary analysis with a group-level contingency in one site, three distinct analytical approaches were used, selected on an outcome-by-outcome and site-by-site basis according to data availability:

- **Whole-ward analysis (WW)** became the primary approach for most outcomes and sites, comparing all eligible individuals resident in ABS wards with a weighted comparison group in matched non-ABS wards, regardless of whether they had engaged with ABS services.

- **Consented beneficiary analysis (CBA)** used records for beneficiaries who had provided opt-in consent in Blackpool, Bradford, Nottingham and Southend, linked by NHS England. This was the approach originally intended as the main analysis, but it could be used for only a small number of outcomes in a single site.
- **Pseudonymised beneficiary analysis (PBA)** used pseudonymised beneficiary data supplied directly by partnerships where this could be done without disproportionate burden – principally Blackpool, Lambeth and Nottingham.

Analysis was only undertaken where a minimum number of observations was available in each of the ABS and non-ABS groups, a threshold derived from power calculations designed to detect small-to-medium effects. This ruled out a substantial number of outcome-site combinations before analysis began. A small number of further models were fitted but subsequently excluded because they failed key diagnostic tests on covariate coverage, common support or residual balance.

Taken together, these constraints meant that the set of outcomes for which any analysis could be attempted was narrower (in some areas³²) than the thirteen originally specified in the Study plan, and that the analyses that were possible varied in approach from one partnership area to another.

Two further methodological additions were introduced in response to the constraints encountered. First, a Red-Amber-Green quality rating was developed and applied to each analysis, reflecting the extent to which the underlying modelling assumptions were met – covariate coverage, residual balance after weighting, common support, and sample size. Second, a structured missing data analysis was undertaken for higher-quality models where missingness exceeded a set threshold, using drop-out models to test for data missing at random and multiple imputation where appropriate. Estimates were to be expressed as percentage-point differences with 95% confidence intervals rather than as statistical significance tests, with standard errors bootstrapped and clustered at ward level.

Table 12. Objective 1: intended and delivered approach compared

Design element	Intended (Study Plan, 2022)	Delivered (2026)
Area-level matching	Mahalanobis distance matching of ABS wards to non-ABS wards on 24 pre-2020 covariates	Delivered as planned; closeness of matches varied by area and residual imbalance remained on some covariates
Primary analysis group	Consented individual ABS beneficiaries, linked to NHS and DfE records	All eligible residents of ABS wards (whole-ward analysis), supplemented by beneficiary analyses where feasible

³² Of the 13 outcomes, we were able to attempt analysis for 12 outcomes in Blackpool; 5 in Bradford; 8 in Lambeth; 7 in Nottingham; and 9 in Southend.

Number of analytical approaches	One main approach plus one group-level contingency for Lambeth	Three approaches: whole-ward, consented beneficiary, and pseudonymised beneficiary
Whole-ward analysis	Restricted to Key Stage 1 and Key Stage 2 attainment	Used as the primary approach for the majority of outcomes and sites
Outcomes analysed	13 beneficiary-level outcomes plus 2 whole-ward attainment outcomes	A narrower set of outcomes; several planned outcomes could not be analysed at all
Modelling	Approximately 20 propensity score models and 52 outcome models	Substantially fewer models fitted; a small number of further models excluded on quality grounds
Service use linkage	Beneficiary service use data linked to outcomes to assess dosage and intensity	Not achievable consistently; service use data reported descriptively and separately
Reporting of quality	Diagnostics reported (pseudo-R ² , c-statistic, standardised mean differences, Tukey test)	Diagnostics supplemented by a Red-Amber-Green quality rating for each analysis and a formal missing data analysis

Objective 4: what was delivered

Those components of the cost-consequence analysis that did not depend on the Objective 1 impact estimates were carried out broadly as intended. Programme inputs were analysed using financial data supplied by The National Lottery Community Fund and the five partnerships, covering grant commitments and spend, leverage and in-kind contributions, central programme costs, and support and delivery costs. Working with the partnerships, this spend was mapped to the national evaluation outcome measures, with an additional category for other Common Outcomes Framework and partnership-specific outcomes; any spend that could not be mapped directly was allocated to outcomes on a pro-rata basis in line with mapped spend.

Monitoring data on unique primary beneficiaries reported by each partnership was analysed to describe participation, the proportion of the eligible population reached, and average programme spend per beneficiary. This analysis was treated as indicative rather than precise, for three reasons: recording methods varied between partnerships and between the services within them; beneficiary counts capture neither the intensity of support nor the resources required to deliver it, so that intensive targeted provision and light-touch universal provision are counted alike; and beneficiaries accessing more than one service in a year are counted once, while those returning in a later year are counted again. These limitations also constrained the quasi-experimental analysis, as discussed earlier.

The cost consequence pathways and the associated unit costs were also constructed as planned, for each in-scope Common Outcomes Framework indicator, and uprated to 2025/26 prices. Several practical adaptations were

needed in doing so. Where no suitable UK data existed for an indicator, proxy measures were substituted, for example, effect sizes from the Strengths and Difficulties Questionnaire were used in place of the ASQ-SE, and funding provided to primary schools for COVID-19 catch-up was used as a proxy for the additional per-pupil funding associated with children who were not school ready. Where source studies reported the total cost and duration of an intervention without a yearly profile, costs were assumed to be spread evenly across the period. Where pathways overlapped, for example, between smoking in pregnancy and low birth weight, only one chain was modelled, to avoid double counting. Evidence of systems change was drawn from the Objective 2 interviews and used qualitatively, alongside the partnerships' expenditure in that area.

What could not be delivered was the final step. Applying the pathways and unit costs to the estimated changes in outcomes produced under Objective 1 was the point at which the analysis would have generated cost consequences for the ABS programme, and that step depended entirely on those estimates. The cost model and the analysis of programme inputs therefore exist as a completed method, but no cost consequences for ABS have been produced or are reported here.

Why the original approach was not possible

A series of interlocking constraints meant that the intended design could not be delivered as specified. None of these was fatal in isolation; taken together, they made the planned beneficiary-level analysis unviable for most outcomes and sites, and limited what could be concluded from the analyses that were possible. It was on this basis that NatCen recommended that the findings should not be published in this report, a recommendation The Fund agreed.

The consented sample was too small for the intended analysis, and linkage reduced it further

This was the single most consequential constraint. A consent process was designed, approved by NHS Digital, consulted on with sites and the Parent Panel, and run in four partnership areas. By autumn 2023, partnerships had recruited 511 consented adults and 439 children in Bradford, 305 adults and 301 children in Nottingham, 89 adults and 139 children in Southend, and 58 adults and 55 children in Blackpool. Our November 2023 power analysis showed what these numbers would allow, even if every recruited beneficiary were linked and had the relevant outcome recorded.

The minimum detectable effect sizes (Cohen's h , at 80% power, adjusted for multiple outcomes) would be 0.19 in Bradford, 0.25-0.26 in Nottingham, 0.38-0.47 in Southend and 0.59-0.62 in Blackpool. Only Bradford could therefore detect a small effect ($h = 0.2$). In Blackpool, the sample was too small to detect even a medium-sized effect ($h = 0.5$).

On this basis, we concluded that the planned comparison of consented beneficiaries with a non-ABS group was not feasible in Blackpool, Nottingham or Southend. Data from these areas would be used descriptively only. These figures were upper bounds, and the usable sample for each outcome was smaller still. Not every consented child was the right age for each outcome,

not every beneficiary had the outcome recorded in national datasets, and many lacked an NHS number, which made linkage less reliable. **After linkage, the sample for many outcomes amounted to only a handful of individuals.** The intended primary analysis was therefore not viable across most of the programme.

The data window available for consented records was shorter than planned

Linkage through the consent route was restricted to April 2023 to March 2024, compared with June 2022 to June 2024 for whole-ward health outcomes. During the data application process, NHS England advised that, for the relevant datasets (CSDS and MSDS), date restrictions could only be applied at the financial year level rather than by individual months. As a result, it was not possible to provide data for the full consented period while excluding records outside that timeframe. Consequently, access to consent-linked data was limited to the single financial year from April 2023 to March 2024. This further reduced the number of eligible events captured for consented beneficiaries and compounded the sample size problem described above.

Site data systems constrained what beneficiary data could be shared

The study plan correctly anticipated that Lambeth's data system would preclude the release of individual-level beneficiary data. In practice, variation in data systems across all five partnerships was greater than expected. Some sites could share pseudonymised beneficiary records covering some outcomes; others could not, or could only do so at disproportionate cost. Differences in recording practice between site-held data and NHS England data also meant that beneficiary and whole-ward sample sizes were not directly comparable, limiting what could be inferred about the reach of ABS from sample sizes alone.

Administrative data completeness and quality were weaker than assumed

The study plan acknowledged that data quality could not be fully assessed until data were received. In the event, coverage and completeness varied considerably across outcomes, datasets and partnership areas. Some measures were recorded for too few individuals in too few areas to support analysis, and some planned outcomes could not be constructed at all from the data received. In one instance, discussion with partnerships and subsequent data checks revealed that a planned measure (the ASQ-SE) is generally only administered where concerns have already been identified, making it unsuitable as an outcome indicator; the personal-social domain of the ASQ-3 was substituted instead.

Covariate coverage was insufficient to support strong causal claims

The weighting approach could only adjust for differences between the ABS and non-ABS groups that were recorded in the data. It therefore relied on the assumption of 'selection on observables': that the available covariates captured all the relevant ways in which the two groups differed. If the groups also differed in ways that were not recorded, and those differences affected the outcome, any gap in outcomes could reflect those unmeasured differences rather than the effect of ABS.

For several outcomes, particularly those relating to children's early development, the underlying datasets contained only a small number of covariates, such as the child's sex, ethnicity and month of birth. They did not include factors known to be strongly associated with early development, such as parental education, household income, maternal mental health or the home learning environment. For example, if mothers in ABS areas had higher levels of perinatal depression than mothers in comparison areas, this would not appear in the data. The weighting could not adjust for it, and any difference in children's developmental scores could not be confidently attributed to ABS. As a result, the selection on observables assumption could not reasonably be considered satisfied.

Where covariates were available, some were limited to characteristics that do not change over time, such as sex or ethnicity, rather than circumstances that do, such as household income or housing situation. This adds a further risk of bias because the population of ABS areas changed over the programme. As described in Chapter 4, some areas had high residential churn (for example, Blackpool) or families moving out because of housing costs (for example, Lambeth). If the families moving into or out of ABS areas differed in ways that fixed characteristics cannot capture, for example if families whose circumstances improved were more likely to move away. In that case, the weighting would not correct for these changes. Estimated differences could then reflect who was living in the area rather than the effect of ABS.

The evaluation was prospective, and no pre-programme baseline was available

Peer review of the evaluation's outputs has asked why the analysis did not compare outcomes before and after the introduction of ABS. It is worth setting out plainly why such a design was not available to the team. Three factors converged, and each would independently have been sufficient to rule it out.

First, by 2021 the programme had already reached full implementation. Any measurement taken from the point at which this evaluation began was therefore taken after six years of exposure to ABS, and would not have constituted a baseline in any meaningful sense. A genuine pre-programme measurement would have had to be taken in or before 2015.

Second, the necessary historic data did not exist at the relevant geography. ABS operated at electoral ward level, and for almost all of the selected outcomes, ward-level statistics on prevalence prior to 2020 were not published or otherwise obtainable. The only meaningful exceptions were low birth weight and A&E attendance for children aged 0-4, both of which were incorporated into the area-level matching for precisely this reason. Even had a retrospective design been within scope, the data required to construct a credible pre-programme baseline for the majority of outcomes was not available.

Third, the agreed scope of the evaluation was prospective. As set out in Section 1, the evaluation was commissioned in 2021 with a scope built around data generated from that point onwards, and the use of retrospective data to construct a pre-programme position did not form part of the agreed approach.

The study plan and the wider evaluation design were developed on that basis and were reviewed and signed off accordingly.

The consequence is that neither the matching nor the weighting process could account for baseline differences in outcome levels between ABS and non-ABS areas, and proxy variables predictive of, or plausibly correlated with, those outcomes had to be used instead. It also meant that stronger designs such as difference-in-differences or interrupted time series were not available. What remained was a cross-sectional comparison of matched contemporaneous groups.³³ This approach assumes that there were no unmeasured factors, such as changes in local services, population characteristics or economic conditions, that affected ABS and comparison groups differently and also influenced their outcomes. Because the available data cannot establish whether all such factors have been accounted for, this assumption cannot be tested directly and is consistently reported as a limitation of the approach.

Measurement timing did not align with plausible exposure to ABS

The study plan recognised that the evaluation window allowed roughly one year between beneficiary registration and outcome measurement, and selected outcomes accordingly. In practice, even this proved optimistic for some outcomes. Children whose Key Stage 2 attainment would have been analysed were born well before ABS reached full implementation and are unlikely to have been meaningfully exposed to the programme at all. Whole-ward analyses more generally capture area-wide effects rather than the effect of participation, and would be expected to understate any impact on direct beneficiaries, particularly where only a minority of the ward population engaged with ABS services.

Objective 4 was contingent on Objective 1

The cost-consequence analysis under Objective 4 was designed to take the impact estimates produced by Objective 1 and, using cost consequence pathways drawn from published research, translate them into indicative implications for public sector spending during children's primary school years. Because the analysis depended directly on those impact estimates, the constraints described above carried through to Objective 4, and the cost consequences of the ABS programme could not be robustly estimated.

Two further constraints are worth recording about Objective 4 in its own right, since they would have shaped the interpretation of any estimates the analysis produced. First, most of the cost consequence pathways rest on evidence of correlation rather than established causation, so the analysis could only ever have indicated the likelihood of costs avoided or incurred; it does not calculate cost savings. Second, the evidence base required a number of working assumptions (proxy measures where no suitable UK data existed,

³³ **Matched contemporaneous comparison group:** a group of individuals or areas that did not receive ABS, selected because they share key characteristics with ABS areas or beneficiaries (matched), and observed over the same time period (contemporaneous). Comparing the two groups would have helped estimate what outcomes might have been without ABS, while accounting for wider events, such as the Covid-19 pandemic, that affected all areas at the same time.

an even distribution of costs across years where source studies reported only totals, and the exclusion of overlapping pathways to prevent double counting) and the deliberate restriction of scope to the primary school years means that any figures produced would have understated the programme's full cost consequences. The test-and-learn nature of ABS also meant that systematic evidence on the costs of individual services was limited.

The underlying cost model itself remains sound and transferable. It sets out, for each Common Outcomes Framework indicator, the conceptual pathways linking early years outcomes to later public sector activity, and the unit costs associated with each pathway. It was reviewed by academic partners at the University of Sussex and by the evaluation's Advisory Group. Although it has not been applied to ABS outcomes in a form that can be published, the model could be applied by others to interventions seeking to influence the same outcomes, provided it is updated as new evidence becomes available.

Lessons learned for similar evaluations

The following lessons are offered for funders, commissioners, data controllers and evaluators designing impact evaluations of complex, place-based programmes in the early years and comparable fields.

Design the evaluation at the same time as the programme

- Impact evaluation requirements should be built into programme design from the outset, not retrofitted part-way through delivery. Consent processes, beneficiary identifiers and outcome measurement need to be embedded in routine service delivery from year one so that a full exposure period is captured.
- Baseline outcome measurement at the relevant geography should be commissioned before, or at the point of, programme launch. Without it, stronger designs such as difference-in-differences are unavailable and matching cannot balance on prior outcome levels. Once a programme is underway, this cannot be retrieved.
- Where an evaluation is commissioned part-way through a long programme, or where an evaluation function is interrupted and later resumed, the design options available to the incoming team are constrained by decisions already taken and by data already collected or not collected. Continuity of evaluation across the life of a programme is itself a methodological asset, and its loss carries a real cost to the strength of evidence that can ultimately be produced.
- The scope agreed at commissioning, including whether an evaluation is prospective or is expected to draw on retrospective data, should be recorded explicitly in the evaluation plan and revisited periodically with the commissioner. Doing so provides a shared and durable reference point as teams, priorities and personnel change over the life of a long programme.

- Where a programme is expected to run for a decade, evaluation timelines and outcome selection should be aligned to the point at which exposed cohorts will actually reach the age at which outcomes are measured.

Treat data access and quality as a feasibility question, not an assumption

- Undertake a data feasibility exercise (ideally a dummy or test extract) before finalising the outcome set and analysis plan. Coverage, completeness, recording practice and variable availability should be verified empirically rather than inferred from dataset documentation.
- Confirm the measurement properties and clinical use of each proposed indicator with practitioners as well as data controllers. The ASQ-SE experience shows that an indicator can be technically present in a dataset but generated through a selective process that makes it unusable as an outcome measure.
- Build realistic contingency into timescales for information governance approvals. Data access processes are long, and delays compress the observation window at the end of a programme, when it matters most.

Be cautious about designs that depend on opt-in consent for data linkage

- Opt-in consent for administrative data linkage proved a fragile foundation for a programme-wide impact analysis. Even with extensive co-design, sign-off from the data controller and engagement with parents and practitioners, the yield of usable linked records was an order of magnitude below what was required.
- Where consent-based linkage is unavoidable, set an explicit minimum yield, monitor it in real time against that threshold, and agree decision points at which an alternative design will be triggered. Consider resourcing consent collection directly, so it does not compete with frontline delivery time.
- Explore alternative legal gateways and whole-population approaches early, in partnership with data controllers, rather than as a fallback. Where consent is required, plan for a longer recruitment window and for consent to be sought at multiple, routine points of contact.
- Recognise that consent-based samples also carry a risk of selection bias, since consenting beneficiaries may differ systematically from those who do not consent.

Standardise beneficiary and service use data across sites

- In multi-site programmes with local autonomy over delivery, agree a minimum common data specification at the outset: consistent definitions of a beneficiary, consistent identifiers, and consistent recording of service type, dosage and intensity.

- Without this, it is not possible to link exposure to outcomes, to distinguish intensive targeted support from light-touch universal provision, or to interpret null findings, because the analysis cannot establish whether individuals received a meaningful dose of the intervention.
- Local autonomy and a common data specification are not incompatible, but the latter has to be a condition of funding rather than a request made later.

Pre-specify quality thresholds and report transparently against them

- Applying minimum sample size thresholds, excluding models that failed diagnostic tests, and attaching a Red-Amber-Green quality rating to each analysis was, on reflection, one of the strengths of the delivered approach. It made the limits of the evidence explicit and supported an informed judgement about whether findings could responsibly be published.
- Setting these rules in advance protects against selective reporting and against over-interpretation of findings drawn from weak data. It also gives commissioners and evaluators a shared, objective basis for deciding what should and should not enter the public domain.
- Reporting confidence intervals rather than binary significance tests better conveys the precision of estimates and is more honest about uncertainty.
- Agree at the outset how a decision not to publish would be handled, and what would be published in its place. Documenting the methodological journey transparently, as this appendix does, preserves the learning value of the work even where the findings themselves cannot responsibly be released.

Position quantitative impact analysis within a wider evidence framework

- The decision to embed the QED within a contribution analysis, alongside qualitative research with families and practitioners and evidence from local evaluations, proved essential. Because the quantitative strands could not ultimately support publishable conclusions, the other strands carried the evaluation's account of whether the mechanisms of change described in the theory of change were operating.
- For complex, adaptive, place-based programmes, a theory-based framework should be the organising structure, with quasi-experimental analysis as one contributing strand rather than the definitive test of impact.
- Commissioners and evaluators should agree in advance how divergence between strands, and the possibility that one strand may not yield publishable findings, will be interpreted and communicated. This is

important so that this is settled as a matter of methodology rather than negotiated late in the reporting process.

Design economic analysis so that it does not depend wholly on a single evidence strand

- The cost-consequence analysis was designed so that its final step could only be taken once the Objective 1 impact estimates were available. That created a single point of failure: when the impact estimates could not support publishable conclusions, the economic analysis could not be completed either, despite every other component having been delivered.
- Where an economic strand depends on an impact strand, agree at the outset what the economic analysis will report if the impact estimates do not materialise or cannot be published.
- Set decision points for the economic analysis that are aligned to the milestones of the impact analysis, so that emerging constraints on the impact side trigger a timely conversation about the scope and form of the economic outputs rather than being discovered at the reporting stage.
- Consider designing the economic analysis so that it can also be run against illustrative or scenario-based changes in outcomes. This preserves its value as a decision-making tool for commissioners even where programme-specific estimates are unavailable, provided such scenarios are clearly labelled as illustrative and not presented as programme findings.

Treat the cost model as a durable, transferable asset

- Building the cost consequence pathways and unit costs from published evidence, and documenting the conceptual link behind each one, meant the model retained value independently of the programme it was built for. It can be applied by others to interventions targeting the same outcomes, and updated as new evidence emerges.
- Record every working assumption explicitly and in one place: which pathways rest on correlation rather than causation, where proxy measures have been substituted and why, how costs have been profiled across years, and which overlapping pathways have been excluded to prevent double counting. This is what allows the model to be re-used, challenged and revised.
- Subject the model to independent review early and more than once. Review by academic partners and by the evaluation's advisory group at successive stages improved the treatment of double counting and identified sources to fill gaps in the evidence base.
- Set the boundary of the analysis deliberately and state it plainly. Confining the scope to a defined age group and a defined set of public

sector costs supported more robust analysis, but it also means any resulting figures understate the full cost consequences of a programme. That trade-off should be made visible to commissioners at the design stage, not explained at the end.

Collect cost and reach evidence alongside delivery, not after it

- A test-and-learn programme generates limited systematic evidence on the cost of individual services. If economic analysis is intended, a minimum specification for recording service-level costs, including the intensity and duration of support, should be agreed as a condition of funding at the outset.
- Map expenditure to outcome domains prospectively and in partnership with delivery sites, rather than reconstructing the mapping at the end of the programme. Doing so reduces reliance on pro-rata allocation of unmapped spend and gives a more accurate picture of where investment was directed.
- Beneficiary counts alone cannot carry a cost-per-participant analysis. Without consistent definitions across sites, and without a measure of intensity, intensive targeted provision and light-touch universal provision are counted identically, and figures derived from them can only ever be indicative.
- Where a programme invests substantially in systems change, agree in advance how that investment will be evidenced. It does not lend itself to the same form of quantification as child- and parent-level outcomes, and needs a qualitative account planned alongside the expenditure data rather than assembled retrospectively.

Invest in the data infrastructure that future evaluations will depend on

- Several of the constraints described above are systemic rather than specific to ABS: incomplete recording in maternity and community services datasets, limited small-area outcome statistics, and the absence of routine mechanisms to link programme participation to routine records.
- Improving the completeness and consistency of these datasets, and developing accessible, ethically governed routes to link programme data to them, would materially increase the quality of evidence available on early years interventions.
- Funders of long-term programmes are well placed to contribute to this infrastructure, and doing so may deliver more value over time than any single impact estimate.

Summary

The Objective 1 analysis delivered was not the analysis that was planned. The area-level matching stage was implemented as designed, but the individual-level beneficiary analysis that was to have been the centrepiece of the QED could not be delivered across the programme. This was principally due to the very low number of consented beneficiaries whose records could be located and linked to administrative data: although a consent process was designed, approved by NHS Digital and run in four partnership areas, for most outcomes and areas the linked sample fell well short of the minimum needed to detect even a medium-sized effect. As a result, whole-ward analysis, originally reserved for two longer-term attainment outcomes, became the primary approach. The set of outcomes that could be analysed was narrower than intended, reflecting the limited number of common outcome measures across partnerships, gaps in the quality and completeness of administrative data, and a shorter than planned data window for consented records. The approach used also varied between partnership areas, depending on whether consented records were available and on the data each area could provide. Because Objective 4 depended on the Objective 1 estimates, the cost-consequence analysis could not be completed as intended either.

While low linkage was the most consequential factor, it was compounded by the design and timing of the evaluation. The evaluation was commissioned in 2021, six years into a ten-year programme, with a prospective scope and no pre-programme baseline, and, for most outcomes, no historic ward-level data from which one could have been constructed. Beyond the data limitations described above, the analysis was further constrained by limited covariate coverage and a mismatch between measurement timing and plausible exposure to the programme. The team applied transparent quality thresholds and ratings to the resulting estimates. Those thresholds ultimately informed the judgement, agreed with The National Lottery Community Fund, that the estimates were not sufficiently robust to publish, and that the national evaluation's published account should rest on the qualitative evidence from Objectives 2 and 3, the local evidence synthesis, and the contribution analysis.

The central lesson is that the feasibility of an impact design depends less on the sophistication of the statistical method than on the timing of commissioning, the data infrastructure and the delivery arrangements that surround it. For complex, place-based programmes, those arrangements need to be designed in alongside the programme itself, sustained continuously across its life, tested empirically before the analysis plan is fixed, and supported by a theory-based framework capable of generating credible conclusions when the quantitative evidence cannot.

Appendix F: List of national evaluation outputs

Table 13. Outputs produced for the national evaluation of ABS

Output	Link
ABS National Evaluation Phase 2 Protocol	https://natcen.ac.uk/sites/default/files/2023-08/2023%20revised%20phase%20%20protocol.pdf
First ABS National Evaluation Annual Report	https://natcen.ac.uk/sites/default/files/2023-05/ABS%20First%20Annual%20Report_Final%20for%20publication.pdf
A Better Start National Evaluation Themed Annual Report: Place-based Approaches	https://natcen.ac.uk/sites/default/files/2023-06/ABS%20thematic%20report_final_June2023.pdf
First Annual Update from A Better Start - National Evaluation (podcast)	https://www.youtube.com/watch?v=dirUD_ICWiE
A Better Start - national update webinar (first)	https://www.youtube.com/watch?v=lo2gWhRyt9o
Working with families to support early childhood development: learning from the evaluation of A Better Start	https://www.researchinpractice.org.uk/media/nek-m03lh/working-with-families-to-support-early-childhood-development-18jan2024.pdf
Second ABS National Evaluation Annual Report	https://natcen.ac.uk/sites/default/files/2024-05/2nd%20ABS%20Annual%20Report_final_forpublication%20V2.pdf
A Better Start National Evaluation Themed Report: Parental Engagement	https://natcen.ac.uk/sites/default/files/2024-05/ABS%20themed%20report_2024_final_forpublication.pdf
Local evidence synthesis 1: implementation	https://natcen.ac.uk/sites/default/files/2024-05/ABS%20Local%20evidence%20synthesis1_final_for%20publication.pdf
A Better Start - National Evaluation	https://www.youtube.com/watch?v=4TtL7TDYK68

Annual Report Webinar (second)	
Second Annual Update from A Better Start - National Evaluation (podcast)	https://www.youtube.com/watch?v=iZY7_5TRtqY&t=36s
Moving Towards Tapestries of Care and Connection: Insights from the second annual report of the A Better Start evaluation	https://www.researchinpractice.org.uk/media/i4tpqjbr/moving-towards-tapestries-of-care-and-connection-insights-from-the-second-annual-report-of-the-a-better-start-evaluation-sb-web.pdf
ABS National Evaluation Third Annual Report	https://natcen.ac.uk/sites/default/files/2025-05/3rd%20ABS%20Annual%20Report.pdf
A Better Start - National Evaluation Annual Report Webinar (webinar)	https://www.youtube.com/watch?v=7RNSQ0lUvYU&source_ve_path=MjM4NTE&embeds_referring_euri=https%3A%2F%2Fnatcen.ac.uk%2F
Third Annual Update from A Better Start - National Evaluation (vlog)	https://www.youtube.com/watch?v=kTmoybwgNwQ
Scaffolding support and prioritising family voices for child development: Learning from the third annual report for the evaluation of A Better Start	https://www.researchinpractice.org.uk/media/hea15hg/scaffolding_support_and_prioritising_family_voices_for_child_development.pdf
Local evidence synthesis 2: implementation and impact	Publication pending
Final practitioner briefing	Pending