

Final learning report

Team Around the School (TAS) pilot
Phase 1 (2024/25)

September 2025

This document presents summary statistics and qualitative findings for the TAS pilot across Bedford Borough in the 2024/25 school year and makes recommendations for Phase 2.

It builds on an earlier Interim Learning Report circulated in May 2025. Data sources include case-level summaries, perceptions survey of pilot participants and service-level referrals data.

A standalone Executive Summary with key findings is provided alongside this report.

Delivered by:



We seek to rekindle humanity in public services through data, storytelling and co-production.

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Change is not always easy. Even when we know there is potential to improve ways of working, processes and, most importantly, outcomes for children, young people and their families.

Taking part in a pilot adds another layer of challenge. By definition, a pilot tests different approaches, adapts as it goes and makes more changes along the way. This calls for curiosity, optimism and commitment: qualities we have seen consistently from partners across education, health and care in the Teams Around the School (TAS) pilot.

The nature of this type of change is continual, sometimes disruptive, but always an opportunity to learn together. Even where learning can be drawn from what's worked well in other locations, there can still be uncertainty of how things will work here, across partnerships and with local families in Bedford Borough.

The focus of this report is on learning. Not everything in the pilot went to plan, and some aspects have been difficult. Added to this is the reality that change can take time to embed before results are visible. This report reflects on what has been learned so far, and how this knowledge can be built on towards future sustainability.

Before we turn to the findings and opportunities in this report,

We want to pause and acknowledge the commitment and contributions from every person who has taken part in the pilot so far.

At Spark the Difference, we believe it is these collective efforts – the small, consistent actions taken in partnership – that go on to make the biggest difference.

Sam Meikle

Spark the Difference
September 2025

1. Scope and purpose of this document

This section sets out core details of the TAS pilot, and the purpose of this learning report.

1.1 What is the TAS pilot?

The Team Around the School (TAS) is a pilot initiative involving schools, local authority services and health services in Bedford Borough. Phase 1 of the pilot ran from October 2024 to July 2025, and aimed to create school-level opportunities for:

- (i) early identification of children and young people’s additional needs; and
- (ii) delivery of the right support, at the right time, in the right place.

These goals align with the objective to strengthen inclusive practice in mainstream settings that is identified in the Department for Education’s national Special Educational Needs and Disabilities and Alternative Provision (SEND & AP) Change Programme.

What was the pilot testing?

The key innovation of the TAS approach is to **regularly convene multi-disciplinary team (MDT) meetings at school level**. This approach brings together school-based, local authority and health services. In each school-based meeting, school staff prepare and present case summaries for pupils who may benefit from early identification and joined-up support across services.

Phase 1 of the pilot aimed to test the feasibility and scalability of the approach and comprised 12 primary schools and 7 secondary schools across Bedford Borough. Each participating school was supported by (i) a Strategic Lead to facilitate meetings and share learning across the pilot, and (ii) a Case Coordinator to help plan, track and organise follow-up actions. Figure 1 reproduces the pilot design as it was presented to the TAS Steering Group in August 2024.

Figure 1a: Goals of TAS pilot
(Presentation to TAS Steering Group, August 2024)

Testing what a ‘Team Around The School’ approach could look like in Bedford

Our shared aims for a TAS approach:

1. **Deliver improved outcomes** for children and young people and their families
2. **Establish improved support for schools, in schools** to develop understanding of needs and more inclusive strategies to meet these needs within their settings
3. **Transition from reactive to proactive needs assessment:** creating opportunities for the early identification of diverse needs among children and young people through timely, appropriate conversations. **Right support, right place, right time**
4. **Test the feasibility and scalability:** of an effective, system-wide ‘Team Around the School’ model across the Borough.
5. **Identify potential “quick wins”:** test innovative in-setting provisions designed to address immediate local needs effectively, for example within Alternative Provision
6. **Reduce** the need for referrals to services, and thus waiting times

Some of the proposed features:



Practitioners across education, health and the local authority will work *with* schools



Build on existing meetings & ways of working to create capacity for *fewer* but *more frequent* TAS meetings



Testing the approach with 18 schools in Bedford across primary and secondary



As they mature, these ways of working can replace duplicative paperwork and governance

Intended outcomes of TAS

The pilot design documents and TAS Charter defined the following specific outcomes:

- (i) Transition from reactive to proactive needs identification and intervention.
- (ii) Create opportunities for early identification and intervention of diverse needs of children and young people
- (iii) Speed and clarity on best support for the child, rather than different referral pathways proceeding on different timelines.
- (iv) Provide guidance and confidence for schools; document and evidence what's been done.
- (v) Reduce duplicative paperwork and governance, as the above ways of working mature.

A further planned outcome was to adapt the referral pathway for the neurodiversity service of Community Paediatrics. The intention was for participating schools to introduce and use an Early Concerns Toolkit (ECT) prior to a referral. This toolkit was originally developed in Portsmouth and has also been rolled out for neurodiversity pilots in Luton and Central Bedfordshire. The adaptation for this Bedford Borough pilot is that the toolkit can be used in schools to improve the early identification for any emerging need – not only neurodiversity needs.

1.2 How this report captures emerging learning

This report shares insights and lessons learned for Phase 1 of the TAS pilot (school year 2024/25), and builds upon the Interim Learning Report circulated in May 2025. Its goals are to:

- (i) understand, document and consolidate the different experiences of the schools and services involved in the pilot.
- (ii) provide findings to the TAS Steering Group on pilot progress against intended outcomes; and
- (iii) make actionable recommendations to further develop the pilot in a second phase.

The assessment and learning process has been coordinated by Spark the Difference, an independent partner, contracted by Bedford Borough Council, on behalf of the TAS pilot team and SEND & AP Change Programme.

Where did we expect the pilot to make a difference?

The approach and methodology to assess the effectiveness of the pilot were co-produced with partners. An evaluability assessment, a discussion of how best to measure the pilot's effectiveness, was shared with the TAS Ops Group in summer 2024. A draft methodology including survey and interview protocols was then shared with the TAS Steering Group in April 2025.

In brief, this report looks at four levels of assessment (overleaf, Figure 1b).

Reading from the bottom upwards in Figure 1b, we ask the following questions:

- (4) What happened in and around TAS meetings? Did meetings and processes go as expected? Were there emerging variations?
- (3) What were the changes in working behaviours? What were the immediate outputs of the TAS process, and how did they differ to normal practices?
- (2) What changed for system partners? Are there trends that are visible in service-level data held by local authority and health partners?
- (1) Is there any evidence (yet) of changes for children and young people?

Figure 1b: Levels of assessment for the TAS pilot



What data and information did we draw upon?

Data sources for this assessment include the following:

- demographic data for all cases considered within the TAS pilot.
- all case summaries prepared at school-level (a total of 225 cases).
- case trackers managed by Case Coordinators.
- semi-structured interviews with stakeholders across participating schools and all services.
- feedback from an anonymous survey of TAS participants in April / May 2025; and
- data on permanent exclusion rates and referral levels provided by some health and local authority services.

All data has been anonymised where appropriate. Cases mentioned in this Learning Report use pseudonyms and are presented without identifying information.

2. Key facts and figures

This section narrates the design, launch and delivery of the pilot in 2024/25, and summarises what happened in and around meetings, including use of the Early Concerns Toolkit (ECT). It includes a Data Dashboard of key metrics, as well as an easy-read summary of TAS activities.

2.1 Design and launch of the pilot

In summer 2024, Bedford Borough engaged with 12 primary and 6 secondary schools to join the TAS pilot. One school later withdrew due to exceptional circumstances. The participating schools were then as follows:

- **Primary schools:** Balliol, Bromham, Cauldwell, Goldington Green Academy, Kings Oak, Kymbrook / Thurleigh, Putnoe, Scott Primary, Shackleton, Shortstown, Springfield and The Hills Academy.
- **Secondary schools:** Bedford Academy, Biddenham International School and Sports College, Daubeney Academy, Kempston Academy and Wixams.

Together, these schools represent 33% of the Bedford Borough school population (as of May 2025). Primary schools ranged from 71 to 890 pupils (average = 400 pupils), while secondary schools ranged from 574 to 1,371 (average = 1,008 pupils).

From engagement to launch

Once schools agreed to participate, the next step was to confirm preferred meeting frequency and coordinate staff availability. This fed into staff scheduling arrangements for local authority and health services. This required extensive coordination, including contracting and back-fill arrangements.

In September 2024, a drop-in session for Head Teachers and Deputy Heads introduced the pilot. Training on the Early Concerns Toolkit (ECT) was delivered to schools by the Community Paediatrics team via online sessions in October 2024 and January 2025.



Membership of TAS meetings

Core membership for each TAS meeting included:

- **Primary schools:** Heads, SENCOs, Assistant Heads, Pastoral leads
- **Secondary schools:** Deputy Heads, SENCOs, Pastoral leads
- **Local authority:** Early Help team; Educational Psychology team; TAS Strategic Leads and Case Coordinators
- **Health:** Speech and Language Therapy (SALT), Mental Health Support Teams (MHST), Community Paediatrics, school nurse.

Additional participants were invited where needed. In practice this included, for example, a Social Worker from the Adoption Team.

Support for TAS meetings

The intention was for TAS meetings to be chaired by the Head or Deputy Head of the school. Alongside this, four Strategic Leads from Bedford Borough Council, each working with 3-5 schools, supported school leaders, helped guide conversations and ensured consistency of approach across the pilot.

Two Case Coordinators supported the planning and delivery of all meetings, splitting their workload between primary and secondary settings. Their responsibilities included:

- coordinating scheduling of all TAS meetings and service representatives.
- summarising key discussions and actions from TAS meetings.
- tracking progress on follow-up on individual cases; and
- ensuring timely engagement from required services.

How meetings worked

Most schools held their first TAS meetings during October 2024, with a few starting in the first week of November due to scheduling pressures. These first meetings typically included:

- Review/agreement of a TAS Charter
- A forward plan for how to align TAS meetings with other multi-agency interactions.
- Orientation for TAS tools, including the Case Summary template and ECT
- A "triage-style" discussion of pupils who might benefit from TAS support.

Meeting schedules varied. Most primary schools met every three weeks, while most secondary schools met fortnightly. This rhythm was adapted where necessary to fit existing timetables and operational pressures.

2.2 Delivery of TAS meetings

Between October 2024 and July 2025, the pilot achieved:

- **74 professionals** engaged across education, health and local authority settings
- **111 TAS meetings** delivered across **17 local schools**
- **263 children and young people** discussed
- **225 documented case summaries** prepared
- **38 Early Concern Toolkits**, often representing the first structured reflection on a child or young person's emerging needs.

The Data Dashboard on the following page sets out summary statistics for the first year of the TAS pilot. This is followed by an easy-read summary of TAS activities.

Data Dashboard for TAS pilot

(October 2024 to July 2025)

In-school TAS meetings held

Measure	Primary	Secondary	Total
Number of schools in the TAS pilot	12	5	17
Meetings planned	120	72	192
Meetings held	71 (59%)	40 (56%)	111 (58%)

Number of pupils' cases presented at TAS

Measure	Primary	Secondary	Total
New cases presented at TAS			
Pupils' cases presented	175	88	263
New cases / meeting (average)	2.5	2.2	2.4
Returning cases to TAS (based on documented updates)			
1 follow up / update	127 (73%)	27 (31%)	154 (59%)
2 follow ups and updates	30 (17%)	8 (9%)	38 (14%)
3 or more follow ups and updates	22 (13%)	0 (0%)	22 (8%)

TAS working procedures and outputs

Measure	Primary	Secondary	Total
Documentation before a TAS meeting			
TAS Case Summary available	155 (89%)	70 (82%)	225 (86%)
Early Concerns Toolkit complete	34 (19%)	4 (5%)	38 (14%)
Documentation after a TAS meeting			
Arising actions (documented)	545	296	841
Actions / pupil (average)	3.5	4.2	3.7

School and service representation at TAS meetings

Measure	Primary	Secondary	Total
Total meetings	71	40	111
Agreed TAS membership			
School	71 (100%)	40 (100%)	166 (100%)
Community Paediatrics	61 (86%)	17 (43%)	78 (70%)
Early Help	53 (75%)	33 (83%)	86 (77%)
Educational Psychology (EP)	53 (75%)	28 (70%)	81 (73%)
Mental Health Support Teams (MHST)	0 (0%)	14 (35%)	14 (13%)
Speech and Language Therapy (SALT)	8 (11%)	32 (80%)	40 (36%)
Strategic Lead	55 (77%)	24 (60%)	79 (71%)
Case Coordinators	71 (100%)	40 (100%)	111 (100%)
Guest members			
Social Worker (Adoption Team)	1 (1%)		

Easy-read summary of TAS activities

(October 2024 to July 2025)



Meetings held

- 111 meetings were held out of a planned total of 192 (58%).
- Most meetings were held in person, and 12 meetings were held online (8%).



Cases discussed

263 pupils' cases were discussed throughout the school year. These included:

- Primary schools: 175 pupils (an average of 2.5 cases per meeting)
- Secondary schools: 88 pupils (an average of 2.2 cases per meeting).



TAS documentation

- Written case summaries were prepared for 225 cases (85% of the total). Case Coordinators recorded notes in meetings where case summaries were not available.
- The Early Concerns Toolkit was completed for 38 cases (14% of the total). Use of the toolkit was higher in primary schools (19%) than secondary schools (5%).



Service Attendance

- Early Help, Educational Psychology and Community Paediatrics attended 70-80% of meetings overall.
- Attendance was lower in secondary schools for Community Paediatrics (43%), and MHST (35%).
- Speech and Language Therapy (SALT) contributed in 11% of primary meetings and 80% of secondary meetings.



Parent carers

- Parent carers did not attend TAS meetings. This was a design decision to distinguish TAS from the Team Around the Family (TAF) model already in use.
- No child or young person was discussed in a TAS meeting without explicit parental consent.
- The intention was to provide feedback to families after TAS meetings, but there is limited documentation of this. Feedback suggests that schools did use TAS inputs in later co-production meetings with families.



Follow-up actions

There was a total of 841 actions recorded in writing for TAS cases (an average of 3.2 per pupil). About 60% of cases (154 cases) were reviewed in at least one subsequent meeting. At a more detailed level:

- Primary schools: 73% of cases were revisited at least once.
- Secondary schools: 31% of cases were revisited at least once.

This suggests secondary schools often used TAS for one-off advice and problem solving, while primary schools developed a more iterative review or case management process. Strategic Leads' approaches varied in the review processes.

2.3 Costs of TAS meetings

Estimated direct staff costs for TAS meetings across education, health and care partners are indicative, based on national salary averages (with on-costs). Actual staff costs for the pilot were not available.

The **average direct staff cost for a typical TAS meeting** across education, health and LA services was **around £1,150**. This figure includes preparation, the meeting itself, follow up actions and travel when necessary.

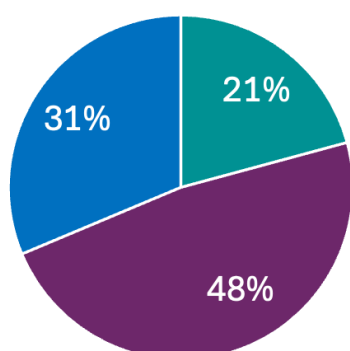
On this basis, estimates suggest that the **full programme of planned TAS meetings** (assuming 100% meeting delivery and attendance) would have had **direct costs of around £290,000**. In practice, **based on meetings and attendance that took place**, this figure was **around £89,000**.

See figure 2a for comparison of planned and actual in-kind contributions across services. These figures highlight the substantial staff time contributed in-kind by schools, local authority and health partners to support the TAS model. They provide useful context for discussions about sustainability in Phase 2, and for considering cost-benefit compared to other existing models of service engagement.

Figure 2a: Comparison of planned and actual direct staff costs for the TAS pilot

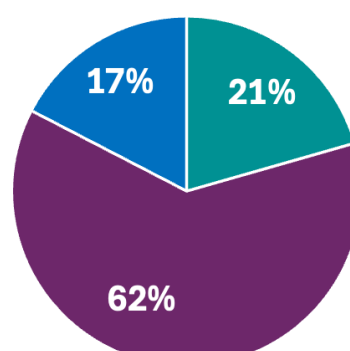
TAS pilot: planned direct staff costs (£290k)

■ School ■ LA ■ Health



TAS pilot: actual direct staff costs (£89k)

■ School ■ LA ■ Health



TAS alongside existing service engagements

TAS meetings are designed to include linked practitioners from relevant health and LA services where possible, with the intention that existing service interactions with schools can feed directly into discussions.

These “status quo” arrangements for linked practitioners, outside of the TAS, vary across primary and secondary settings. They include the following:

- **Early Help:** secondary schools usually meet every four weeks, often aligning TAS with these existing visits; primaries every 4-6 weeks, depending on school request. Rural primaries may receive less routine contact.
- **EPs:** planning and review meetings for all schools at the start of the year, followed by additional termly meetings. In addition, there are consultations (in person and remote), assessments and wider support such as Team Around the Family (TAF), Way Forward and coproduction meetings, ELSA supervision and parent/teacher drop-ins.

- **MHST:** consultation meetings are offered every fortnight, with weekly visits if interventions are in place.
- **SALT:** link therapists for primary schools, with planning meetings at the start of each term. Visits are then arranged for assessments and packages of support as needed. No routine secondary link: contact is referral-based.

This raises an important consideration for the Phase 2 evaluation: Are TAS meetings:

- adding value to service practitioners' workloads (for example, Section 6.1: Case Study 1)?
- duplicating existing meetings without clear, added value?; or
- helping to streamline service interactions, e.g. by covering issues within a TAS meeting and removing / reducing the need for additional interactions.

Further analysis of the relationship between TAS meetings and other service interactions will be undertaken in Phase 2. This will help clarify whether TAS represents an additional cost to complement existing practice; a replacement of, or a modest extension of current practice.

Learning for Phase 2

For the most part, analysis suggests TAS meetings currently sit alongside, rather than replace, these existing models. In some cases, they consolidate touchpoints schools already have (e.g., Early Help), while in others they introduce new expectations. Phase 1 learning indicates the need for further review of alignment with current practices, to:

- Consider how TAS meetings can be scheduled efficiently alongside existing link practitioner models.
- Assess whether TAS offers additional value compared to existing consultation/meeting structures, and how best to demonstrate this.
- Explore sustainability of in-kind contributions given capacity pressures across services.

2.4 Pause for thought

The activity-level data indicates some differences between how TAS was originally envisaged and how it has operated in practice. The following questions and learning points can guide design decisions for Phase 2 (see Section 7.1 for the consolidated learning and implications):

Learning from Phase 1	Implications for Phase 2
Meeting schedules were challenging, with cancellations reflecting capacity pressures and variations in the number of new cases	Explore light-touch meeting schedules, with options for online participation.
Follow-up of cases varied, particularly between primary and secondary.	Introduce guidance to ensure meetings begin with a review of previous cases.
Use of the Early Concerns Toolkit was lower than expected.	Clarify expectations and provide support for consistent use of the Toolkit.
Service attendance varied across setting.	Work with service leads to agree expectations and explore flexible cover arrangements.
TAS meetings required substantial in-kind staff time across schools, health and LA partners.	Analyse cost-benefit alongside existing practitioner models to understand TAS' added value.
Existing service arrangements (e.g., SALT in primaries, EP link work, MHST consultations) vary across phases and settings.	Align TAS meeting schedules with current service practices to maximise efficiency, sustainability and better outcomes for children and young people.

3. Overview of TAS cases

This section describes the characteristics of the children and young people considered in TAS meetings during the pilot. The analysis draws on the meta-data from case summaries and, where available, meeting minutes. It covers gender, year group, ethnicity, and prior contact with services. We then compare the demographics of TAS cases with those of SEND support more broadly.

3.1 Demographic attributes

Gender

Of the 263 pupils discussed in TAS meetings, 63% were male, 35% female and 1% non-binary. The gender split was more pronounced in primary (69% male) than in secondary (53% male).

Figure 3a: TAS cases by gender
(% share of all cases where gender identity is identifiable in case summaries)

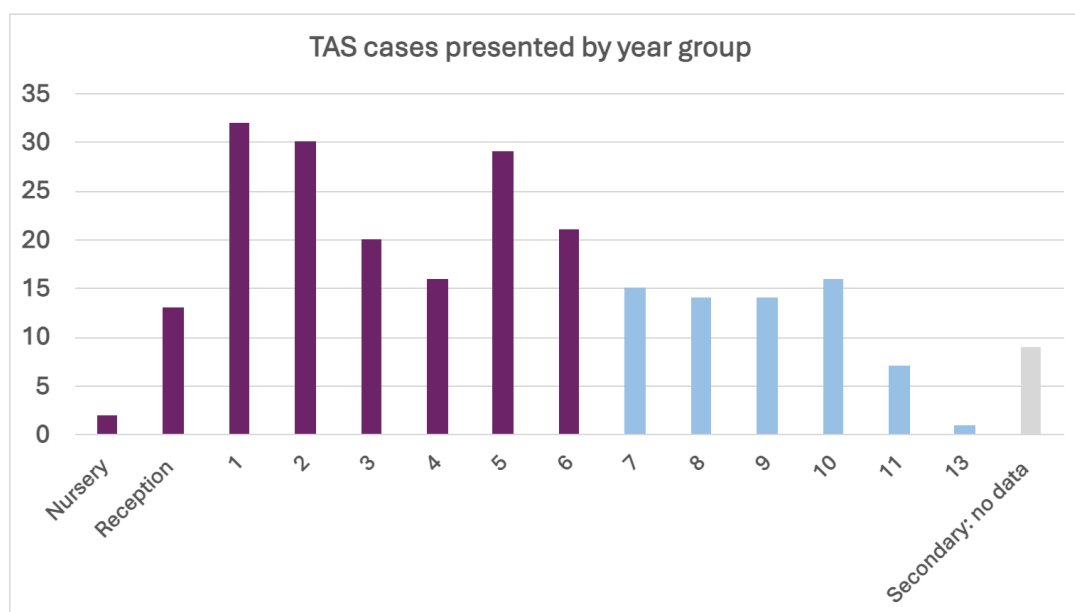
	Primary (of 175 pupils)	Secondary (of 88 pupils)	Total (of 263 pupils)	Total pupil population		
				Bedford Borough 24/25	East of England 24/25	National 24/25
Male	69%	53%	63%	49%	49%	49%
Female	31%	44%	36%	51%	51%	51%
Non-binary	0	2%	1%	Not recorded		

TAS cases overall were more likely to be for male pupils, though the pattern was stronger in primary schools than secondary. We compare these figures with the wider profile of SEND support in-schools below (Section 3.2).

Year groups

There were higher proportions of cases in Years 1, 2 and 5. This may suggest value in proactively exploring cohort-level needs in these groups, particularly around the key transition points.

Figure 3b: TAS cases by year group



Ethnicity

Findings here should be treated cautiously due to incomplete TAS data on ethnicity (22% missing). Case summaries did not consistently record ethnicity data or use GSS ethnicity codes. We accordingly organise the available data by GSS categories.

Figure 3c: TAS cases by GSS ethnicity category

	Primary (of 175 pupils)	Secondary (of 88 pupils)	Total (of 263 pupils)	Bedford Borough 24/25	East of England 24/25	National 24/25
Asian or Asian British	7%	7%	7%	17%	9%	14%
Black, Black British, Caribbean or African	3%	6%	4%	9%	5%	7%
Mixed or multiple ethnic groups	10%	13%	11%	12%	7%	7%
White	58%	48%	55%	48%	66%	61%
Other ethnic group	1%	0%	0%	13%	11%	10%
Not recorded	21%	26%	22%	1%	2%	2%

Observations:

- Where data is available, pupils with identified ethnicities of 'Asian or Asian British' and 'Black, Black British, Caribbean or African' appear under-represented in TAS cases compared with their share of the Bedford Borough pupil population, while White pupils are proportionally higher. *Caution is needed here as 22% of TAS Case Summaries did not record ethnicity.*
- Further analysis will take place in Phase 2 to better understand the range of pupil ethnicities identified for early support through the TAS process, compared with the wider pupil population. This will help assess equity of access to early support, highlight potential training needs for front-line staff and inform outreach and engagement with local communities.

Prior contact with services

One of the pilot's aims was to shift from reactive responses to pupil needs, to proactive early identification. It is therefore important to understand whether cases brought to TAS were already known to services and how this reflects the reality of the current needs in schools (Figure 3d).

Figure 3d: TAS cases by prior contact with services
(% share of all cases where prior contact is mentioned)

	Primary (of 175 pupils)	Secondary (of 88 pupils)	Total (of 263 pupils)
CDC / Community Paediatrics	25%	44%	31%
MHST or CAMHS	14%	39%	22%
Early Help	31%	59%	40%
CSC (e.g. IFD, CIN, CPP, LAC)	7%	19%	11%
In-school SEN support	32%	73%	46%
ECHNAF request	3%	3%	3%
EHCP in place	11%	8%	10%
Prior suspensions	1%	22%	8%
At risk of permanent exclusion	1%	15%	5%

Secondary school observations:

- 73% of cases already had SEN support in place (i.e. in-school adjustments to support inclusion), while under 10% had an Education, Health and Care Plan (EHCP).
- Most pupils (59%) had previous contact with Early Help, and a fifth with children’s social care.
- 44% had previously been in contact with CDC / Community Paediatrics, and 39% had previous contact with CAMHS / MHST.

Primary school observations:

- In general, fewer cases had prior contact with services involvement.
- 32% were receiving existing SEN support.
- 31% had previous contact with Early Help.
- 25% had previous contact with CDC / Community Paediatrics.

3.2 Emerging selection criteria

The TAS pilot set out to enable *early, proactive identification of diverse needs ... through timely, appropriate conversations* (Section 1.1 above). In this regard there is a significant emerging difference in selection of TAS “cases”:

- At primary level, a minority of pupils were already receiving SEN support (32%), with a similar proportion in contact with Early Help (31%).
- At secondary level, most pupils were already receiving SEN support (73%) and/or in contact with Early Help (59%).

Given the importance of this data point we can break the data down in further detail, looking for significant gender differences.

Figure 3e: TAS cases and existing SEN support
(% proportion of all cases where existing support is mentioned)

Setting		Male	Female	Non-binary
Primary	No previous SEN	66%	72%	n/d
	Existing SEN support	34%	26%	n/d
Secondary	No previous SEN	28%	28%	0%
	Existing SEN support	72%	72%	100%* (small sample)

The differences between genders here are not large in size. We can accordingly say with confidence that selection of cases has tended towards “early identification” at the primary level, but this is much less the case at secondary level. More concretely, the pilot reached:

- 119 pupils with no history of SEN support at primary level.
- 24 pupils with no history of SEN support at secondary level.

The policy question follows: Should this emergent approach to case selection be sustained, or adjusted? Or, at a practical level, has the TAS added value in situations where there is existing SEN support and multiple services are already engaged? (We return to this question in detail in Section 4, in looking at specific TAS actions and outputs.)

Another important feature of case selection is the variation in gender distribution, which needs to be considered alongside wider education data for Bedford Borough (Figure 3f).

Figure 3f: TAS cases vs broader SEND statistics
 (% of TAS case summaries; and DoFE 'Special Educational Needs in England 2024/25')

Setting	Mechanism	% of caseload		
		Male	Female	Non-binary
Primary	TAS	69%	31%	0%
	SEN	63%	37%	n/d
	EHCP	74%	26%	n/d
Secondary	TAS	54%	44%	2%*
	SEN	59%	41%	n/d
	EHCP	68%	32%	n/d
Overall	TAS	63%	36%	2%*
	SEN	62%	38%	n/d
	EHCP	72%	28%	n/d

The overall pattern here is that while TAS cases are gender-imbalanced (more boys than girls), this reflects the wider data in school-based SEN support. At a finer level of detail:

- TAS cases were significantly more gender-balanced at secondary level (44% girls / 54% boys) than at primary level (31% / 69%).

3.3 Pause for thought

The demographic data reveals differences compared to initial assumptions, which provides useful insights for refining case selection. The following learning points can guide design decisions for Phase 2 (see Section 7.1 for the consolidated learning and implications):

Learning from Phase 1	Implications for Phase 2
Many cases, especially in secondary schools, already had some level of service involvement.	Clarify which types of cases TAS is best suited to support (emerging needs vs. complex support)
Peaks in demand for TAS discussions occurred at key transition years (years 1-2 and 5-6)	Consider adding cohort-based discussions around phased transfers, beyond individual case discussions.
Gender and ethnicity data was not consistently captured.	Collect these fields routinely throughout Phase 2 to support equity monitoring and learning.

4. What's changing in work practices?

This section reviews the immediate outputs of TAS meetings. The main data source is the 841 actions recorded in case summaries: an average of 3.7 actions per pupil. There was considerable variation in the level of detail of recorded actions, but they nonetheless offer useful insights into the “upstream” outcomes of the TAS pilot.

Overall, the vast majority of TAS actions focussed on supporting schools and families directly, rather than triggering formal referrals.

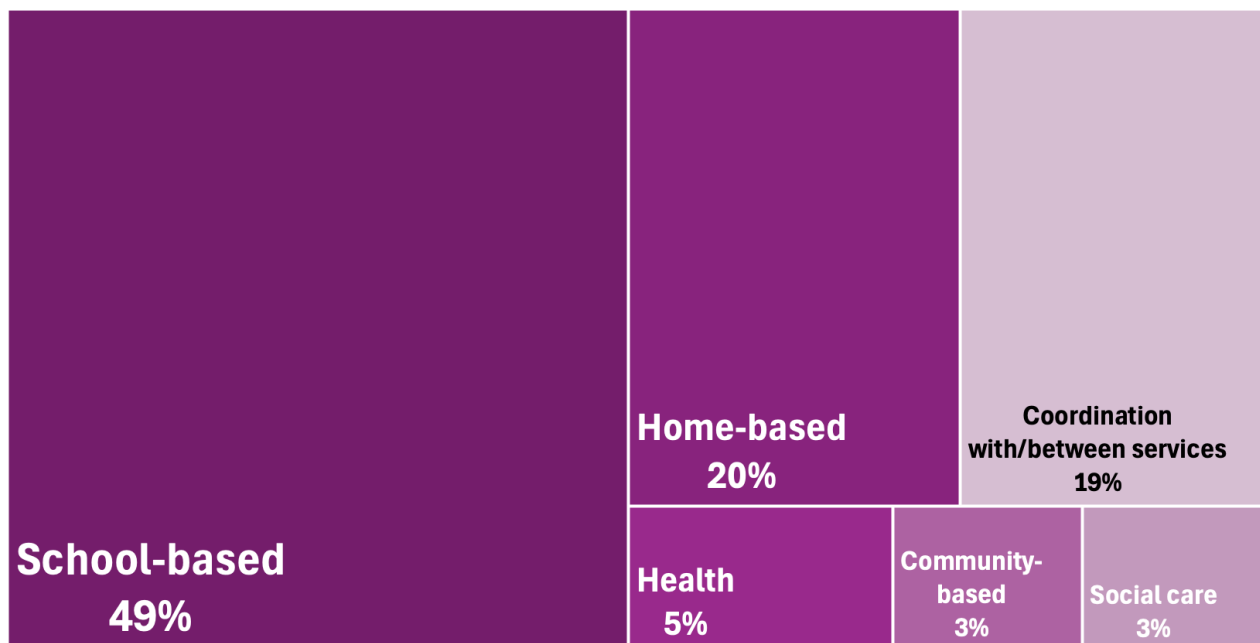
4.1 Where did TAS actions focus?

The TAS pilot aimed to deliver “more support for schools, in schools” and “the right support at the right time”. TAS actions were coded into three main settings:

- School-based
- Home-based
- Service-based (health, social care or other)

The overwhelming emphasis was on school-based and home-based actions, with only 5% of actions linked to health services and 3% to social care outside the home. Excluding coordination activities, this rises to 60% school-based and 25% home-based actions.

Figure 4a
Where were actions expected to happen?
 [Data from 821 actions across all TAS meetings 2024-25]



Examples of school-based actions

Year 8, F	School to colour Code her timetable to remind her about going to toilet and drinking etc
Year 3, F	Consider Emotional Literacy intervention
Year 2, M	Work with the class teachers to ensure that consistent behaviour management approaches are being used

Examples of coordination between services

Year 6, F	School to talk to [previous primary school] to see if they have strategies that were used with them
Year 3, F	School can book an EP drop-in to discuss needs further
Year 7, M	School will complete an EHA to request support from a mentor or practitioner within the Early Help team. (signposting example)

Examples of home-based actions

Year 6, F	Provide parents with the Triple P information. Parents can book onto any courses. School can complete an EHA if the family want to attend the Strengthening Families course.
Year 8, M	Some work at home with mum to support parenting through TAF
Year 5, M	Find out how [child] sleeps – can signpost to sleep resources on the CDC website if necessary.

4.2 What was the nature of TAS actions?

The same data shows that TAS actions primarily concerned:

1. Coordination and information-sharing between services already involved (21%)
2. Signposting families or schools to available resources (20%)
3. School-based adjustments (15%)
4. Informal advice and consultation with health/local authority services (14%)

Conversely, the TAS has not for the most part been about formal referrals and intake pathways for specialised services. Fewer than 10% of actions related to health services, and fewer than 5% to local authority services.

This is reflected in school-level feedback that the process was most useful in building confidence around school-based and home-based measures and improving communication / relationship with services (Section 5.1 below).

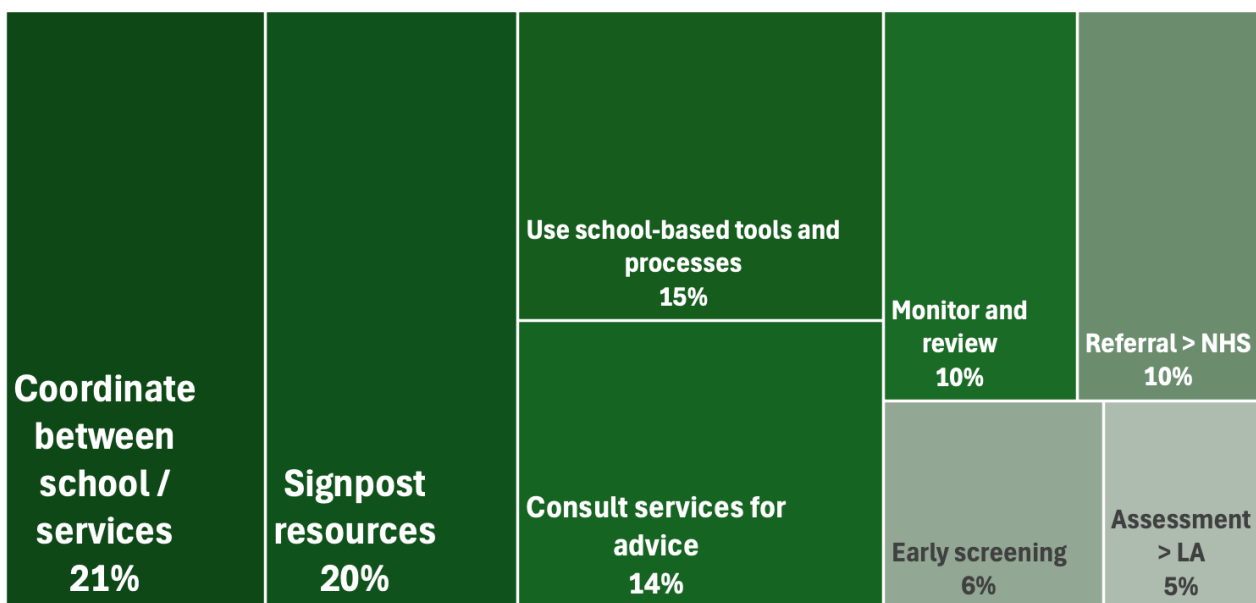
Examples of coordination actions include the following:

Year 5, M	(Early Help) will find a contact for the CAMHS Looked after team and pass this onto school. School will explore this option.
Year 3, F	(Educational Psychology) will email (Speech and Language) a copy of the EP report.
Year 11, F	(Early Help) to follow up with social care re (Multi-Agency Safeguarding Hub) referral if no eha in place then school will resubmit

The limited use of the Early Concerns Toolkit (14% of cases, Section 2) reflects two factors:

- Many pupils were already in contact with services at the time of the discussion (Section 3.4 above).
- Cases demonstrate a diverse profile of needs not limited to neurodiversity (the subject of the Toolkit). While case summaries do not attempt to designate a “primary need”, and nor would this typically be appropriate without an appropriately qualified assessment, there are references to the full range of SEND categories (including physical disabilities), home circumstances, behavioural issues and masking behaviours.

Figure 4b
Types of actions agreed at TAS
 [n=821, all TAS meetings 2024-25]



Where TAS has mainly supported coordination, signposting and informal advice on school-based processes, the key question for Phase 2 is: **what distinct value can it add for schools and services beyond these functions?**

4.3 About signposting actions

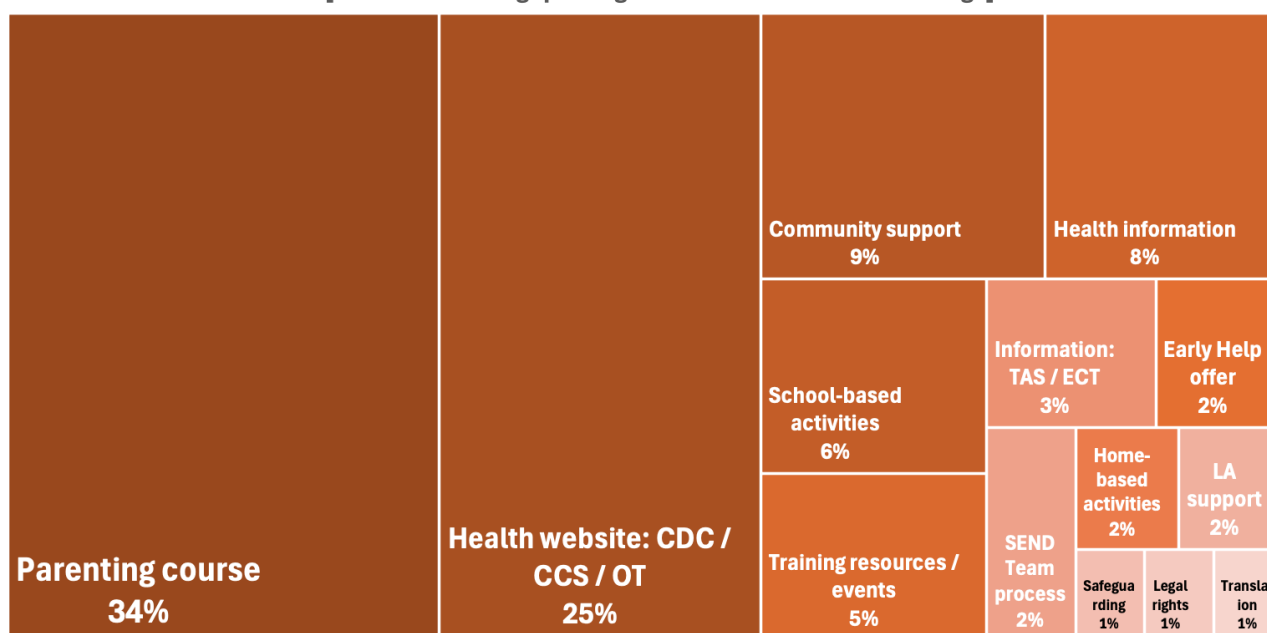
The largest single category of actions involved signposting of resources. Examples include

Year 8, M	<u>Signposting to schools</u> SALT to share the questions about differences in trauma, behaviour, mental distress, mental health, neuro diversity and SEND needs
Year 2, M	<u>Signposting to parent carers</u> School will signpost parents to the Strengthening Families course and the resources/workshops on the CDC website.
Year 5, M	<u>Signposting to parent carers</u> School will signpost parent to the Early Support Workshop at the CDC and the Triple P courses.

At secondary level, signposting often went alongside with existing processes such as Team Around the Family (TAF). Some stakeholders questioned whether cases already open to other processes (such as Child in Need) should enter TAS discussions at all.

Figure 4c

What types of resources were signposted?
 [Data from 170 signposting actions across all TAS meetings]



4.4 Pause for thought

The demographic data indicates some important differences to expectations at the beginning of the pilot. The following learning points can guide design decisions for Phase 2 (see Section 7.1 for the consolidated learning and implications):

Learning from Phase 1	Implications for Phase 2
TAS supported a wide range of emerging needs, with fewer neurodiversity referrals than expected	Continue clarifying TAS' role in early identification across a diverse range of needs.
Most actions focussed on signposting, advice and informal consultation	Develop a shared resource or playbook-style guide to capture common queries, freeing TAS for discussion of more complex needs.
Most actions were school and home-based, consistent with early support.	Strengthen the link between school/home actions and longer-term outcomes tracking.
Coordination between services was a frequent output	Consider whether coordination is best place within TAS, or if additional pathways would help.

5. What's changing for schools and services?

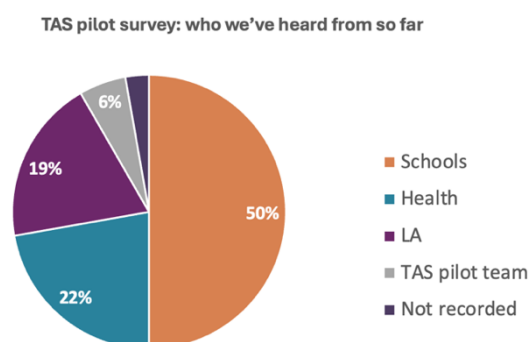
This section examines changes for participating services. It considers the overall perceptions of TAS participants; the experiences of schools that hosted the TAS pilot; and the experiences of health and local authority services.

5.1 Perceptions of pilot participants

We gathered feedback directly from participating services with an anonymous, online survey that was circulated in April/May 2025.

The 36 responses were as follows:

- Schools (50% of responses): Head Teachers, Deputy Heads, SENCOs, other
- Health services (22% of responses): Community Paediatrics, MHST, SALT
- Bedford Borough Local Authority (25% of responses): Early Help, Ed Psych
- 3% of respondents chose not to identify their role(s).



The overall perceptions of survey respondents about the TAS pilot are summarised in Figure 5a. This breaks out respondents' perceptions about clarity of goals for TAS meetings; the effectiveness of working processes; and the consistency of follow-up actions.

Figure 5a: Perceptions of TAS activities

(% of respondents who "agree" or "strongly agree" with the following statements, n=36)

	Health	LA	School	Overall
The goals of the TAS meeting were clearly defined	75%	44%	78%	68%
The working processes used in TAS meetings supported the overall goals	63%	86%	72%	68%
In TAS meetings I attended, follow-up actions were consistently identified and acted upon	57%	67%	78%	71%

Around 70% of respondents agreed or strongly agreed with all three statements, including positive feedback comments from schools, such as:



"It has allowed us to earlier support of ideas from professionals some of which have eliminated the need to go for further referrals, access to information and historical documentation that we would not otherwise have had to have a better picture of a child."

Overall, health staff were less likely to agree that processes were effective, while LA staff were less likely to agree that goals were clearly defined.

We also asked survey participants about the overall outcomes that they had observed around the TAS process, and these responses are aggregated in Figure 5.

Figure 5b: Perceptions of TAS outcomes
(sentiment analysis for open-text responses, n=36)

	Positive	Negative or unsure
There were meaningful changes for services involved in the pilot	46%	42%
There were meaningful changes for schools involved in the pilot	62%	21%
There were meaningful changes for children and young people involved in the pilot	60%	26%

Several LA services responded that they were often already in contact with schools about cases; however, **schools valued the support provided through TAS discussions.**

While some health services did not consistently perceive “meaningful changes” in the existing pathways to access services, **they did see changes in schools – and schools were more willing to take on advice and felt supported:**



“Fewer referrals from the schools involved and the support is being implemented earlier meaning the children are getting support for their needs”

“Greater understanding of roles and responsibilities, greater understanding of services and what can be offered by who”

Most schools valued TAS, and while they reported that follow-up actions were “mainly for schools”, they also reported **increased speed and ease of access to professional feedback:**



“There are clearer pathways and the conversations with professionals at the same time is helpful.”

“Yes. We tried lots of suggested strategies, which impacted positively on the children.”

A further major theme from school respondents, was **increased confidence in measures that could be taken in-school:**



“Really useful forum for discussing issues and identifying support pathways for pupils and families. We have sourced support and gained different ideas to support ourselves, preventing escalation.

“For schools it has been really useful to hear from external professionals to ensure what we have in place is correct and any next steps ...”

5.2 Changes for schools

While most TAS actions remained the responsibility of schools, particularly SENCOs (around 80% of recorded actions, compared with less than 5% for health or LA services, see Figure 5c), this raises the question of how best to balance responsibilities across services in Phase 2.

Figure 5c
Who was responsible for actions identified by the TAS?
 (n=821, all TAS meetings 2024-25)



Despite these concerns, most survey responses were positive when asked about changes observed at the level of schools, with 62% coded as positive, and 21% coded as negative.

Positive themes included:

- Clearer pathways and joint conversations with professionals
- Earlier support, with some referrals avoided.
- Opportunities to trial new strategies that positively impacted children.
- Access to professional insight, strengthening confidence in discussions with parents.





“The pilot has definitely been a success in our opinion, and we would be very keen to continue with it. It has allowed us to [have] earlier support of ideas from professionals some of which have eliminated the need to go for further referrals, access to information and historical documentation that we would not otherwise have had to have a better picture of a child”

5.3 Changes for health and local authority services

The analysis in this section is based on data provided by services. This has been standardised to rates per 100 pupils, in line with DfE reporting, to help in comparing “like with like”. No data was available for SALT or MHST referrals levels between 2023-24 and 2024-25; we aim to include this in the Phase 2 report.

Community Paediatrics (a health service)

Survey feedback for the Community Paediatric service indicated that staff had been seen in fewer referrals from pilot schools, including observations such as:

-  “We have seen fewer referrals from those schools that have regular TAS meetings”
-  “Fewer referrals, great professional discussions with agencies we can’t normally speak easily to”



Data provided by the service (Figure 5d) indicates that:

- **In pilot schools**, monthly average referrals **decreased by 5%**, falling from about 1 in 70 pupils to 1 in 74 pupils.
- **In non-pilot schools**, monthly average referrals **increased by 20%**, rising from about 1 in 62 pupils to 1 in 52 pupils.
- The “difference in differences” – the gap between the trend in pilot schools and the trend in non-pilot schools – is 25%.
- The TAS pilot thus **coincided** with substantially lower referral rates from pilot schools, relative to non-pilot schools.

	Prior to pilot (2023-24)	During the pilot (2024-25)	Change year-on-year (per 100 pupils)	Change year-on-year (%)	Difference in differences (per 100 pupils)	Difference in differences (%)
Pilot schools	1.43 <i>(1 in 70 pupils)</i>	1.35 <i>(1 in 74 pupils)</i>	-0.08	-5%	-0.40 <i>(1 fewer pupil in every 250 pupils being referred in pilot schools)</i>	-25%
Non-pilot schools	1.61 <i>(1 in 62 pupils)</i>	1.93 <i>(1 in 52 pupils)</i>	0.32	20%		

Robust evidence to establish that the TAS pilot **caused** this lower rate of referrals will necessitate (i) multi-year data to account for high variability in referral patterns; and (ii) a stronger evaluation design to account for confounding factors. We suggest how to achieve this in Section 7.2 below.

Several schools expressed concern that when Community Paediatrics referrals could not proceed without an ECT, this created tension with families, as parents perceived schools to be blocking access to diagnosis:

-  “It’s causing difficulties with our relationship with parents”
-  “It has been detrimental to several parent relationships as the school is perceived to not be supporting the parents wish to pursue a diagnosis”

While some other schools and families reported receiving letters redirecting referrals back into TAS, even when an Early Concerns Toolkit had already been completed. This was experienced as confusing and, in some cases, caused concern for families and schools, highlight the need for clearer, borough-wide guidance.

Education Psychology (a LA service)

The data shared by Bedford Borough Council’s Education Psychology (EP) team, summarised in Figure 5e, indicates that:

- New EP referrals increased for **both** pilot and non-pilot schools.
- **In pilot schools**, total referrals **increased by 12%**, rising from about 1 in 47 pupils to 1 in 42 pupils.
- **In non-pilot schools**, total referrals **increased by 8%**, rising from about 1 in 49 pupils to 1 in 45 pupils.
- The “difference in differences” – the gap between the trend in pilot schools and the trend in non-pilot schools” – is minus 4%.
- The TAS pilot thus coincided with **4% higher referrals** from pilot schools, relative to non-pilot schools, but this is a **small difference** of about 1 in 1,000 pupils.

	Pre pilot (2023-24)	During the pilot (2024-25)	Difference (per 100 pupils)	Difference (%)	Difference in differences (per 100 pupils)	Difference in differences (%)
Pilot schools	2.12 <i>(1 in 47 pupils)</i>	2.38 <i>(1 in 42 pupils)</i>	0.26	12%	0.10 <i>(1 more pupil in every 1,000 pupils being referred in pilot schools)</i>	-4%
Non-pilot schools	2.05 <i>(1 in 49 pupils)</i>	2.21 <i>(1 in 45 pupils)</i>	0.16	8%		

This may suggest that the TAS pilot was associated with earlier engagement by the EP team with pupils’ needs. Some observations from schools highlighted the value of earlier EP consultation:



“It has been really useful to speak with the EP to discuss strategies. It is also useful when feeding back to parents that the outcome has been agreed by several professionals and not just the school.”

The data that is available for the Phase 1 pilot cannot (yet) provide strong evidence for this, as a small difference in trend should not be over-interpreted outside of a controlled experimental setting. We discuss how to develop further evidence in Section 7.2 below.

Early Help (a LA service)

The data from Bedford Borough Council’s **Early Help team** is based on the number of **new Early Help episodes** during the school year. This means that there was an Early Help Assessment, a Team Around the Family or an ‘Early Help-recommended’ action from the Integrated Front Door.

This data is summarised in Figure 5f. It includes all Early Help episodes in mainstream primary and secondary settings, including Resourced Provision, and excludes episodes linked to Children’s Centres. (This subset represents about 51% of all Early Help episodes recorded during the period.) The data indicates that:

- New Early Help episodes increased for **both** pilot and non-pilot schools.
- **In pilot schools**, total referrals **increased by 7%**, rising from about 1 in 60 pupils to 1 in 56 pupils.
- **In non-pilot schools**, total referrals **increased by 9%**, rising from about 1 in 79 pupils to 1 in 73 pupils.

- The “difference in differences” – the gap between the trend in pilot schools and the trend in non-pilot schools” – is minus 2%.
- The TAS pilot thus coincided with **2% higher referrals** from pilot schools, relative to non-pilot schools, but this is a **very** small difference of about 1 in 10,000 pupils.

Figure 5f: Early Help episodes
(rate per 100 pupils)

	Pre pilot (2023-24)	During the pilot (2024-25)	Difference (per 100 pupils)	Difference (%)	Difference in differences (per 100 pupils)	Difference in differences (%)
Pilot schools	1.68 <i>(1 in 60 pupils)</i>	1.80 <i>(1 in 56 pupils)</i>	0.12	7%	0.01 <i>(1 more pupils in every 10,000 pupils being referred in pilot schools)</i>	-2%
Non-pilot schools	1.26 <i>(1 in 79 pupils)</i>	1.37 <i>(1 in 73 pupils)</i>	0.11	9%		

The data from Phase 1 accordingly does not suggest significant changes in the rate of Early Help engagement.

At a qualitative level, schools reported positive experiences of Early Help involvement:



“Early help have been strong with bespoke offerings”

5.4 Pause for thought

The following points summarise key learning about service roles and referral pathways, offering areas to clarify and align in (see Section 7.1 for the consolidated learning and implications):

Learning from Phase 1	Implications for Phase 2
Schools took on delivery of most recorded actions, reflecting their central role in early support.	Clarify how responsibilities can be more evenly shared across services, where appropriate.
Health and LA staff reported mixed experiences of TAS' contributions, with some noting pressures while other highlighting stronger dialogue with schools.	Align expectations and goals of TAS across schools, LA and health partners
Referrals from pilot schools, relative to non-pilot schools, decreased significantly for Community Paediatrics referrals (a -25% difference); rose slightly for Education Psychology; (+4%); and did not change significantly for Early Help.	Collect referral data more consistently across all services (including school-level and pupil-level data) and compare with non-pilot schools to understand impact.
Referral pathways (especially Community Paediatrics) were not always clear for schools and families.	Provide clear borough-wide guidance to ensure TAS is experienced as an enabler of early support in the right place at the right time, not a barrier.

6. What's changing for children and young people?

This section considers the early impact of TAS for children and young people, based on case studies, parent carer feedback and available data.

6.1 Change stories

While the pilot duration was too short to assess longer-term significant impact, there is evidence in some cases of earlier identification, stronger and earlier school-based support, and improved confidence for children and young people and their families.

The following two case studies were selected for demonstrating a “significant change” due to the TAS pilot. They illustrate the different situations children, young people and their families faced, what the TAS meetings agreed and how coordinated actions made a difference. (All personal details have been changed to protect privacy.) It should be emphasised that these demonstrate the upper end of the range of outcomes rather than the typical or modal case, and we discuss how to develop robust population-level outcomes data in the next section.

Case study 1: Supporting a pupil with severe anxiety (EBSA)

(Personal details changed to protect privacy)

Context

Nathaniel, age 10, had been moving between school and home learning since Covid. His attendance had dropped to 40%, with high anxiety about attending. His mother felt unsupported, despite seeking help via the GP and an EP drop-in session.



TAS multi-disciplinary discussions

At TAS meetings, professionals identified steps to reduce Nathaniel's anxiety and help his family. They agreed to:

- Set clear attendance expectations, with gradual build-up
- Provide parenting support on the issues, including courses
- Explore his anxiety with resilience cards
- Use local EBSA guidance and Early Help support

TAS actions

- School used resilience cards and developed a reduced timetable
- Early Help well-being practitioner worked with the family
- Parents attended an anxiety management course
- School submitted a part-time timetable to the local authority

These actions were all consultation based within the TAS planned ways of working and no additional contact points with members of LA staff were allocated to supporting this child.

What changed

Over the year, Nathaniel's anxiety reduced significantly. His parents reported feeling more confident. The school praised TAS for “amazing support and guidance around EBSA” (emotionally based school avoidance)”, highlighting his slow but steady reintegration to near full-time schooling.

Case study 2: Supporting a pupil with low engagement and mental health needs

(Personal details changed to protect privacy)

Context

After being out of school for some time, Amelia, age 14, was back in school full-time but not making expected progress, particularly in maths. Her mother raised concerns about her wellbeing and lack of happiness in school. Amelia believed no one liked her and admitted she could appear abrupt. She had been receiving CAMHS support in the past six months, including drama therapy. The school noted her reluctance to engage in lessons despite strategies such as a safe space and trusted adult contact.



TAS multi-disciplinary discussions

At TAS meetings, the group agreed to:

- Explore completion of the Early Concerns Toolkit to clarify potential additional needs
- Offer parental support through an Early Help Assessment (EHA)
- Provide pre-teaching to prepare for Year 10 transition
- Explore external support via the SHINE outreach programme and AP funding

TAS actions

- An EHA was opened to support the family
- Pre-teaching support arranged ahead of Year 10
- SHINE outreach programme started weekly in school
- Ongoing access to safe space and trusted adult within school

What changed

Amelia developed a positive relationship with her Head of Year and her engagement improved. The school felt reassured that coordinated support was in place. Her family also benefitted from Early Help involvement, and the SHINE programme gave her new ways to connect with school.

6.2 Decreased rates of permanent exclusions in pilot schools

Bedford Borough has historically had higher than national average rates of permanent exclusions across its mainstream education settings. Reducing these rates has been a shared partnership priority, supported by several concurrent interventions to strengthen inclusive mainstream practice.

Between the academic years 2023/24 and 2024/25, the data showed **the overall number of permanent exclusions in Bedford Borough mainstream schools decreased** (see Figures 6a and 6b).

Within this, **secondary schools participating in the TAS pilot showed a greater reduction** than those outside the pilot (see figure 6b).

Figure 6a: Permanent exclusion rates across primary schools

(rate per 100 pupils)

Primary	Pre pilot (2023-24)	During the pilot (2024-25)	Difference (per 100 pupils)	Difference (%)	Difference in differences (per 100 pupils)	Difference in differences (%)
Pilot schools	0.035 <i>(1 in 2,800 pupils)</i>	0.035 <i>(1 in 2,800 pupils)</i>	0.000	0%	-0.009 <i>(1 more pupil excluded per 11,000 in pilot schools)</i>	-13%
Non-pilot schools	0.067 <i>(1 in 1,500 pupils)</i>	0.058 <i>(1 in 1,700 pupils)</i>	-0.009	-13%		

Observations across primary schools:

- In **pilot schools**, rates stayed the same (about 1 in 2,800 pupils).
- In **non-pilot schools**, rates fell slightly (from 1 in 1,500 to 1 in 1,700 pupils).
- These are very low rates, so small variations year-on-year are unlikely to be meaningful.

Figure 6b: Permanent exclusion rates across secondary schools

(rate per 100 pupils)

Secondary	Pre pilot (2023-24)	During the pilot (2024-25)	Difference (per 100 pupils)	Difference (%)	Difference in differences (per 100 pupils)	Difference in differences (%)
Pilot schools	0.634 <i>(1 in 160 pupils)</i>	0.337 <i>(1 in 300 pupils)</i>	-0.297	-47%	0.169 <i>(1 fewer pupil excluded per 590 pupils in pilot schools)</i>	21%
Non-pilot schools	0.502 <i>(1 in 200 pupils)</i>	0.373 <i>(1 in 270 pupils)</i>	-0.129	-26%		

Observations across secondary schools:

- Permanent exclusion rates decreased in **both** pilot and non-pilot schools, possibly as a result of other ongoing measures (outside TAS) to reduce exclusion rates;
- In **pilot schools**, permanent exclusion rates fell by 47% (from about 1 in 160 pupils to 1 in 300 pupils)
- In **non-pilot schools**, permanent exclusion rates fell by 26% (from about 1 in 200 pupils to 1 in 270 pupils).
- This indicates that **permanent exclusions fell by a greater amount (+21%)** in TAS pilot schools, relative to non-pilot schools. This is equivalent to 1 fewer exclusion for every 590 pupils.

While there are important caveats here (see below), this represents an encouraging trend for children and young people in the pilot.

Caveats:

1. Reducing permanent exclusions has been a wider partnership priority, and TAS is one of several interventions that may have contributed.
2. Establishing that the TAS pilot **caused** or materially contributed to lower exclusion rates will require an evaluation design that accounts for other ongoing initiatives.
3. Permanent exclusion rates can vary from year to year, so caution is needed when interpreting changes over a single year. Multi-year data including Phase 2 will provide an opportunity for further review.

6.3 Parent carer perspectives

Feedback from the Bedford Borough Parent Carer Forum (BBPCF) has highlighted both positive aspirations for TAS, while identifying areas for clearer communication and stronger involvement. A key drawback was the lack of consistent, borough-wide communication and ‘myth-busting’, which led to some confusion for local parent carers and families, including:

- (1) **Information gaps:** Families reported being told that referrals, particularly CDC, but also EHCPs & Early Help, could only be made through TAS. This is not in line with statutory guidance. Some families perceived TAS as limiting access to services, underlining the importance of clear communication and reassurance about processes.
- (2) **Parent carer voice in TAS:** while no child or young people was presented without parental consent, parent carers were not directly involved in meetings. It was felt that feedback loops were inconsistent. This left some families feeling decisions were “about them, without them”.
- (3) **Funding uncertainty:** towards the end of Phase 1, some families expressed concern about TAS sustainability after seeing positive changes. Limited updates about Phase 2 added to mistrust and uncertainty.

6.4 Pause for thought

Together, these stories, data and perspectives provide early signals of impact for children, young people and families. They highlight opportunities to build Phase 2 around outcomes that matter most (see Section 7.1 for the consolidated learning and implications):

Learning from Phase 1	Implications for Phase 2
Case studies show that earlier, school-based and coordinated support can build confidence for children, families, and professionals.	Capture more structured “significant change” stories to illustrate outcomes consistently alongside data.
Permanent exclusions decreased in secondary schools more (21%) in TAS pilot schools than in non-pilot schools.	Track exclusions longitudinally, using robust comparison with non-pilot schools, to understand TAS’ contribution within the wider system of interventions.
Parent carers valued TAS but asked for clearer communication and stronger involvement in decision-making and feedback loops.	Strengthen outward communication and embed consistent feedback processes with families, ensuring TAS is experienced as inclusive and transparent.

7. Way forward

7.1 Learning and implications for Phase 2

Phase 1 generated key learning with implications for how the TAS pilot can be further developed in Phase 2. See Sections 2-5 for full details.

Figure 7a: Summary of Phase 1 key learning

Learning from Phase 1		Implications for Phase 2
Pilot design and delivery	<ul style="list-style-type: none"> Meeting frequency and scheduling were affected by capacity pressures, highlighting the need for realistic planning. Documentation practices varied, reflecting different local approaches. Follow-up of cases was less consistent in some settings, offering scope to strengthen accountability. 	<ul style="list-style-type: none"> Plan fewer, more sustainable meetings (half-termly in primaries, twice per half-term in secondaries), with online options to ease pressures. Introduce a revised Case Summary template to reduce duplication and increase consistency. Begin each TAS meeting with a review of previous cases to embed continuity and support outcomes tracking.
Case mix	<ul style="list-style-type: none"> A high proportion of secondary cases already involved other services, showing TAS is often being used for coordination around complex needs. Some year groups (1–2 and 5–6) saw more referrals, pointing to pressure points around transition. Gender and ethnicity data was incomplete, making it harder to fully assess equity. 	<ul style="list-style-type: none"> Clarify which types of cases TAS is best suited for (emerging needs vs. coordination of existing cases). Explore cohort-based discussions at key transition points alongside individual case reviews. Routinely collect gender and ethnicity data to strengthen equity monitoring.
Outputs and actions	<ul style="list-style-type: none"> TAS was used for a wide range of needs beyond neurodiversity, with relatively few direct referrals to Community Paediatrics Signposting, advice and consultation were the most frequent outputs, showing TAS' role as an early-support forum. Most actions were school or home-based, aligning with preventative support. Coordination between already-engaged services was a common feature, reflecting schools' need for joined-up advice. 	<ul style="list-style-type: none"> Continue clarifying TAS' focus on early identification and support, beyond neurodiversity. Develop a "playbook" of frequently asked questions/resources so TAS time can focus on more complex needs. Link school/home-based actions more explicitly to outcomes tracking. Decide whether service coordination should remain a core TAS role, or whether some issues are better addressed outside TAS.

Learning from Phase 1		Implications for Phase 2
Schools and services	<ul style="list-style-type: none"> • Schools took on most recorded actions, reflecting their central role in early support. • Health and LA staff reported mixed experiences of TAS' added value. • Referrals from pilot schools, relative to non-pilot schools, decreased significantly for Community Paediatrics referrals (a -25% difference); rose slightly for Education Psychology; (+4%); and did not change significantly for Early Help. • Referral pathways (especially to Community Paediatrics) were not always clear, which created uncertainty for some schools and families. • TAS required substantial in-kind staff contributions across schools, LA and health partners, with actual costs lower than anticipated due to attendance patterns. 	<ul style="list-style-type: none"> • Clarify division of responsibilities so actions are more evenly shared, where appropriate. • Align expectations of TAS' purpose across schools, health, and LA. • Track referral data longitudinally with more robust comparisons. • Strengthen and communicate referral pathways, to ensure TAS is understood as an enabler of support, not a barrier. • Review sustainability by comparing TAS with existing link practitioner models (e.g., Early Help, EPs, MHST, SALT).
Children, young people and families	<ul style="list-style-type: none"> • Case studies illustrate positive early impacts on individual children and families, though the pilot was too short to evidence longer-term change. • Permanent exclusions decreased more (21%) in TAS pilot secondary schools than in non-pilot secondary schools. • Parent carers welcomed TAS but wanted clearer communication and stronger involvement in feedback loops. 	<ul style="list-style-type: none"> • Develop outcome indicators at pupil level to capture impact over time. • Collect and share structured change stories to complement data. • Track exclusions longitudinally, using robust comparison with non-pilot schools, to understand TAS' contribution within the wider system of interventions. • Strengthen outward communication and ensure consistent feedback loops with families.

7.2 How we will measure impact going forward

Phase 1 of TAS has generated rich descriptive data and highlighted important questions for how the model works in practice. To take this forward, Phase 2 must focus on building stronger evidence of what difference TAS makes for children, young people and families.

This means moving beyond describing activities and outputs, towards systematically tracking outcomes. We will need to understand not only what happens in TAS meetings, but also whether this leads to better support, improved inclusion and ultimately stronger life opportunities for children and young people.

To do this, schools and service partners will be asked to contribute more regular and consistent data. This will include short, light-touch tools to capture outcomes, as well as clearer processes for documenting TAS actions and their follow-up.

We recognise this adds to the workload of already stretched staff, but it is essential: without robust evidence we cannot show the value of TAS, nor ensure it is sustainable in the long term.

The detailed framework for evaluation design, including proposed outcome indicators, comparison with non-pilot schools, and an approach to capturing case-level change stories, is included in Annex A.



A final note

Thank you for your time and energy in reading this learning report.

As we move forward, your insights and experience will continue to help build a stronger, fairer and more inclusive education system for children, young people and families in Bedford Borough.

Annex A: Framework for Phase 2 evaluation design

The pilot has generated a rich set of descriptive data and scoping questions for an extension to the 2025/26 school year.

To build evaluative evidence that contributes to the national SEND & AP policy conversation, three priorities are proposed:

1. Defining outcome indicators for children and young people
2. Capturing change stories to understand the how and why
3. Comparing outcomes between TAS and similar non-TAS schools

Details of the technical approaches to this evaluation are outlined below.

(1) Define a panel of indicators for children and young people-level outcomes

The evaluation will generate outcome data at four levels:

- (1) TAS activities.
- (2) changes in working behaviours.
- (3) changes for system partners.
- (4) changes for children and young people.

It should be a principal focus of the design and delivery Phase 2 to generate evidence at the fourth level, i.e. what is changing for children and young people.



(2) Capturing change stories: Collect case-level stories through semi-structured interviews to interpret process changes and outcomes and to avoid a disconnect between observed outcomes and the underlying mechanisms driving them.

The “curation” of case-level stories should look at the different process-outcome patterns in the figure below. This includes successful “early interventions” of the kind presented in Section 6 of the final report. But it should also be alert for two other patterns:

- **“Inappropriate referrals”** that are unnecessary or premature
- **“Missed opportunities”** where urgent needs are not actioned appropriately.

Outcomes matrix for TAS cases

		Referral made	
		Y	N
Early intervention appropriate	Y	“Inappropriate referrals”	As intended
	N	As intended	“Missed opportunities”

(3) Comparing outcomes between TAS and similar non-TAS schools

The TAS pilot took place in a “noisy” context from a data point of view (for example, demographic and socio-economic differences, policy shifts, fiscal constraints and post-covid effects).

A pragmatic approach is a differences-in-difference design (which compares trends over time between TAS and similar non-TAS schools), which:

- Matches TAS schools with statistically similar non-participating schools
- Tracks service and pupil-level outcomes for both groups
- Estimates impact as the difference in trends between the two groups
- Compares estimated impact with overall cost to services of the TAS pilot.

Figure A2: Evaluation roadmap for TAS Phase 2

	Proposed measures	Means of verification
1. Activities (What happened in and around TAS meetings?)		
1.1	TAS dashboard: Cases discussed; cases followed up; attendances; referral actions; use of Early Concerns Toolkit.	Case summaries maintained by Schools/Strategic Support (existing documentation)
1.2	Demographic data: Breakdown of TAS cases by gender, age, ethnic group, SEN status, existing contact with services prior to TAS.	Case summaries prepared by Schools/Strategic Support (existing documentation). <i>(Forms to be iterated and revised for “phase 2”).</i>
2. Outputs (What working behaviours changed?)		
2.1	Actions meta-data: Where actions were targeted; which service had responsibility; nature of actions.	Case summaries prepared by Schools/Strategic Support (existing documentation). <i>(Stratified random sample, to supplement coding of all pilot data.)</i>
2.2	Emerging opportunities & constraints	Fast feedback questionnaire (new instrument). Anonymous, grouped by service perspective.
3. Outcomes (What changed for system partners?)		
3.1	Change in incoming referrals relative to appropriate “control” group.	Service-level data for referrals and intake processes (existing documentation). <i>(Collected for participating schools and for statistically matched non-participating schools.)</i>
3.2	Perceptions of significant change in how services engage with children and young people.	Fast feedback questionnaire (new instrument). Anonymous but grouped by service / institutional perspective.
4. Impact (What changed for children and young people?)		
4.1	Change in educational outcomes & PEX/suspension rates relative to appropriate “control” group.	Attainment and behaviour data to be co-curated with Education service. (Use already-collected data rather than create new requirements.)
4.2	Perceptions of significant change in outcomes for children and young people	Fast feedback questionnaire (new instrument). Anonymous but grouped by service / institutional perspective.
4.3	Significant change narratives for pseudonymised cases.	Process tracing through semi-structured interviews with school and service-level staff.