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What Works and cohort studies

A scoping report

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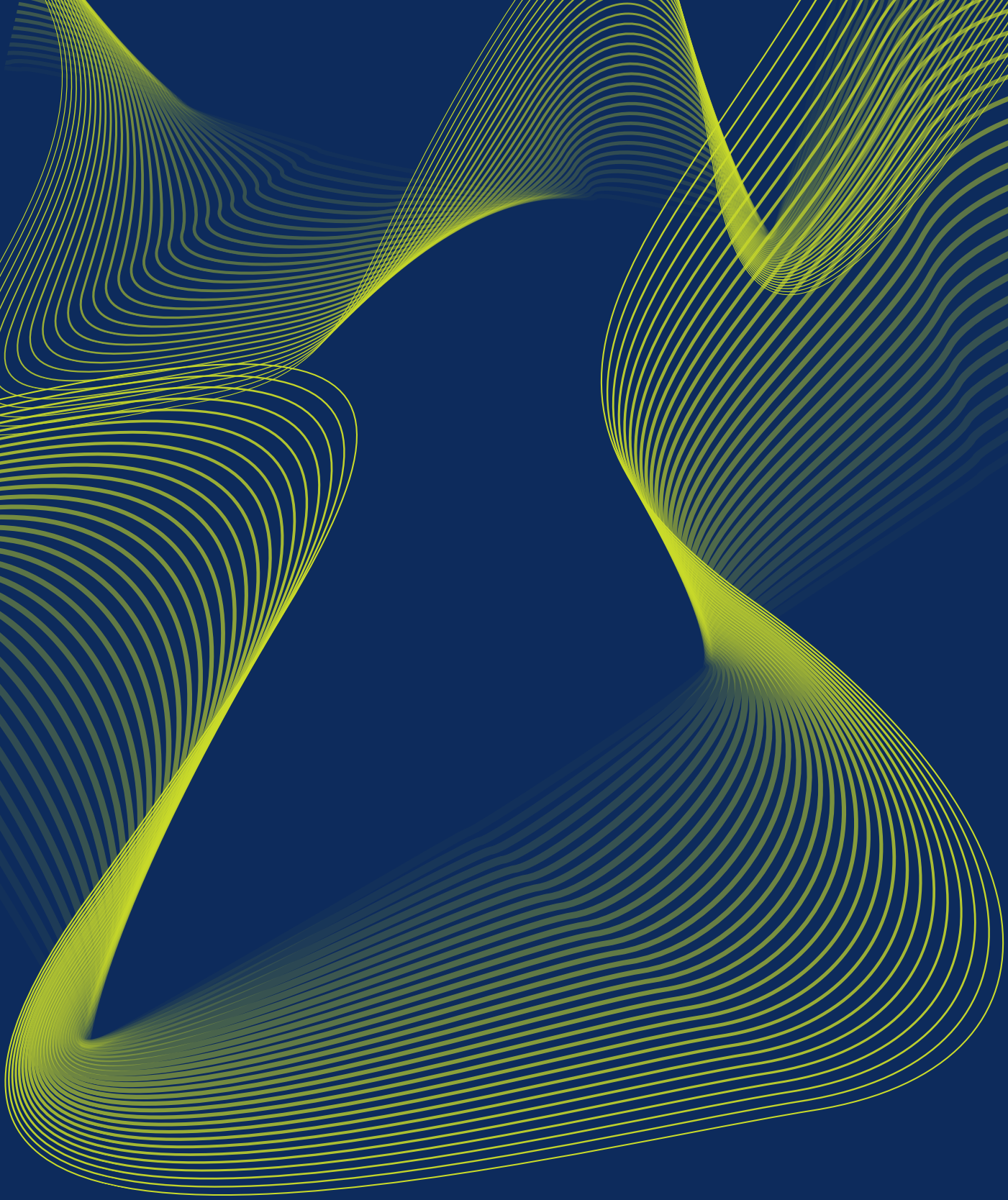

About this paper

This paper was commissioned by the Centre for Homelessness Impact as part of a programme of work to investigate ways to understand how What Works Centres can collaborate better; how they can make better use of existing data, and how new methods can be applied to social problems. A part of the project was also funded by the Cabinet Office's Evaluation Accelerator Fund.

In this paper we draw on a programme of research that briefly reviews existing use of cohort studies by what works centres, and other uses of cohort studies for causal research; interviews with What Works Centre staff relating to cohort studies, and interviews with the principal investigators and researchers working with three of the major cohort studies: The Millenium Cohort Study (MCS), the Avon Longitudinal Study of Parents and Children (ALSPAC), and the Covid Social Mobility and Opportunities study (COSMO).

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Introduction

Social Research is an area in which the UK unambiguously punches above its weight. Two particular areas in which Britain leads the world are in the causal analysis of social problems - most prominently in the form of the dozen "What Works Centres" that collectively form the What Works Network - and cohort studies. Although Britain does not have a monopoly on such cohort studies, the number and longevity of this collection of cohort studies are greater than any others.

Both What Works Centres and cohort studies have substantial benefits, and raise their own challenges.

What Works and cohorts – complementarities

What Works Centres, which are inherently government-and-practice focused, have changed the culture in a diverse range of policy areas to embrace quantitative and causal research, and in turn have been able to exercise substantial influence over decision-making in their chosen fields. Centres and the randomised trials they conduct have led to a step change in our understanding of the impacts of interventions on outcomes. However, centres have notable challenges too. Funding interventions is expensive and many centres (particularly those without endowments) do not have the budget to do so; there is a shortage of expertise in randomised trial design in universities and elsewhere; primary data collection is time consuming, expensive, and risky, with many large scale, expensive studies falling at the last post due to substantial attrition. Data collection at scale is a highly specialised task, and the variety of studies and measures within the What Works Network prevents evaluators from developing this specialism. Studies are also often short term, looking at outcomes only a few months after interventions have been delivered, even when anticipated changes would be many years in the making.

Cohort studies, by contrast, allow us to see changes over a much longer time window, with cohort studies lasting several decades. As well as length, their data collection is broad, with the longer term nature of engagement between the study and its participants allowing for a wider variety of outcomes to be collected. The scale of cohort studies, as well as the number of them that have been conducted, means that infrastructure and expertise exists to support data collection for these purposes. However, cohort studies lack the ability to make causal claims about impacts, and instead are very often limited to describing the world, or providing correlations between variables. This lack of actionable insight puts their funding at risk from policymakers who do not see the value in this research.

As we have sketched here, cohort studies and what works centres are complementary to one another, and each could benefit from a closer partnership.

Interviews with What Works Centres

We spoke to nine of the What Works centres in March and April 2022 about their current use of, and future desires for, collaboration with cohort studies (see Appendix A).

All centres were keen to support greater collaboration between themselves and the cohort studies and recognised the opportunity this presents for not only their own research agenda but also for increased collaboration within the What Works network and with other experts in their respective policy areas. Across the conversations, three primary key topics were addressed:

1. How What Works centres currently use cohort studies and where they didn't why this was the case.
2. What What Works centres would hope to gain from greater collaboration with the cohort studies.
3. How a collaboration would need to work if it were to be useful and the challenges thereof.

These areas all provided insight into how What Works centres use, or could use, cohort studies as well as some of the key considerations and barriers and any attempt to introduce greater collaboration should understand if such attempts are to be successful.

Do What Works centres collaborate with cohort studies at present?

Amongst the centres we spoke to, almost no collaboration currently existed between them and cohort studies. This included for experimental research but also the utilisation of the rich data available from cohort studies in their own analyses. In the few that do 'use' cohort data, this tended to be through collaborations they had with other researchers or using attainment data from the National Pupil Database (NPD).[1] What Works for Wellbeing, which of the centres we spoke to arguably most frequently utilises cohort studies at present, has connections to projects which use multiple cohort studies including the Millennium Cohort Study (MCS), although do not directly analyse the data themselves. Only the EIF had both used and analysed cohort studies themselves, most recently in a project two years ago using BCS data. For most centres, 'using' cohort studies is a passive activity; that is, they read the outputs from other researcher's analysis rather than analysing or commissioning analysis themselves.

Centres with a focus on educational outcomes such as EEF and TASO had frequently used the cohort data that is available in the NPD. However, the area of interest has focused specifically on demographics, attainment, absences, and exclusion. In this aspect, it differs from studies such as MCS, ALSPAC and COSMO which provide more detailed information on family structure and stability, emotions, faith and

1 The National Pupil Database is a collection of data compiled by the Department for Education. While not a cohort study, it does allow for an individual to be followed over a period of time in relation to specific education outcomes. It comprises several data sets including the termly school census, alternative provision census, national curriculum test performance and other examinations, absences and exclusions, children in need and looked after status and a number of demographic variables. It is used by the DfE to directly inform policy but also by approved researchers to explore broader research questions related to education.

beliefs, aspirations and health amongst other topics for individuals born at similar times. In some cases, data are also collected on broader relationships with ALSPAC including data from parents and MCS including parents and class teachers. Such cohort studies, which are the focus of this report, can therefore provide a richer insight into the lives of a considerable number of people and the differences and inflections that contribute to different paths and outcomes.

Despite not widely using them at present, all the What Works centres we spoke to expressed interest in working more closely with cohort studies in the future. In some cases, this assertion, and the overall positivity for a collaboration, was preceded by a general uncertainty about what cohort studies were, how they differed from other longitudinal designs (i.e. panel data) and how they could be best utilised by What Works centres. This suggests that, for at least some centres, a lack of awareness of cohort research may partly explain their under use. Once described to them, all centres could see how such life-cycle longitudinal data could be of value to them either in looking into the past at key inflections or into the future after a new intervention is introduced to the cohort sample (or a subset thereof).

For many centres - particularly those which are smaller - resource constraints were also a prominent reason for the current under-utilisation of cohort studies. Where the issue was capacity rather than cost, some centres were making progress in recruiting researchers with the quantitative expertise necessary to make use of the cohort data and hoped that it would be a possibility in the near future. Even where resource (both budgets and capacity) was not expected to change in the near future, a move towards being more proactive in utilising cohort studies was widely voiced given the benefits for measuring longitudinal outcomes.

Where cost was presented as a barrier, some centres recognised the efficiencies that could be drawn from a collaboration such that an intervention of interest to multiple centres could be set up together, spreading the cost across centres, with the 'baton' of responsibility passed between centres as the longitudinal data are collected. This is such that a poverty reduction intervention may be introduced to young people and the impact on their wellbeing, school attainment, interaction with the criminal justice system and employment outcomes could all be measured by different centres over time. Given many What Works centres are interested in the outcomes of young people, such a design would arguably need to be included in a new cohort study where the sample are still in their pre-school years (or a multi-generation extension to a current trial). An intervention implemented in early childhood could have EIF examining the initial impact. In subsequent waves, the YFF could take over the analysis looking at the impact of the intervention on outcomes in childhood and adolescence before TASO take the baton as individuals make decisions around higher education. As the individuals enter adulthood, What Works for Wellbeing, Neighbourly Lab, the Global Institute for Women's Leadership and What Works for Crime Reduction would take over, looking at whether the intervention has any long-lasting impacts on various outcomes into adulthood.

A final reason given for the under utilisation of cohort data was that the outcomes that could be tracked had simply not been considered by What Works centre as part of their broader research agenda. Ultimately, the data are only valuable to What

Works centres where the outcomes are aligned to their area of interest or research agenda. While cohort studies measure a wealth of outcomes some centres either did not know whether the cohort study would address their specific policy area (although they likely would) or were aware that they used different measures than the centre for the same construct. The benefits of lifetime longitudinal data are likely to outweigh such concerns and building stronger relationships with the cohort studies now may allow What Works centres to have a voice on the items included in future waves of cohort surveys.

What do What Works centres want to gain from using cohort studies?

As noted in the introduction, there are three ways that What Works centres could use cohort studies in their research. The first is simply to use the descriptive statistics they produce to identify problems the interventions could seek to solve. Second, to use them to take a retrospective look at the past, examining whether policy changes or points of inflection between groups affect outcomes. The third is prospectively, using experimental research designs, to examine the long-term impact of interventions introduced in the present. The value for What Works centres is in the ability to track the impact of past changes or current interventions well into the future and beyond the weeks or months that interventions are commonly evaluated for. It is also possible to look at more nuanced effects given many variables are collected prior to any prospective or retrospective intervention being deployed and can be used to increase statistical power by using controls to explain variation in the outcome of interest.

Simply using the cohort studies to describe the life of participants is valuable and is frequently undertaken by the cohort studies themselves. One centre spoke of the need to build a pipeline of activities for making funding bids and acknowledged that utilising cohort studies could provide "strong hints" as to what interventions may work in different contexts and for different groups, even where the measures used did not exactly align or the conclusions drawn are not causal. This allows potential for the 'description of the world' provided by cohort studies to be used in the targeted development and application of interventions into the future.

Examining research questions that use cohort data retrospectively can be valuable to determine the impact of an event, value of a policy or establish how factors like gender, socioeconomic status and academic attainment influence outcomes. Such quasi-experimental designs perhaps lend themselves more to some centres than others due to the outcomes of interest. For example, the What Works Centre for Crime Reduction noted that many of the outcomes they are interested in may be considered less 'desirable' in nature (e.g. interaction with the criminal justice system, victims of crime) and may not always be collected (or as frequently) as a result. While arguably true, this is not necessarily problematic as data from cohort studies could possibly be combined with other data sets in order to use the richness of cohort study data with markers of interest from other sources (e.g. the Justice Data Lab).[2] Research may, for instance, allow for a greater understanding of the precursors to an individual's first interaction with the criminal justice system and the protective factors. The longitudinal element also means that beyond this first interaction with

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/794249/User_Journey_Document_Update_PDF.pdf

criminal justice it may be possible to see how different experiences affect wellbeing, further interactions with the police, aspirations and so on many years beyond this one experience.

Most centres did not express any concern with the data collected by cohort studies and all could think of some use for it (even in the brief time they were provided to think about it). Some suggestions included comparing differential experiences of furlough during the Covid pandemic on the wellbeing of individuals into the future, how past interactions with public services can impact the perceived legitimacy of them in the future and likelihood to comply with law, or a comparison of educational attainment for those just 'passing' the 11+ to those just 'failing' it. In cohort studies, the data have already been collected - in some cases many years if not decades after the point of interest - and also often benefit from large sample sizes and low levels of attrition between waves. This could allow many What Works centres to observe the impact of certain factors on outcomes of interest without engaging in costly and time consuming data collection themselves. The insight gained could then be used to inform interventions and experimental research designs.

When thinking about experimental uses for cohort data there was more flexibility to think creatively about interventions. This is primarily because, while there would be restrictions, there is the possibility for more input into the outcomes measured in future waves of the cohort study (one is not bound by what has been done in the past). Similarly, if no input into the outcome measures can be included, one can be mindful of what the proposed longitudinal outcomes would be and design the intervention accordingly. This notion of experimental research and the potential to examine the impact many years into the future was unsurprisingly appealing to What Works centres. This is perhaps because funding cycles frequently do not allow for the evaluation of an intervention more than a few months after its implementation.

The use of experimental designs to include interventions in the cohort studies would also allow What Works centres to examine 'what does good look like' in more depth as well as having the possibility to include factors to examine how the dosage, timing and targets of an intervention affect this. Many of the What Works centres noted the particular value of working on interventions in the cohort studies with outcomes that bridge multiple centres. This is also particularly desirable given only a finite number of interventions could be run on the same sample of participants. Given this, any collaboration is arguably going to need a governing council for decision making and principles to ensure that both What Works centres and the cohort studies benefit from the collaboration.

What would the governing principles of collaboration between What Works Centres and cohort studies be?

Each What Works centre has their own research agenda and area of policy interest and, while these are not necessarily conflicting, they do place the focus on interest, particularly for outcome variables, in different arenas. There is also the consideration that, especially for experimental studies, there is a finite number which can be run given the sample is restricted and, repeatedly applying interventions to the same pool, is often not desirable. Therefore, it was widely agreed that some form of governing council would be needed to ensure that each What Works centre had an

equal opportunity to contribute to and benefit from the cohort studies regardless of their size or funding. Assuming the council had representatives from all What Works centres and cohort studies that wanted to participate, some core principles would need to be developed to ensure that projects could be fairly decided upon and reduce the likelihood of a stalemate where each What Works centre votes for their own project.

Across the What Works centres, it was agreed that any experimental studies implemented should use an intervention that is of interest to multiple centres in the network and which have the potential to make the greatest contribution to public policy and society more widely. The bounds of this depend somewhat on the cohort studies that join the collaboration, the age of their participants and the outcomes of interest for the What Works centres. For example, an intervention introduced now to the COSMO study (where the sample is around 17 years old) has the potential to be valuable for looking at core outcomes of interest to What Works centres like higher education, employment, and homelessness into the future. However, centres looking at outcomes that may happen earlier in life (e.g. care experience, early interventions) may find this less valuable. Instead, for them, the MCS (where the sample is around 22 years old) which has retrospective data from birth may be valuable for targeting individuals who have experienced specific life events with current interventions to examine the impact they may have as an individual enters adulthood. The pool of those who have experienced certain life events may also be limited (e.g. care experience, victim of crime, experience with criminal justice) in which case consideration should be given to the impact of eligibility for any intervention on future possible trials on specific groups.

Another key principle suggested was that any interventions introduced should benefit from the added value a longitudinal perspective could bring to the research. Some studies may be easier run with a cohort study either because the recruitment is simpler, the attrition lower, or the participant history is desirable for context. However, if they will not benefit directly from the longitudinal nature of the data then it was generally considered that such research should be studied using other methods.

With the above points reflected upon, the cost of, and value for money, of the remaining suggestions was the next point most What Works centres thought should be considered. Evaluating a never-before-tested intervention is less likely to be considered with this criteria given it is more challenging to estimate the costs versus benefits. Instead, including this as a criteria may mean a leaning towards interventions that have shown promise using other methods but for which the long-term impact and or differential impact on specific groups is unknown.

Overall, What Works centres were supportive of the idea of running RCTs in the context of cohort studies. Reticence was mostly found among smaller centres who worried about an inability to fund interventions directly, or, relatedly, that larger (richer) centres would be able to dominate the process. This needs to be accounted for when designing governance processes to ensure that research maximises impact and social usefulness (which is not necessarily correlated with funding), and to ensure buy-in from as many stakeholders as possible.

Interviews with cohort studies

We interviewed representatives and researchers from three cohort studies - The Avon Longitudinal Study of Parents and Children (ALSPAC, also known as Children of the 90's), the Covid Social Mobility and Opportunities Study (COSMO), and the Millennium Cohort Study (MCS). In two cases we were able to speak with the Principal Investigator of the study.

Our interviews with the cohort studies focused on a number of key questions, which we will cover in turn in this section.

Is there interest in collaborating with What Works centres/doing more causal work?

Across the three studies there was an acknowledgement that cohort studies in general have done too little causal research. There was also a clear link identified between producing research that is valuable for policymakers in a timely fashion, and securing ongoing funding for the cohort studies. Cohort studies are expensive to conduct, and take place over decades. They aid our understanding of how society has changed over time, as well as allowing us to estimate social mobility. However, they are often criticised for lacking a timely production of useful knowledge. This was identified as an increasing focus for studies and an area in which greater collaboration could be of mutual benefit.

The Principal Investigators of COSMO and MCS both have a history of conducting randomised trials (outside of the cohort studies), and while acknowledging that they hadn't previously thought that they would be conducting such studies inside cohort studies, there was a high degree of understanding of the approaches that would need to be taken to introduce randomised trials, the benefits and the risks involved.

There as relatively less familiarity with the work done by What Works centres among the cohort studies (with the exception of COSMO), and so researchers felt less able to comment to the value of specific collaboration. One study (ALSPAC), which is the most medicalised of the three, is increasingly involved in causal research using "Mendelian Randomisation". This refers to identifying the impact of particular things which are themselves caused by (or increased/decreased in probability by) the presence or absence of a particular gene or multiple genes which are inherited 'at random' based on participants' parents' genomes. As such, researchers involved in ALSPAC thought there was likely to be less interest in conducting RCTs with this cohort study.

Do the cohort studies think that RCTs might be possible?

Interviewees were keen to preserve the integrity of their cohort studies as a means of looking at the state of the nation and the cohort, given that this is the primary reason for their existence. The implications of this were mixed. Some interviewees suggested it meant that any trials should focus on light touch interventions which would not dramatically change the course of the participants' lives, while others were more focused on testing more impactful interventions which could be studied with a relatively smaller sample size, preserving a larger proportion of the overall sample as a 'clean' cohort.

The cohort studies were keen to stress that while they were supportive of conducting RCTs, that this would need to be undertaken with substantial caution. In particular,

they identified a number of processes and groups that would need to be gone through/ engaged with to make an RCT happen successfully.

Stakeholders

- Researchers involved in the Cohort studies' wider research activities;
- Participant representative groups;
- Cohort study funders, including research councils, philanthropists and government departments.

Processes

- Any RCT would need to be cleared as an ethical amendment to the cohort studies existing clearances;
- The RCT would also need to independently go through a university Research Ethics Committee (REC) (although not necessarily the same REC as the Cohort study itself);
- Written approval from funders would need to be sought;
- GDPR and data protection processes would need to be gone through. This applies whether quasi experimental or RCT designs are used.

If these are successful, then cohort studies thought that trials should be possible to implement.

Another obstacle for RCTs relates to funding of two components: the intervention and data collection. We will come on to funding of interventions later on, but the funding of data collection varied substantially between studies. As we understand it, ALSPAC charges a substantial cost to add questions to their panel, and this is likely to be prohibitive for any early stage study we would consider. Costings for similar additions to other studies were not discussed, but do appear less formalised than ALSPACs. In any case, we would recommend making use only of data that is already being collected by cohorts at this stage.

How would you go about selecting questions/interventions for RCTs?

We discussed what interventions would be a priority for cohort studies to test using RCTs. Opinions differed on this. Some interviewees suggested low cost, light touch interventions which could plausibly be scaled in future would be a priority, so as to minimise the extent to which the treatment group were diverted from their pre-existing path through life, to preserve the integrity of the cohort study as a whole.

Other interviewees argued in favour of using more intensive and potentially costly intervention which could be tested using smaller samples. For example, we might think about an intervention costing several thousand pounds to administer per person (e.g. a cash transfers or unconditional income trial). Given the cost of the intervention, we should focus not on Minimum Detectable Effect Size (the most common approach used in sample size calculations for trials), but Minimum

Effect Size of Interest (MESI). Under a MESI framework, we would say that an intervention couldn't be cost effective if its effect was less than X, and so we need only power our trial to detect effects of that size with reasonable probability. Having done this, we could then randomly (if the intervention isn't targeted at a particular group), or purposively (if it is) choose a fairly sub-sample of the cohort study to be involved in the trial, and then randomised half of that group to treatment and the other half to control.[3]

As with the What Works centres, there were some points of agreement, specifically that RCTs should focus on interventions theorised to have effects across a range of outcomes; interventions which can be scaled and interventions with potentially *long-term* effects.

Cluster randomisation was not considered viable for cohort studies where participants are scattered around the country (even in the case of ALSPAC participants, who were all born in the now defunct county of Avon), unless they were carried out on a regional of other geographical basis.

Quasi-experimental evaluations

There was less qualified, more positive support for quasi-experimental evaluations to be carried out using cohort studies. Interviewees remarked that the older cohort studies had some quasi-experimental work conducted on them but that this was fairly limited.

Investigators identified a challenge with quasi-experimental evaluations through cohort studies, including that they would need highly specialised knowledge of the intervention domain, and the intervention would have to have been carried out in such a way that some people within the cohort were effected by it and others weren't. Given the relatively narrow birth window of many cohort studies, this was identified as a challenge, albeit not an insurmountable one.

Children

Both ALSPAC and MCS have participants who are no longer children, and who are beginning to have children of their own (the "Children of the Children of the Nineties" study has been running for several years, for example). Researchers involved in those studies suggested that it may be more straightforward to conduct an RCT with these children than with their parents.[4] This would allow the testing of early interventions (a particular focus for several What Works centres). However, it would also necessarily take longer, as children will be born over the next decade or more, particularly in the case of the MCS/COSMO studies where participants are younger.

3 As a small technical note, if sampling is to be conducted randomly from the whole sample of the cohort study, the most statistically efficient use of the data would be to randomly allocate the entire cohort study to either treatment or control, with a very high rate of allocation to the control group.

4 This would be similar to King's College London's CoTED Study which is an offshoot of the Twins Early Development Study (TEDS), looking at the children of participants of the original cohort study.

Thoughts on governance

Perhaps unsurprisingly, the cohort researchers were very concerned to ensure that the primary purpose of their studies were not impacted upon by any causal research (either RCTs or quasi-experimental) that were to be carried out. They were clear that any governance arrangement, while collaborative, would need to reflect the primary importance of the cohort studies.

Recommendations and conclusions

We have interviewed researchers from across the What Works network and from several cohort studies. Based on these discussions, we are able to conclude that conducting causal research, including RCTs, in the context of cohort studies, is both technically and logistically possible, and that there is substantial goodwill from both the What Works network, and the cohort studies themselves, towards making this happen.

We should not, however, underestimate the challenges associated with this approach. Cohort studies have existed for decades, and RCTs in social policy have been fairly commonplace for at least the last decade. The fact that RCTs have yet to be carried out within cohort studies should give an indication that this is not a straightforward task. Instead, it is one in which administrative, ethical, logistical and technical challenges must be overcome in order to bring the promise of combining what works and cohort studies to fruition.

Despite these challenges, the potential rewards are very substantial. The bringing together of large sample, long-term longitudinal data collection with robust causal inference could help us to understand the long-term impacts of social interventions - strengthening the case for rolling out or expanding those that are successful, and to cease those whose benefits are short-lived. We could build an understanding of the effects of interventions across a wide variety of outcomes and domains without prohibitive costs. Crucially, we could also deepen our understanding of both our society, and what works to drive social change.

At the end of our study, we are able to make recommendations about how best to structure any collaboration between what works centres and cohort studies to overcome challenges and maximise impact:

- The collaboration should be convened through a governing council, which takes suggestions from individual researchers or centres for particular studies to be conducted, and decides how to prioritise these, which to take forward and how. This governing council should include;
  - Representatives from individual centres
  - Representatives from cohort studies
  - Participant representative groups
  - Funder representation
  - An ethicist
  - A trial statistician
  - A representative of the cross government evaluation task force.

- The governing council should be viewed as a decision-making group. As such, its members should either by executive director/principal investigator level, or should have delegated authority.

- Given the need to prioritise the integrity of cohort studies, cohort study representatives/PIs should have veto power over any suggested approaches.

- Beyond this, the council should be as democratic as possible.

- Intervention selection should adhere to several general principles;
  - Interventions chosen for trials should have theories of change relating to multiple outcomes
  - Interventions should have theorised long-term impacts
  - Interventions that could be easily tested using a non-cohort study RCT should not be tested in this medium
  - There should be a focus on providing a range of potential interventions including;
    - Intensive, high cost, small sample size interventions, and;
    - Light touch low cost interventions

- As well as the main cohort studies, interventions should be developed and proposed which can provide early intervention for the children born to cohort participants in their first years of life. This approach is likely to take longer to yield results, but could be valuable.

Overall, we have found less resistance to the idea of intervening on participants in cohort studies. In line with the focal areas of existing What Works centres, and the background of the Principal Investigators of cohort studies, the MCS and COSMO cohort studies appear to be more accepting of the idea of RCTs within their samples, and so any initial programme of work should prioritise these two studies.

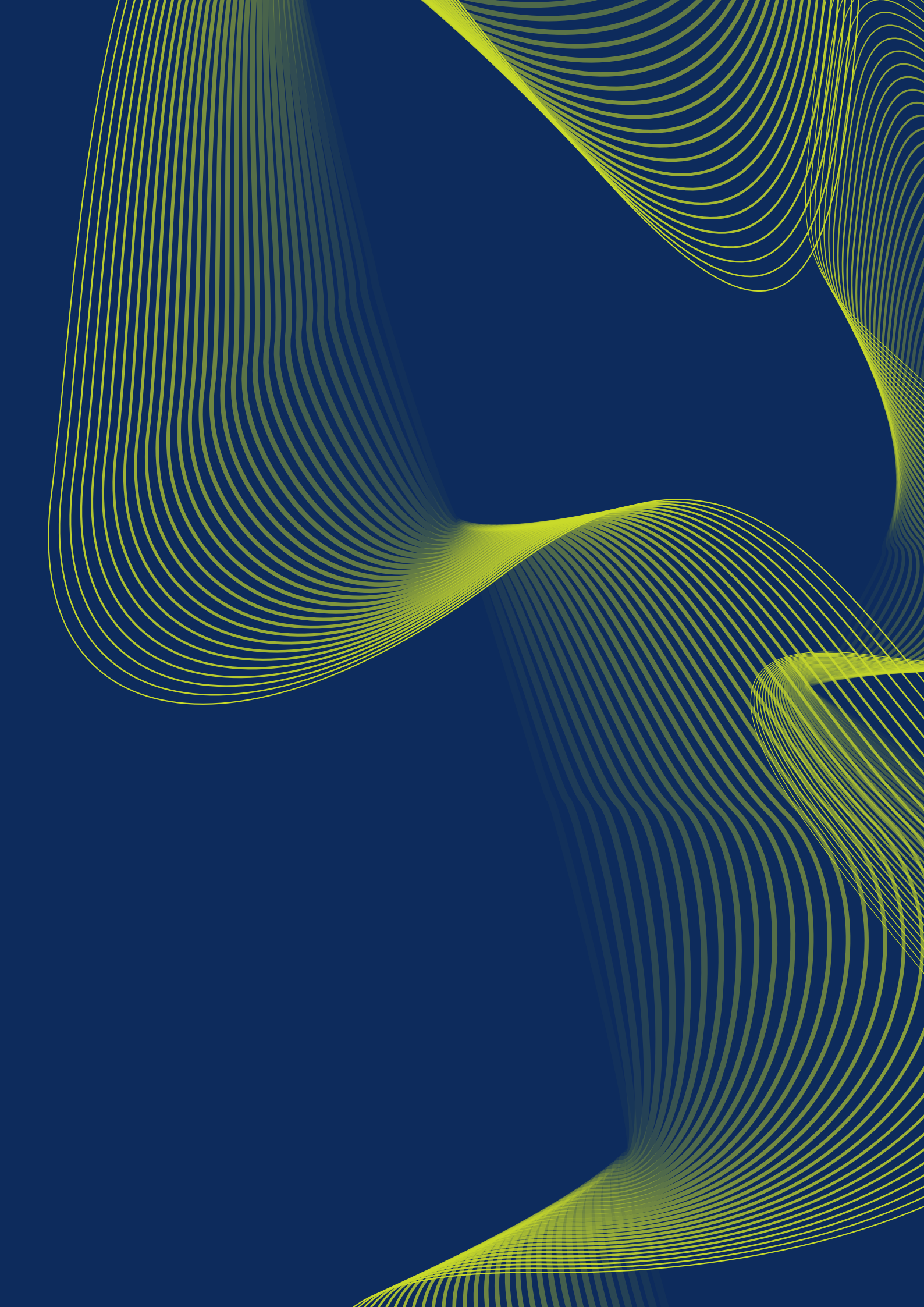
An important shortcoming of this study is that it focuses on fairly young cohorts (ALSPAC participants are in their 30's). Two what works type initiatives - the Centre for Ageing Better and IMProving Adult Care Together (IMPACT) are focused on outcomes for older adults, and the earlier cohort studies have participants which are in older age ranges (the absence of a 1980's cohort study means that the next youngest cohort are from the 1970 British Cohort Study, who are now in their early 50's. Future research into working between cohorts and What Works centres should look at these age groups.

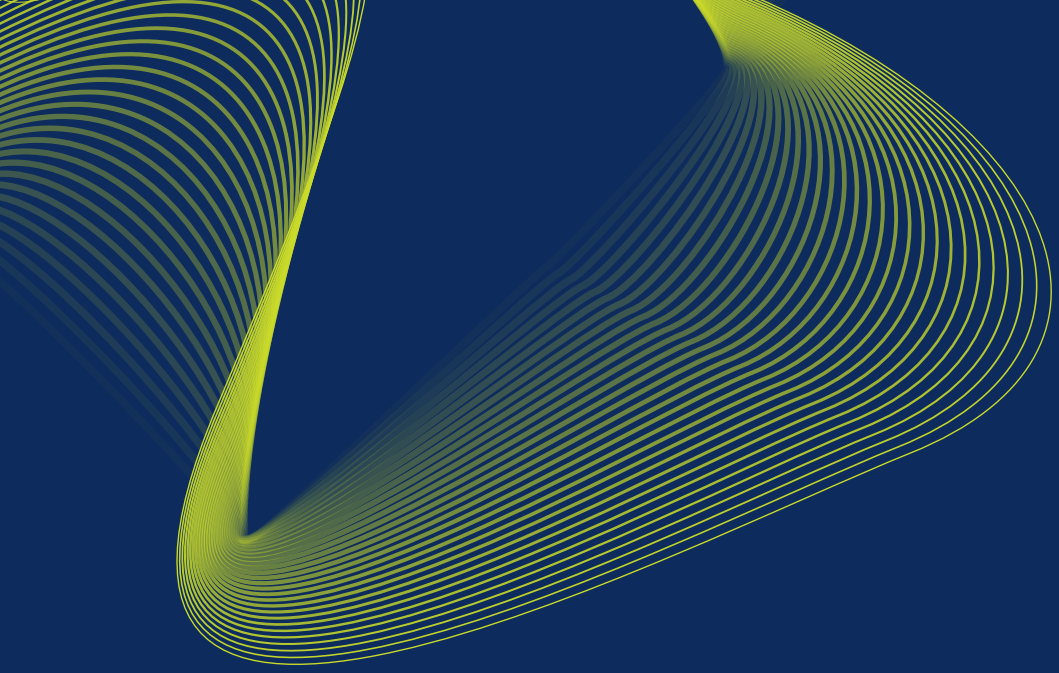
In closing, there is substantial enthusiasm on both sides of this potential partnership about the prospect of collaboration and producing RCT evidence from cohort studies. Careful but ambitious work should follow that can see the potential of this approach realised.

Appendix A: What Works centres involved in this study

The following table provides a summary of the What Works centres involved in this research, and their areas of policy and research interest:

What Works centre	Description
Education Endowment Foundation	Seeks to break the link between family income and educational achievement by supporting schools to improve teaching and learning.
Youth Futures Foundation	Aims to improve employment outcomes for young people from marginalised backgrounds.
Centre for Transforming Access and Student Outcomes in higher Education	Aims to eliminate equality gaps in higher education and improve lives.
What Works for Wellbeing	Seeks to improve people's wellbeing through effective policy and community action.
Early Intervention Foundation	Aims to improve the lives of children and young people at risk of experiencing poor outcomes through early intervention.
Neighbourly Lab	Seeks to understand what shapes 'strong neighbourhoods' and communities.
The Global Institute for Women's Leadership	Aims to break down barriers to women becoming leaders and challenging what leadership looks like.
The Centre for Homlessness Impact	Aims to act as a catalyst for evidence-led change for those experiencing or at risk of homelessness.
What Works for Crime Reduction	Aims to collate evidence on what works for crime reduction to provide tools for practitioners to conduct more rigorous research.





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