SUPERVISING DESIGNATED SAFEGUARDING LEADS IN PRIMARY SCHOOLS

April 2023

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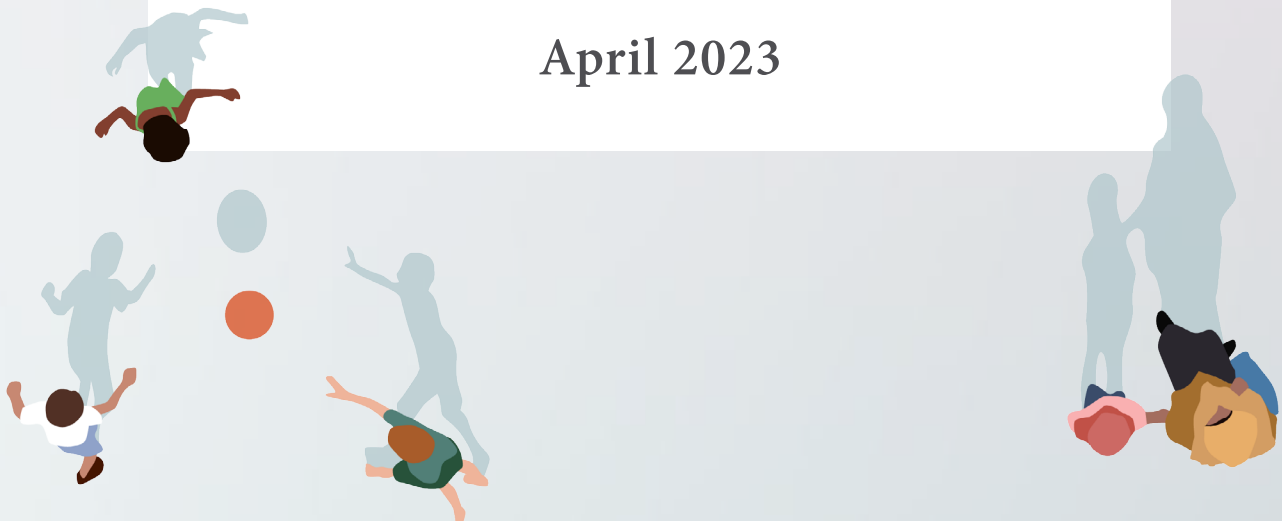What Works for Children's Social Care (WWCSC) and the Early Intervention Foundation (EIF) are merging. The new organisation is operating initially under the working name of What Works for Early Intervention and Children's Social Care. Our new single What Works centre will cover the full range of support for children and families from preventative approaches, early intervention and targeted support for those at risk of poor outcomes, through to support for children with a social worker, children in care and care leavers.

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EXECUTIVE SUMMARY

Introduction and background

This study aims to establish the impact of providing a designated social worker to supervise Designated Safeguarding Leads (DSLs) in primary schools. DSLs are responsible for child protection and safeguarding in schools. The role of a DSL can involve making difficult decisions about vulnerable children in often complex circumstances.

Through the provision of supervision, the key aims of the programme are to:

- Improve knowledge and understanding of children's social care processes and issues among DSLs, resulting in reductions in "inappropriate" contacts to children's social care

- Reduce DSL stress and anxiety, resulting in reduced rates of DSL burnout and turnover.

The programme builds on the intervention originally developed by Bolton Council and explored as part of a pilot evaluation in 2019/20.

Objectives

This evaluation aims to establish whether the programme is successful in meeting its aims. The evaluation includes a randomised controlled trial (RCT), an implementation and process evaluation (IPE) and analysis of costs.

The primary research question assessed in the RCT is whether there is a difference in the number of contacts made by schools resulting in no further action (measured as a proportion of pupils) between schools assigned to receive the programme and those that are not. This outcome measure is used as a proxy for whether there is an impact of the programme on the appropriateness of contacts made by schools to children's social care. That is, contacts are considered "inappropriate" when they do not lead to further action by children's social care. It is important to acknowledge that this is an imperfect measure. Reducing inappropriate contacts may help in ensuring the resources of children's social care services are focused where they are most needed.

Secondary research questions explored are: whether there is an impact on the total number of contacts made by schools; the number of referrals originating from schools; referrals resulting in no further action; and contacts from all sources. We also consider whether there is evidence of greater impacts on contacts and referrals in the latter period of the intervention and whether there are differences in effectiveness between urban and rural areas. Finally, the impact evaluation assesses whether the programme has an impact on the wellbeing of DSLs.

The IPE aims to explore fidelity and adaptation, programme differentiation, reach and acceptability and perceived impacts and outcomes.

Design

The trial involved a total of 1205 state-funded primary schools across ten local authorities (LAs) in England. Both LA and academy schools participated. Within each LA, schools were randomly allocated to either the intervention group, who received the programme (446 schools), or the control group (779 schools), who did not receive the programme and continued with business as usual.

The IPE involved a total of 82 interviews, including with DSLs (61 interviews), supervising social workers (SSWs) (11 interviews) and LA managers (10 interviews) across all participating LAs. Data was also collected through a baseline and endline survey with control and treatment schools, achieving 714 responses in total (with around a quarter of schools responding to the baseline survey, and one-fifth responding to the endline survey). SSWs also provided data on how many supervision sessions happened in each school, alongside estimates of DSLs' engagement during the programme and their need for support.

The intervention was delivered to schools from September 2021 to July 2022.

Findings

The key findings can be summarised as follows:

- The impact evaluation did not find that the programme had a statistically significant impact on the primary outcome of contacts resulting in no further action. The analysis points to a lower rate of contacts leading to no further action (NFA) among treatment schools, but not to a statistically significant extent. The magnitude of this effect is smaller than the trial was designed to effect, and so an effect of this size would not have been found to

be statistically significant. The estimated effect of -0.06 (95% confidence interval (CI) [-0.15; 03]), while statistically insignificant, would be equivalent to a difference between treatment and control groups of about 0.33 NFA contacts per school. In an LA with 120 primary schools, this would be equivalent to a difference of about 40 NFA contacts per LA

- A number of sensitivity analyses were conducted in relation to the primary outcome; but the main result remains robust to these additional analyses. In addition, the findings did not suggest evidence of an impact in the latter period of the intervention, and no differences in effectiveness were apparent between schools located in urban and rural areas

- Analysis of secondary outcomes relating to contacts and referrals also showed no statistically significant differences between schools allocated to receive the programme and those that were not. Thus we observe no impact of the programme on total contacts made by schools, new referrals originating from schools or referrals resulting in no further action (all measured as a proportion of pupils)

- Effects on DSL wellbeing were considered using two scale measures: job-related anxiety–contentment and job-related depression–enthusiasm.
The impact evaluation did not find a statistically significant impact on either measure

- 70% of schools in the treatment group had at least one supervision session, while 30% did not have any sessions. The reasons for lack of take-up included: schools participating in other support programmes and feeling they did not need support, lack of time and concerns that supervision was a way of monitoring schools. When supervisors managed to organise the first session to introduce

the programme properly to schools, they most often maintained engagement throughout the programme

- Apart from the lower than anticipated take-up and slow start to delivery and recruitment, the IPE found that the programme (when taken up by schools) was delivered largely as intended, and that the programme model itself would not require changes to be rolled out on a larger scale. DSLs expressed support for potential wider rollout

- DSLs interviewed found the supervision sessions useful, including having the time for reflection, developing new ideas, discussing complex cases or new types of cases, being signposted by the SSW to useful resources or local support organisations, learning from a social worker's perspective and discussing their own wellbeing

- There were mixed findings on perceived impacts. Many DSLs interviewed reported that supervision had no impact on their practices, because they were already confident in their ability to perform the role and their knowledge, including about thresholds that applied for children's social care referrals. At the same time, many DSLs described positive impacts, particularly in relation to improving confidence in the role and their emotional wellbeing

- The cost of the intervention is estimated at around £850 per school, per school year. This cost is based primarily on the cost of employing a SSW; although this is the most substantive element of expenditure, it is likely to underestimate the full cost of programme delivery because it does not include, for example, training or support for the SSW.

Limitations, conclusions and implications

Overall, the findings from the impact evaluation do not provide evidence to suggest that the programme impacted the outcome measures considered in the study. However, lower than anticipated take-up, as well as challenges in outcome measurement and data collection, mean these results should be interpreted with caution. Findings from the IPE, while noting some changes in practice around making contacts and referrals, tended to suggest that such changes were more subtle in nature and may not have been expected to influence the rate of contacts resulting in no further action.

The IPE suggests that the most substantive perceived improvements were in relation to the wellbeing and confidence of DSLs, and in bridging the gap between schools and children's social care. It is important to bear in mind that there may be bias among the sample of individuals who respond to the surveys and interviews that form part of the IPE. Nevertheless, the findings indicate that these views were prevalent among the subset who did respond. No measurable impacts on wellbeing were found in the impact evaluation, although issues in survey response cast doubt on the robustness of these results.

Decisions about the value of such a programme going forward will need to be informed by which outcomes decision-makers are most seeking to influence as a result. The current design of the programme may not substantially impact the appropriateness of contacts and referrals to children's social care, but rather the key focus may be on other outcomes not considered as part of the impact evaluation, such as confidence and/or joint working between education and social care. These causal pathways remain untested, and may be areas for exploration in future research.

INTRODUCTION

Background

This report presents findings from the evaluation of a programme providing a designated social worker to provide supervision to Designated Safeguarding Leads (DSLs) in primary schools. The evaluation includes a randomised controlled trial (RCT), an implementation and process evaluation (IPE) and analysis of costs.

DSLs are responsible for safeguarding and child protection in schools, and are expected to: manage referrals; act as a point of contact with safeguarding partners; liaise with head teachers and other school staff; undergo specialist training; raise awareness; and maintain child protection files.

The role of DSL can involve making difficult decisions about vulnerable children in often complex circumstances. In this project, each local authority (LA) assigned a dedicated supervising social worker (SSW) to supervise DSLs to support children and families more effectively, and with the aim of improving the appropriateness and quality of contacts made by schools to children's social care. In this evaluation, as a proxy for the appropriateness of contacts, we explore whether contacts result in further action by children's social care. That is, contacts are defined as "inappropriate" when they result in no further action by children's social care, although it is important to recognise that this is an imperfect measure. Recent years have seen increases in the number of referrals to children's social care that originate from schools (DfE, 2022); while some recent trends

are likely to be affected by the pandemic, rising referrals were already apparent before this period (Baginsky et al., 2019). Reducing the number of inappropriate contacts made can help to ensure that resources are focused on addressing those contacts where further action by children's social care is most needed. This has potential benefits not just for social care services, but also for schools, in ensuring their limited resources are concentrated where most needed, and ultimately for children and families, so that the most appropriate sources of help and support are provided. A further aim of the intervention was to improve DSLs' wellbeing, with increased confidence in decision-making and reduced anxiety among DSLs.

The DSL role is often undertaken in addition to other duties – for example, in addition to an individual's teaching and other leadership responsibilities. Schools structure their safeguarding teams differently, and there can be multiple staff with DSL responsibilities. In primary schools, the DSL is often the head teacher, although in some schools a deputy DSL may hold many of the day-to-day responsibilities, with the head teacher providing oversight.

In this study, supervision was provided in the form of one-to-one sessions, intended to take place on an approximately monthly basis during the school year 2021/22. The intervention evaluated in this trial (described in more detail below) was originally developed by Bolton Council. This evaluation builds on a pilot study providing supervision to DSLs in primary schools in Bolton in the school

year 2019/20; although this did not find a statistically significant impact on the measured outcomes, it showed some signs of potential (Stokes et al., 2021) and was thus considered to warrant further research.

Three additional evaluations of similar programmes of DSL supervision, also funded by the Department for Education, via WWCSC, have been conducted in parallel to this evaluation:

- A programme providing group supervision for DSLs in secondary schools

- A variant of the DSL supervision programme with a specific focus on addressing child sexual abuse, in both primary and secondary schools

- A programme providing individual supervision for DSLs in secondary schools in Greater Manchester.

Results from these evaluations will be reported and published separately.

Intervention and logic model

The main features of the intervention are described below, drawing on key elements from the template for intervention description and replication (TIDieR) framework (Hoffmann et al., 2014).

Name: Supervision of Designated Safeguarding Leads in primary schools

Rationale: Statutory guidance developed in previous years has highlighted the importance of the role of a DSL, the training and support this individual ought to receive and the critical role of supervision to ensure the best outcomes for the child and family at risk. The "Keeping children safe in education" guidance stipulates that DSLs ought to be senior members of a school's leadership team (Department for Education, 2014). [1] This guidance also states that DSLs "should be given the time, funding, training, resources and support to provide advice and support to other staff on child welfare and child protection matters …" Further guidance such as "Working together to safeguard children" (HM Government, 2018) also emphasises that "effective practitioner supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support practitioners to reflect critically on the impact of their decisions on the child and their family."

Despite this guidance, concerns have been raised over a lack of formal supervision and sufficient training for DSLs. [2] DSLs support children in challenging and complex circumstances, and this can be stressful, challenging and emotionally taxing for the DSLs themselves. [3] DSLs receive statutory (including refresher) training, but as highlighted in the findings of this evaluation, while DSLs typically found this training useful, it was not necessarily considered sufficient. The provision of supervision aims to build on this and add further support for DSLs, providing a space for reflective practice.

At the same time, it is important to bear in mind that there have been changes to the environment in which schools and social care services are operating over recent

1   First edition published in 2014; most recent edition published in 2022 and available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1101454/Keeping_children_safe_in_education_2022.pdf.

2   https://www.et-foundation.co.uk/safeguarding-and-prevent/the-role-of-dsl-its-time-to-speak-up.

3   https://www.tes.com/magazine/archive/wellbeing-who-safeguards-safeguarding-leads.

years; Baginsky et al. (2019) discuss, for example, the academisation of schools and the changing nature of relationships between LAs and schools in the context of increased diversity in school provision. There is also acknowledgement of the growing pressures faced by schools, with recent years seeing cutbacks in funding of welfare services and difficulties in accessing, for example, child and adolescent mental health services (Baginsky et al., 2022).

Supervision: Supervision is defined by this programme as an activity that brings skilled supervisors and practitioners together (in this case social workers and DSLs respectively) to reflect on their practice. "Supervision aims to identify solutions to problems, improve practice and increase understanding of professional issues" (UKCC, 1996). It serves to manage the emotional demands of the work, maintain relationships and make difficult judgements and decisions, often in light of conflicting information (Wonnacott, 2012). Supervision serves to reflect critically on one's own practice, receive emotional support and develop skills, knowledge and an increased understanding of the mechanisms of children's social care threshold limits and processes.

Existing work has explored how supervision can be used in schools to support staff in their safeguarding role (for example, Sturt and Rowe, 2018). Supervision is a fundamental process within a social care context, supporting the development of staff skills and practices in their work; this programme applies the same principles to be used within the supervision of DSLs in schools and builds on the original model tested in the Bolton primary school pilot.

Supervision sessions are delivered on a one-to-one basis, based on Wonnacott's (2012) 4x4x4 model. This model identifies four stakeholders in supervision (service users,

team members (DSLs), organisations (school) and partner organisations); four functions of supervision (management, development, support and mediation); and four elements of the supervisory cycle (experience, reflection, analysis and action). The approach aims to promote reflective practice, critical thinking and secure decision-making.

Aim of programme: The key aims of the intervention are to:

▪ Improve knowledge and understanding of children's social care processes and issues among DSLs, resulting in reductions in inappropriate contacts to children's social care

▪ Reduce DSL stress and anxiety, resulting in reduced rates of DSL burnout and turnover.

The manual for the programme (described below) also notes more general objectives for the supervision as identifying learning and development needs of DSLs; signposting DSLs to useful resources to support evidence-informed practice; and providing feedback to DSLs on their continuing professional development.

Materials: What Works for Children's Social Care (WWCSC) worked with Bolton Children's Services to develop a manual for the Supervision of DSLs programme, building on materials originally developed for the pilot programme in primary schools in Bolton. The manual provides guidance on how supervision should be delivered and template documents for use in setting up and maintaining good-quality supervision.

This includes agreements drafted for supervisors and supervisees, in order for all involved to have an understanding of the processes, and of expectations of roles and

responsibilities. Template documents for primary schools include:

- Memorandum of understanding

- Supervision agreement

- Record of supervision

- First session sheet

- DSL session worksheet

- Record of ad hoc or unplanned supervision

- Reflection form.

These documents form the basis for those used by all participating LAs, although each can make adaptations where necessary to tailor this as required for their own authority.

The manual also includes an introductory guidance document for the DSLs involved, providing an overview of the programme, roles and responsibilities, and outlines what DSLs can expect.

Who: Each participating LA recruits a supervising social worker (SSW) to provide the supervision. This supervisor is also in charge of scheduling sessions and ensures the programme moves forward as expected. The typical model is that there is one SSW per LA, although there may be more than one if the number of schools require this or, for example, due to part-time working patterns. The SSWs are invited to an induction event, to explain their role and ensure they are comfortable with the materials.

Supervision is undertaken with school DSLs. Where schools have multiple DSLs, while schools are provided with some guidance on selecting the DSL who will participate, ultimately the school will be given the opportunity to choose which DSL to put forward for supervision. In some cases this could be a deputy DSL.

A community of practice for SSWs was also set up by WWCSC as part of the project, which was held on a termly basis. These sessions aimed to give SSWs the opportunity to share their experiences of delivering supervision as part of the programme (and involved SSWs from across the three different projects providing supervision for primary schools, secondary schools and the programme with a specific child sexual abuse (CSA) focus).

How: Supervision sessions follow the same format for each session and for each DSL. These sessions take the form of individual supervision sessions for each school, which may take place either face-to-face or remotely. All sessions are logged and a written record kept. It should also be noted that SSWs were instructed not to discuss cases already open to children's social care where a child already had a social worker. This was originally implemented to avoid supervision conversations potentially duplicating or contradicting those of the case-holding social worker and to avoid any potential issues with information-sharing (for example, if a DSL disclosed information to the SSW rather than the case-holding social worker).

Where additional support or sessions are needed on an ad hoc basis, these should be logged and recorded as well, specifying whether they took place by email, phone or in person.

Where: The supervision sessions take place within the schools of the DSLs, or remotely, especially in the context of COVID-19. Where possible, the location of the sessions should remain consistent throughout and the space used should be quiet and private, to minimise disruptions and allow for open discussion.

When: The formal supervision sessions are intended to take place at regular monthly intervals (every four to six weeks), for a maximum of two hours at a time. Sessions were offered between September 2021 and July 2022.

Tailoring/adaptation: Given the nature of supervision, the content of the sessions could be tailored to the needs of each DSL; however, the format and style of sessions remains constant throughout.

Logic model

The logic model for the intervention is presented in Figure 1. This sets out the context for the intervention, the activities that the intervention comprises and the stakeholders involved. It outlines the mechanisms through which the intervention is expected to operate and the intended outcomes.

A key underlying idea is that supervision can ultimately help to reduce inappropriate contacts (defined below) through DSLs benefiting from the experience of the SSW's knowledge and through increased reflection on their work. If knowledge of thresholds for referrals improves, and there is greater understanding of how best to make a contact (for example, improving the quality of information provided), this has the potential to reduce inappropriate contacts. The intervention also aims to help DSLs feel better supported in their work and, together with increased feelings of self-efficacy, has the potential to lower levels of stress and anxiety and increase confidence in the role. Note that the evaluation focuses on these two outcomes, and does not consider whether the programme led to an increase in Early Help plans or whether there were improved outcomes for children and families.

Figure 1. Logic model

Logic model: Supervision of Designated Safeguarding Leads in primary schools

Context	Interventions / activities	Mechanisms and intermediate outcomes	Outcomes

Designated Safeguarding Leads (DSLs) are staff appointed to have the lead responsibility for child protection and safeguarding within their school. DSLs should be senior members of a school's leadership team.

The DSL role can involve making difficult decisions about vulnerable children in challenging and complex circumstances.

While supervision is a statutory requirement, many DSLs do not have a formal, designated space to reflect on the difficult decisions they are making, the emotionally taxing information they are hearing and the toll it might take on their wellbeing.

Around 1205 schools to participate within 10 LAs.

Intervention:
Individual supervision offered to DSLs in selected primary schools in 10 LAs. Experienced social work managers in LA to provide regular, individual supervision to DSLs. Sessions should take place every 4 to 6 weeks, for up to 2 hours.

DSLs from selected primary schools:
Attend monthly individual supervision sessions (2 hours max), between September 2021 and July 2022

Experienced social work manager hired as supervisor throughout programme (one or more per LA depending on size of LA):
- Provide supervision for DSLs in schools.
- Schedule regular sessions with DSLs
- This supervisor should not be a case-holding SW

Participating schools:
- Encouraging DSL's attendance of supervision sessions
- Demonstrate buy-in to programme.
- Facilitates DSL attendance, by allowing DSLs to take time to attend sessions

Local authorities:
- Managing and promoting the programme
- Recruiting an experienced SW as supervisor
- Promoting the welfare of children
- Managing and making decisions on contacts/referrals into CSC

Education Safeguarding Team:
- Facilitating relationships with schools
- Provide schools with support
- Manager from this team to line manage the supervisor

Local safeguarding children partnership:
- Promoting welfare of children, coordinating safeguarding activities, encouraging supervision

Challenge: Attendance and up-take of the supervision offer to DSLs

Using supervision to reflect on complex cases, decisions made and the emotional toll of their work

Supervising SW sharing experience, knowledge and expertise relevant to DSL/school's cases

Building relationships within network around children and families

Develop reflective capacity, and foster a reflective practice

Gain knowledge of guidance and good practice

Enable, promote and develop better multi-agency working

Increased understanding of CYP difficulties, and problems faced by families

DSL feels better supported

Increased feeling of self-efficacy and competence among DSLs

Better continuity of care for children

Reduce DSL stress and anxiety

CSC develop better understanding of challenges faced by DSLs and schools

Increased confidence in decision-making

DSLs/schools have better understanding of thresholds/ Increased understanding of roles and responsibilities between schools and CSC

Better relationship and interaction between DSL/school and families

Increased DSL job satisfaction

Earlier and more effective support or signposting provided to families

Better quality information provided to CSC at point of contact and referral

Improved outcomes for children and families

Improved DSL wellbeing, reduced DSL burnout and turnover rates

Increase in Early Help plans by schools

Reduction in inappropriate contacts to CSC

Evaluation objectives and research questions

Impact evaluation

The main objectives of the impact evaluation centre on the two key aims of the programme: increasing understanding of children's social care processes and thus reducing inappropriate contacts to children's social care, and improving the wellbeing of DSLs.

In relation to the first aim, ideally we would want to know whether contacts are being made for the children who are in need of support or services, and whether these contacts or other mechanisms of support are being put in place as early as they feasibly can be. Unfortunately these concepts are not easily measured, particularly in routinely collected administrative data.

While counting number of contacts made may appear relatively straightforward (although it is clearly important to take account of school size), such a measure is limited; greater expertise among DSLs could result in a reduction in contacts if it reduces the likelihood of DSLs making a contact "just in case", but could also result in an increase in contacts if DSLs become more skilled in identifying children who may be in need.

One way of capturing "appropriate" contacts is to consider them as appropriate where they lead to referral (or, conversely, as "inappropriate" where they do not lead to any further action). We use this as the basis for our primary outcome, exploring whether there is a difference in the rate of contacts not leading to further action, as a proxy for inappropriate contacts.

This does not mean that all contacts that do not result in further action are inappropriate or that no assistance can be provided. For example, the school may be pointed to alternative sources of support or advice, or early help actions may be instigated. Contacts that result in no further action can also support information-gathering or decision-making if future contacts are made.

A further weakness of the measure is that it does not provide any information about children for whom contacts were not made, and whether any of these should have required a contact to children's social care to be made. In an attempt to address this, although the main focus of our research questions is on contacts made by schools (RQ1–RQ4 below), we also explore, where data is available, whether there is any change in contacts made from all sources (RQ5). If, for example, contacts from schools fell, but contacts from all sources increased, this may provide some indication that some contacts were being "missed" by schools (and therefore picked up elsewhere in the system).

It is important to be aware that different LAs use varying terminology around contacts and referrals; they vary in the way in which "contacts" are dealt with as they enter the system (organising their "front door" differently) and in how no further action is defined/determined, all of which adds further complexity.

For the purposes of this study (in line with the definition used in most of the LAs participating in this project), we define a "contact" as being made where children's social care services are contacted about a child (for example, by a DSL). This contact may then be progressed to a referral, where children's social care services consider an assessment and/or whether services may be required. Thus the contact is made by the DSL, but the decision about whether this progresses to a referral is made by children's social care.

While recognising that contacts leading to no further action is an imperfect measure, it is nevertheless the closest proxy we can obtain from routine administrative data.

The primary research question this evaluation is therefore designed to answer is:

1. What is the effect of providing support to DSLs in primary schools on the proportion of pupils for whom a contact is made by a school that does not lead to a social care referral (i.e. no further action at contact)?

The impact evaluation also sets out to address the following secondary research questions:

2. What is the effect of providing support to DSLs in primary schools on the proportion of pupils for whom a **new contact is made by a school?**

3. What is the effect of providing support to DSLs in primary schools on the proportion of pupils for whom a **new referral** is made?

4. What is the effect of providing support to DSLs in primary schools on the proportion of pupils for whom a **new referral does not lead to further action** (at referral or assessment stage)?

5. What is the effect of providing support to DSLs in primary schools on the **number of contacts** (as a proportion of pupils) **from all sources** (comprising contacts from school and all other sources)?

6. What is the effect of providing support to DSLs in primary schools on the **wellbeing of DSLs?**

7. Is there evidence of a difference in the timing of any effect on contacts and referrals? More specifically, **is there evidence of a greater effect in the latter half of the intervention?**

8. Does the effectiveness of the programme differ according to the urban or rural context of the area in which it is operating?

As noted above, a key motivation for the programme was to reduce inappropriate contacts made. In practice, the data collected as part of the evaluation suggested that in many of the primary schools, there were low or indeed zero contacts resulting in no further action (with the latter able to occur both as a result of no contacts being made, or because those that were made resulted in further action). At first sight this seems at odds with the desire to reduce contacts made. However, while an individual school may not generate a high number of contacts (although there is inevitably variation across schools), when considering the total number of contacts across all schools, this may still represent a figure that is stretching the resources of children's social care services.

The protocol noted that the ability to address the research questions above would depend on being able to access the necessary data. Ultimately we were able to address each of these research questions. However, data was not always available for all outcome measures in all participating LAs; information on availability of each outcome measure is included in the later section of this report on sample size and attrition.

Implementation and process evaluation

The IPE set out to address the following research questions, covering four main areas:

Fidelity and adaptation

- Is the programme delivered as intended?

- How well is compliance/fidelity achieved?

- Can the programme be rolled out on a larger scale, or would anything need to be adapted?

Programme differentiation

(what do the service structure and practice look like before the introduction of the model, or in control conditions?)

- How does usual practice look before the intervention or compared with the control condition?

- How do DSLs feel supported before the programme or compared with the control condition?

- How is the level of stress and anxiety experienced by the DSLs before the intervention or compared with the control condition?

Reach and acceptability

(who the intervention reached and what the experience was of those delivering and receiving the intervention)

- How are individual DSLs chosen to receive the support sessions and what are their characteristics and role in terms of the wider DSL structure within the school?

- To what extent are DSLs engaged in the programme and what are the main barriers? To what extent do participants engage other staff within the school and are they expected to?

- What are the main barriers to attending the sessions? If compliance is not achieved, what are the reasons why? (Including contextual reasons, such as COVID-19)

- What's the experience of social workers delivering the programme? How is the intervention received by participants and by the school in general?

- What's the experience of key stakeholders in LAs delivering the programme? How does it fit into their wider support packages to schools?

Mechanism and outcomes

- What are the perceived impacts of the intervention?

- How well do participating DSLs feel they have performed their role (and, where applicable, how does this compare with when they had no supervision), including in assessing threshold levels of concern, managing referrals appropriately to children's social care and other issues related to supporting children and families?

- How equipped do participating DSLs feel they are to perform their role, including any changes in their level of anxiety and stress?

- Do school leaders and other school staff (not receiving the monthly supervision sessions) feel the intervention benefits the school?

- Do participants feel the programme is worth their investment of time?

Ethics and data protection

Ethical approval for the evaluation was granted by the NIESR Research Ethics Committee in August 2021. This required the submission of an application form by the evaluation team to the research ethics committee outlining the key features of the project and setting out the ethical issues involved and associated mitigations.

Each participating LA coordinated the recruitment of schools within its area. LAs were provided with an initial template letter by WWCSC for LAs to distribute to schools. Schools were able to withdraw from the evaluation. In the information provided to potential participants in approaches for interviews, and in distributing the surveys to school staff, individuals were informed that their participation was voluntary and that they could withdraw at any stage.

A project privacy notice was developed in collaboration with WWCSC, informing participants about the purpose of the study, the type of information being collected, how this would be used as part of the research and their rights in relation to their data. A copy of the privacy notice is available at: https://www.niesr.ac.uk/wp-content/uploads/2021/09/Data-Privacy-Notice-2121-DSL-FINAL.pdf

Data-sharing agreements were set up between WWCSC, NIESR and the individual participating LAs. Limited personal data was to be shared for the purposes of the evaluation; this related mainly to contact details of DSLs and other school staff, as well as SSWs and other LA staff involved in the project and evaluation, mainly for the purpose of facilitating the interviews and surveys that formed part of the study. Further details relating to data protection are given in the trial protocol.

The trial is registered on the Open Science Framework at: https://osf.io/c38hb

METHODS

In this section we outline the methods applied for the three key strands of the evaluation in turn: the impact evaluation, the IPE and the evaluation of costs.

Impact evaluation

The key features of the trial design are summarised below.

Design

The impact evaluation was conducted as a randomised control trial. There are two trial arms; receiving the supervision (the intervention or treatment group) and not receiving the supervision (the control group). Randomisation took place at school level, with approximately half of schools being allocated to the treatment group (receiving the support of the designated SSW) and half to the control group (who would not receive this support and continue with business as usual).

Trial type and number of arms		Two-armed randomised trial
Unit of randomisation		School
Stratification variables (if applicable)		LA and proportion of pupils in school eligible for free school meals (FSM)
Primary outcome	Variable	Proportion of pupils for whom a new contact is made by a school that results in no further action (at the point of contact)
	Measure (instrument, scale)	LA administrative data
Secondary outcome(s)	Variable(s)	▪ Proportion of pupils for whom new contact is made by a school ▪ Proportion of pupils for whom new referral is made ▪ Proportion of pupils for whom new referral leads to no further action ▪ Proportion of pupils for whom new contact is made (all sources) ▪ DSL wellbeing
	Measure(s) (instrument, scale)	▪ Wellbeing: pre- and post-intervention surveys of DSLs ▪ All other outcomes: LA administrative data

The primary outcome for the trial is the proportion of pupils for whom a new contact is made by a school that does not lead to further action. The secondary outcomes considered are:

- New contacts (RQ2)

- New referrals to social care (RQ3)

- Referrals resulting in no further action (RQ4)

- Contacts made from all sources (RQ5)

- DSL wellbeing (RQ6).

All measures, except DSL wellbeing, are measured as a proportion of pupils in the school. We describe these measures in greater detail in the section on outcome measures below.

As noted earlier, we explore two additional research questions:

- Whether there is evidence of a greater effect in the latter half of the intervention period (RQ7)

- Whether there are differences in effectiveness between urban and rural areas (RQ8).

Both RQ7 and RQ8 focus on impacts in terms of the primary outcome of contacts leading to no further action.

Randomisation

Schools were randomised within blocks defined on the basis of LA and the proportion of children eligible for free school meals (FSM) within each school. Two FSM groups were determined using median splits: "high" and "low" – with schools ranked by the proportion of pupils eligible for FSM, with thresholds for the "high" and "low" groups chosen so that half of all schools within each LA were allocated to each group. This

blocking was used to reduce the risk of imbalance between the treatment and control groups when randomising schools. Stratifying on the basis of previous activity relating to children's social care may have been beneficial (using, for example, information on contacts made to children's social care before the intervention starting). This could help reduce the risk of imbalance between treatment and control groups if, by chance, the treatment and control group differed in this respect before the programme started. Due to the short timeframe within which randomisation needed to take place, it was necessary to make use of readily available data instead. FSM eligibility is used for this purpose given these data are readily available and may help to act as a proxy for contact with children's social care (for example, Children in Need are more likely to be eligible for FSM than other pupils (Department for Education, 2018)).

Randomisation of schools was conducted by assigning each school a randomly generated number, with schools then sorted within block by random number. Schools were allocated to treatment and control groups in accordance with the randomisation ratio for that LA. In eight of the ten LAs, randomisation was conducted on a 50:50 basis. In the remaining two LAs, the size of these LAs meant that it was not feasible to deliver the intervention to half of the schools, and in these authorities the randomisation ratio was therefore set such that a feasible number of schools were allocated for delivery. This equated to just under 30% of primary schools in these LAs being allocated to the intervention group. Overall, this meant that when considering the sample as a whole, 37% of schools were allocated to the treatment group and the remaining 63% to the control group.

Randomisation was conducted by the evaluation team. Analysts were not blind to group allocation.

Participants

Ten LAs across England participated in the trial, with all mainstream state-funded primary schools located within these LAs eligible to take part. A list of schools was identified by each participating LA; all were expected to participate in the trial unless the school declined. LAs were provided with a template letter by WWCSC to provide to schools, but also had flexibility over how to approach and inform schools regarding the project. The nature of the intervention is such that it potentially applies to all children within all schools, thus all children within the study schools are included in our sample. In total 1205 schools were involved in the trial.

Outcome measures

The primary outcome is the number of new contacts made (at school level) that result in no further action (at the point of contact) as a proportion of the number of pupils (in that school) between September 2021 and July 2022. This is calculated as the total number of such contacts per school, made between September 2021 and July 2022,[4] divided by the number of pupils in that school.

Secondary outcomes are:

- New contacts to children's social care, made by a school (as a proportion of pupils)

- New referrals to children's social care (as a proportion of pupils)

- New referrals leading to no further action (as a proportion of pupils)

- New contacts from all sources (as a proportion of pupils)

- DSL wellbeing (job-related anxiety–contentment and job-related depression–enthusiasm).

With the exception of DSL wellbeing, information on both primary and secondary outcomes was obtained from administrative data held by the participating LAs, and assessed for the same time period as for the primary outcome measure.

In assessing whether new referrals lead to no further action, this is measured on the basis of observing this outcome within the lifetime of the delivery period (that is, by the end July 2022).[5] For some children, towards the end of the school year, it may be possible that some referrals would result in no further action after the period that we are observing in the data, but this applies equally across both treatment and control groups. If more than one contact/referral is made for the same child, these are counted as separate contacts/referrals.

There can be variations across LAs in both data systems and definitions. As part of the data collection process, the evaluation team met with every participating LA at least once, to better understand the systems in place and to understand what data may be feasible to obtain.

The data collection process highlighted some challenges in data collection – for example, the ease with which LAs can identify schools within contact and referral data is varied. That is, it is not always straightforward for LAs to provide data on the number of contacts that relate to a particular school. Where this

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4   One LA was only able to provide data up to the end March 2022, and therefore for this LA this measure is calculated on the basis of September 2021 to March 2022 only.

5   The same is applicable for contacts, although it is assumed that the decision as to whether a contact progresses to further action may be quicker than for a referral, and is thus less likely to fall outside this period.

information exists, often school has been recorded as a free-text field, which can raise data quality issues. In some LAs, linkage to education data systems in order to improve the accuracy of data is possible, but not in all. In some LAs, this also meant that data was assigned to schools on the basis of the school attended by the child; while it is assumed in most cases that this is likely to be the school that also made the contact, this will not always be the case. In some LAs, it was more feasible for school-level data to be provided for contacts that were made by schools, rather than for contacts that originated from non-school sources. Three of the participating LAs were unable to provide this data from non-school sources, which means that the analysis of contacts from all sources (RQ5) is based on a smaller sample size and may therefore be less robust.

Wellbeing of DSLs is captured through a survey of DSLs administered by the evaluation team (and discussed below under methods for the IPE). The wellbeing measure used is a measure of work-related wellbeing that has been used in previous nationally representative surveys of employees in British workplaces (van Wanrooy et al., 2013) and aims to capture job-related anxiety–contentment and job-related depression–enthusiasm (Warr, 2007). These aspects of wellbeing are analysed as two separate outcome measures. Each is based on responses to three items; with responses on the five-point scale scored from -2 to +2, and then summed to form a scale ranging from -6 to +6 (where a higher score indicates higher wellbeing).[6]

As these measures are collected via surveys, there is inevitably non-response, which may bias the estimates obtained. That is, those individuals who completed the surveys may

not be representative of all individuals who were eligible to complete the survey. It is not clear a priori, however, the direction of any such effect. As with any survey, other forms of bias can also occur – for example, social desirability bias (if respondents feel that they ought to give a certain answer, rather than stating how they truly feel). The endline measures were collected towards the end of the programme in June–July 2022. At baseline, wellbeing measures were collected before the start of the intervention, but when schools were already aware of their allocation to treatment or control groups (due to the need for the intervention to start as early as possible, it was not feasible to conduct the survey in advance of randomisation). It is possible that this may have introduced bias as a result, although it is hard to judge to what extent experimental status may have affected how an individual responded to the actual question. It is arguably of more concern that this may partly have resulted in the fact that we observe higher rates of survey completion among the treatment group than the control group (see Appendix 1), which may have had greater potential to result in bias. It is important to bear this in mind in interpreting the results.

In addition, due to delays in having signed data-sharing agreements in place, the surveys were not able to be issued to schools directly by the evaluation team. Instead, LAs distributed the surveys to schools on behalf of the evaluation team. This meant that it was not possible to include a unique identifier for survey respondents when distributing the survey, which means that we cannot track with accuracy whether the same individual within a school responded at both time points. We provide details of survey response in Appendix 1.

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6   The survey asks, "Thinking of the past few weeks, how much of the time has your job made you feel each of the following? Tense; Depressed; Worried; Gloomy; Uneasy; Miserable." Response options are: "All of the time; Most of the time; Some of the time; Occasionally; Never."

Analysis approach

Primary analysis

The estimated impact is based on the difference between the intervention and control groups, regardless of any drop-out by schools allocated to the treatment group. This approach is taken in order to estimate the "intention to treat" (ITT) effect.

The analysis is carried out using linear regression. The regression model used for the primary analysis controls for the previous year's proportion of pupils with no further action at contact, defined as per our primary outcome measure. The model also includes a dummy variable capturing treatment allocation and strata indicators reflecting randomisation blocks. [7]

The equation estimated is:

$$Y_{it} = a + \beta_1 \text{Treat}_i + \beta_2 Y_{it-1} + \beta_a y_i + \varepsilon_{it}$$

where Y_{it} is our primary outcome measure (contacts leading to no further action as a proportion of pupils in school j), Y_{it-1} is the equivalent (baseline) measure for the previous school year (2020/21), Treat_i is the dummy variable indicating treatment allocation, y_i represents the set of stratum dummy variables and ε represents an error term. The estimated impact is recovered from the coefficient on the treatment variable (β_1).

Statistical significance is evaluated at the 5% level, as stated in the protocol.

Effect sizes are reported, expressed as a proportion of the school-level standard deviation in the control group (Glass's Delta), as per the WWCSC Statistical Analysis Guidance.[8] As there is one primary outcome

measure the analysis is not subject to multiple comparison adjustments.

As noted earlier, a different randomisation ratio was used in the two larger LAs. As we include dummy variables for randomisation strata (which relate to LAs) within our models, this uneven randomisation is accounted for by this approach.

Secondary analysis

The analysis is repeated for each of the secondary outcome measures relating to contacts and referrals based on administrative data, following the same approach as described above for the primary outcome, and using the relevant corresponding baseline measure. For example, for the secondary outcome of contacts as a proportion of pupils, we control for contacts as a proportion of pupils in the school year 2020/21.

The same approach is adopted for analysis of DSL wellbeing; here the models control for wellbeing as measured before the start of the intervention based on the baseline survey (October 2021). However, a significant proportion of schools with wellbeing data at endline had not responded to the survey at baseline. To maintain sample size, we impute zero values where baseline wellbeing is missing and include a dummy to capture missing baseline wellbeing data in our main models, but also run a model based only on cases for which we have data at both baseline and endline.

The protocol stated that as a number of secondary outcomes were to be considered, we would adjust for multiple comparisons, using the Hochberg step-up procedure as

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detailed in the WWCSC Statistical Analysis Guidance. In practice, however, none of our results are statistically significant at the 5% level and therefore further adjustment for multiple comparisons is not necessary.

Subgroup analysis

We conduct two subgroup analyses, as set out in the protocol:

First, we explore whether results are sensitive to the time period over which outcomes are measured. The primary analysis uses outcomes measured over the full intervention period, but we check whether there is evidence of effects in the latter half of the intervention period, with the aim of exploring whether it takes time for the intervention to have an effect on the actions of DSLs. To do so we construct two outcome measures, one based on contacts between September and February, and the latter based on contacts between March and July. We estimate separate models for each time period.

Second, we explore whether there are differences in the effectiveness of the programme between schools located in urban and rural areas, to understand whether the context of the area may matter for the programme's impact. We do so through the inclusion of an interaction term with treatment status in the model (as well as a separate dummy variable capturing urban/rural location). This is with the aim of addressing RQ8 on differences between urban and rural areas to help inform whether there are differences in effectiveness according to the context in which schools and DSLs are operating. This could potentially happen if there are systematic differences in the types of issues DSLs are dealing with in urban and rural areas or, for example, if schools in more remote areas may have fewer opportunities to build wider networks for support.

Analysis in the presence of non-compliance

The primary analysis focuses on identifying an intention to treat effect, but we additionally produce estimates accounting for non-compliance with the aim of providing insight into the impact of actually participating in supervision rather than the impact of being in a treatment school.

Doing so requires a definition of compliance. A record of attendance by DSLs at supervision sessions was maintained by the SSWs; we use this information to explore compliance with the intervention.

As specified in the protocol, we first estimate a model excluding those schools allocated to the treatment group who received zero sessions (and who could therefore be considered to have "dropped out" of the intervention). Note that excluding these schools invalidates the causal properties and is thus a nonexperimental analysis. It can still be informative, as if drop-out is random, the results reflect the effect of treatment itself rather than intention to treat. The randomness of drop-out is an unverified assumption, so the results should be interpreted with this in mind.

We then estimate a simple dose response model, where the treatment variable in our main analytical model is replaced with a dosage variable, set to 0 for control group schools, and varying between 0 and 1 for the treatment group, where schools that had no sessions are scored 0, and those that attend all intended sessions are scored 1 ("all sessions" is defined here as the maximum of 7 sessions that we observe in the data). If a school attends half the sessions, for example, they are scored 0.5. We use instrumental variable (two-stage least squares) regression to estimate this impact. Again an analysis of this type is not experimental, and so findings can only be interpreted causally under additional assumptions.

The main assumption underpinning this approach is that the treatment only has an effect via the number of sessions attended. This design of the intervention – specifically, that it is confined to supervision sessions rather than extending to any ancillary practice – is such that it is credible to believe it operates only via sessions. Since treatment status is randomly assigned and sessions are not available to the control group, treatment group indicator is the ideal instrument. However, estimating dose response in this way does constrain the relationship between number of sessions and the outcome to be linear. Since there is no basis for believing this to be the case, we also conduct an analysis whereby the impact of attending any sessions is estimated (this latter analysis is additional to the planned analysis set out in the protocol).

Additional analysis

As set out in the protocol, we conduct the following additional analyses, with all estimated for the primary outcome:

- We assess the sensitivity of results to using baseline data from the preceding school year (2019/20) instead of the school year 2020/21. The original motivation for doing so was due to concerns that data for 2020/21 may have been affected by the COVID-19 pandemic; however, the same argument could be made in respect of 2019/20. Ideally, data from 2018/19 could have been used as an additional check; however, the data request already proved burdensome for many LAs, and retrieving historical data was typically more challenging – for example, where there had been changes in data systems over time

- The primary analysis is unweighted, giving equal weight to all schools, but in an additional specification, we run the same regression using frequency weights in order to relate the results to the number of pupils on which they are based

- A model that additionally controls for the proportion of pupils in the school eligible for FSM

- A model that also controls for other school characteristics, including Ofsted rating, size and measures of pupil composition

- We also explore whether there are differences in outcomes according to the length of time someone has held the DSL role, to inform whether the benefits of supervision may differ according to DSL experience. We do this based on information collected in the survey, which uses the categories less than one year; one to two years; three to four years; five to six years; seven to nine years; ten or more years; we combine those for less than one year and one to two years into one group due to small sample sizes. We explore this through the inclusion of an interaction term between length of time in the DSL role and treatment status. This analysis is based on a smaller sample because it can only be estimated for those schools for which we have survey responses.

The protocol also stated that we would estimate a model additionally including LA fixed effects; however, this is in fact not necessary as our analysis already includes dummy variables for randomisation strata relating to LAs.

We undertake a further additional analysis that was not set out in the protocol. The programme is typically delivered by one SSW in each LA. However, in one LA, supervision was delivered by two SSWs (who worked with different schools). In two additional LAs,

schools received supervision from the same SSW. We therefore repeat our analysis for the primary outcome with the additional inclusion of SSW fixed effects.

All impact analyses were conducted using Stata, version 17.

Sample size and attrition

The sample size for the trial was determined by the number of schools within the participating LAs. For the purpose of the power calculations at the point of preparing the protocol, it was assumed that 1205 schools would take part; this was the number of schools randomised. The minimum detectable effect size (MDES) was therefore determined by the maximum available sample (and assumed no attrition by the point of analysis).

At the point of preparing the protocol, the proportion of variance in the outcome explained by the covariates was assumed to be 0.2, in line with the estimate obtained in the original Bolton study for primary schools. Based on these figures, and the assumptions set out in Table 1 below, the MDES stood at 0.15 (in units of school-level standard deviation). This is equivalent to a difference of around 0.75 NFA contacts per school. Our power calculations focus on the primary outcome and, as we have one primary outcome, we do not make adjustments here for multiple comparisons.

At the point of analysis, the proportion of variance in the outcome explained by covariates was higher than assumed at the point of preparing the protocol. This meant that the MDES stood at 0.14 at the point of analysis.

Table 1. Minimum detectable effect size (MDES) at randomisation and analysis

		Randomisation	Analysis
MDES (proportion of a standard deviation)		0.15	0.14
Proportion of variance in outcome explained by covariates (R^2)	**School**	0.2	0.3
Intracluster correlations coefficient (ICCs)	**School**	-	
Alpha		0.05	0.05
Power		0.8	0.8
One-sided or two-sided?		Two-sided	Two-sided
Level of intervention clustering		School	School
Average cluster size (if cluster-randomised)*		266	266
Sample size (schools)	**Intervention**	446	446
	Control	759	759
	Total	1205	1205

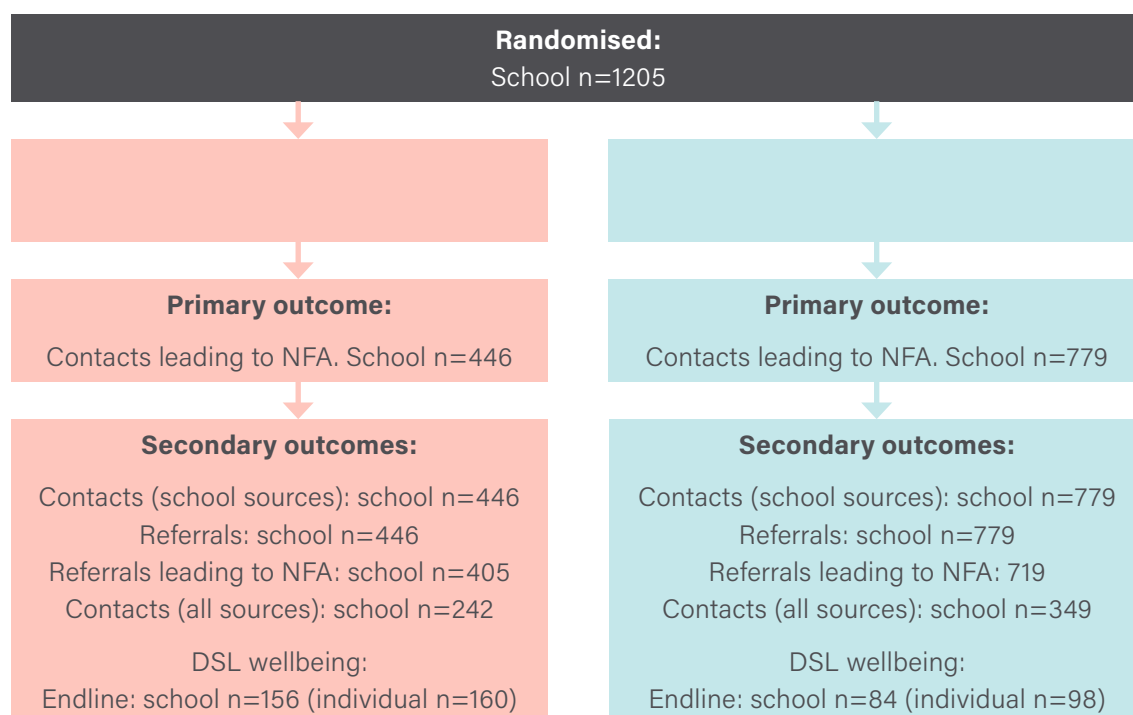* This is the average number of pupils per school.

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For the primary outcome assessed in this trial, data were available on all 1205 schools included at randomisation (Table 2). One LA did, however, provide information on the number of contacts resulting in no further action based on contacts from all sources, rather than only those from school sources. We retain this information in the analysis, to proxy the rate of contacts resulting in no further action for contacts made by schools. We test the sensitivity of the results to removing this LA from the analysis. As discussed elsewhere in this report, not all schools assigned to the treatment group took up the offer of supervision sessions, or received the originally intended number of sessions, but all are included within the main analysis.

Data was not available for all secondary outcomes in all LAs; Figure 2 summarises availability, by trial arm, for each outcome measure. From this it can be seen that for two of the secondary outcome measures, data was available for all schools. For referrals leading to NFA, data was missing for one LA. Three LAs were unable to provide data on contacts from all sources. It is the wellbeing measures where we see the highest amount of missing data (unsurprisingly, given these are based on survey responses rather than administrative data), and where we also observe differential attrition across treatment and control groups (with the extent of missing data greater in the control group).

Table 2: School-level attrition from the trial (primary outcome)

		Intervention	Control	Total
Number of schools	**Randomised**	446	759	1205
	Analysed	446	759	1205
Attrition (from randomisation to analysis)	**Number**	0	0	0
	Percentage	0	0	0

Figure 2. Availability of outcome data

Randomised:
School n=1205

Primary outcome:
Contacts leading to NFA. School n=446

Primary outcome:
Contacts leading to NFA. School n=779

Secondary outcomes:
Contacts (school sources): school n=446
Referrals: school n=446
Referrals leading to NFA: school n=405
Contacts (all sources): school n=242

DSL wellbeing:
Endline: school n=156 (individual n=160)

Secondary outcomes:
Contacts (school sources): school n=779
Referrals: school n=779
Referrals leading to NFA: 719
Contacts (all sources): school n=349

DSL wellbeing:
Endline: school n=84 (individual n=98)

School and LA characteristics

Appendix 3 presents the characteristics of schools assigned to the intervention and control groups.

In terms of the observed school characteristics considered, the sample appeared balanced across treatment and control groups. The distribution of Ofsted school inspection ratings was similar for both groups, as was the distribution by school type. School composition was broadly similar across both trial arms, with similar percentages of pupils eligible for FSM and pupils where English is not a first language across treatment and control schools. Performance at the end of Key Stage 2 (KS2) was also similar on average in both the intervention and control schools.

The trial was conducted in schools across ten LAs, eight of which are defined as predominantly urban, while a substantial proportion of the population in the two remaining LAs live in rural areas. Overall, 77% of schools in the intervention group were located in an urban environment compared with 66% of schools in the control group; this was equivalent to a standardised difference of 0.2 (with values above 0.1 typically indicating imbalance); however, when tested in a regression context controlling for the randomisation strata, this was not a statistically significant difference.

If we consider social care outcomes based on the school year 2020/21, the year before the intervention started, average outcomes are generally similar across both treatment and control groups. Standardised differences between treatment and control groups of more than 0.1 were present both for the primary outcome of contacts resulting in no further action measured as a proportion of pupils, and for contacts from all sources (Table 3). However, when accounting for randomisation strata in a regression, there were no statistically significant differences between treatment and control groups at the 5% level.

Table 3. Children's social care outcomes, 2020/21, standardised differences between treatment and control groups

	Standardised difference between treatment and control group
Number of contacts made by schools leading to no further action (NFA)	0.10
Contacts leading to NFA (as proportion of pupils in school)	0.15
Contacts (as proportion of pupils in school)	0.10
Referrals (as proportion of pupils in school)	0.01
Referrals leading to NFA (as proportion of pupils in school)	0.06
Contacts from all sources (as proportion of pupils in school)	0.15

The measures of DSL wellbeing, as captured by the baseline survey, indicate slightly higher levels of wellbeing among the treatment group compared with the control group at baseline; this difference is only statistically significant for the depression–enthusiasm measure and not for anxiety–contentment. It is important to bear in mind, though, that this can only be evaluated on the basis of those responding to the survey (and that the response rate was lower among the control group than for the treatment group). This difference may potentially reflect response bias at baseline. We present the distribution of all outcomes measured at baseline by trial arm in Appendix 4.

Overall, on the basis of most of the observed characteristics considered, the sample was balanced at baseline. As all schools randomised remained in the trial, this also applies to the point of analysis as the sample is unchanged, at least for the purpose of evaluating the primary outcome.

We can also consider the characteristics of participating schools and LAs in terms of how they compare with national averages. Overall the distribution of the school sample closely reflects the national distribution of schools by both Ofsted inspection rating and school type, was similar on average in terms of pupil composition (for example, the percentage of pupils eligible for FSM) and fared similarly in terms of average performance scores at the end of KS2.

In terms of LA characteristics, 6 of the 10 LAs have a percentage of children living in low-income families above that of the national average of 19.1%, as indicated by the Department for Education's Local Authority Interactive Tool.[9] Based on the most recent inspection of LA Children's Services as of 2021, two of the LAs were rated as "outstanding", three LAs were rated as "good" and the remaining five LAs were rated as "requires improvement to be good".

Six of the 10 participating LAs had a Children in Need rate (measured per 10,000) above the national average of 321.2. Eight of the 10 participating authorities had a children looked after rate (measured per 10,000) above the national average of 67. The LAs varied in terms of referral rates to children's social care services, with half of the participating LAs having a referral rate above the national average, and half at or below the average.

Overall, while the study does not (and does not intend to) provide a nationally representative picture of LAs across England, it does include LAs facing a range of different circumstances.

Implementation and process evaluation

The following data collection methods were used in the IPE:

- Interviews with 61 DSLs and other school staff in 55 treatment schools, in April–July 2022[10]

- Interviews with 11 SSWs, in April–July 2022

- Interviews with 10 managers in LAs, in July–August 2022. These were typically the individual with overall responsibility for the LA's involvement in the programme. In reporting findings we refer to these individuals as "LA managers" and/or "LA stakeholders"

9   https://www.gov.uk/government/publications/local-authority-interactive-tool-lait.

10   Note that the protocol refers to school "case studies", and that these could involve interviews with both the DSL and a senior leader in the school, but where the DSL was a senior leader, the number of schools/interviews would be expanded to reach around 60 interviews in total.

- Baseline and endline surveys with DSLs in all schools (both treatment and control schools), in October 2021 and June–July 2022

- "Engagement" and "need" scores as well as attendance data for each school receiving supervision, estimated by the SSWs for each LA.

The following paragraphs provide more detail about each of the data collection methods.

Interviews with SSWs, DSLs and LAs

The interviews were carried out by telephone or online. They were semi-structured, using topic guides (see Appendix 7), and explored the experiences and perspectives of SSWs, DSLs and LAs, to assess how the intervention was delivered across LAs, how it was experienced and the extent to which the intervention had led to changes in DSL practices. The interviews were recorded, with the permission of participants, transcribed verbatim and then analysed using a framework approach. The DSLs were contacted by email and sampled to include a mix of schools, including by LA, school size, proportion of FSM pupils and geographical context (see Appendix 2). The qualitative findings provide an in-depth and diverse perspective into the experiences of DSLs that we spoke to, but may not necessarily reflect the views of all practitioners receiving the supervision. The sample of 55 schools represents only 12% of the 446 schools in the treatment group, it disproportionately includes schools that engaged with the programme and it does not include any control schools. All SSWs and LAs were interviewed.

Baseline and endline survey

The baseline survey was distributed by email in October 2021, before the intervention started (although after allocations to the treatment and control group were known).

The survey was mostly completed by lead DSLs, and in some cases other safeguarding staff such as deputy DSLs. We collected a total of 456 responses (from 311 unique schools). This included 221 responses from treatment schools and 235 responses from control schools. At a school level, the response rates were 33% for treatment schools and 21% for control schools. The endline survey was distributed in June and July 2022, at the end of the intervention. We collected a total of 258 responses (from 240 unique schools). This included 98 responses from control schools and 160 responses from treatment schools. At a school level, the responses rates were 35% for treatment schools and 11% for control schools. As for the qualitative sample, the survey sample is likely to be biased towards schools that engaged in the intervention. Appendix 1 provides more detail on survey responses, including the response rates, and responses by LA and by years of experience. The survey was distributed using SmartSurvey and the data was analysed using Stata.

Review of materials and available data, including engagement and need scores

Finally, the SSWs were asked to provide information about the DSLs in their treatment schools. Specifically, they were asked to estimate the "need" and "engagement" of each DSL receiving supervision on a score of 1–4. "Need" referred to whether the SSW felt the DSL needed additional support. "Engagement" referred to whether the SSW felt the DSL engaged during the supervision sessions and whether the DSL subsequently used the insights to inform their practices. We also observed community of practice sessions for SSWs. These informed the design of topic guides and sampling. In addition, we collected attendance data from SSWs detailing the number of sessions and, where available, dates for each of the supervision sessions, with each school. These are used throughout in the IPE section on findings.

Cost evaluation

Analysis of costs is based on data provided by WWCSC on the costs of delivering the intervention. This is based on actual spend by LAs over the life of the project (rather than the initially agreed budgets).

The protocol describes working with LAs to understand data on expenditure. In practice, as LAs were completing financial statements for WWCSC, it was considered practical for the cost analysis to make use of this information rather than creating additional burden on LAs by requiring them to provide this separately to the evaluation team. The information from the financial statements was summarised for the evaluation team by WWCSC. In addition, costs were also explored during interviews with SSWs and LAs, as well as with DSLs in schools, as part of the IPE, to identify any potential hidden costs of the intervention and to understand perspectives on whether the intervention was considered a worthwhile use of DSLs' time.

All the participating LAs were involved in more than one of the concurrent DSL trials, and total costs reported in the financial statements covered involvement in both trials. Information was available on the share of the originally agreed budget that was to be allocated to the primary trial, and this proportion was applied to the eventual actual spend to allocate an amount to the primary trial. Costs were converted to a cost per school on the basis of the number of primary schools allocated to the intervention group in each LA.

The analysis of costs is conducted purely as a financial analysis, to understand costs of delivery of the intervention, rather than undertaking a value for money or cost–benefit analysis. As anticipated in the protocol, monetising any benefits would have been challenging and, given the extent of uncertainty that would have been involved in making the necessary assumptions, it was felt that such an analysis would be unlikely to result in sufficiently meaningful estimates in these circumstances.

FINDINGS

Impact evaluation

Outcomes and analysis

Primary analysis

Table 4 summarises the results of the primary analysis, which explores whether the programme has an impact on the proportion of pupils for whom a contact is made by a school that results in no further action.

The left-hand panel of the table presents the mean values of the primary outcome (contacts leading to no further action, as a proportion of pupils). These are similar in the treatment and control groups, standing at 0.010 in the treatment group and 0.009 in the control group. That is, on average there were 10 contacts resulting in no further action per 1000 pupils in the treatment group and 9 per 1000 pupils in the control group.

The results of the regression analysis are summarised in the right-hand panel of the table, presenting the effect size associated with the treatment (i.e. being allocated to receive the intervention). As described in the "Methods" section, this effect size is based on a regression that controls for contacts leading to no further action in the previous school year and randomisation strata.

The regression results indicate a non-statistically significant impact of the intervention on the primary outcome measure, with a small negative sign on the regression coefficient (equivalent to an effect size of -0.06). A negative effect would here have a favourable interpretation, reducing contacts leading to no further action (as a proportion of pupils). However, the size of this effect is small and not statistically significant, with a confidence interval that crosses zero (-0.15, 0.03). That is, there appears to be no real difference in the primary outcome among schools that were allocated to receive the programme and schools that were not. It should be noted, however, that the trial was not powered to detect an effect size of this magnitude (the minimum detectable effect size stood at 0.14). An effect size of -0.06 is equivalent to a difference between treatment and control groups of around 0.3 fewer contacts resulting in no further action per school. The underlying regression results are presented in Appendix 6.[11] [12]

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11   Note that the difference in unadjusted mean outcomes is positive; controlling for baseline outcome and randomisation stratum changes the sign to negative. In neither case is the estimated treatment coefficient statistically significant.

12   As noted in the "Methods" section, one LA provided information on contacts resulting in NFA based on those made by any source rather than just those from school sources. We retain this information in the analysis to proxy the rate of NFA contacts from school sources; however, if we exclude this LA from the analysis, the results are largely unchanged, with an estimated effect size of -0.07 (p-value=0.141).

Table 4. Primary analysis

Outcome	Unadjusted means				Effect size			
	Intervention group		Control group					
	n (missing)	Mean (95% CI)	n (missing)	Mean (95% CI)	Total n (intervention; control)	% point change in outcome* (95% CI)	Glass's Delta (95% CI)	p-value
Contacts leading to no further action (as proportion of pupils)	446 (0)	0.010 (0.008, 0.011)	759 (0)	0.009 (0.008, 0.010)	1205 (446; 759)	-0.104 (-0.262, 0.054)	-0.061 (-0.153, 0.031)	0.196

* Contacts leading to no further action is measured as a proportion of pupils. If considered in percentage terms instead, the unadjusted means stand at 1% in the treatment group and 0.9% in the control group, and thus a difference of 0.1 percentage points (when rounded). The percentage point change found in the regression analysis stands at -0.104, which multiplies the estimated regression coefficient by 100 to convert to percentage terms.

Figure 3. Contacts leading to NFA as proportion of pupils, 2021/22, by trial arm
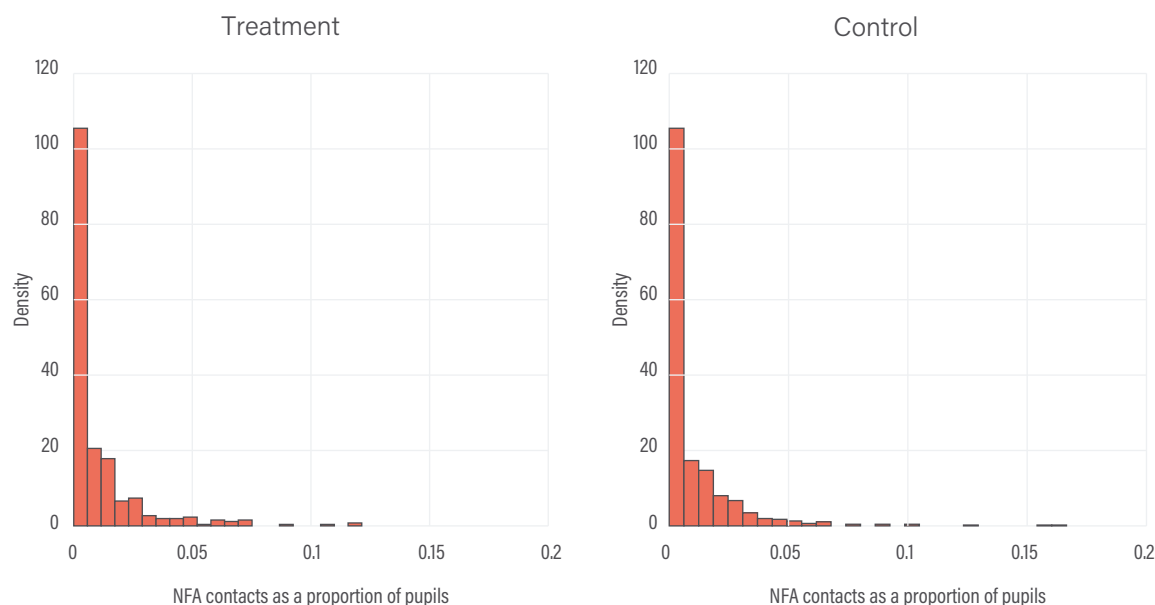

Figure 3 presents the distribution of the primary outcome, by treatment and control group. The distributions are similar for both groups. The protocol specified that we would undertake linear regression; given the distribution of the measures we also conducted two robustness checks. First, considering whether there was an impact on a binary measure, and second estimating the model using Poisson[13] regression (see Appendix 6). Under both alternative approaches, there remained no statistically significant impact of the intervention on the primary outcome.

Secondary analysis

Contact and referral outcomes

This section presents the results of the analysis for the specified secondary outcomes relating to contacts and referrals. To recap, this analysis aimed to address the following questions:

2. What is the effect of providing support to DSLs in primary schools on the proportion of pupils for whom a new contact is made by a school?

3. What is the effect of providing support to DSLs in primary schools on the proportion of pupils for whom a new referral is made?

4. What is the effect of providing support to DSLs in primary schools on the proportion of pupils for whom a new referral does not lead to further action (at referral or assessment stage)?

5. What is the effect of providing support to DSLs in primary schools on the number of contacts (as a proportion of pupils) from all sources (comprising contacts from school and all other sources)?

Table 5 presents the results of the anaysis for each of the outcomes listed above. There were no statistically significant impacts on any of the measured outcomes. Histograms for each of the secondary outcome measures by treatment and control group are presented in Appendix 5. Again, given the distribution of

13   This included also checking robustness of results to running a zero-inflated Poisson regression.

Table 5. Secondary analysis, contact and referral outcomes (measured as a proportion of pupils in all cases)

Outcome	Unadjusted means				Effect size			
	Intervention group		Control group					
	n (missing)	Mean (95% CI)	n (missing)	Mean (95% CI)	Total n (intervention; control)	% point change in outcome (95% CI)	Glass's Delta (95% CI)	p-value
Contacts (schools)	446 (0)	0.025 (0.022, 0.028)	759 (0)	0.022 (0.020, 0.024)	1205 (446; 759)	0.070 (-0.223, 0.364)	0.023 (-0.074, 0.120)	0.639
Referrals (schools)	446 (0)	0.009 (0.008, 0.011)	759 (0)	0.009 (0.008, 0.010)	1205 (446; 759)	-0.064 (-0.210, 0.082)	-0.042 (-0.137, 0.053)	0.387
Referrals leading to NFA (schools)	405 (41)	0.003 (0.002, 0.004)	719 (40)	0.002 (0.002, 0.003)	1124 (379; 693)	0.018 (-0.061, 0.096)	0.030 (-0.092, 0.151)	0.658
Contacts (all sources)	242 (204)	0.124 (0.106, 0.141)	349 (410)	0.120 (0.106, 0.133)	591 (242; 349)	-0.346 (-1.537, 0.845)	-0.027 (-0.119, 0.065)	0.569

the outcomes, we also ran Poisson models for each outcome, but no statistically significant impacts of the intervention were found (see Appendix 6).

Note that complete data was not available for all secondary outcomes. For referrals leading to NFA, data was missing for one LA. For one further LA (included within the sample analysed in Table 5), data was missing for the months from April 2022 to July 2022 for this outcome measure. The exclusion of this LA had no substantive impact on the results for this outcome (referrals leading to NFA), with the effect size remaining very similar in magnitude and not statistically significant.

The sample size for analysis of contacts from all sources is notably smaller, with three LAs unable to provide data on this outcome. Again we see no statistically significant impact, which does not suggest that there was any increase in contacts from non-school sources. If we repeat our analysis of contacts from schools only within this sample for which data on contacts from all sources is also available (to help ascertain whether findings may be a result of the change in sample, rather than the different outcome measure), we still see no statistically significant impact of the intervention on contacts from school sources only (effect size=0.087, p-value=0.26).

DSL wellbeing

Table 6 presents the results of the analysis for the secondary outcomes relating to DSL wellbeing, namely job-related anxiety–contentment and job-related depression–enthusiasm. Histograms for the distribution of both measures at endline, by trial arm, are presented in Appendix 5.

The scales are constructed so that a higher score on each measure represents greater job-related wellbeing; each scale has a potential range from -6 to +6. Considering first the raw

(unadjusted) mean wellbeing scores, Table 6 shows that at endline, average scores on the anxiety–contentment scale were similar in the treatment and control groups (standing at 0.6 in the treatment group and 0.3 in the control group); this apparent difference (of 0.3 points on a 12-point scale) is not statistically significant. Average scores on the depression–enthusiasm measure were higher among the treatment group than among the control group at endline, standing at 3.9 in the treatment group and 2.9 in the control group (and thus a difference of 1 point on a 12-point scale); a statistically significant difference.

In interpreting these findings, it is important to bear in mind that only a subset of DSLs responded to the survey and it is possible that non-response may bias the results. However, it is not clear a priori the direction of any such effect and whether those with higher or lower wellbeing may be more or less likely to respond. Furthermore, as discussed elsewhere in this report, response rates, especially at endline, were notably lower among the control group (see Appendix 1). Response rates at baseline (measured at school level) stood at 33% in the treatment group and 21% in the control group; at endline, these stood at 35% and 11% respectively.

In addition, it is not always the same schools responding at baseline and endline; of the schools responding at endline, just over half had also responded at baseline (thus a substantial amount of baseline data is missing). Schools responding at baseline only are necessarily excluded from the analysis because no endline scores are available. The regression analysis presented in Table 6 controls for baseline wellbeing where this measure was available (and includes a dummy variable to indicate missing baseline data, and zero imputes missing baseline values, to main the full sample size; see "Methods" section). Where multiple individuals per school

Table 6. Secondary analysis, DSL wellbeing outcomes

Outcome	Unadjusted means				Effect size		
	Intervention group		Control group				
	n	Mean (95% CI)	n	Mean (95% CI)	Total n (intervention; control)	Glass's Delta (95% CI)	p-value
Wellbeing: anxiety–contentment scale	160	0.60 (0.21, 0.99)	98	0.30 (-0.18, 0.77)	240 (160; 98)	-0.07 (-0.32, 0.18)	0.742
Wellbeing: depression–enthusiasm scale	160	3.94 (3.61, 4.27)	98	2.86 (2.34, 3.37)	240 (160; 98)	0.19 (-0.02, 0.41)	0.083

responded at baseline, we create a measure of average DSL wellbeing in that school to use as our baseline measure. As noted earlier in this report, for the depression–enthusiasm scale, there was already imbalance at baseline, with higher wellbeing scores in the treatment group; thus it is important to control for this where possible.

The results of the regression analysis show no statistically significant impact of the intervention on the anxiety–contentment measure, with a small negative effect size (-0.07). On the depression–enthusiasm scale, we observe a positive effect size (0.19); this estimate is not statistically significant at the 5% level, which is the standard threshold used to evaluate significance here. Overall, the imbalance in response across treatment and control groups means we should be particularly cautious in drawing inferences based on these results.

As there is extensive missing data on wellbeing at baseline, we undertake a further analysis, restricting the sample to only those schools where wellbeing data is available at both time points. This model is based on a much smaller sample (138 observations in total); there is no statistically significant

impact of the intervention for either wellbeing measure in this sample.

We do not undertake a multiple comparisons adjustment as part of our secondary analysis because none of our secondary outcomes, when estimated in line with the approach set out in the protocol, are statistically significant at the 5% level.

Subgroup analyses

Table 7 presents results from analysing whether there is evidence of effects in the latter half of the intervention period, with the aim of exploring whether it takes time for the intervention to have an effect on the actions of DSLs. We measure this latter period on the basis of data covering the months from March to July 2022 inclusive. Again, although we observe a small negative effect size, this is not statistically significant. There is also no statistically significant impact in the first half of the intervention period (defined as September to February); the effect size appears smaller than that for the latter period but, in both periods, confidence intervals cross zero.

Table 8 summarises results exploring whether there is evidence of differences in impact between urban and rural areas, presenting

Table 7. Contacts leading to NFA, by intervention period

Outcome	Unadjusted means				Effect size			
	Intervention group		**Control group**					
	n (missing)	Mean (95% CI)	n (missing)	Mean (95% CI)	Total n (intervention; control)	% point change in outcome (95% CI)	Glass's Delta (95% CI)	p-value
Latter part of intervention period (March to July)	446 (0)	0.004 (0.003, 0.005)	759 (0)	0.004 (0.003, 0.004)	1205 (446; 759)	-0.063 (-0.159, 0.032)	-0.069 (-0.174, 0.035)	0.194
First part of intervention period (September to February)	446 (0)	0.006 (0.005, 0.007)	759 (0)	0.005 (0.004, 0.006)	1205 (446; 759)	-0.020 (-0.132, 0.092)	-0.017 (-0.112, 0.078)	0.727

Table 8. Regression results, interacting treatment and urban-rural status, primary outcome

	Contacts leading to NFA	
	Regression coefficient (robust standard error in parentheses)	P-value
Treatment	-0.001 (0.001)	0.288
Urban area	0.001 (0.001)	0.561
Treatment*Urban area	0.000 (0.002)	0.771
N	1205	

Note: This table shows selected coefficients from a regression of the outcome on treatment arm, a dummy variable for urban location of school, treatment*urban location, NFA contacts as a proportion of pupils in the previous school year, and dummy variables indicating randomisation strata. Robust standard errors in parentheses. Statistical significance is indicated as *significant at 0.05, **significant at 0.01

the coefficients for treatment status, a dummy variable for urban location and the interaction term between the two. We see no evidence of a differential impact according to urban or rural location of the school, with no statistically significant impact for the interaction term.

Analysis in the presence of non-compliance

SSWs provided information on the attendance of DSLs at supervision sessions (as noted earlier in the methodology section for the IPE). As documented in the trial protocol, we use this information to explore compliance with the intervention.

As noted earlier, not all treatment schools took up the offer of supervision sessions and, among those that did, there was variation in the number of sessions that were received. Reasons for choosing to participate, or not participate, were varied and are discussed in the findings of the IPE.

Table 9. Attendance at supervision sessions among schools assigned to the treatment group

	Number of schools	% of schools
No supervision sessions	132	29.6
1	44	9.9
2	34	7.6
3	42	9.4
4	61	13.7
5	85	19.1
6	43	9.6
7	5	1.1
Total	**446**	**100**

Note that for a small number of schools (less than ten), information on attendance was missing; these schools are assumed to have had zero sessions.

Table 9 summarises sessions attended. These figures exclude introductory appointments. In all, around 30% of schools assigned to the treatment group did not receive any supervision sessions. The maximum number of supervision sessions delivered was 7, although this applied in only around 1% of schools. Just under half (44%) of schools received 4 or more sessions over the course of the school year. These figures focus on the provision of the supervision sessions; some schools also received some additional support on an ad hoc basis (see IPE findings), but the provision of this was not systematically recorded.

We first present results from estimating a model excluding those schools allocated to the treatment group who received zero sessions (and who could therefore be considered to have "dropped out" of the intervention). If drop-out is random, the results reflect the effect of treatment itself rather than intention to treat. The randomness of drop-out is an unverified assumption, so the results should be interpreted with this in mind – however, again we see no statistically significant impact when restricting to this sample (Table 10).

Table 10. Contacts leading to NFA, excluding treatment schools receiving zero sessions

Outcome	Unadjusted means				Effect size			
	Intervention group		Control group					
	n (missing)	Mean (95% CI)	n (missing)	Mean (95% CI)	Total n (intervention; control)	% point change in outcome (95% CI)	Glass's Delta (95% CI)	p-value
Contacts leading to no further action (as proportion of pupils)	314 (0)	0.010 (0.008, 0.011)	759 (0)	0.009 (0.008, 0.010)	1073 (314; 759)	-0.142 (-0.330, 0.047)	-0.083 (-0.193, 0.027)	0.141

* The number of missing observations is considered zero here, because there is complete data on the outcome measure for those treatment schools that received at least some supervision sessions.

Tables 11a and 11b present results from estimating a simple dose response model, where the treatment variable in our main analytical model is replaced with a dosage variable, set to 0 for control group schools, and varying between 0 and 1 for the treatment group, where schools that had no sessions are scored 0, and those that attended all intended sessions are scored 1 ("all sessions" is defined here as the maximum of 7 sessions that we observe in the data). We use instrumental variable (two-stage least squares) regression to estimate this impact. Again an analysis of this type is not experimental, and so findings can only be interpreted causally under additional assumptions.

The results from the first stage – where dosage is regressed on treatment status and the baseline number of NFA contacts in 2020/21 – are reported in Table 11a. As expected, we obtain a statistically significant association between treatment status and the dosage variable. The first row of Table 11b then shows the coefficient obtained on the dosage variable from the IV estimation, indicating that this is not statistically significant. As an additional exploratory analysis, we also checked how the results varied if we used a binary variable, set to one for receiving any sessions and zero when receiving no sessions, instead of the dosage variable described above. This also showed no statistically significant impact (see Appendix 6 for results).

Table 11a. Contacts leading to NFA, first-stage regression results (dependent variable=dosage variable)

	Regression coefficient (robust standard error in parentheses)	P-value
Treatment	0.372** (0.014)	0.000
NFA contacts, 2020/21	-0.486 (0.334)	0.145
N	1205	

Note: the model also includes dummies for randomisation strata but these are not shown here for ease of reporting. Statistical significance is indicated as *significant at 0.05, **significant at 0.01. Results of F-test: F (21, 1183)=49.71. Prob>F=0.000.

Table 11b. Contacts leading to NFA, compliance analysis, IV (2SLS) results

	Regression coefficient (robust standard error in parentheses)	P-value
Dosage	-0.003 (0.002)	0.191
NFA contacts, 2020/21	0.408** (0.066)	0.000
N	1205	

Note: the model also includes dummies for randomisation strata but these are not shown here for ease of reporting. Statistical significance is indicated as *significant at 0.05, **significant at 0.01.

Overall, the analysis does not provide evidence of significant impacts for those schools receiving more supervision sessions.

Additional analysis and robustness checks

Table 12 reports results from a number of additional analyses for the primary outcome measure, as set out in the trial protocol.

The first row of Table 12 shows results from replacing the baseline measure of contacts leading to NFA in 2020/21 with a measure based on data from 2019/20 instead (although, as noted earlier, both 2019/20 and 2020/21 were years where data may have been affected by the COVID-19 pandemic). Use of this alternative baseline has no substantive impact on the main results.

The second row reports results from using frequency weights in order to relate the results to the number of pupils on which they are based. Again, this has no substantive impact on the main results.

In the third row, we check the sensitivity of results to additionally controlling for the percentage of pupils in the school eligible for FSM, and in the fourth row we control for a set of additional school characteristics. Neither specification makes a substantive difference to the results, with effect sizes remaining of similar magnitude and statistically insignificant.

We also conducted an additional analysis, not stated in the protocol, which included SSW fixed effects (reported in the final row of the table); again no statistically significant impact of the intervention is observed.

Table 12. Contacts leading to NFA as a proportion of pupils, additional analyses

Outcome	Unadjusted means				Effect size			
	Intervention group		Control group					
	n (missing)	Mean (95% CI)	n (missing)	Mean (95% CI)	Total n (intervention; control)	% point change in outcome (95% CI)	Glass's Delta (95% CI)	p-value
NFA contacts, alternative baseline (2019/20)	446 (0)	0.010 (0.008, 0.011)	759 (0)	0.009 (0.008, 0.010)	1205 (446; 759)	-0.063 (-0.226, 0.100)	-0.054 (-0.192, 0.085)	0.45
NFA contacts, pupil-weighted estimates	446 (0) Pupil-weighted: 124, 390	0.010 (0.010, 0.010)	759 (0) Pupil-weighted: 199, 744	0.009 (0.009, 0.010)	1205 (446; 759) Pupil-weighted: 324, 134 (124, 390; 199, 744)	-0.059 (-0.214, 0.096)	-0.037 (-0.135, 0.061)	0.458
NFA contacts, also controlling for % FSM pupils in school	446 (0)	0.010 (0.008, 0.011)	759 (0)	0.009 (0.008, 0.010)	1205 (446; 759)	-0.085 (-0.239, 0.069)	-0.050 (-0.140, 0.040)	0.279
NFA contacts, also controlling for other school characteristics*	446 (0)	0.010 (0.008, 0.011)	759 (0)	0.009 (0.008, 0.010)	1205 (446; 759)	-0.101 (-0.260, 0.058)	-0.059 (-0.152, 0.034)	0.214
NFA contacts, with SSW fixed effects (FEs)	446 (0)	0.010 (0.008, 0.011)	759 (0)	0.009 (0.008, 0.010)	1205 (446; 759)	-0.089 (-0.302, 0.123)	-0.052 (-0.176, 0.072)	0.410

* School characteristics included are: Ofsted rating; number of pupils; % FSM pupils; % pupils for whom English is an additional language (EAL); % special educational needs (SEN) pupils.

We ran one further additional analysis exploring whether differences were apparent according to the length of time someone has held the DSL role in their school; results are presented in Table 13. As survey responses are only available for a subset of schools, these results are based on a smaller sample size. One further limitation of this analysis is that it can only be based on the circumstances of the individual who responded to the survey, and so will not necessarily reflect the overall experience of all individuals with DSL responsibility in the school. Furthermore, in some schools we do have survey responses from multiple DSLs; in these cases, we base the analysis on the DSL with the most years of experience.

In this reduced sample, before introducing controls for years of DSL experience, there is still no statistically significant impact of the intervention (effect size=-0.013, p-value=0.893). Thus the change in sample itself does not result in a substantive change in our main results.

Once we add in controls for years of DSL experience, there are no statistically significant interaction terms between years of experience and the treatment; thus we did not find evidence to suggest that benefits of supervision differed systematically according to years of experience of the DSL.

Table 13. Regression results, interacting treatment and years of experience as DSL, primary outcome: contacts leading to NFA as a proportion of pupils

		Contacts leading to NFA as a proportion of pupils	
		Regression coefficient (robust standard error in parentheses)	**P-value**
Treatment		0.000 (0.002)	0.875
Years of experience as DSL (reference category: less than 2 years)	**3–4 years**	-0.001 (0.003)	0.856
	5–6 years	0.002 (0.004)	0.590
	7–9 years	0.002 (0.004)	0.617
	More than 10 years	0.000 (0.003)	0.897
Treatment* years of experience	**1–2 years**	0.002 (0.005)	0.701
	3–4 years	0.000 (0.004)	0.903
	5–6 years	-0.002 (0.004)	0.672
	7–9 years	0.002 (0.005)	0.742
N		388	

Note: The table shows selected coefficients from a regression of the outcome on the treatment arm, a set of dummy variables for years of DSL experience, interaction terms between treatment and years of DSL experience, NFA contacts as a proportion of pupils in the previous school year, and dummy variables indicating randomisation strata. Robust standard errors in parentheses. Statistical significance is indicated as *significant at 0.05, **significant at 0.01.

Implementation and process evaluation

Fidelity and adaptation

Is the programme delivered as intended? How well is compliance/fidelity achieved?

Interviews with DSLs and SSWs asked about supervision structure and delivery, to examine whether the programme was delivered as intended. Interviews with DSLs suggest that the programme was delivered largely as intended, with some flexibility around mode of delivery, the number of cases discussed per session and the extent to which SSWs were open to providing their own opinions or advice. Similarly, overall SSWs reported that they tended to stick to the model of supervision as specified by the programme. A few SSWs reported having made some minor additions to the programme model – for example, conducting some group sessions. However, any such additions mentioned

by SSWs did not constitute a significant departure from the intended programme structure. The main issues for fidelity were the delayed start to the programme in some LAs and the number of schools allocated to the treatment group that did not receive any supervision sessions, which will be covered in more depth in the section on "Reach and acceptability".

The following paragraphs outline findings on different aspects of programme delivery.

Programme start dates

Table 14 shows the month supervision began for those schools allocated to the treatment group (based on information on session attendance provided by SSWs). Fewer than half (47%) of schools in the treatment group had completed their first supervision session by Christmas. The remaining schools either started supervision after Christmas (22%), which impacted the number of sessions

Table 14. Supervision start date, data collected from SSWs

	Number of schools	Percentage of treatment schools
October 2021	54	12%
November 2021	116	26%
December 2021	42	9%
January 2022	35	8%
February 2022	11	2%
March 2022	6	1%
April 2022	1	0%
May 2022	5	1%
June 2022	23	5%
July 2022	21	5%
No sessions at all (no start date)	132	30%

N = all 446 treatment schools. Dates are based on the date of the first supervision session, rather than the date of the introductory meeting.

Table 15. How many group supervision sessions have you received so far, if any?

	Number of respondents	Percentage of respondents
0 sessions	133	90%
1 session	6	4%
2 sessions	2	1%
3 sessions and above	6	4%

Treatment: N=147 at endline.

they were able to complete and potentially therefore the ability of the programme to affect outcomes, or they never completed any supervision sessions at all (30%).

Group vs one-to-one supervision

Responses to the survey indicated that most DSLs only received one-to-one supervision sessions (90% in Table 15) but, in some schools, DSLs reported that some of their sessions were with a colleague. This typically occurred in schools with larger safeguarding teams, where responsibility was spread across multiple people. In such cases, DSLs felt that it was important that all key safeguarding staff could benefit directly from supervision.

Online vs face-to-face delivery

Supervision session delivery varied widely, with a fairly even mix of online and face-to-face sessions, according to the survey data. In interviews, DSLs said the flexibility to choose the format according to their preference was useful and important for successful delivery.

The different approaches were largely driven by different individual preferences. For many DSLs, face-to-face sessions were a preference. DSLs spoke of the advantages of meeting in person for having sensitive conversations, establishing a personal connection with the SSWs and reading body language and facial expressions.

Table 16. Which statement best describes whether the supervision sessions have been face-to-face or online?

	Number of respondents	Percentage of respondents
All sessions have been face-to-face	48	33%
Most sessions have been face-to-face	16	11%
Around the same number of face-to-face and online sessions	22	15%
Most sessions have been online	10	7%
All sessions have been online	50	34%

Treatment: N=146 at endline.

At the same time, DSLs tended to express a preference for the arrangements they had. The DSLs who took part in online sessions reported that they had no issues with the online format, and that it made it easier and more efficient to schedule the sessions. Some DSLs mentioned that during periods when their schools had high numbers of COVID-19 cases, holding sessions online was helpful because it made it possible to complete sessions even when they were self-isolating or working from home.

Equally, some DSLs did not have a strong view on delivery and were happy to accept supervision online or in person.

SSWs tended to prefer conducting supervision in person, but this was unrealistic for those working in large LAs. Some SSWs found DSLs to be distracted when working online, but others found that schools were more willing to commit to online than in-person sessions. Overall, SSWs were happy to adapt the mode of delivery flexibly according to the DSLs' preferences.

"I prefer face-to-face because it's relational, isn't it. You can pick up on atmosphere and body language more when you're in person. So, a lot of the schools prefer face-to-face, so I'm happy with that. I'd say there's probably two or three primaries that prefer online still and that's because of their diary and it's easier for them to manage and I'm happy with that also." SSW

Ad hoc communication and support

Among DSLs responding to the survey, most (58%) reported not receiving any ad hoc support in addition to the support they received during the supervision sessions. When asked about this in interviews, many DSLs explained that they assumed ad hoc support was not part of this programme. Regardless, many DSLs reported that they would not have enough time to receive this support and that they were able to contact other sources for immediate advice, such as a Multi-agency Safeguarding Hub (MASH) phone line. Those who did request ad hoc support did so because they valued hearing a second opinion before acting on safeguarding concerns or felt the need to offload after serious incidents. They would usually contact their SSW, by email and phone, to ask advice on current complex cases or issues, and found that their SSW was accessible (especially compared with their local safeguarding hub) and provided very useful advice, helped by their understanding

Table 17. How often, if at all, have you received ad hoc support via email and phone?

	Number of respondents	Percentage of respondents
0 times	85	58%
1 time	13	9%
2 times	14	10%
3 times	11	8%
4 and above times	23	16%

Treatment: N=146 at endline.

of the school context and their existing relationship with them. Some of those DSLs saw the ad hoc advice as one of the most valuable parts of the programme, and it had effectively replaced and enhanced the advice they had previously received from the local safeguarding hub or private providers.

Structure of the sessions: In interviews, DSLs described the usual structure of the sessions, which was in line with programme design. DSLs described the sessions starting with an icebreaker exercise to discuss mood and wellbeing, following up on action points set at the previous meeting and discussing new cases. As such, DSLs tended to describe session structure as including both case-focused and wellbeing-focused elements, but the structure was flexible and informal so it was responsive to DSLs' needs, which they appreciated:

"I suppose the sessions have always been quite fluid in the sense that we will have a loose agenda as such. There are things that we will cover but, depending on where the conversation takes us, the priorities for that session might change. So, [their SSW] has always sort of said to me, have you got any concerns about any families, if I'm struggling with a certain family for whatever reason and I need a bit of help, we'll talk about that and [their SSW] has always been very good at saying well there's this, there's that and giving me signposts and pointing me." DSL

"So, we're following the format that we were given, but it varies from person to person. So, one head or one DSL might really focus on the emotional support part at the beginning, and one might want to go straight into talking about the update on cases etc. So, I've been doing it in a way that everyone's different, so I just adapt to however they want things to run, and that's what I've said to them, this is your one and half hours, two hours, whatever amount of time you feel you need, to discuss what you need to discuss." SSW

Can the programme be rolled out on a larger scale, or would anything need to be adapted?

The section on "Reach and acceptability" will discuss school buy-in separately and provide learnings and recommendations about how to increase the number of schools engaging in the programme. This section will discuss how it was implemented in the schools that engaged in the programme.

The interviews conducted did not identify any fundamental changes that would need to be made to the programme model for it to be rolled out on a larger scale. Timescales for recruitment of SSWs would need to be considered for wider rollout, as LA managers reported some challenges in recruitment. It was harder to recruit for a fixed-term position than permanent positions, as more SSWs preferred the stability permanent positions offered. Recruitment, particularly job evaluations, was time-consuming and it was challenging to fit it into the project timelines. These challenges around recruitment relate particularly to the set-up that was required as part of the trial, but are nevertheless worth consideration in thinking about how any future wider rollout may operate (or, indeed, for any similar trials). In addition, DSLs reported that it was useful that they had the same supervisor for a prolonged period of time, allowing them to build a close and trusted relationship with a social worker, and they appreciated that the SSW role was not affected by the issues of staff turnover that they felt was the norm for social workers. Given that many SSWs reported that they could not see themselves in this type of role on a permanent basis, any potential future rollout would need to consider how to ensure consistency in this respect.

The DSLs expressed support for potential wider programme rollout. Around nine in ten DSLs responding to the survey stated that they would recommend other schools or DSLs to take part in potential future versions of this programme.

Similarly, in interviews most DSLs said they would recommend this programme to others. Some DSLs specified that they would particularly recommend the programme to DSLs whose schools do not have extensive support available internally – for example, not having regular safeguarding team meetings within the school.

"If you didn't have regular supervision with colleagues around you, this would be absolutely invaluable because I think you do carry so much with you all the time, you are constantly thinking about the families that you work with. Sometimes, you don't need someone to provide a solution, you just need someone to listen and if you've got the opportunity to, sometimes you need to have a good cry with your colleagues or you need to just release that and then go okay, I can do this again now." DSL

Other DSLs stated that they would particularly recommend the programme to new DSLs, and that a more targeted rollout might be beneficial.

"I think it should be made available to all new DSLs definitely, I think it should be something that is there all the time for them. Although I have been the deputy [DSL] for a while, it still is different when you're the DSL yourself, because you're the first point of contact, and I think any, all new DSLs should have this opportunity." DSL

Programme differentiation

This section outlines the evidence on what service structure and practice looked like before the introduction of the programme, or in control conditions.

Control schools and contamination

We did not find evidence to suggest contamination effects in control schools, where they inadvertently received or were exposed to the supervision programme. Table 19 shows that relatively few DSLs surveyed received other training and support directly from social workers during the programme, and the percentages are similar for control and treatment schools.

Table 20 shows that most schools surveyed stated receiving a similar amount of training and support (excluding this programme) compared with the year before. Again, the

Table 18. Would you recommend other schools/DSLs to sign up for potential future versions of the programme?

	Number of respondents	Percentage of respondents
Definitely yes	104	72%
Probably yes	28	19%
Not sure	11	8%
Probably not	2	1%
Definitely not	0	0%

Treatment: N=145 at endline.

Table 19. Treatment schools:
"Apart from the support received from your supervisor as part of this programme, did you receive any other type of training or support from social workers since September 2021 (the start of the school year)?"; control schools: Did you receive any type of training or support from social workers during the current school year (2021/22)?"

	Control: Number of respondents	Control: Percentage of respondents	Treatment: Number of respondents	Treatment: Percentage of respondents
Yes	11	11%	15	10%
No	85	89%	128	90%

Endline: N=96 for control; N=143 for treatment.

percentages are similar across treatment and control schools, suggesting that the main change from the year before is the introduction of the supervision programme in treatment schools.

In interviews, some DSLs said other training and support that they received from schools, trusts and LAs did not overlap with the supervision support, while others said there was some crossover and interaction between the supervision and other support they received. This included schools with access to emotional counselling, supervision and helplines. It is unclear to what extent this impacted engagement and outcomes of supervision; however, it was relatively uncommon and seems unlikely to have affected our findings on impact.

Table 20. Treatment schools:
"Excluding the support from your supervising social worker, to what extent do you think the amount of training or support you have received since September 2021 has been more/less compared to what you have received previously?"; control schools: "To what extent do you think the amount of training or support you have received to perform your role as DSL during the current school year has been more/less compared to what you have received previously?"

	Control: Number of respondents	Control: Percentage of respondents	Treatment: Number of respondents	Treatment: Percentage of respondents
Much more training and support	6	6%	11	8%
Slightly more training and support	16	17%	33	23%
Around the same amount of training and support	67	70%	87	61%
Slightly less training and support	4	4%	9	6%
Much less training and support	3	3%	3	2%

Endline: N=96 for control; N=143 for treatment.

How does usual practice look before the intervention or compared with the control condition?

Our findings suggest that before the intervention, DSLs described themselves as being confident in their ability to perform the role and their knowledge of the relevant guidelines and procedures, including thresholds for referrals to children's social care (CSC). For example, on the basis of responses to the baseline survey only, around 90% of respondents in both treatment and control groups considered themselves either very confident or fairly confident in performing the DSL role.

As seen in the table below, the vast majority of DSLs expressed confidence in understanding the thresholds for referral to CSC. In interviews, similarly, most DSLs stated that they feel confident and experienced in understanding thresholds and do not require further support in this area.

Many DSLs explained that the majority of referrals [14] from their school do get accepted by CSC. In some cases, DSLs disagree with CSC decisions about whether cases "should" meet the threshold to be accepted. DSLs spoke of the thresholds increasing due to the limited capacity of CSC to respond to cases.

"I think there's just that frustration that a lot of us as head teachers have, where it's almost like the standing joke, of 'oh, what's the point, because it will never meet threshold?'" DSL

Some DSLs reported that they may choose to refer a case to CSC even if they do not think it would meet the threshold, to make sure that there is a record of the concern being reported. This is particularly the case when DSLs do not see options other than referral to CSC.

Table 21. Overall, how confident are you in performing the role of Designated Safeguarding Lead (DSL)?
(Baseline proportions in brackets)

	Control: Number of respondents	Control: Percentage of respondents	Treatment: Number of respondents	Treatment: Percentage of respondents
Very confident	43	44% (40%)	49	31% (23%)
Fairly confident	49	50% (53%)	100	63% (66%)
Neither confident nor unconfident	5	5% (6%)	10	6% (10%)
Not very confident	1	1% (2%)	1	1% (2%)
Not at all confident	0	0% (0%)	0	0% (0%)

Endline: N=98 for control; N=160 for treatment. Baseline: N=235 for control; N=221 for treatment.

14   Note that here and in some other instances throughout this section, we use the term "referral", as the term typically used by DSLs; however, in practice, this is describing a contact, rather than a referral, as it would typically be defined in children's social care.

"We would put the referral through but it's obviously, then it's up to MASH if they wanted to engage in it, if they wanted to pick up on it. But I think our motto in school is, always to err on the side of caution and always to do what we think is right to safeguard children." DSL

How supported do DSLs feel prior to the programme or compared to the control condition?

A majority of the DSLs responding to the baseline survey reported feeling well prepared for their roles as a result of the training and support they had received

Table 22: How confident are you about the following aspects of the DSL role, if applicable? ("Very confident" or "fairly confident").
(Baseline proportions in brackets). The survey compares overall rather than individual responses between baseline and endline.

	Control: Number of respondents	Control: Percentage of respondents	Treatment: Number of respondents	Treatment: Percentage of respondents
Understanding of thresholds that require a referral to Social Care	92	94% (91%)	149	93% (88%)
Providing high-quality information at point of contact and referral	92	94% (88%)	146	91% (88%)
Understanding Early Help processes and providing Early Help interventions	78	80% (77%)	125	78% (64%)
Understanding processes around child protection cases	83	85% (74%)	136	85% (78%)
Providing support to other staff	95	97% (96%)	148	93% (92%)
Communicating with and supporting families	93	95% (94%)	151	94% (91%)
Understanding school's help in providing Early Help interventions	82	84% (81%)	134	84% (74%)
Understanding CSC processes and issues	75	77% (60%)	113	71% (57%)
Keeping records of Early Help assessments, concerns and referrals	89	91% (87%)	148	93% (83%)

Endline: N=98 for control; N=160 for treatment. Baseline: N=235 for control; N=221 for treatment.

(see Table 23). At the same time, some DSLs noted that the standard DSL training, despite involving refresher courses, is not extensive enough and does not prepare DSLs for the broad scope of scenarios they may encounter in the role. Some DSLs noted that reflective practice is more valuable than training, and although DSLs can never feel "fully confident" in the role, their confidence improves with experience.

In the interviews, DSLs were asked about other support they had received in their roles before this programme, how useful it was and how it compared with this programme. For many DSLs, this programme was their first experience of receiving supervision.

The previous support received by DSLs broadly fits into the following categories: training, practical advice, wellbeing support and knowledge sharing, as outlined below.

Training

All DSLs receive the standard DSL training and complete refresher courses. The DSLs regarded the compulsory DSL training as useful, but insufficient. While the compulsory training developed some skills and knowledge

around safeguarding, DSLs did not think it prepared them adequately for the realities of safeguarding, and some argued that no amount of training could prepare someone for dealing with a child in crisis:

> *"I've had all the required safeguarding training, the high-level stuff, not just the basics, but no amount of training can prepare you for the actualities of dealing with a child in crisis."* DSL

In addition, some DSLs mentioned receiving other one-off training from their LAs, trusts and academies or from charities such as the NSPCC. One-off courses often cover specific topics such as exploitation, mental health awareness or responding to domestic abuse cases. DSLs describe the training available as useful, although not sufficient.

Practical advice and support

DSLs described different sources from which they could obtain practical advice on specific cases. Many DSLs, particularly deputy DSLs, reported that they are able to get practical advice and run their decisions

Table 23. Overall, to what extent has the overall package of training and support you have received prepared you for the DSL role? Baseline.

	Control: Number of respondents	Control: Percentage of respondents	Treatment: Number of respondents	Treatment: Percentage of respondents
Very well prepared	37	16%	24	11%
Well prepared	128	54%	140	63%
Neutral	57	24%	52	24%
Not well prepared	12	5%	5	2%
Not prepared at all	1	0%	0	0%

Baseline: N=235 for control; N=221 for treatment.

Table 24. Apart from the formal DSL training and refresher training, what type of formal or informal training or support, if any, have you received to support you in performing the DSL role? (Select all that apply)

	Control: Number of respondents	Control: Percentage of respondents	Treatment: Number of respondents	Treatment: Percentage of respondents
Training course by LA	111	47%	113	51%
Training course by NSPCC	44	19%	43	19%
Training course by other	94	40%	88	40%
Support from head teacher or Senior Leadership Team (SLT)	129	55%	126	57%
Support from other DSLs in school	122	52%	119	54%
Support from other DSLs in other schools	51	22%	53	24%
Other support	16	7%	12	5%
No additional training received	18	8%	10	5%

by their line manager or their lead DSL. Some safeguarding teams have weekly meetings in school to discuss any concerns or cases. Usually, DSLs are able to contact the education lead at MASH via a consultation phone line or the Children's Hub at their LA, to get advice on specific cases. However, some DSLs reported not having access to such consultation lines, as the MASH lacked capacity. Some multi-academy trusts also have safeguarding leads, who can also be contacted by DSLs for advice and guidance.

"I feel, with the authority, really quite supported in what they offer and you can pick up the phone and ask for advice; [they're] amazing." DSL

However, some DSLs noted that such practical support is significantly different

from this supervision programme, because consultation phone lines only allow a short slot of time to ask specific questions about a case and receive concrete advice and actions for DSLs to take forward. By contrast, the supervision programme created space for in-depth discussion and reflection.

Wellbeing support

With the DSL role often being emotionally challenging, support for wellbeing is seen as highly important by the DSLs. This is often offered informally, by the DSLs' head teachers, line managers, other safeguarding team members, school nurses or even partners or family members who themselves work in similar roles. Some schools and multi-academy trusts also offer additional wellbeing support, such as counselling delivered by private providers.

"A couple of weeks ago I had an issue where I was running around an estate after a child. The police were involved, the parents were involved, it all got really high profile. Every single member of the team checked in with me, and then checked in with me later on in the evening via text messages and phone calls. And I think that's important; it does depend on your team if you do have a really good team. So I feel very supported by them as well." DSL

Knowledge sharing and networking

Many DSLs also spoke about opportunities to meet other DSLs and relevant services through networking events. Such events include DSL network meetings run by LAs or multi-academy trusts. Some trusts also facilitate knowledge sharing between DSLs from different schools by running supervision programmes that match DSLs with other DSLs as supervisors. In some schools, DSLs meet in groups to discuss safeguarding concerns.

"We have a regular meeting where we triage our families who we're most concerned about; what we're worried about, what's

working well for one family … So, that in itself is kind of like a regular debrief, regular supervision. I've got the support of my colleagues who know what I'm dealing with, I don't feel isolated because there is more than one of us, so we've always got that option to talk." DSL

How was the level of stress and anxiety experienced by the DSLs before the intervention or compared with the control condition?

Survey results show a mixed picture among DSLs in terms of their satisfaction and wellbeing in relation to their roles. On the one hand, as shown by the responses to the baseline survey below, a majority of the DSLs report being satisfied in their role and finding it rewarding and meaningful. At the same time, around two-fifths of DSLs felt that the role made them stressed or anxious.

Interview findings mirror this mixed picture. When asked about their experiences in the role before receiving supervision, DSLs described the role in the following terms (the section on mechanisms and outcomes later in the report discusses how some of

Table 25. Overall, how satisfied or dissatisfied are you in your role as DSL? Baseline.

	Control: Number of respondents	Control: Percentage of respondents	Treatment: Number of respondents	Treatment: Percentage of respondents
Very satisfied	40	17%	30	14%
Satisfied	107	46%	119	54%
Neither satisfied nor dissatisfied	69	29%	67	30%
Dissatisfied	19	8%	5	2%
Very dissatisfied	0	0%	0	0%

Baseline: N=235 for control; N=221 for treatment.

Table 26. Overall, how does your role as Designated Safeguarding Lead (DSL) affect your job satisfaction and wellbeing? Please indicate to what extent you agree with each statement. ("Strongly agree" and "agree").

	Control: Number of respondents	Control: Percentage of respondents	Treatment: Number of respondents	Treatment: Percentage of respondents
The DSL role negatively affects my job satisfaction	35	15%	20	9%
The DSL role negatively affects my wellbeing	72	31%	58	27%
The DSL role makes me anxious or stressed	112	48%	91	41%
I find the DSL role to be rewarding and meaningful	157	67%	171	77%

Baseline: N=235 for control; N=221 for treatment.

those experiences were addressed by the supervision's focus on emotional wellbeing):

Emotionally challenging

The role of a DSL was most commonly described as difficult, with DSLs using words such as tough, stressful, intense, overwhelming, exhausting, draining and "taking a toll" on the people in the role. The role involves making challenging decisions and dealing with serious concerns and threats to children's welfare. As a result, many DSLs described struggling to "switch off" at the end of the working day and "put away" cases. DSLs spoke of feeling anxious of failing and letting children down.

> *"Being a DSL is emotionally very taxing as a role. I tend to wake up in the night thinking about it, it's the thing that lingers with me the most outside of school hours. It's the thing that I need to process the most in my role." DSL*

Demanding

DSLs describe the role as being busy and fast-paced. The role is dynamic, with changing requirements and unexpected events. Understanding complex needs and knowing the safeguarding procedures and landscape are time-consuming. On a positive side, as a result some DSLs note opportunities for learning and development in the role; however, this also results in excessive demands. DSLs often described the need to work out of hours, in the evenings and over holiday periods, to respond to urgent cases.

The demanding nature of the role means that it is often a reactive role, requiring most of the time being spent on addressing urgent concerns that "take priority over everything else". One DSL described their usual approach to the role as "fire-fighting". DSLs said this leaves little time for in-depth discussion of cases as a team or for proactive, strategic thinking. DSLs were often daunted by the level of responsibility that was placed on them to protect and advocate for children's wellbeing. They described having to deal with difficult

disclosures from children, navigating tense discussions with families, trying to coordinate help from CSC, but lacking the time to process the hardships of the role. This was usually on top of their other responsibilities, which included teaching, pastoral support and other senior leadership duties.

"You get so used to having to have a thick skin and getting on, just moving on, next day, next day, next day and not really giving yourself the time to think and process. Then imagine if you were to look at the number of DSLs who take early retirement, who drop out of the profession, who hit fatigue, who drink too much. I suspect it's probably alarming." DSL

During interviews, DSLs reported that their job had become more demanding in recent years, due to staff shortages, COVID-19, increasing caseloads and increasing thresholds. They also felt less supported by social care and agencies, who they felt had a tendency to place more and more safeguarding responsibilities on schools.

Isolating

Some DSLs describe the role as being "lonely", with a DSL having to "carry it all" by themselves. The role can require working independently and exercising own judgement on cases, with little scope to consult colleagues. DSLs describe having to "step out of your comfort zone" when it comes to independently handling new or unfamiliar cases. This is particularly the case for schools with small safeguarding teams, where the responsibility lay predominantly in one person's hands.

"It is a scary role because you know the stakes are so high. You know what's at risk if you make the wrong call." DSL

Frustrating

Many DSLs described facing frustrations in the role and feeling disempowered to change those. Some commonly mentioned frustrations included long waiting lists for services such as CAMHS, referrals to CSC taking a long time, not receiving feedback from CSC on the outcome of referrals, high staff turnover at CSC, increasing safeguarding demands on schools and increasing thresholds for referrals to CSC.

Rewarding

Despite the negative sides of the role identified, many DSLs described the role as rewarding. DSLs value opportunities to help children and families, and to make a positive impact on the lives of young people. Many DSLs described being passionate about children's wellbeing, and therefore accepting the challenges of the role.

"It's a rewarding role when you are working with families, and you can see that you're having a positive difference. Especially when you can see where a family have started, and the journey that they're on and where they'll end up." DSL

Reach and acceptability

This section overviews who the intervention reached and the experiences of those delivering and receiving the intervention.

How are individual DSLs chosen to receive the support sessions and what are their characteristics and role in terms of the wider DSL structure within the school?

Supervision was usually received by the head teacher because they were the named DSL. However, in some schools the main responsibilities of safeguarding were given to the deputy DSL, and the head teacher/DSL acted in a supervisory role. In these cases, the

deputy DSL was offered supervision because they were deemed to benefit the most from additional support. In some exceptional cases, supervision was offered to multiple members of the safeguarding team, such as the DSL and deputy DSL or other members of the pastoral and wellbeing team. The interviews showed this occurred in schools where safeguarding was the shared responsibility of multiple members of staff and where they already worked collaboratively to resolve cases.

To what extent are DSLs engaged in the programme, and what are the main barriers?

Overall, 70% of treatment schools engaged in any supervision sessions, and 30% of schools did not receive any sessions. There was notable variation across LAs, with the average number of sessions per school

ranging from less than one to just over four sessions. For context, a session every six weeks (per term) would have amounted to six sessions over the school year. In one LA, in particular, 62 of 80 schools did not take part in any sessions; this LA only began to deliver sessions in the final term of the school year due to delays in recruiting an SSW.

The success of the programme often depended on getting schools engaged and organising the first session. Once the first session was organised, and the SSW had the opportunity to introduce the purpose of the programme properly to individual DSLs, SSWs said schools most often maintained engagement throughout the rest of the intervention, and most often at a high level. However, although some LAs described the process of achieving initial buy-in among

Table 27. Number of treatment schools receiving sessions, and average number of sessions received, by LA

	N schools allocated to intervention	Number of schools with no sessions	Number of schools with any sessions	Percentage of (treatment) schools in LA with no sessions	Percentage of (treatment) schools in LA with any sessions	Average sessions per school
LA 1	26	6	20	23%	77%	3.2
LA 2	80	62	18	78%	23%	0.3
LA 3	120	29	91	24%	76%	3.2
LA 4	15	1	14	7%	93%	4.6
LA 5	33	5	28	15%	85%	3.5
LA 6	22	2	20	9%	91%	3.6
LA 7	36	6	30	17%	83%	3.0
LA 8	41	12	29	29%	71%	0.8
LA 9	43	4	39	9%	91%	4.4
LA 10	30	5	25	17%	83%	3.9
Total	**446 (100%)**	**132**	**314**	**30%**	**70%**	**2.7**

Total number of schools: 446 schools. Number of sessions excludes introductory sessions. LA2 did not start until May.

schools as straightforward, others had found it more difficult, and in many cases impossible, which meant that overall, 30% of schools did not receive any supervision. The next two sections describe the facilitators and barriers to engagement.

Facilitators to engagement

In interviews, DSLs were asked why they or their school decided to accept the supervision programme. Some of the reasons mentioned by DSLs included their desire to build on their knowledge and skills (such as understanding of complex needs or safeguarding procedures), curiosity and trying new things, need for support to respond to complex cases or rising numbers of cases, and to improve communication between schools and CSC. The fact that supervision was free and linked to the LA was a motivating factor for some schools. Some DSLs accepted supervision as they stated considering any additional support as useful, whereas others were specifically keen to try supervision. Additionally, schools in LAs that had previously offered supervision were keen to continue receiving this type of support.

"I snapped it up because it's not something that is widely on offer really. We have got a high level of need here, and we're in an area of deprivation and so that need is growing. And it can feel quite, isolating, when you're trying to sort it all out, and do these things, and then it's not gone into Social Care, it's all down to us." DSL

"I think I was quite excited when I found out about it, because I do think it was needed and I'd already thought that a long time ago. So, I was happy when it came about and I was happy to start it." DSL

From the perspective of LAs, an important factor that facilitated buy-in was when SSWs were supported actively by other staff in their LA. For example, introducing the programme to schools, and sometimes also laying the groundwork before the SSW had been appointed to the post. Some LAs even consulted their schools before applying for the funding, to gauge interest in the programme. Similarly, an LA manager who had previously worked with schools within the LA found that his endorsement, and the trust DSLs had in him, was a powerful motivating reason for the schools to join the programme:

"Some of our schools said, 'I'm only doing this because you've said that we need to do it and I trust what you say.' So, some of our schools didn't see the potential impact from the outset, but they have that trust with us now, they have that relationship with us and they'll take what we're saying, they'll take that advice from us, which is positive." LA

This meant that when SSWs with this type of support initially emailed and phoned schools, they were usually more successful in getting a response and organising the first session.

Barriers to engagement

Although we were unable to interview many DSLs who had not engaged at all in the programme, we interviewed some who had been apprehensive at first, and our interviews with LAs and SSWs also identified various barriers to contacting schools and encouraging them to join the programme.

Some DSLs reported that they did not think the programme would be valuable since they already received sufficient support from their team, their academy/trust or their LA. Others felt supervision would be less relevant to them as they felt confident in their role due to

numerous years of safeguarding experience. Capacity and lack of time were also commonly cited as reasons to refuse supervision.

Miscommunication was another barrier. Some SSWs reported that DSLs had not been made aware of the programme by their LA, and in some cases DSLs had suspected the supervision to be a scam when they were contacted by the SSW, who they had not previously been in contact with. Others felt suspicious about why they had been allocated to receive the programme over other schools and were concerned that they were going to be monitored or "told off" by the SSW. This related to a common concern about the term "supervision", as they felt it implied being watched or judged by CSC. Some also highlighted the need for the programme to be offered to every school in the future, which would be considered fairer and to mitigate concerns around why some were receiving this and not others.

There were also some more fundamental concerns about the programme that led to apprehension among DSLs. In particular, some DSLs expressed disappointment that the primary aim of the supervision sessions was to reduce inappropriate contacts, because they perceived themselves as efficient and knowledgeable.

> *"When it was presented to us that the pilot was really about reducing the amount of [contacts] … the load for social care. Me and my peers were disappointed by that really, because actually we feel like we are a very effective safeguarding team. And actually we do have good points of contact in [the LA] with our Children's Hub. So, I don't know if it was presented in a way that didn't appeal, or it was just our point of view at it." DSL*

Additionally, some understood the programme to be mandatory, and "accepted" supervision unenthusiastically, even though they did not perceive supervision to be valuable. In many cases where schools had been unenthusiastic or delayed their buy-in, SSWs found that once they had spoken with the DSL, and they were able to explain the programme aims, they were able to engage them in the programme.

SSWs often expressed frustrations at not being able to contact DSLs directly, especially when they were also head teachers. They were sometimes "ghosted" or stuck with a receptionist who would not forward messages. Without a response, they were left to speculate about the reasons why DSLs had chosen not to engage. SSWs suspected staff absences, COVID-19 and hectic schedules among head teachers as reasons and eventually had to accept their lack of response as a "no":

> *"Some of them I've emailed a couple of times directly to the heads, and I put a little read email on it, so I know that they've received it, but then, if they don't reply then you have to take that as a no eventually, don't you?" SSW*

To what extent do participants engage other staff within the school and are they expected to?

There is some evidence of the programme having an impact on wider school safeguarding staff. Some DSLs described cascading information – for example, through weekly meetings with the wider pastoral team or through communications about specific cases where wider staff may be able to offer support. SSWs signposted DSLs towards training and additional support, which they shared with their safeguarding team. In some cases, supervision also led to the creation of new policies within the school.

Supervision also reminded DSLs that their staff were facing similar struggles to them and needed additional support. In response to this, some introduced debrief sessions with colleagues, where the larger safeguarding and pastoral team could share concerns and best practice, and offload. In those sessions, DSLs were also able to share information discussed during the supervision session. In schools where the DSL felt isolated, this helped them feel supported and brought in new perspectives. It also facilitated delegation and upskilling of the wider team and reduced the workload on the DSL.

"I think talking it through with [SSW] has made me feel that I'm probably giving my team a bit more responsibility, which lightens my load slightly, but it also means that they gain that knowledge and experience but in a more supported way, which I think is important. As a DSL, I never really had that in the beginning, I was in the role and you just got on with it, and you kind of worked your way along, as you went along, type of thing. So, it's trying to give them the support now, preparing for them, for whatever the future may be, which I never had." DSL

There were some cases of other members of the safeguarding team accessing supervision when the DSL and SSW agreed it would be beneficial. This was sometimes together with the DSL, or as a one-to-one session replacing the session with the DSL. For example, one DSL explained how their special educational needs coordinator (SENCO) benefited directly from the emotional and practical support provided by the SSW:

"My SENCO was really struggling with a couple of really challenging parents, who were being quite aggressive towards her. So, [SSW] was really, really good and did a couple of sessions with my SENCO. But that is something that I have said this morning, is that actually I think instead of me having the supervision I think my SENCO would probably benefit even more from having it. Just because I have that experience of working with really tricky cases in the past. I have a really good network around me anyway in terms of colleagues and other people outside of work that I can go to." DSL

Supervision also led to some changes to the structure of safeguarding within a few schools. This was adapted to the needs of the schools and led to some changes in the members of staff named "DSL" and increasing or decreasing the number of deputy DSLs.

Finally, there were also some DSLs who felt the programme only had a minimal impact on their ways of working in schools. Those DSLs typically said they already had a strong team who collaborated and touched base frequently:

"We have a working team in school really who come together to constantly review our safeguarding practices in school and make sure that everybody's in the loop about changes and new legislation and things that are coming out and stuff. So, we work quite closely anyway." DSL

What are the main barriers to attend the sessions? If compliance is not achieved, what are the reasons why?

When asked about barriers to implementation, scheduling was discussed by most DSLs as the main, and often only, barrier. A quarter of the DSLs responding to the survey found fitting the sessions into their usual working schedule "quite difficult" or "very difficult".

Table 28. To what extent has it been easy/difficult to fit the supervision sessions into your usual working activities and schedule?

	Number of respondents	Percentage of respondents
Very easy	26	18%
Quite easy	62	42%
Neither easy nor difficult	22	15%
Quite difficult	32	22%
Very difficult	4	3%

Treatment: N=146 at endline.

In interviews, DSLs explained that their role involves urgent meetings, frequently scheduled without notice. As a result, many DSLs reported having to cancel or reschedule their supervision sessions, due to clashes with other meetings, such as Child Protection or Child in Need meetings. SSWs also referred to frequent cancellations by some schools as a challenge, but were flexible when rescheduling, which was appreciated and acknowledged by DSLs.

What's the experience of social workers delivering the programme?

Overall, SSWs reported positive experiences of the programme, and some positive impacts from it for their own knowledge and practice. SSWs spoke about how taking part in the programme increased their understanding of the challenges and pressures that schools face. Some SSWs described how the programme raised their awareness of the rising safeguarding demands on schools, and the pressures on school staff.

"I did not realise the amount of work schools did and how much they take on, and there's been some absolutely creative and amazing things going on around the county, with schools having their own

food banks, their own clothing shops … things like if a parent's having trouble getting a child into school, some of them will go and pick the child up. If parents can't come to a Team Around the Family (TAF) meeting they'll go and pick them up. So, in some ways they're doing some real lower-level social work." SSW

SSWs often described that they had gained a new perspective on safeguarding through being away from the frontline and conducting supervision with schools, allowing them to reflect on cases in more depth. Some SSWs described that they had further developed their analytical and supervisory skills throughout the programme – for instance, in terms of adapting supervision to fit the needs and personalities of each DSL, as well as improving their knowledge on thresholds, legislation and Early Help:

"Yes, for me, I loved it. It made me hone my supervision skills, and meeting people where they're at, because I was dealing with 30-plus personalities; whereas I might have, at most, during a year, have 9 supervisees, here I'm dealing with 30-plus, and kind of meeting them at their needs." SSW

As noted earlier, the interviews with SSWs highlighted barriers to getting schools started with the programme. SSWs described how initial buy-in varied across schools, with some engaging from the start and others requiring more chasing and convincing. SSWs recognised that limited capacity in schools was a challenge for finding the time to arrange the sessions.

In terms of preparing for the sessions, SSWs described having to take some time before each session to remind themselves of the school context and what was discussed in the previous session. Other than this, each session did not require extensive preparation from SSWs.

SSWs valued the support available to them, from their LAs, line managers and informal support from other SSWs working on the pilot. SSWs also received their own supervision within their LA. However, some SSWs also described challenges in getting support from WWCSC, such as unclear communication and occasional lack of response to emails. Some SSWs also missed out on some of the LA training, due to being recruited late into their roles.

Overall, most SSWs did not express an interest in continuing in their post, for a variety of reasons. At the time of the interview with SSWs, future funding had not been secured. Some had enjoyed the professional challenge of delivering supervision and liked working with DSLs to resolve cases. There were a handful of SSWs who wanted to continue supervising but had secured new roles elsewhere due to lack of certainty around the programme continuing. Others had been offered the SSW as a secondment opportunity and were moving back to being frontline workers. They had enjoyed their short-term placement but found it didn't use the skills they had built up as social workers. Although SSWs had enjoyed seeing improvements in

DSLs' practices, many missed working directly with children and families.

"I think that it's a good opportunity and it's probably one of the only jobs that actually gives you time to do social work without being stressed. But I do think you miss out on some of the skills that you've acquired over the years of being qualified. I love working with families and children, I think it's a privilege to be able to work with people that are vulnerable and that struggle, and to be able to work with them to empower them, to make better choices and have a better life, I think it's fantastic. Well, obviously, you're doing that still, because you're doing it through working with DSLs to help them see that, but then you're not seeing the successes I suppose." SSW

"I think if I did this role permanently, it would be very isolating if it was only on my own, and I think that would make it very, very difficult." SSW

How was the intervention received by participants and by the school in general?

The majority of the DSLs responding to the survey found the supervision sessions useful, with 73% of the respondents reporting that the sessions were "very useful" and 20% describing the sessions as "quite useful".

Similarly, in interviews a majority of the DSLs spoke about finding the sessions useful. Some of the aspects of the sessions that DSLs highlighted as useful included having the time for reflection and discussion with colleagues, developing new ideas, discussing complex cases or new types of cases, being signposted by the SSW to useful resources or local support organisations, learning from a social worker's perspective and discussing their own wellbeing. These themes are discussed further in the later section on perceived impacts of the programme.

Table 29. Overall, how useful did you find the supervision sessions?

	Number of respondents	Percentage of respondents
Very useful	107	73%
Quite useful	29	20%
Neutral	8	5%
Not very useful	2	1%
Not at all useful	0	0%

Treatment: N=146 at endline.

What was the experience of key stakeholders in LAs delivering the programme? How does it fit into their wider support packages to schools?

Interviews with LA stakeholders mentioned a number of reasons why LAs had signed up to deliver the programme. LAs mentioned their desire to offer more support to schools, as they recognise the challenges that DSLs face in their roles as well as increasing safeguarding demands on schools. This programme was seen by LAs as potentially offering benefits to the schools, by receiving regular support and encouraging reflective thinking.

> *"We know that Designated Safeguarding Leads in schools have a very difficult job to do in terms of managing their safeguarding responsibilities. We know that it can be tough and challenging emotionally on those people who hold those high-level caseloads." LA*

Some LA stakeholders spoke of their prior knowledge of the benefits of supervision. One interviewee stated that they were aware of positive experiences of supervision from other LAs, while another stakeholder mentioned that social workers themselves benefit from supervision. Another LA was recommended to provide supervision in schools in their serious case reviews.

A number of LA stakeholders also spoke about the potential of the programme to improve communication and links between them and the schools.

LA managers often expressed frustrations about the number of inappropriate referrals they received, and they were concerned about the quality of support provided to families and children who did not meet the threshold for children's social care. As such, LAs saw the programme as an opportunity to develop DSLs' safeguarding skills, especially their knowledge of thresholds and referral processes, as well as improving their broader support to families:

> *"So, for us really, that was one of the key reasons, to see whether having a social work supervisor directly attached and linked in with DSLs improved their understanding around threshold application, enabled more professional curiosity and confidence around working with families. Where they might be working with families at an Early Help intervention level, rather than requiring social care." LA*

Overall, the programme was perceived very positively by the key stakeholders in participating LAs. The stakeholders interviewed spoke about receiving positive

feedback from SSWs and schools, and observing a positive impact on the quality of referrals and joint working between schools and CSC.

Mechanisms and outcomes

What are the perceived impacts of the intervention?

The survey results provide a mixed picture of the perceived impact of the programme and change in practice among DSLs.

Overall, 91% reported that supervision had a positive impact on them as a DSL. This included over a third (36%) of respondents

who reported the programme as having quite a large positive impact (and around a further third (35%) a very large positive impact).

At the same time, survey responses indicated that only 9% of the DSLs in treatment schools felt their approach to safeguarding was "quite" or "very" different compared with before the programme in September 2021. This figure is similar for treatment schools and control schools. The percentage of respondents stating that their approach was "very similar" to the one they had before September 2021 was higher among the control group (49%) than the treatment group (34%).

Table 30. Overall, what impact, if any, do you think the programme had on you as a DSL?

	Number of respondents	Percentage of respondents
Very large positive impact	51	35%
Quite a large positive impact	52	36%
Small positive impact	30	21%
No impact/change	11	8%
Negative impact	1	1%

Treatment: N=145 at endline.

Table 31. To what extent is your approach to safeguarding similar/different to the one you had before September 2021?

	Control: Number of respondents	Control: Percentage of respondents	Treatment: Number of respondents	Treatment: Percentage of respondents
Very similar	48	49%	50	34%
Quite similar	41	42%	82	56%
Quite different	8	8%	12	8%
Very different	0	0%	2	1%

Endline: N=97 for control; N=146 for treatment.

Almost two-thirds (64%) of respondents in treatment schools felt their overall performance had become "better" or "much better" due to the programme. The outcomes with the highest self-reported changes were "providing support to other staff" (59% of the DSLs), "understanding EH processes and providing EH interventions" (57%) and "communicating with and supporting families" (57%).

Findings from interviews with DSLs similarly provide a mixed picture. Many DSLs interviewed reported that supervision had no impact on their practices. At the same time, many DSLs described positive impacts across a range of areas, particularly in terms of their confidence in the role through reassurance.

The following sections focus on how DSLs perceived different impacts and outcomes in specific areas, based on findings from the interviews.

Referrals and understanding of thresholds

Reducing the number of inappropriate contacts made by schools was one of the key aims of the intervention. However, there is limited evidence from the interviews that the programme supported this aim.

A few DSLs described their practices changing as a result of supervision. For instance, some said that supervision gave them better awareness of other options for support that they could use before escalating a case to CSC. For some, supervision had significantly impacted their approaches

Table 32. Self-reported change in outcomes. "Reflecting on your experiences of taking part in the programme so far, please indicate to what extent you think it has changed your performance in your role as DSL, on the following indicators?". ("Much better" and "better")

	Number of respondents	Percentage of respondents
Overall performance	93	64%
Understanding thresholds requiring a referral to Social Care	79	54%
Providing information at point of contact/referral	75	52%
Understanding EH processes and providing EH interventions	83	57%
Understanding processes around child protection cases	63	43%
Providing support to other staff	85	59%
Communicating with and supporting families	82	57%
Understanding school's role in providing EH interventions	73	50%
Understanding CSC processes and issues	80	55%
Keeping records of EH assessments, concerns and referrals	56	39%

Treatment: N=145 at endline.

to contacting CSC about safeguarding concerns. In particular, DSLs new to the role or their LA learned about processes of making contacts and referrals, and of the different thresholds levels:

> *"The whole framework of how the levels within the [local authority] thresholds work, she's explained all of that to me." DSL*

However, most DSLs feel that they already were knowledgeable and experienced in understanding thresholds before supervision and did not need additional support in this area. Many DSLs explained that the contacts coming from their school are rarely inappropriate and most of the time are accepted by CSC. Some DSLs also mentioned that they were also already able to get advice and guidance on thresholds in any specific challenging case through consultation phone lines. Therefore, many DSLs reported that instead of changing practices around contacts, supervision confirmed to them that their practices were correct.

However, some DSLs said that supervision helped them to gain a better understanding of how to refer cases to ensure they do meet the threshold. For instance, some DSLs explained that supervision encouraged them to collect more evidence on cases, thus improving the quality of information they provide at the point of referral. They were also advised on the type of language to use and what to include in the referral.

> *"It was certainly the kind of language to use, and also like just sort of real precise of the actual needs, rather than the life history [laughs], of a family, you know. You can kind of get into a bit like 'oh, I'll just put everything in, so that they see how bad it is', but a lot of it isn't necessarily what they're really interested in." DSL*

As discussed in the section on DSLs' experiences of the role before the programme, some DSLs choose to contact CSC even if they do not think a case will be accepted. In a couple of cases, DSLs felt their SSW had encouraged this practice, despite the LAs saying that schools referred too many cases.

> *"I think we're pretty clear on what the thresholds are and we're pretty clear on when to get in touch with social services. I would say that I had some questions about what should I do in this particular situation and I'd give her a scenario. And it appeared that, the answer always was refer it in, don't contact the social worker that had them before. And so that's cleared that up quite nicely for me and made it more straightforward. So, I would know if a new incident met the threshold is what I think I'm saying, but sometimes things are a little bit more muddy and she's helped me to understand from a social work perspective how to make them less muddy and how, and that basically yeah, if you've got a worry just refer it in social and it'll be screened. So, not to be afraid to put something that you don't think meets the threshold in because actually it's really good for social work to know about it. So, yeah, that was useful information." DSL*

In other cases, supervision had highlighted areas of concern and encouraged DSLs to think critically about signs and indicators of concerns, and SSWs had advised DSLs to flag these to social care services. This would lead to more contacts, but probably appropriate ones.

In a couple of rare cases, DSLs questioned the relevance of the advice on contacts, referrals and thresholds during supervision and some DSLs were sceptical about advice given by their SSWs. For instance, one DSL explained that thresholds are blurred, with "no definitive right answers", so they relied on their intuition

and years of experience and had not found the supervision to offer new perspectives on their practice. Another DSL was unconvinced of the advice given by their SSW. It had been their instinct to refer a case, but their SSW had advised against it. Although they had listened to their SSW's advice, and were investigating other avenues of support, they were still tentative about their decision.

> *"The fact is though you know some of these calls we make are extremely tricky and you base it on second-hand information from either children or families. You might get advice from a social worker along the lines of 'nah I don't think you should put that call in, how do you know the dad clipped the child, there's no mark on the leg?' But just because that's the case doesn't mean it hasn't happened and I think experience in this role is vital. There's some times we had to make tricky calls; we don't always get them right but neither do social workers always get them right, otherwise there wouldn't be serious case reviews, which happen every single year. So, there's nothing to date which has come out [in a] way which has caused us to change how we do things."* DSL

Generally, many felt frustrated about the process of referring cases, especially the lack of communication of decisions, and what they perceived as increasing and high levels of thresholds. Some also expressed frustration that certain cases, which they considered met thresholds, received no further action. Some DSLs continued to send referrals regardless of whether they met thresholds.

Supporting children and families

While many DSLs interviewed said supervision had had no impact on the support they offer to children and families, some DSLs described positive impacts in this area.

DSLs described how they had gained increased awareness of wider support services and referral options. For instance, one DSL suggested that, as a result of taking part in this programme, they are better able to support children and families by not just relying on CSC and Early Help but thinking more widely about what options can be offered. Another DSL said that their SSW signposted them to resources for parents, which they had not previously been aware of.

> *"Incredibly useful. One example would be a child that we've got in a special guardianship arrangement, so, [SSW] was able to point me in the direction of the Special Guardianship Services, that I didn't know existed and I had tried to find this service before, just by Googling, but couldn't find it, and [SSW] was able to put me in touch with them and that was incredibly useful."* DSL

Another DSL suggested that supervision made them more confident to communicate with children and families about difficult decisions, which they used to find challenging before the programme.

SSWs highlighted improvements to "professional curiosity" among DSLs who had become better at unpicking cases, looking at the bigger picture and being proactive as well as reflective.

> *"I think that there's been a marked difference in some schools, some DSLs, in some circumstances, spotting the signs of ongoing exploitation. What they're very good at is when a child comes along and says my father has sexually abused me last night, they know exactly what to do and they do it, bam, bam, bam, it gets sorted, but they're not so good at spotting the ongoing risk of exploitation to that child because of other factors. So, I think that that has improved because they've been analysing cases in supervision and having the time to realise, to look into the future about what the risks might be in the future."* SSW

During the supervision sessions, DSLs were encouraged to look at cases objectively and through the perspective of a social worker. Many DSLs found this useful, helping them to develop new support plans, to better support children:

"You think about the wider picture a bit more, rather than just thinking of it from a school point of view, it actually makes you think a little bit more from the social worker point of view, so, it gives you a more rounded view of the whole situation really." DSL

Bridging the gap between schools and social care

Many interviewees identified a gap in communication and in understanding between schools and CSC as a significant issue for safeguarding in schools. In that context, any positive impact of this programme on bridging this gap is valuable.

While many DSLs reported having already had extensive knowledge of the CSC context and processes, some said that this improved through taking part in supervision. DSLs particularly valued the supervisor being a social worker, since it allowed them to gain "a social worker's perspective" on cases and learn more about the decision-making processes at CSC.

Some DSLs said they believe the programme also improved the understanding in their LA and CSC of the school context and the specific challenges that schools face. DSLs valued such impacts.

At the same time, some DSLs emphasised that despite taking part in the programme, they still have their frustrations with how social care works – for example, with CSC taking a long time to respond to referrals. This suggests that some of the issues in communication between schools and social

care are more structural and could not be addressed by this type of intervention. However, there may be some extent to which learning more about the work of CSC can make schools more sympathetic to the challenges they face.

"The frustration from our side is that some of our concerns aren't taken seriously enough or as seriously as we see them to be, but there's also a great amount of professional sympathy on my point of view, because I know that they're an overstretched resource. They're underfunded, they're overworked, and I sympathise with that, because so are we. It's really challenging. So, it's really good to talk to a social worker and be able to talk about those sorts of things, and get a little bit of a better understanding, about what it's like on her side of the fence, compared to what it is like on my side of the fence." DSL

Some SSWs also believe that the DSLs improved their communications with CSC through participating in the programme – for instance, by following up on cases more and providing better-quality information to CSC.

LAs and SSWs reflected that the programme had been a first step in bridging the gap between CSC and schools. SSWs reported back to their managers within the LA and highlighted issues that had not previously been heard. LAs saw this as a positive step towards building trust with their schools. For some, this had also led to internal conversations on how to better support DSLs, and where the LA could improve:

"This project is one very small strand of how we have had to repair the relationship between local children's services and partner agencies, like schools, police, health etc. We're still on that journey and we will be on that journey for a long time, before partners and parents and families fully trust." LA

"I hope that it's going to bridge the gap between education services and social care, because I think that there's a real disparity in terms of what each service does and how they see things. Schools can become fixated on a specific child, whereas social workers probably have 20 children that are like that 1 child in school. I think that social workers probably think that teachers are just … exaggerating things, and teachers probably feel that social workers don't listen to them. So, I think that in terms of sharing information and kind of passing their worries back to the local authority, that should hopefully improve the quality of the work." SSW

Impact on DSLs' confidence and mental wellbeing

Responses to the endline survey indicate some differences in confidence levels between the treatment and control groups of DSLs. The DSLs in the treatment group were more likely than those in the control group to report feeling "slightly more confident" or "much more confident" in the role compared with September 2021, with this applying for 80% of DSLs in the treatment group and 38% in the control group.

Survey responses to wellbeing questions were analysed as part of the impact evaluation. Interview findings suggest that the programme had some positive impacts on participants' confidence and emotional wellbeing. Some DSLs said supervision improved their confidence in the role, because it encouraged them to assess their practice. Many DSLs reported feeling reassured about their practice by their SSW. During the supervision, they were able to analyse their actions and better understand the outcomes of the cases. For DSLs who felt isolated, supervision provided invaluable support and a place to offload concerns. Some also felt encouraged to continue in the role where they otherwise might not have, because the supervision addressed previous doubts and feelings of guilt in relation to past actions. At times, DSLs appreciated the SSWs' presence and empathy, with many stating that they do not otherwise have a space to offload concerns. Similarly, they appreciated the concrete advice SSWs provided, helping them improve their practice, which in turn improved their confidence. However, the lack of capacity in schools and increasing caseloads were outside the scope of the programme and remained a serious barrier to DSLs' mental wellbeing.

Table 33. Do you feel more/less confident in your role as DSL now, compared with September 2021?

	Control: Number of respondents	Control: Percentage of respondents	Treatment: Number of respondents	Treatment: Percentage of respondents
Much more confident	9	9%	42	29%
Slightly more confident	28	29%	75	51%
No difference	54	56%	29	20%
Slightly less confident	5	5%	0	0%
Much less confident	1	1%	0	0%

Endline: N=97 for control; N=146 for treatment.

Some DSLs also valued the opportunity to speak to SSWs through ad hoc calls and emails, to receive reassurance before acting on new cases, and not having to carry the weight of the case until the next session.

"The fact that I'm having supervision, I think personally, has taken a bit of the stress out of this job. It can be very stressful and it can be quite isolating, in terms of you're kind of like, oh no, I've got to do this, I've got to do this. And if that kid gets hurt, then you know, it's my fault, … you can get sort of in a bit of a spiral with that sort of thoughts. And as I say, it's made me think, you know, stop, and let's just think about this, and what we can do? … and it's through to talking to [their SSW], and all of that, I've kind of been able to sort of unpick that a little bit, and just think no, it's not a failure, because you haven't got it through into social care, it just means that you've got to go a different path, you know. And yeah, so I mean, she's been a good support in that sense." DSL

DSLs repeatedly expressed surprise that SSWs showed interest in their mental wellbeing. They explained that "nobody really is that bothered about our wellbeing ever". In particular, head teachers highlighted that they were the person colleagues turned to for support, so they had to be strong for their school.

"I am very good at building other people up and giving everybody a 'ah you're doing really well, well done', but I suppose in my role I don't have quite as many people saying well done, you've done a good job. I think through the supervision it has made me sit back and think, do you know what, I have done a really good job getting that support for that family and that support and so I think it has made me appreciate how hard I work." DSL

"I come out of our meetings feeling a little bit lighter, I feel refreshed that I've just offloaded. It's a nice feeling to think that you can make an impact and make a difference and just be able to share it with somebody who understands what you're going through, understand the whole safeguarding in a school. So, I think it does have a positive impact." DSL

In addition to improving confidence, supervision allowed DSLs to acknowledge how much work they were doing, and in many cases that they were doing too much work, and during supervision sessions SSWs encouraged them to set boundaries around work. This included taking a lunch break, reducing additional working hours from home, not doing the job of social workers, delegating to their team and placing responsibility back onto the parents. This had some direct positive impacts on mental wellbeing, but some also felt unable to act on the advice due to the amount of work they needed to complete. During these discussions, some DSLs also concluded that, even with the support from the supervision, they wished to move to another role to regain more work–life balance.

"Yes, it helped me understand that we needed to take, it helped me to see the wood for the trees and to understand we needed to set proper boundaries for parents, which we have done. I think in terms of the workload, sort of I think the suggestion was sort of have a lunch break and look after yourself, but my conclusion is that I can't look after myself in this role. I think that's what I am facing. I just can't; it is not a role for one person." DSL

As mentioned previously, the supervision sessions often improved DSLs' confidence in pushing back and placing responsibility back to social workers and parents. Mainly, DSLs felt more comfortable in having difficult discussions, having practised them with their supervisor. This allowed them to redraw their work boundaries and remind social workers and parents of theirs. In discussions with social workers, they also felt more able to challenge decisions and voice their opinions.

Improvements in confidence and wellbeing could be linked to the relationship between DSLs and their SSW. DSLs described their SSWs as "warm", "friendly", "lovely", "not judgemental," "patient" and "knowledgeable". Feeling they could open up to their SSW meant DSLs felt comfortable offloading and reflecting on cases where they were unsure about the outcomes. In addition to valuing the soft skills of SSWs, they appreciated that the advice was grounded in their experience as social workers. Consistency was also important. DSLs were often used to a high turnover of social workers, and often expressed frustrations about this. However, this programme had enabled them to build a relationship with the SSW over time, and they found that this consistency and having someone they trusted was invaluable.

"She's just got a really good manner about her. She's very easy to talk to, she's not judgemental, she really knows her stuff, as well; she can pretty much signpost me straightaway. That's been great as well. So, I've got absolute confidence in her ability … She knows her stuff and that's been really good, because it doesn't waste any time." DSL

Some DSLs also reported limited or no impact of the programme on their wellbeing, as they believe their wellbeing was already sufficiently supported by their school culture.

Facilitators to impact

Interview responses were analysed to establish which elements of the programme design were perceived by the DSLs to result in the positive impacts. This section overviews the key facilitators for perceived positive impact through the programme.

Designated supervision time: DSLs spoke extensively about the value of supervision creating time for in-depth reflection. Formal scheduling of time slots for a one-to-one session meant that DSLs had to use those time slots for discussion and reflection. Many DSLs noted that this was more time than they would usually get to reflect on cases.

An external supervisor: Having an external facilitator for the supervision sessions provided DSLs with "fresh eyes" and "another perspective". DSLs also explained that the SSW being external was the reason why they particularly valued their views about the DSLs' and school practices.

Supervisor being a social worker: DSLs felt that having a social worker as a supervisor was helpful for learning about decision-making processes at CSC. DSLs highlighted the value of "learning about a social worker's thought process" as well as tapping into the SSW's experience of similar cases in their practice. DSLs described SSWs as having a breadth of experience and being knowledgeable about CSC and other support services. As a result, supervision highlighted other available options for intervention before contacting CSC.

Some DSLs were frustrated at the high staff turnover in CSC and the high number of social workers assigned during single cases. They therefore valued the consistency of the SSW in this programme, as it took time to build a relationship and develop trust. If the supervision programme is rolled out on a larger scale, they underlined the need for

the same supervisor to be allocated to each school for a prolonged period of time, and for it not to be affected by the same issues of staff turnover. Given that many SSWs reported that they could not see themselves in this type of role on a permanent basis, any potential future rollout would need to consider how to ensure consistency in this respect.

Flexibility: DSLs described supervision sessions as beneficial when they were tailored to their needs. This included being able to discuss issues that were important to them, at a time which suited them and delivered (remotely or face-to-face) as they preferred.

LA managers echoed the need to prioritise flexibility for potential future rollouts and the desire to offer supervision to more schools. Building on the information SSWs had fed back to LA managers, some LAs were looking at new ways to provide support to DSLs. This included training, network meetings, drop-in clinics and looking into concerns raised on Early Help and why some cases, which were perceived to meet the threshold, resulted in no further action.

"The schools weren't getting any support really that I am aware of. We are changing that. So, the knowledge that [SSW] has gained about the schools and the locality is going to help us to develop specific training … we are developing network meetings and briefings and drop-in clinics and things like that. [SSW] has found that a lot of DSLs were not confident in their decisions, and they didn't have anybody else to talk to and share their worries with and talk about things generally, cases generally and get different ideas. And that's what we want to develop, and I think we have made a good start on it." LA

"[DSLs] have raised some concerns about the Early Help offered in [LA], so we're going to think about how, very tactfully, we can feed that back into Early Help to make things better for DSLs." SSW

Particular value to new staff: Some DSLs said that being "fairly new to the post" was a factor that contributed to them finding supervision useful. One DSL who started supervision around the same time as starting the DSL role said that this "has been really helpful". Supervision was particularly helpful for those new DSLs because they tend to face unfamiliar cases more frequently. DSLs also noted that supervision allowed less-experienced members of staff to learn about support options other than contacting CSC, which was particularly useful to them.

Barriers to impact

Time and capacity constraints: The number of responsibilities DSLs deal with made it difficult for them to allocate time to take part in supervision. Some DSLs mentioned that due to the reactive nature of the role, they felt they did not have the time or capacity to engage in this programme or to change their practice through the programme.

Structural barriers between schools and CSC: Although there is some evidence that the programme has had some positive impacts on communication between schools and CSC, many of the issues raised by DSLs and SSWs are more structural and could not be addressed by this intervention. Some DSLs explained that, despite having taken part in the programme, they still have frustrations with CSC. Many DSLs interviewed felt that the safeguarding demands on schools are increasing, and those may not necessarily be best addressed within schools.

Restrictions on which cases DSLs were able to discuss: Not being able to discuss the cases that have already been referred to CSC during supervision was seen as a major barrier by DSLs. This resulted in DSLs not being able to discuss high-level cases, including the ones that "cause staff the most stress and anxiety" and the cases that "kept them up at night".

Similarly, some DSLs mentioned that SSWs not being able to give them advice and guidance in this respect was a barrier to impact. To them, this meant they were not fully using the knowledge of their SSWs, because they were not able to discuss the live cases that truly worried them and caused them a lot of stress, and where they needed support. Similarly, when SSWs were more open and flexible to provide advice to DSLs, this was appreciated by DSLs.

"I think that actually the idea of being able to talk about all of them would be more beneficial; we have a few cases, at the moment, that are at the high end, that actually those are the ones we're getting more frustrated with, if they're stuck. If they're coasting a bit, but we don't have the supervision for those ones. So, we're actually, a version of, even

though a social worker is involved and there's escalating processes and things like that, but sometimes when you just need that kind of conversation and for someone to say, oh no, it's not stuck, it just takes more time to do the parenting assessments, stuff like that or yes, it is, and this is what you've got to do. I think it would be more helpful if it was all cases." DSL

Sessions being scheduled rather than on-demand: Some DSLs felt that scheduling the sessions over regular time periods was a barrier to improvement through the programme, because they would have preferred to be able to access supervision at the points of highest need. DSLs explained that the regular sessions were not always necessary if they had low cases of safeguarding concerns.

Do participants feel the programme was worth their investment of time?

Finding the time for the sessions in the busy school schedule was the key challenge in programme delivery. Even so, the survey results show that most DSLs (79%) described the sessions as a good or very good use of their time.

Table 34. Do you think the supervision sessions have been a good or poor use of your time?

	Number of respondents	Percentage of respondents
Very good use of my time	92	63%
Good use of my time	39	26%
Neutral	11	8%
Poor use of my time	4	3%
Very poor use of my time	0	0%

Treatment: N=146 at endline.

"I can't say anything about it that's negative because it has been so, so valuable and I'm so grateful that I was one of the lucky ones that was chosen, to be honest with you, because in schools, post COVID, it has been a really, very, very challenging time. So, to have somebody there, that was for me, for that period of time, to fully support, has just been really invaluable, it's just been a brilliant experience, so I'm very appreciative." DSL

The DSLs who were interviewed also strongly believed that supervision should continue. Many argued that pressures on schools and safeguarding concerns will only continue to rise, and argued that supervision is a good first step, but not sufficient, in ensuring that children and families receive the support they need.

"And I think it would be … if this was rolled out to DSLs across schools properly and done effectively, not a half job but done properly. Then I think we would see a significant increase in the number of children that are not falling through the gaps. And they are not going unnoticed." DSL

"It would be great, I would hate for it not to happen, I would love for it to continue. I can't imagine it not being of benefit to whoever, no matter how much experience you've got. It's just having that person who's knowledgeable and who's right in it, who can be a sounding board and a fount of advice. I might have been lucky with the person I've met, I've no idea, but she's been brilliant." DSL

DSLs often argued that safeguarding was such an important area, but they received little support compared with other areas in education. As such, the supervision programme had been welcomed, and filled a gap, and they hoped it would continue so

they were properly supported in their role, both in terms of having an emotional outlet and to provide advice on safeguarding:

"I think it's a shame if it doesn't continue, really, because safeguarding in schools is huge and it's only getting bigger now because of everything that our families are contending with. And I think that schools are manic, busy places, but getting busier with less funding and fewer resources. And I think that when people are pulled in so many different directions and spread so thinly that's when mistakes happen and at a safeguarding level – mistakes at a safeguarding level can be fatal and so, any kind of additional support and advice that can be given to people who are trying to navigate their way through safeguarding with these, with families in the current situation is always going to be helpful, extremely helpful." DSL

"The majority of my week is spent on social care issues. Without a shadow of a doubt. So, I think that does need highlighting, and I absolutely should be doing that, but it does need some support, like everything else does in education. We get support on the curriculum, we get advice on this, we get advice on all kinds of things, but there's a lack of support and information, other than expectation." DSL

"Our mental health and wellbeing counsellor, she received supervision because of the nature of the role she does, and I have thought before, you know, that it is a very taxing role and it's a role that you don't, you know, you're not prepared for really, you get your DSL training, you get to know what the systems are, you're told very, very clearly what your legal obligations are. You're told very, very clearly what the systems and structures have to be, and you're told really, really clearly what

the consequences of failure in that role could be for you in your job and your life. That's very daunting, but they don't spend a huge amount of time preparing you for the emotional stress that it can put you under. I think that's, it's not something I haven't really thought about before, having, before speaking to you about it, but that is something that is lacking." DSL

However, DSLs were often concerned about the future funding model and emphasised that schools would struggle to prioritise it in their budgets:

"Yes, we are finding it helpful; whether or not we'll be able to find the money in the budget to sustain it once this programme's finished, I don't know, but I would recommend the process, I think it's really helpful." DSL

"I think it should get rolled out across the country and that yes, the government should fund it, certainly not schools." DSL

The question of funding came up repeatedly when LA managers were asked about wanting to continue supervision. Many expressed interest but were not able to fund it themselves. Before the Department for Education (DfE)'s temporary funding extension had been announced, some had considered charging schools for supervision to cover the SSW's salary. Positive feedback from SSWs and DSLs were the main motivators for continuing the offer. Only one LA had made plans to permanently offer the

post, not wanting to wait on a DfE decision on funding. One LA had lost their SSWs to other posts and, despite the extension in DfE funding, had decided that the process of recruiting new SSWs and restarting school buy-in was unfeasible. However, should the offer return as a permanent role, they would be interested in re-applying. Some LAs had found that the supervision programme was too similar to existing projects and had declined future funding. Another had decided to move towards peer supervision, taking the learnings from the one-to-one model and developing a new supervision model.

"There was some crossover I think in some of what we already offer, and there was the expression of interest that went out to look at whether we wanted to apply for a second year, and we declined that." LA

"What we've done is we took the learning that we have got from the pilot to look at how we can roll that out across all of our schools so that everyone gets the same offer. We took the key learning elements and brought it into our existing positions and forums, rather than having lots of overlapping positions really." LA

"I find that it has really benefited the schools, and therefore that's going to benefit child social care and the children in the schools. So, we really value it. Really value the programme; we think it's been a really good decision to go with that. And hence that's why we are keeping her on permanently even after the pilot is finished next year." LA

Cost evaluation

Data on the costs of delivery were obtained from WWCSC, based on the expenditure statements provided by LAs as part of the financial reporting process for the project. This comprised information on actual spend by LAs over the life of the project as well as the initially agreed budgets.

As noted earlier, the analysis of costs is conducted purely as a financial analysis, to understand costs of delivery of the intervention, rather than undertaking a value for money or cost–benefit analysis.

All the LAs were involved in more than one of the concurrent DSL trials, and total costs covered involvement in both trials. Information was available on the share of the originally agreed budget that was to be allocated to the primary trial, and this proportion was applied to the eventual actual spend to allocate an amount to the primary trial.

These LA costs typically related to the cost of employing the SSW(s). This would be an additional cost to the LA compared with business as usual, either requiring an individual to be hired into the role or to be reallocated from another role or duties. While the salary cost of the SSW is expected to be the main cost of delivering the programme, it is possible that LAs incurred other costs. In some LAs, the financial reporting templates included "other costs", but with no further detail on what these comprised – WWCSC advised that these other costs typically amounted to no more than a couple of hundred pounds per LA, at the most. It is possible that LAs also incurred other costs that were not covered under the project budget, although these were not raised during interviews with the LAs. These may, for example, include any costs involved in hiring into the SSW role and potential travel costs where supervision sessions were held in person rather than online. In producing our cost estimates our focus is solely on costs that were covered under the project budget (i.e. those funded by WWCSC) and included within the financial reporting, and thus any additional costs incurred by LAs will not be included.

The costs above relate to LA expenditure. It is important to note that there were other costs relating to delivery for which it was not possible to obtain a cost estimate. These are:

- The cost of developing and providing the manual for SSWs (led by WWCSC)

- The cost of providing the initial training and induction session organised by WWCSC.

In addition, there were costs involved in running the community of practice sessions. For the purposes of the trial these were run by WWCSC, and it is unclear whether these would form a part of any future potential rollout but, if so, they would also incur additional cost. Actual costs would vary depending on the format of such sessions, with in-person sessions potentially involving venue and catering costs, as well as travel expenses for attendees. Regardless of whether sessions take place virtually or in person, there is a cost in terms of time required to organise such events.

To calculate an average cost per school, total expenditure is summed across all ten LAs based on the totals from the financial reporting. This total is divided by the number of schools that were assigned to receive the intervention. On this basis, the cost per school per year (the period of the intervention) is estimated at just over £850 per school. Note that if we instead calculate cost per school per LA, and take a simple average across LAs, this would be equivalent to a cost of around £925 per school. For the reasons described above, these estimates are unlikely to fully cover all costs involved in delivery.

It should be noted that this cost varied by LA, from a minimum of just over £400 to a maximum of nearly £1500. The LAs with the lowest cost were those that started the intervention later due to delays in recruiting SSWs and so this figure of around £400 is highly unlikely to represent a true cost over a full school year.

In considering the costs of any future delivery of the programme, it is worth considering which costs are start-up costs and which are recurring costs. The main cost of the salary of the SSW is a recurring cost, as are any associated travel costs. However, any hiring and training costs will typically be start-up costs (which are not included in our analysis because information is not available on these). As these are likely to be much smaller in comparison to recurring costs of

an SSW salary, it is unlikely that there would be a substantial cost saving in delivering the programme in future years. It is, however, worth bearing in mind that in the early stages of the project, a considerable amount of effort and time was spent by SSWs in engaging schools, and this time should not need to be repeated in a future year as the programme becomes more established.

The above analysis was supplemented by specific cost-related questions during interviews with DSLs, SSWs and LAs. We did not identify any additional costs associated with the programme, and in fact DSLs reported that they appreciated the very limited preparation time required in between sessions and described the intervention as a good use of their time.

LIMITATIONS

In interpreting the findings from this evaluation it is important to bear in mind the limitations of the research.

The use of administrative data to measure outcomes has the benefit of reducing the extent of missing data, with complete data available for the primary outcome considered. However, it also means that the choice of measures is limited to those that are available in the data. A key aim of this intervention is to reduce inappropriate contacts to children's social care. Here we are proxying this by measuring contacts leading to no further action, which may be a proxy but is certainly far from a perfect measure. The fact that a contact does not lead to further action does not necessarily mean that the contact itself was inappropriate. Among those contacts classified as resulting in no further action, some form of assistance will often be given; this may be signposting to other sources of information and advice, or the initiation of an Early Help plan. It is possible that the incidence of contacts resulting in no further action could also be driven by other factors, such as increasing thresholds. A further limitation is that we do not have information on the nature of contacts made (so we cannot distinguish between contacts that a school is making with a view to a referral, as opposed to a contact that may simply be in relation to seeking advice, for example).

In addition, while there is variation across schools in the proportion of pupils for whom a contact resulted in no further action, in many participating schools this proportion was very low or indeed zero. In such schools there is less (or no) scope to reduce this number further, and therefore we may have concerns that floor effects reduce our chance of detecting an impact. It should also be noted that the effect size we observe on this measure is below the minimum that the trial was powered to detect (and thus the trial would be unable to show a statistically significant impact of the magnitude we find here).

Furthermore, there were practical challenges in collecting the contact and referral data from LAs. Different LAs use different terminology, data systems and processes, and in some cases there were particular challenges in assigning data to school level (where, for example, school names were recorded in free-text fields). Thus we may have some concerns around data quality and the consistency of data across LAs. For example, this may mean that not all contacts were assigned to schools (or to the correct schools), if the information on schools was not accurately recorded. It is possible this may have resulted in some under-reporting of contacts. In some cases, contacts were assigned to schools on the basis of the school attended, rather than the school making the contact; while this can often be the same, there may be instances where a school makes a contact about a child attending another school (for example, in the case of a sibling). Furthermore, it was not possible for all LAs to provide data on all requested outcomes, due to the differing nature of data systems; some of our secondary outcomes are therefore based on a smaller sample size and as such these findings may be less robust.

When using survey data to measure outcomes (DSL wellbeing), it is important to acknowledge that our results could be affected by non-response bias, especially if the likelihood of response is correlated with wellbeing, and especially given there is differential response between treatment and control groups. It was also not possible to tell with certainty whether it was the same individual within a school responding to both baseline and endline surveys.

In addition to these points relating to outcome measurement, a further limitation is the fact that around 30% of treatment schools did not receive supervision sessions and, among those that did, many had fewer sessions than had originally been intended. This may have limited the ability to detect an impact or fulfil its potential. This assumes that dosage matters; it is also plausible that the intervention does not affect the measured outcomes. Furthermore, some schools in the treatment group declined to participate because they already received DSL supervision (for example, through a private provider). In the case that some control schools were also receiving alternative forms of DSL supervision, this may also have reduced the chance of detecting an impact.

The main limitation of the IPE is the potential bias of the sample of DSLs that we interviewed and surveyed. For instance, the interview sample of 55 schools only represents 12% of the 446 schools in the treatment group, and it disproportionately includes schools that engaged with the programme. This means that, even though we made substantial efforts to recruit and interview DSLs who declined to take part in the programme or simply did not engage, we have few direct insights from the 30% of schools that did not receive any supervision sessions. However, we gathered a significant amount of data from supervisors and from participating DSLs that suggest potential reasons why these schools did not engage.

Overall, the sample did include a mix of schools, including by LA, size, proportion of FSM pupils and geographical context (see Appendix 2), so although the qualitative findings may not necessarily reflect the views of all in the treatment group, they provide an in-depth and diverse perspective on the experiences of those who received supervision. The findings of the IPE should be considered with these strengths and limitations in mind.

Finally in respect of both the impact evaluation and the IPE, the timing of the intervention should also be acknowledged, in that schools and social care services were still dealing with a period that had been significantly impacted by the COVID-19 pandemic. It is not possible to determine the extent to which the pandemic may have affected the findings of the evaluation but this context should still be borne in mind. It is also important to acknowledge that the trial took place within ten LAs, and thus caution should be taken in extrapolating the findings more widely.

DISCUSSION

This study set out to establish the impact of providing a designated social worker to supervise DSLs in primary schools. This section brings together and discusses the findings of the impact evaluation and the IPE.

Impacts on contacts and referrals made by schools to CSC

The primary research question assessed in the impact evaluation is whether the programme has an impact on the number of pupils for whom a contact is made by a school that does not result in further action by CSC (measured as a proportion of pupils). This outcome is used as a proxy for whether there is an impact on the appropriateness of contacts made by schools to CSC, although as already discussed earlier in this report, it is important to acknowledge that this is an imperfect measure.

There was no statistically significant difference in this outcome measure between schools that were allocated to receive the programme (treatment schools) and those that were not (control schools). The analysis points to a lower rate of contacts leading to no further action (NFA) among treatment schools, but not to a statistically significant extent. The magnitude of this effect is smaller than the trial was designed to detect, and so an effect of this size would not have been found statistically significant. The estimated effect, while statistically insignificant, would be equivalent to a difference between treatment and control groups of about 0.33 NFA contacts per school. In an LA with 120

primary schools, this would be equivalent to a difference of about 40 NFA contacts per LA.

Analysis of other outcomes relating to contacts and referrals also showed no statistically significant differences between schools allocated to receive the programme and those that were not. Thus we observe no impact on total contacts made by schools, new referrals originating from schools or referrals resulting in no further action (all measured as a proportion of pupils). At the same time, no impact was found on contacts made from all sources, which does not suggest that there were knock-on effects to contacts made by non-school sources as a result of the programme (which is perhaps unsurprising given the absence of impact on contacts made by schools).

The IPE also explored perceived impacts on outcomes relating to contact and referrals, through interviews and surveys with programme participants in schools and LAs. Overall, the IPE showed that the programme was well received by DSLs, who perceived there to be a positive impact on areas other than contacts and referrals. These included improvements to DSLs' emotional wellbeing and confidence (although note the impact evaluation found no statistically significant impact on wellbeing, discussed further below) and in bridging the gap between schools and social care. These outcomes were typically seen as very important by DSLs, and usually more important than practices around contacts and referrals because many already felt confident and experienced in this regard. As such, the perceived positive impacts in

these areas meant most DSLs regarded the intervention as a success. As examples of the positive experiences among DSLs, in the final survey, 91% of DSLs reported that supervision had a positive impact on them as a DSL; 93% found the supervision sessions very useful; 89% said it was a good use of their time; and 91% would recommend other schools/DSLs to sign up for potential future versions of the programme. At the same time, only 9% of DSLs in treatment schools stated that they felt their approach to safeguarding was "quite" or "very" different from the one they had before September 2021 (i.e. before the programme commenced). As discussed in the limitations section, it is important to bear in mind that these percentages are necessarily based only on DSLs who responded to the survey, and we are unable to tell whether they are a representative group of all DSLs who received (or could have received) the programme. It is possible, for example, that those responding to the survey may be those who felt more positively about the programme.

For contacts and referrals specifically, the IPE showed mixed results. On the one hand, at the end of the intervention, 54% of surveyed DSLs in treatment schools reported they now had a better understanding of thresholds requiring a referral to CSC and 52% said they now provided better information at point of contact and referral. There were many examples of this in interviews – for instance, DSLs reporting that they had gained awareness of support options that they could use before escalating a case to CSC and that they had learned strategies to improve the quality of contacts and referrals, such as the language used, what to include, making more references to the threshold document and collecting more evidence. These changes were facilitated by the discussions with the SSW, including learning about the process from the "social worker perspective".

However, on the other hand, in interviews, many DSLs also said they were already knowledgeable and experienced in understanding thresholds before supervision and felt they did not need additional support in this particular area. Many DSLs explained that the contacts coming from their school are rarely inappropriate and most of the time are accepted by CSC. Some DSLs also mentioned that they were able to get advice and guidance on thresholds through consultation phone lines. Therefore, many DSLs reported that instead of changing practices around contacts, supervision confirmed to them that their practices were correct and provided reassurance.

This is also reflected in the findings from the survey of DSLs in treatment schools before the programme, where the vast majority expressed confidence in performing their role as DSL, including specifically in relation to contacts and thresholds. For instance, before the intervention, 88% of DSLs expressed confidence in their understanding of thresholds for a referral to CSC and 88% in providing high-quality information at the point of contact and referral. At the end of the programme, these numbers stood at 93% and 91% respectively. The percentages were similar to the control group, both before and after the intervention.

Based on these observations in the IPE, it is perhaps not surprising that the impact evaluation did not find any impact on the primary and secondary outcomes measures. Most DSLs already had a high level of understanding and confidence in practices around contacts and referrals, and the interviews suggest the impact in relation to contacts and referrals may be most applicable for inexperienced DSLs. The types of change in practice that were observed also tended to be more subtle in nature, such as the information put forward

when making a contact, and while this may represent an improvement in practice, it may not necessarily determine whether a contact results in further action.

The IPE identified some further reasons for why the supervision may, or may not, have led to a reduction in inappropriate contacts.

First, some DSLs said they used their SSW on an ad hoc basis to "test the waters" before contacting CSC. The SSWs would provide advice about whether they thought it reached the threshold and whether they should contact CSC, or alternatively what other support agencies were available. This sometimes led to fewer contacts, and probably fewer inappropriate ones, but at other times it led to more contacts, probably appropriate ones, when SSWs recommended a contact that DSLs would not necessarily have considered themselves.

Second, before the programme, some DSLs said they sometimes contacted CSC even if they did not believe a case met social care thresholds. This practice was driven by frustrations about thresholds increasing over time, which led DSLs to log concerns about cases that may escalate in the future, including to protect themselves. The interviews showed that supervision sessions, in most cases, did not necessarily change those practices. There were some examples of DSLs feeling emboldened to become less reliant on social care services, helped by having the opportunity to discuss potential contacts with their SSW. However, this may not be sustained after the end of the programme when the SSW would no longer be a phone call away, and they may return to their former more cautious approach to contacts and referrals.

Finally, most DSLs simply did not see contacts and referrals as the main element

of the programme, but focused on perceived impacts such as wellbeing and confidence when they spoke about the effects of supervision. This is discussed below.

Impacts on DSL wellbeing and other outcomes

The impact evaluation also explored effects on DSL wellbeing. This considered two measures: job-related anxiety–contentment and job-related depression–enthusiasm; we found no statistically significant impact of the programme on either measure. As discussed elsewhere in this report, the fact that we observe data on wellbeing for a relatively small proportion of DSLs and, in particular, that we see a notable difference in response rates in treatment and control groups cast doubt on the reliability of these results.

Findings from the IPE indicate that before the intervention, almost half of DSLs surveyed (41% in treatment schools and 48% in control schools) felt the DSL role made them anxious or stressed. In interviews, although DSLs stated they found the role rewarding, it was also described as emotionally challenging, demanding, isolating and frustrating. The IPE suggests a clear need for additional wellbeing support for DSLs, whether provided by this programme or another mechanism.

The interviews conducted as part of the IPE found that many DSLs felt the intervention improved their emotional wellbeing and confidence. For instance, many DSLs explained the supervision had improved their confidence through encouraging them to reflect on their practice, and by discussing cases and concerns with their supervisor. This had empowered them when speaking to families and in decision-making on contacts and referrals. Many DSLs said their confidence had improved through supervision

providing reassurance and validation that their practice was appropriate and of a high standard. Supervision helped some DSLs to switch off from challenging cases rather than taking them home and they were less worried about certain children and families, either because they knew they had already discussed issues with the SSW or that they were able to contact their SSW whenever they needed, or they could discuss it in the next session. Supervision also gave DSLs the opportunity to "offload", which made the role feel less lonely, and to reflect on and protect their own wellbeing – for instance, by gaining the confidence to set boundaries around work and delegating tasks to the wider safeguarding team. The opportunity to receive support on wellbeing was particularly, but not exclusively, valued by head teachers, who often did not feel they had others in the school they could go to for emotional support.

The positive perceptions in the interviews in relation to wellbeing contrast with the results of the impact evaluation, which find no statistically significant effect. It may be that these softer impacts are more difficult to capture in quantitative measures collected through online surveys. It may also be that the limitations in administering and response to the survey reduced the ability to reliably assess whether there was a quantitative impact.

The survey evidence on impacts on confidence and wellbeing was largely mixed. On the one hand, there was a substantive impact on self-reported changes to confidence levels among DSLs at the end of the intervention, compared with at baseline. Eighty-two percent of DSLs in treatment schools said they felt more confident in their role now, compared with 39% in control schools. On the other hand, some of the wellbeing measures, including those used in the impact evaluation, did not provide evidence of any substantial changes compared with the control group.

The IPE also identified that the programme has considerable potential to "bridge the gap" between education and social care, which was not an outcome assessed in the impact evaluation, and which would be challenging to measure. Many DSLs explained that it was valuable to gain a "social worker's perspective" on cases and learn more about their decision-making processes. Similarly, SSWs said the programme had increased their understanding of the challenges and pressures that schools face. DSLs felt the programme, in the longer term, had the potential to facilitate joined-up working and mutual understanding, through having the SSW as a middle person who understood their day-to-day challenges. DSLs hoped this would be used proactively to improve joint working and trust between schools and CSC. SSWs and DSLs reflected that this had not yet been fully realised and the programme would probably need to be sustained for longer for this to come to fruition. However, the programme was seen as a first step in bridging the gap, including in facilitating internal conversations in the LA about how to improve their support to DSLs.

Improved delivery and implementation may have facilitated greater opportunities for the programme to achieve impact

There were some additional factors that may explain the lack of impact observed on the primary and secondary outcome measures explored in the impact evaluation.

The delivery of the programme faced some challenges, especially in the early stages when recruiting SSWs and schools. Overall, 30% of treatment schools never received a supervision session. The average number of sessions across all treatment schools was just under three sessions per school. For context, a session every six weeks (per half term) would have amounted to six sessions over the school year. The lower than anticipated take-up may have limited the ability to detect an impact,

or the ability for the intervention to fulfil its potential. However, it should be noted that additional analysis did not suggest statistically significant impacts for those schools that did receive higher numbers of sessions.

A key question is whether low take-up is a fundamental weakness of the intervention, which would also be seen in any potential future implementation. For instance, maybe some schools and DSLs are simply not interested in receiving supervision from a social worker, because they already feel they receive sufficient support or they do not have time. The IPE did find some evidence of this, but it also found that the low take-up was, at least partly, driven by suboptimal delivery, including a delayed start to the programme in some LAs and late recruitment of SSWs, which had knock-on effects on recruitment of schools. There also seemed to be substantial differences in how much LAs supported the SSWs in recruitment of schools, which was identified as an important facilitator to achieving school buy-in. Miscommunication was another barrier, with DSLs sometimes reporting initial concern about the concept of "supervision" and fearing they were going to be monitored or told off by CSC, suggesting that the programme could have been branded differently.

Once the first session was organised, and the SSW had the opportunity to introduce the purpose of supervision properly to individual DSLs, most schools maintained engagement throughout the rest of the intervention, and most often at a high level. For the schools that did engage in the programme, the IPE found that there was a high level of fidelity in implementation. In terms of the structure of supervision sessions and the support provided by SSWs, the interviews did not identify any fundamental changes that would need to be made to the programme model for it to be rolled out more widely. The IPE identified a number of potential improvements to delivery, such as making the support even more flexible and targeted to the needs of individual schools and DSLs, or allowing discussions about cases that were already open to CSC (this was originally implemented to avoid supervision conversations potentially duplicating or contradicting those of a case-holding social worker, and to avoid any potential issues with information-sharing (for example, if a DSL disclosed information to the SSW rather than the case-holding social worker)). However, these changes would not be essential to implement a programme that would still be very well received by DSLs in schools.

Much of the above implicitly assumes that increasing take-up would increase effectiveness. However, the findings of the current evaluation suggest that the current design of the programme may not substantially impact the appropriateness of contacts and referrals to CSC, even if take-up was higher, but rather the key focus would be on improving confidence and wellbeing of DSLs, and joint working between education and social care.

IMPLICATIONS

Based on the evaluation findings, this final chapter outlines some implications and recommendations for policy, practice and research in this area.

Implications for policy and practice

Schools have a critical role in the safeguarding of children and young people, with DSLs playing a vital part in this. Exploring ways in which DSLs and schools can be better supported is therefore an important area for policy consideration.

In taking any decisions about the value of the DSL supervision programme going forward, it is important to reflect on what would be the key motivations for doing so and what the programme is ultimately seeking to achieve.

The findings of the impact evaluation do not indicate that the programme had an impact on the measured outcomes relating to contacts or referrals. Although the findings are subject to a number of limitations, as already discussed, if the programme were to be rolled out in its current form, without any changes, it would not be anticipated that measurable impacts on these outcomes would be observed. This does not necessarily mean that there are no changes or benefits occurring as a result of the programme – indeed, the IPE findings do point to some changes in practices in relation to contacts and referrals – but rather that these do not impact on the outcomes that were measured here. Furthermore, if outcomes are to be considered specifically in terms of contacts

resulting in no further action, it is also worth remembering that there may be limited scope to reduce this number further in many schools, at least based on the data provided for this evaluation.

The impact evaluation also does not find evidence that the programme had an impact on DSL wellbeing; however, for the reasons discussed earlier in this report, greater caution should be applied in interpreting these results. The findings of the IPE highlight that the programme may have most potential to influence wellbeing of DSLs and also DSL confidence (with the latter not measured as part of the impact evaluation). The evaluation also finds qualitative evidence in support of the mechanisms through which improvements in outcomes for DSLs may occur. This may give some cautious grounds for optimism, but would need to be more rigorously tested before making more definitive claims. The evaluation findings do, however, highlight a need for additional support among at least a subset of DSLs. In addition, the programme may have a role to play in helping to strengthen relationships between education and CSC.

A number of more practical implications can also be drawn from the evaluation findings, some of which are also relevant for other research in this area.

The findings emphasise the importance of considering how to boost participation and initial engagement in similar interventions. Particular thought needs to be given to how best to introduce programmes to

schools, with the evaluation highlighting the importance of broader LA support in this process. Once initial engagement from schools is secured, scheduling is perhaps a key barrier to schools' participation. This may require further thought as to how this time can be resourced.

To better understand impacts on CSC outcomes (whether for a similar programme or for other evaluations in this field), there may be value in greater consistency across LAs in the systems and processes that are used for recording contacts made. Better school-level data, perhaps through more systematic systems for linkage between different data systems, would allow greater understanding of impacts for schools and perhaps help to better target support to where it may be most needed.

Recommendations for future research

In this final section we outline potential avenues and considerations for future research.

In furthering understanding of any impacts on the appropriateness and quality of contacts made by schools to CSC, a key challenge is in finding a measure that is both suitable conceptually and practical to collect. A bespoke data collection exercise may allow for more accurate capturing of types of contacts made by schools, for example, but is also more likely to result in missing data (especially among a control group), as well as being more resource-intensive. One area that may also be valuable to explore would be the extent to which the programme changes schools' practices in relation to early help measures (or other forms of earlier or preventative action). Again, a key challenge here is in the ability to obtain accurate data on these types of activities, especially given differences in processes and systems across LAs.

If further research were to explore contacts resulting in no further action, while the current evaluation finds no impact on contacts resulting in no further action overall, future work could explore whether there may be impacts for different groups. This could include, for example, further exploration of whether there is an impact for DSLs who are newer to the role.

One of the original aims of the programme focuses on reducing DSL burnout and turnover (via the impact on wellbeing). Future research to map both the extent of this and whether there are impacts on turnover would be valuable. This could potentially be achieved by linkage to administrative data (for example, the School Workforce Census), which may help to give insights into turnover among DSLs (and in comparison with other school staff). Such research would necessarily need a longer timeframe over which to assess any impact. Given the limitations of the current analysis exploring the impact on wellbeing, and the fact that the IPE highlighted the strongest perceived impacts in relation to wellbeing and confidence, this may be an area for further research. This may include, for example, considering ways to boost survey response or use of alternative wellbeing measures.

The other potential outcome highlighted by the current evaluation is helping to bridge the gap between schools and CSC. Increasing understanding of the programme's effectiveness in this regard would be valuable, but is inevitably difficult to measure in a quantitative sense.

Importantly, it should also be remembered that a further outcome identified in the logic model is to improve outcomes for children and families themselves. This topic is touched

on within the current research (for example, in DSLs' role in communicating with and supporting families) but could be examined in more depth in future work.

Finally, the current study also offers some more general lessons for future evaluations on related topics, including:

- The need to ensure sufficient lead-in time for trials, to ensure the best possible start, including factoring in time to recruit and get schools on board

- The need for clarity regarding the length of an intervention from the start, as otherwise implementation can also be affected by funding uncertainty

- Establishing an advisory group to provide additional perspectives of different stakeholders – for example, in relation to the merits of potential outcome measures

- Allowing sufficient resources for data collection. This includes allowing adequate preparation time – for example, to conduct initial feasibility studies of available data, and to enable data collection activities, such as surveys, to be conducted in the most effective way.

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APPENDICES

Appendix 1. Survey responses

In this appendix we summarise response to the baseline and endline surveys.

Surveys were distributed to schools by the participating LAs. They were sent to all schools within the sample at both time points, regardless of whether the school responded at baseline.

At baseline, a total of 456 responses were achieved (after dropping a small number of duplicate or erroneous entries, accounting for 9 responses in total). These 456 responses were split fairly evenly between treatment and control groups, with 221 responses from the treatment group and 235 from the control group (top panel of Table A1.1).

It was possible for multiple individuals in a school to respond. The total of 465 responses came from a total of 311 schools (and thus on average there were around 1.5 responses per school). We do not know the total possible number of individuals who would have been eligible to respond (as we do not know the number of DSLs and deputy DSLs in each school). We calculate response rates on the basis of the number of schools where there was at least one response to the survey. On this basis, the overall response rate to the baseline survey stood at 26%. The response rate was higher among the treatment group, with 33% of treatment schools responding, compared with 21% of control schools.

At endline, a total of 258 responses were achieved (after removing three duplicate/erroneous entries). These 258 responses came from 240 schools. The school-level response rate among treatment schools remained similar to that observed at baseline, standing at 35% at endline. However, response among the control group fell compared with baseline, standing at 11% at endline.

Furthermore, it is not necessarily the same schools that respond to each survey. Of the 240 schools responding to the endline survey, 125 had also responded at baseline.

Table A1.2 presents response by LA; Table A1.3 shows the role of the respondent.

Table A1.1. Survey response at baseline and endline, by trial arm

	Baseline	Endline
N responses (individuals)		
Total	456	258
Treatment	221	160
Control	235	98
N responses (schools)		
Total	311	240
Treatment	149	156
Control	162	84
Response rate (schools)		
Total	25.8	19.9
Treatment	33.4	35.0
Control	21.3	11.1

Table A1.2. Number of responses in baseline and endline surveys, by LA

Local authority	Control: Baseline	Control: Endline	Treatment: Baseline	Treatment: Endline
LA 1	33 (14%)	12 (12%)	32 (14%)	12 (8%)
LA 2	0 (0%)	0 (0%)	1 (0%)	11 (7%)
LA 3	129 (55%)	41 (42%)	25 (11%)	38 (24%)
LA 4	2 (1%)	4 (4%)	15 (7%)	6 (4%)
LA 5	8 (3%)	11 (11%)	50 (23%)	25 (16%)
LA 6	11 (5%)	2 (2%)	10 (5%)	2 (1%)
LA 7	29 (12%)	7 (7%)	38 (17%)	22 (14%)
LA 8	0 (0%)	8 (8%)	0 (0%)	15 (9%)
LA 9	7 (3%)	6 (6%)	27 (12%)	16 (10%)
LA 10	16 (7%)	7 (7%)	23 (10%)	13 (8%)
Total	**235**	**98**	**221**	**160**

Table A1.3. Number of responses in baseline and endline surveys

Role	Control: Baseline	Control: Endline	Treatment: Baseline	Treatment: Endline
DSL	146 (62%)	68 (69%)	139 (63%)	120 (75%)
Deputy DSL	89 (38%)	30 (31%)	82 (37%)	38 (24%)
Other (receiving supervision)	0 (0%)	0 (0%)	0 (0%)	2 (1%)
Total	235	98	221	160

Appendix 2. Qualitative interview responses

Table A2.1. Number of qualitative interviews by individual DSLs and by schools

	Individual DSLs	Number of treatment schools
LA 1	4	3
LA 2	2	2
LA 3	20	18
LA 4	2	2
LA 5	3	3
LA 6	3	3
LA 7	1	1
LA 8	8	7
LA 9	13	11
LA 10	5	5
Total	**61**	**55**

There were six schools where more than one staff member was interviewed. In total, we conducted 61 interviews in 55 schools.

Table A2.2. Type of establishment

	Number of treatment schools	Percentage (%)	Total treatment schools
Academy convertor	12	11%	105
Academy sponsor-led	5	11%	45
Community school	23	14%	159
Foundation school	3	11%	28
Free school	1	25%	4
Voluntary aided school	9	12%	75
Voluntary controlled school	2	7%	30
Total	**55**	**12%**	**446**

Table A2.3. Percentage of free school meals

	Number of treatment schools	Percentage (%)	Total treatment schools
0–9%	14	5%	265
10–19%	11	16%	67
20–29%	8	22%	37
30–39%	13	52%	25
40–49%	5	31%	16
50–59%	2	11%	19
60–69%	2	25%	8
70–79%	0	0%	6
80–89%	0	0%	1
90–99%	0	0%	2
Total	**55**	**12%**	**446**

Table A2.4. Geographic context (rural to urban)

	Number of treatment schools	Percentage (%)	Total treatment schools
Rural: hamlet and isolated dwellings	2	12%	17
Rural: village	3	10%	29
Rural: village in a sparse setting	1	8%	12
Rural town and fringe	3	7%	43
Rural: town and fringe in a sparse setting	0	0%	4
Urban: city and town setting	19	12%	162
Urban: city and town in a sparse setting	0	0%	1
Urban: major conurbation	27	15%	178
Total	**55**	**12%**	**446**

Table A2.5. Number of pupils

	Number of treatment schools	Percentage (%)	Total treatment schools
0–49	0	0%	7
50–99	0	0%	35
100–149	3	9%	34
150–199	2	3%	59
200–249	13	13%	97
250–299	7	18%	39
300–349	5	14%	37
350–399	8	30%	27
400–449	9	20%	44
450–499	5	19%	26
500+	3	9%	32
Total	**55**	**12%**	**446**

Appendix 3. School characteristics, by trial arm

Table A3.1. Baseline characteristics of groups as randomised and analysed: categorical variables

School-level (categorical)	National-level mean	Intervention group n/N (missing)	Count (%)	Control group n/N (missing)	Count (%)
Ofsted overall effectiveness[1]:					
Outstanding	16%	67/444 (2)	67 (15%)	108/757 (2)	108 (14%)
Good	75%	340/444 (2)	340 (77%)	586/757 (2)	586 (77%)
Requires improvement	8%	30/444 (2)	30 (7%)	49/757 (2)	49 (6%)
Special measures	0%	3/444 (2)	3 (1%)	10/757 (2)	10 (1%)
Serious weaknesses	0%	4/444 (2)	4 (1%)	4/757 (2)	4 (1%)
School type:					
Academy converter	28%	105/446 (0)	105 (24%)	183/759 (0)	183 (24%)
Academy sponsor-led	10%	45/446 (0)	45 (10%)	86/759 (0)	86 (11%)
Community school	34%	159/446 (0)	159 (36%)	262/759 (0)	26 (35%)
Foundation school	3%	28/446 (0)	28 (6%)	45/759 (0)	45 (6%)
Free schools	1%	4/446 (0)	4 (1%)	4/759 (0)	4 (1%)
Voluntary aided school	15%	75/446 (0)	75 (17%)	112/759 (0)	112 (15%)
Voluntary controlled school	10%	30/446 (0)	30 (7%)	67/759 (0)	67 (9%)
Urban/rural location[2]:					
Rural town and fringe	28%	105/446 (0)	105 (24%)	252/759 (0)	252 (33%)
Urban city and town	39%	163/446 (0)	163 (37%)	329/759 (0)	329 (43%)
Urban major conurbation	33%	178/446 (0)	178 (40%)	178/759 (0)	178 (23%)

Notes and sources:
1. Ofsted inspection ratings as at 31 August 2021; based on most recent inspection.
2. Based on 2022 School Census (January 2022). National averages are those for state-funded primary schools in England.

Table A3.2. Baseline characteristics of groups as randomised and analysed: continuous variables

School-level (continuous)	National-level mean	Intervention group n/N (missing)	Mean (SD)	Control group n/N (missing)	Mean (SD)
Pupil composition:[1]					
% of pupils ever eligible for FSM in past 6 years	22.4	446/446 (0)	25.0 (15.9)	759/759 (0)	22.5 (15.5)
Number of pupils on roll	273.5	446/446 (0)	278.9 (146.1)	759/759 (0)	263.2 (152.2)
% pupils where English is not first language	16.3	446/446 (0)	14.3 (18.8)	759/759 (0)	10.7 (15.3)
% eligible pupils with SEN support	12.8	446/446 (0)	12.9 (6.6)	759/759 (0)	12.8 (6.4)
KS2 performance 2019: % reaching expected standard	63.4	391/408 (17)	67.7 (14.3)	672/697 (25)	66.5 (15.6)
KS2 performance 2019: % reaching higher standard	10.1	391/408 (17)	10.5 (7.5)	672/697 (25)	10.5 (8.3)
Prior social care outcomes (2020/21):[2]					
Number of contacts made by schools leading to no further action (NFA)	-	446/446 (0)	2.7 (4.5)	759/759 (0)	2.3 (4.3)
Contacts leading to NFA (as proportion of pupils in school)	-	446/446 (0)	0.011 (0.020)	759/759 (0)	0.008 (0.014)
Contacts (as proportion of pupils in school)	-	446/446 (0)	0.023 (0.031)	759/759 (0)	0.020 (0.027)
Referrals (as proportion of pupils in school)	-	446/446 (0)	0.008 (0.013)	759/759 (0)	0.008 (0.015)
Referrals leading to NFA (as proportion of pupils in school)	-	379/446 (67)	0.002 (0.006)	693/759 (66)	0.002 (0.006)
Contacts from all sources (as proportion of pupils in school)	-	220/446 (226)	0.159 (0.135)	327/759 (432)	0.140 (0.127)
Wellbeing measures (baseline):		**Intervention group** n	**Mean** (95% CI)	**Control group** n	**Mean** (95% CI)
Anxiety–contentment scale	-	221	1.20 (0.88, 1.52)	235	0.63 (0.20, 0.95)
Depression–enthusiasm scale		221	4.00 (3.71, 4.29)	235	3.17 (2.83, 3.52)

Notes and sources: 1. As reported in DfE school performance tables, 2019. National averages are those for state-funded primary schools in England. 2. Based on data provided by participating LAs.

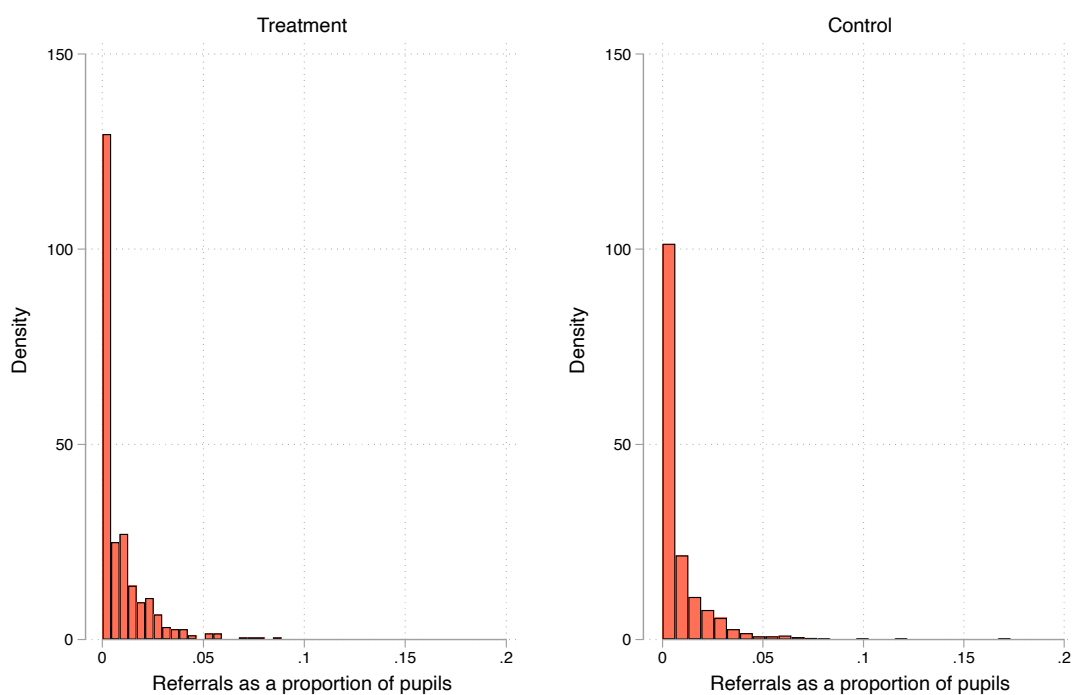**Figure A4.3. Referrals, as a proportion of pupils, by trial arm, 2020/21**

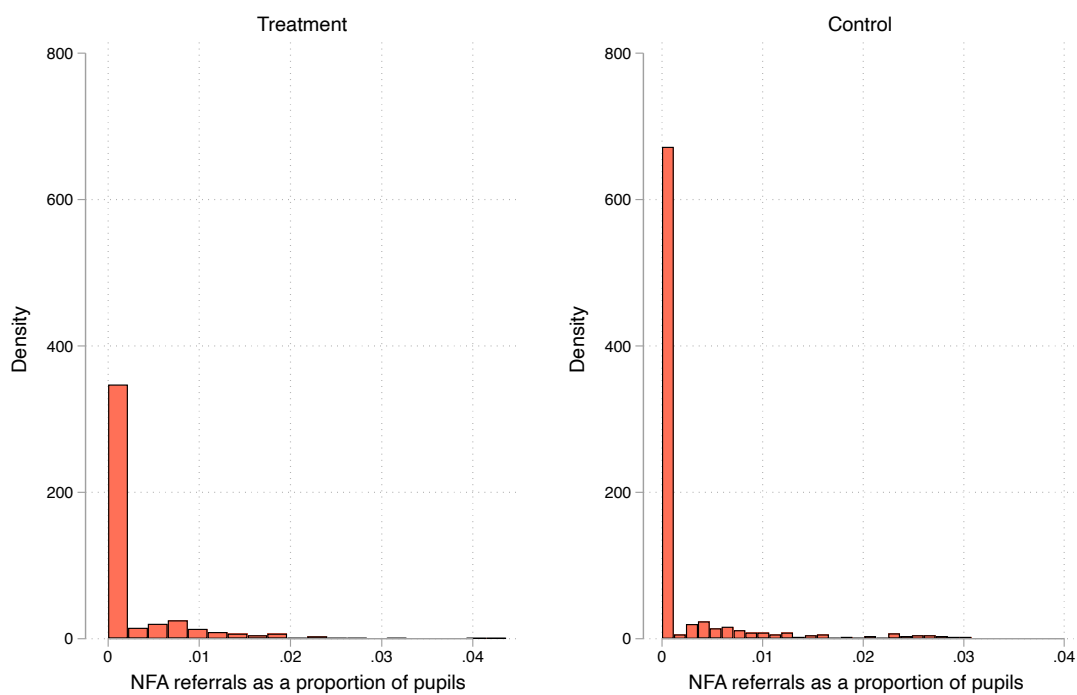**Figure A4.4. Referrals resulting in NFA, as a proportion of pupils, by trial arm, 2020/21**

Figure A4.5. Contacts from all sources, as a proportion of pupils, by trial arm, 2020/21
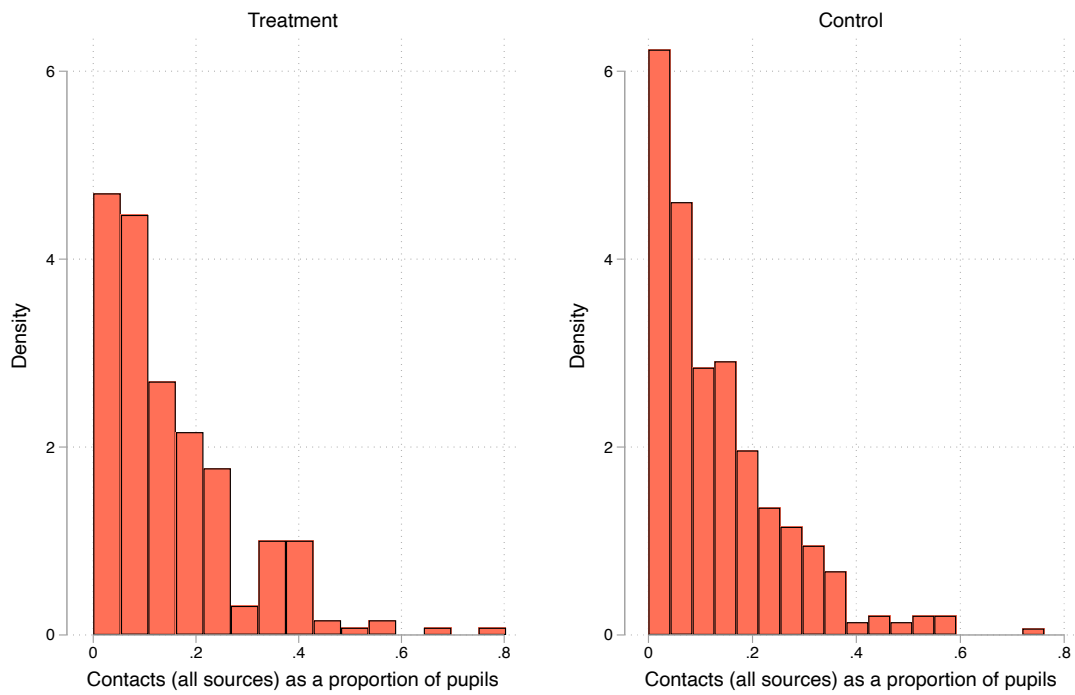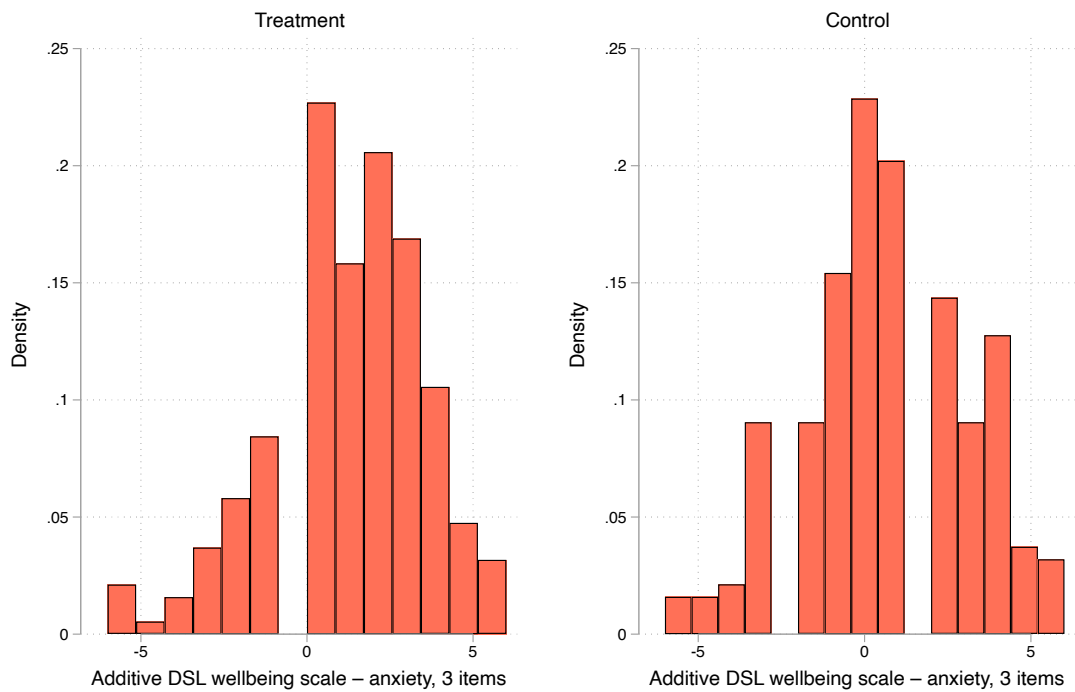
Figure A4.6. Anxiety–contentment scale at baseline

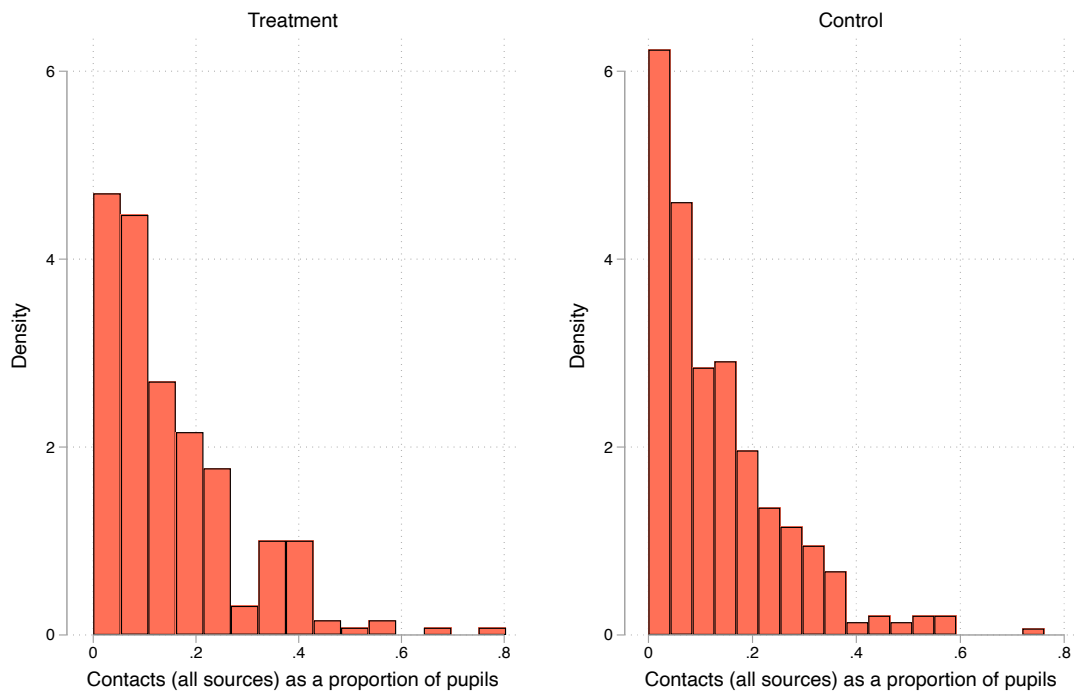**Figure A4.6. Anxiety–contentment scale at baseline**
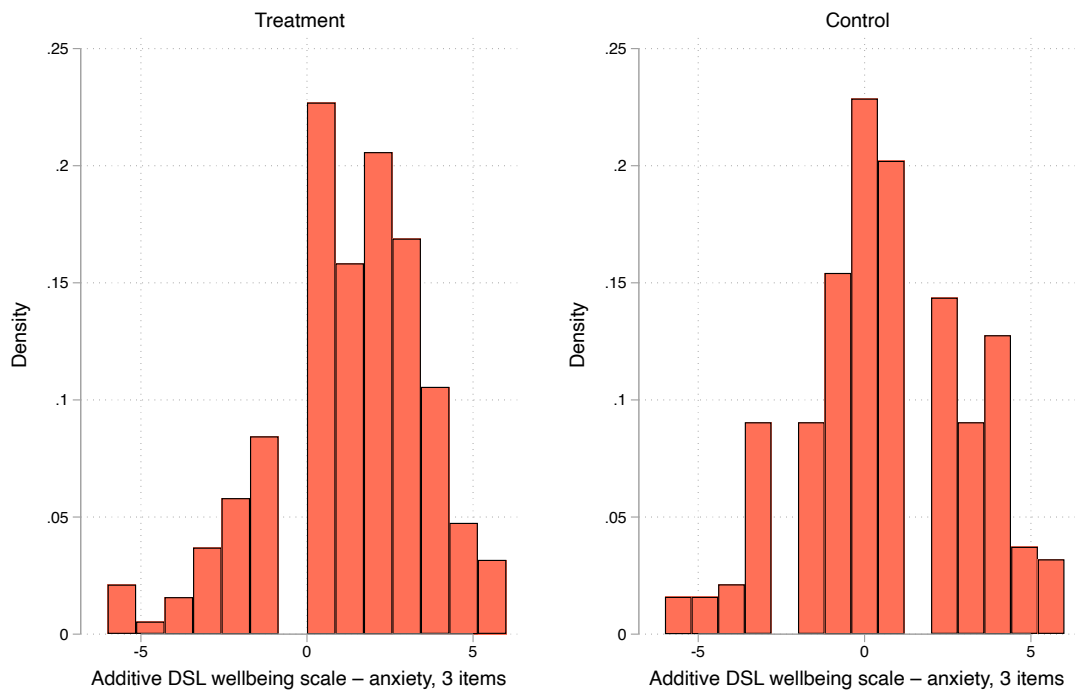
Figure A4.7. Depression–enthusiasm scale at baseline

Treatment

Control
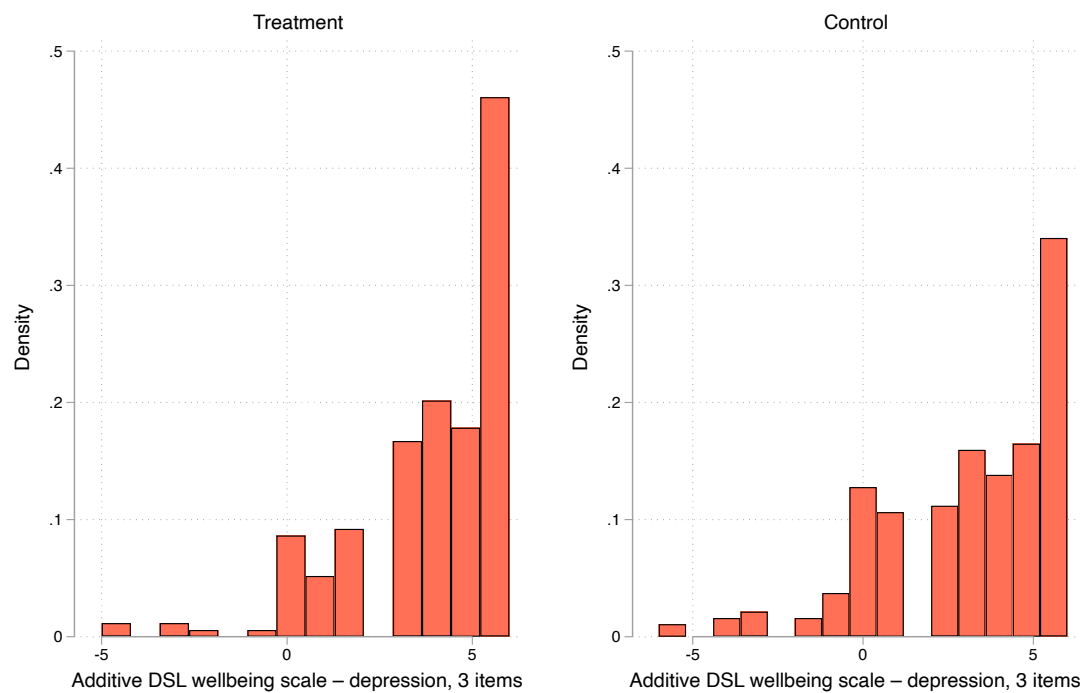
Appendix 5. Secondary outcomes, distributions by trial arm

Figure A5.1. Contacts made by schools, as a proportion of pupils, by trial arm, 2021/22

Figure A5.2. Referrals, as a proportion of pupils, by trial arm, 2021/22

Figure A5.3. Referrals resulting in NFA, as a proportion of pupils, by trial arm, 2021/22
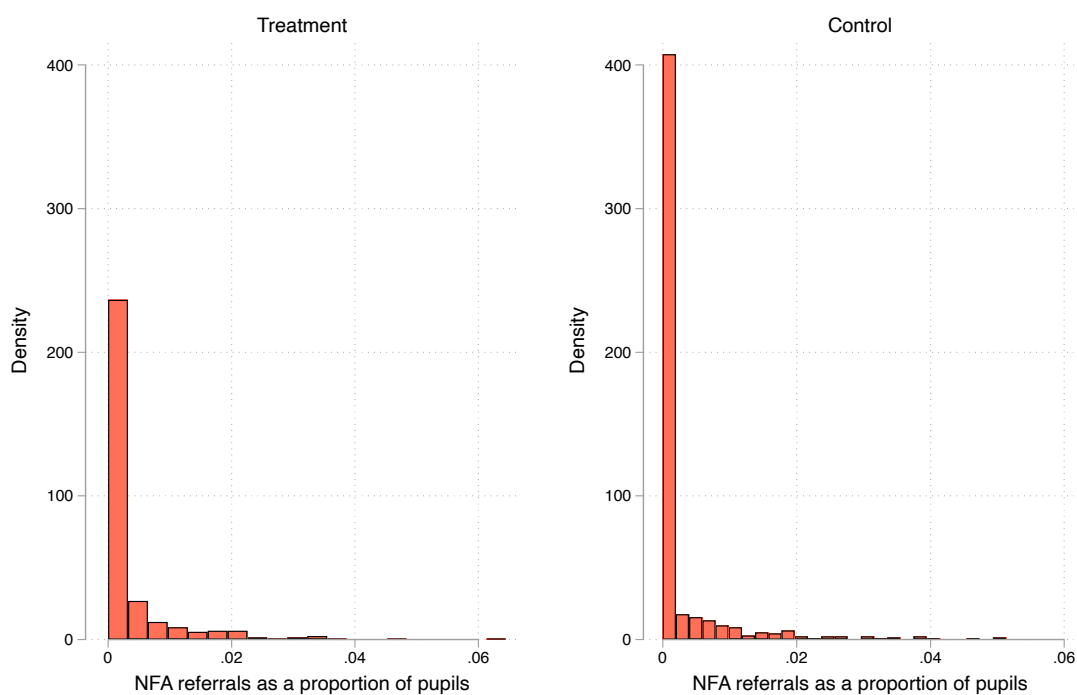
Figure A5.4. Contacts from all sources, as a proportion of pupils, by trial arm, 2021/22
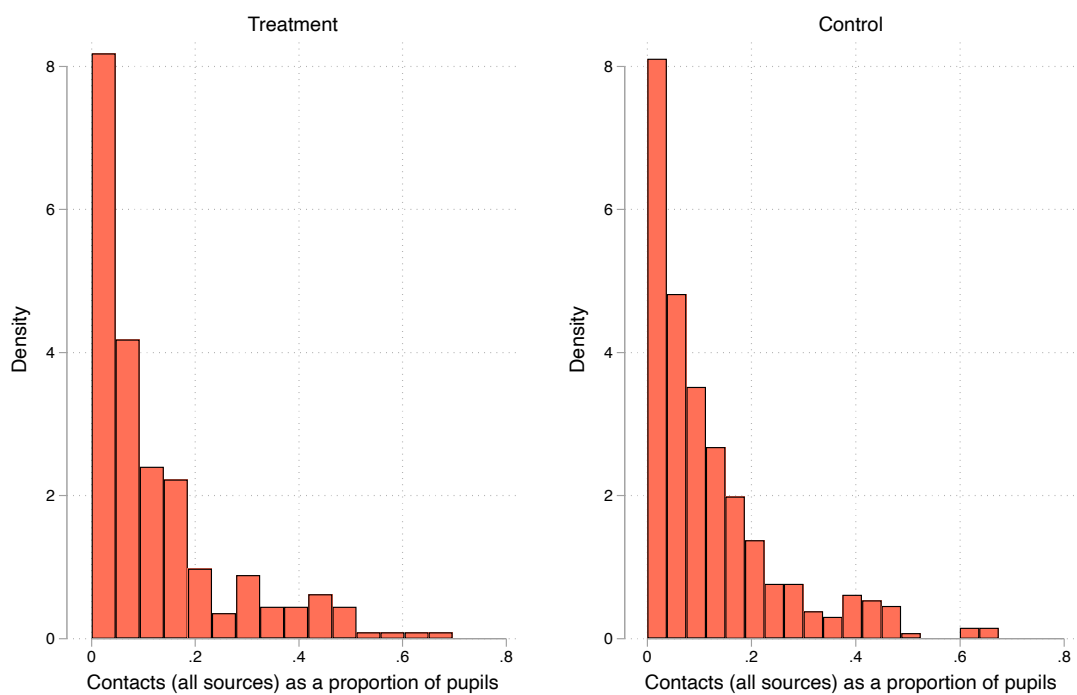
Figure A5.5. Anxiety-contentment scale at endline
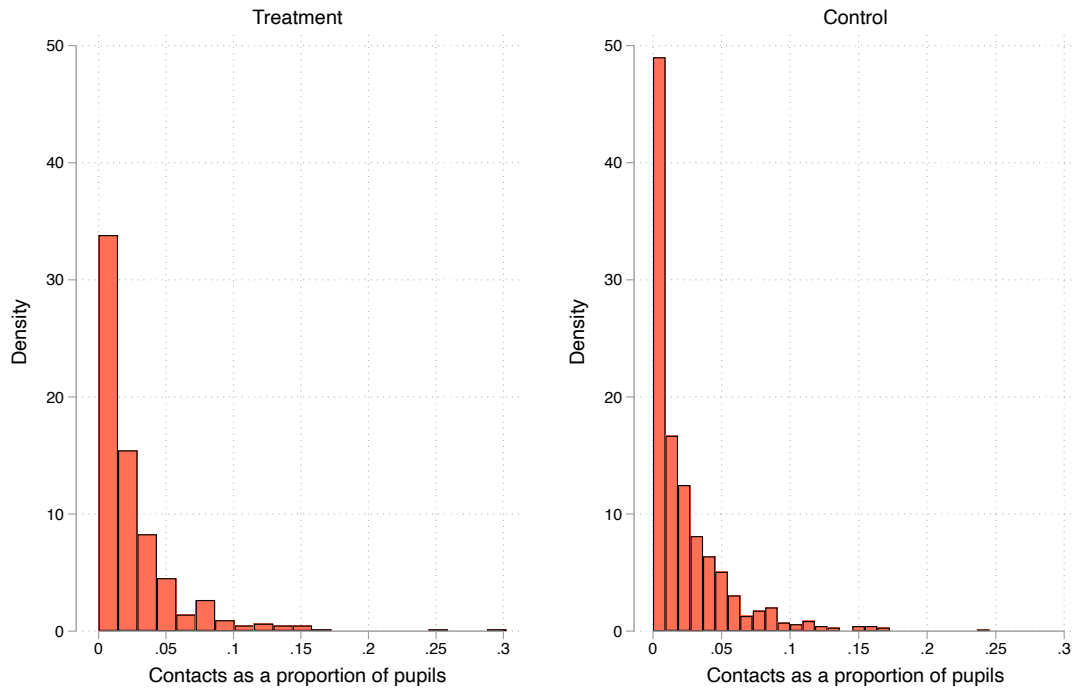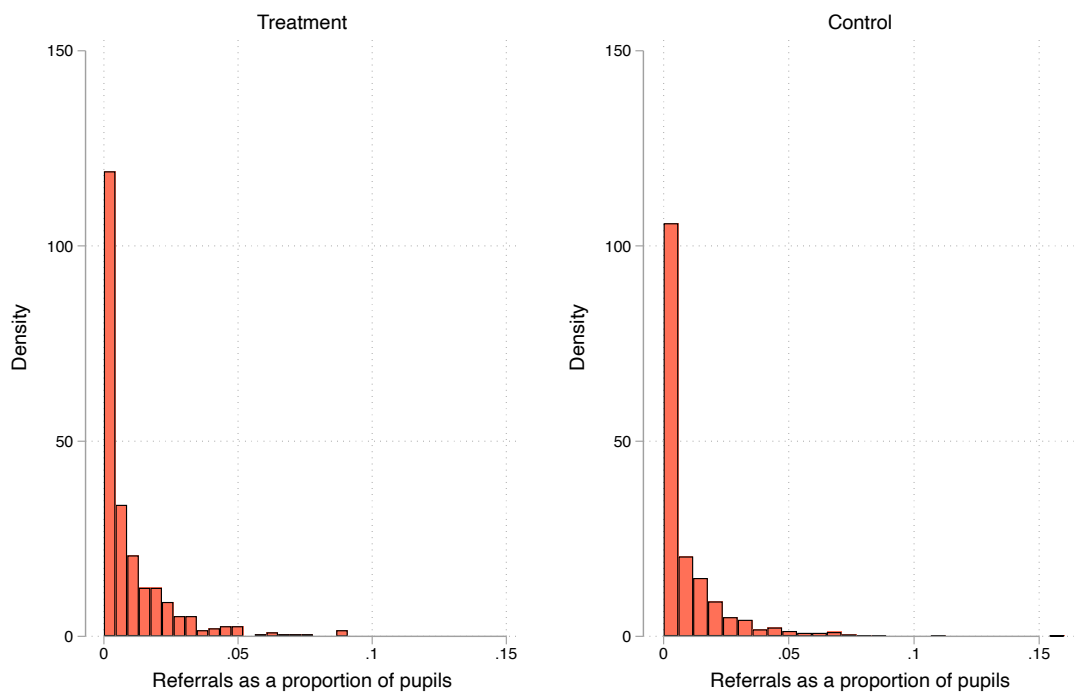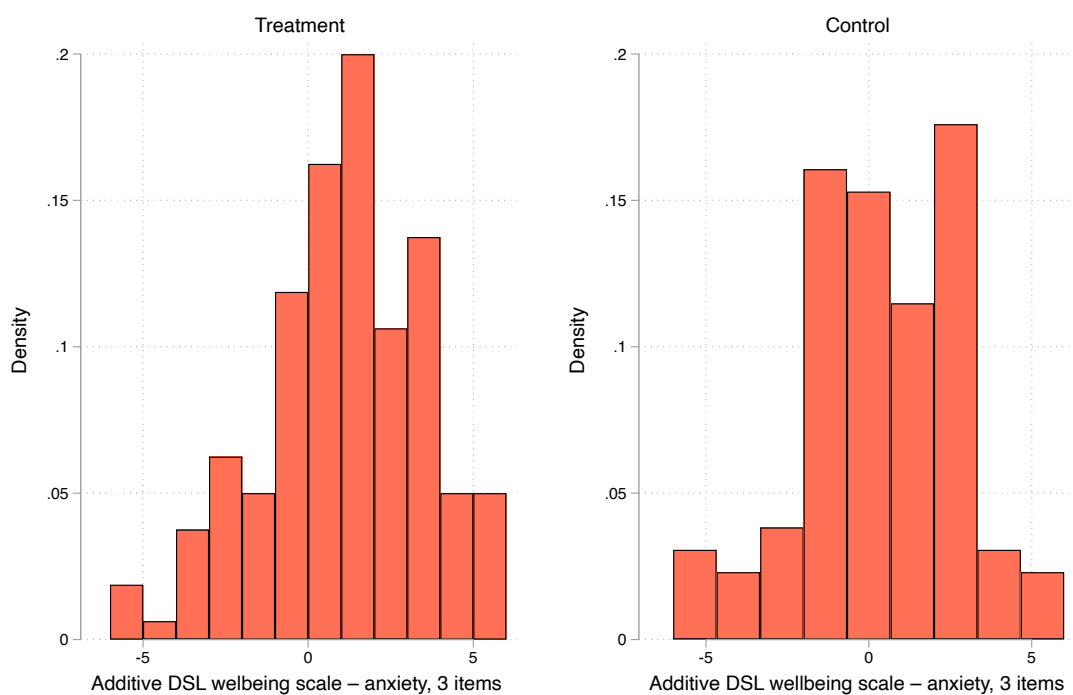

Figure A5.6. Depression-enthusiasm scale at endline
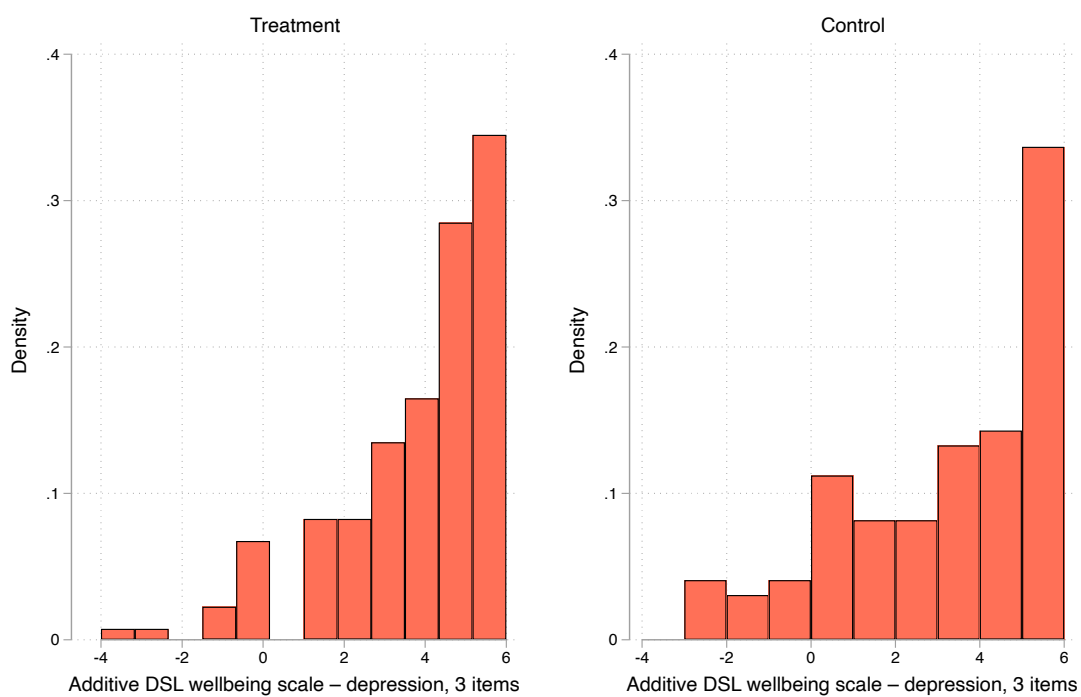
Appendix 6. Regression results

Table A6.1. Regression results, primary analysis, OLS: contacts leading to NFA

Variables	Regression coefficient (robust standard error)
Treated	-0.00104
	(0.000803)
NFA contacts, 2020/21	0.409***
	(0.0666)
block = 2	0.0104**
	(0.00466)
block = 3	-0.00741***
	(0.00165)
block = 4	-0.00771***
	(0.00172)
block = 5	-0.00287
	(0.00183)
block = 6	7.84e-05
	(0.00186)
block = 7	-0.00787***
	(0.00165)
block = 8	-0.00764***
	(0.00168)
block = 9	-0.00668***
	(0.00169)
block = 10	-0.00699***
	(0.00169)
block = 11	-0.00904***
	(0.00198)
block = 12	-0.00593*
	(0.00310)

block = 13	-0.00198
	(0.00183)
block = 14	0.00486
	(0.00365)
block = 15	-0.00779***
	(0.00165)
block = 16	-0.00582***
	(0.00192)
block = 17	0.000146
	(0.00261)
block = 18	0.0179***
	(0.00462)
block = 19	-0.00136
	(0.00245)
block = 20	0.000505
	(0.00334)
Constant	0.00843***
	(0.00167)
Observations	1,205
R-squared	0.332

Robust standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Table A6.2. Regression results, primary analysis, Poisson: contacts leading to NFA

Variables	Regression coefficient (robust standard error)
Treated	-0.129
	(0.0914)
NFA contacts, 2020/21	13.21***
	(3.145)
block = 2	0.591***
	(0.204)
block = 3	-1.511***
	(0.272)
block = 4	-1.068***
	(0.237)
block = 5	-0.498***
	(0.187)
block = 6	-0.0611
	(0.152)
block = 7	-15.88***
	(0.287)
block = 8	-3.578***
	(0.979)
block = 9	-2.020***
	(0.313)
block = 10	-1.888***
	(0.320)
block = 11	-0.757***
	(0.209)
block = 12	-0.107
	(0.207)
block = 13	-0.323*

	(0.175)
block = 14	0.385**
	(0.196)
block = 15	-4.050***
	(0.710)
block = 16	-1.475***
	(0.418)
block = 17	-0.0677
	(0.226)
block = 18	0.659***
	(0.199)
block = 19	-0.275
	(0.242)
block = 20	0.0819
	(0.237)
Constant	-4.468***
	(0.130)
Observations	1,205

Robust standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Table A6.3. Regression results, secondary analysis, Poisson: contacts (schools)

Variables	Regression coefficient (robust standard error)
Treated	-0.0213
	(0.0640)
Contacts as a proportion of pupils, 2020/21	11.29***
	(1.209)
block = 2	0.360**
	(0.170)
block = 3	-0.460***
	(0.161)
block = 4	0.330***
	(0.119)
block = 5	-0.545***
	(0.140)
block = 6	-0.0202
	(0.109)
block = 7	-2.566***
	(0.364)
block = 8	-0.0880
	(0.298)
block = 9	-0.719***
	(0.154)
block = 10	-0.0836
	(0.147)
block = 11	-0.354***
	(0.124)
block = 12	0.0897
	(0.151)
block = 13	-0.135
	(0.153)

block = 14	0.394***
	(0.141)
block = 15	-0.640***
	(0.237)
block = 16	0.702***
	(0.143)
block = 17	-0.0563
	(0.172)
block = 18	0.544***
	(0.176)
block = 19	-0.413**
	(0.200)
block = 20	0.00577
	(0.187)
Constant	-4.054***
	(0.0958)
Observations	1,205

Robust standard errors in parentheses. *** $p<0.01$, ** $p<0.05$, * $p<0.1$

Table A6.4. Regression results, secondary analysis, Poisson: referrals

Variables	Regression coefficient (robust standard error)
Treated	-0.0554
	(0.0820)
Referrals as a proportion of pupils, 2020/21	12.79***
	(1.751)
block = 2	0.912***
	(0.335)
block = 3	0.651*
	(0.352)
block = 4	1.553***
	(0.330)
block = 5	-0.243
	(0.351)
block = 6	0.769**
	(0.330)
block = 7	-1.293*
	(0.731)
block = 8	1.425***
	(0.394)
block = 9	0.814**
	(0.350)
block = 10	1.595***
	(0.335)
block = 11	1.632***
	(0.338)
block = 12	2.177***
	(0.364)
block = 13	1.192***

	(0.343)
block = 14	1.977***
	(0.329)
block = 15	0.801**
	(0.364)
block = 16	2.274***
	(0.340)
block = 17	1.088***
	(0.355)
block = 18	2.056***
	(0.341)
block = 19	0.484
	(0.424)
block = 20	1.308***
	(0.348)
Constant	-6.015***
	(0.310)
Observations	1,205

Robust standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Table A6.5. Regression results, secondary analysis, Poisson: referrals leading to NFA

Variables	Regression coefficient (robust standard error)
Treated	0.0660
	(0.142)
NFA referrals as a proportion of pupils, 2020/21	29.77***
	(8.188)
block = 2	1.192**
	(0.588)
block = 3	1.566***
	(0.565)
block = 4	2.421***
	(0.542)
block = 5	-2.611**
	(1.124)
block = 6	-0.537
	(0.673)
block = 7	-13.08***
	(0.577)
block = 8	-13.08***
	(0.577)
block = 9	2.035***
	(0.555)
block = 10	2.821***
	(0.539)
block = 11	1.833***
	(0.601)
block = 12	2.537***
	(0.561)
block = 13	-13.08***

	(0.542)
block = 14	-13.08***
	(0.542)
block = 15	1.586***
	(0.586)
block = 16	2.963***
	(0.552)
block = 19	1.624***
	(0.618)
block = 20	2.055***
	(0.560)
Constant	-7.607***
	(0.523)
Observations	1,124

Robust standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Table A6.6. Regression results, secondary analysis, Poisson: contacts (all)

Variables	Regression coefficient (robust standard error)
Treated	-0.0233
	(0.0511)
Contacts (all sources) as a proportion of pupils, 2020/21	2.828***
	(0.285)
block = 2	0.191
	(0.116)
block = 3	-0.428***
	(0.0935)
block = 4	0.0844
	(0.0787)
block = 7	0.191**
	(0.0940)
block = 8	0.622***
	(0.120)
block = 9	-0.828***
	(0.108)
block = 10	-0.341***
	(0.0990)
block = 11	-1.541***
	(0.138)
block = 12	-0.815***
	(0.140)
block = 13	0.178*
	(0.0948)
block = 14	0.593***
	(0.0864)
block = 15	-2.922***

	(0.176)
block = 16	-2.420***
	(0.163)
Constant	-2.521***
	(0.0768)
Observations	591

Robust standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.1

Table A6.7a. Contacts leading to NFA, first-stage regression results (dependent variable=any sessions)

	Regression coefficient (robust standard error in parentheses)	P-value
Treatment	0.680** (0.021)	0.000
NFA contacts, 2020/21	-0.074 (0.672)	0.912
N	1205	

Note: the model also includes dummies for randomisation strata but these are not shown here for ease of reporting. Statistical significance is indicated as *significant at 0.05, **significant at 0.01. Results of F-test: F (21, 1183)=89.10. Prob>F=0.000.

Table A6.7b. Contacts leading to NFA, compliance analysis, IV (2SLS) results

	Regression coefficient (robust standard error in parentheses)	P-value
Any sessions	-0.002 (0.001)	0.191
NFA contacts, 2020/21	0.409** (0.066)	0.000
N	1205	

Note: the model also includes dummies for randomisation strata but these are not shown here for ease of reporting. Statistical significance is indicated as *significant at 0.05, **significant at 0.01.

Appendix 7. Topic guides for IPE

Topic guide – DSLs

Thank you so much for participating in this interview.

My name is [X] and I am a researcher at the National Institute of Economic and Social Research. Myself and colleagues at NIESR are evaluating the programme providing supervision for DSLs in primary schools, on behalf of What Works for Children's Social Care who are funding the programme. As part of the independent evaluation, we are interviewing some of the DSLs like yourself. The aim of the interview is to explore your experiences of the programme so far. The interview will last around 45 minutes.

Everything we discuss will be confidential to the evaluation team at NIESR, and all the findings will be reported anonymously, and it will be analysed and presented so that neither you or your school will be identifiable in any reports or publications resulting from the research.

To ensure that the research is as informative as possible, we would encourage you to be open and honest on how delivery has progressed and the successes and difficulties encountered so far.

With your permission, the interview will be recorded and transcribed, and kept at secure servers only accessible to the research team. Your participation is voluntary, so you are free to withdraw at any stage without giving a reason.

Please can you confirm you are happy for this interview to be recorded, and that you are willing to take part in this research? [obtain consent]. Do you have any questions before we start?

About you

1. How long have you been a DSL? How did you become DSL?

2. What are your current responsibilities?

3. How many DSLs are there in the school?

4. How is the role of DSL/safeguarding distributed?

5. What made your senior leadership team, or yourself decide to accept supervision?

6. When did you start supervision?

7. Who is your supervisor?

8. Are you the only one receiving the programme?

Prior to supervision

1. Prior to the project, how did you experience the DSL role?

   a. [probe around what the role usually involves]

2. How did you find the role? Did you enjoy, or did you not enjoy, the role of DSL? Why/why not?

3. Prior to this project, had you received other support to help think about your role as DSL?

   a. Who provided this support? How helpful was it?

4. Prior to the project, how would you describe your "need" for a programme like this? To what extent did you need additional support?

Supervision sessions

5. What types of support have you received from your supervisor so far?

   a. [Ask details about each type of support mentioned]

   b. Do you communicate between sessions? What about? How useful is this to you?

6. Regarding the one-to-one sessions, how many sessions have you had so far?

   a. How regular have they been?

7. How long have the sessions been?

8. Did you receive or use any materials as part of the project? To what extent was this useful, or not?

9. Have the sessions been face-to-face or online?

   a. [if mixed explore differences]

10. Have there been any operational/logistical barriers?

11. Before the one-to-one sessions do you need to prepare?

   a. [explore admin/time implications if any]

12. How would you describe the sessions?

   a. What is the focus and structure of the sessions?

13. How do you find the one-to-one sessions? Are there any parts that you particularly enjoyed? Why? What aspects of the one-to-one sessions have been particularly useful/not useful?

   a. What additional support would you like to receive (from school and/or Social Worker) [i.e. if you had unlimited funds for training/anything to help you with your role as DSL]

14. How do you find the approach of the supervisor? [i.e. friendly, helpful etc]

15. How would you describe your relationship with the supervisor? [i.e. honest, vulnerable, professional etc] And has this evolved since you first sessions?

16. How do you feel your experiences of the supervision have changed (if at all) since they first began?

    a. particular topics; increase/decrease in frequency or length; increase/decrease in usefulness]

17. Do you remember your initial expectations of the programme? What were your initial expectations of supervision, and do you feel those have been met?

18. Do you feel it has been a good or bad use of your time?

Broader support

19. In addition to the one-to-one sessions, how useful do you find the other support that is given to you or your school by the supervisor?

    a. [probe: what form this is taking and to what extent is this critical to the programme? How important is this support compared to the one-to-one sessions?]

Outcomes and impact

20. To what extent have you changed or do you plan to change your practices as a DSL as a result of [x]'s guidance and support?

    a. In what ways? Why/why not? [probe for examples]

21. Do you think that the programme is already having an impact on your performance as a DSL? In what way? Explore for:

    a. Deciding when to contact children's social care? What are the thresholds?

    b. Provided higher quality information to children's social care services at point of contact and referral?

    c. Since starting the project, do you think you have made different decisions, for instance, decided against contacting or decided to contact children social care services?

22. Is the programme improving your knowledge and understanding of children's social care processes and issues?

    a. Do you feel better able to support children and families more effectively?

    b. Have you increased (or changed) your support to children and families, or the school's interaction with families? In what ways?

    c. Do you have a better understanding of roles and responsibilities between school and children's social care services?

d.   Have you increased your use of Early Help plans? (note, not all LAs call them Early Help)

e.   Anything else?

23. To what extent have other DSLs or staff in your school benefited from the programme? In what way?

a.   To what extent has the information been cascaded to other staff members? To what extent have other staff members been involved in support sessions?

24. Overall, do you feel more confident in the DSL role? How has the project affected your mental wellbeing? [probe: stress, anxiety, burnout, turnover]

25. What are the barriers and facilitators, in terms of using the supervision to change and improve how you perform as a DSL? [probe to what extent you feel the senior leadership of the school supports the programme, and supports making changes as a result]

COVID-19

I want to ask a couple of questions about your experience as a DSL of COVID and school disruptions.

26. To what extent and how has COVID and school disruptions changed the number of cases and concerns in terms of safeguarding, child protection, mental health etc.?

27. How has COVID and school disruptions affected how you as a DSL and you as a school approach safeguarding and child protection?

28. How have you been supported during COVID? And what could be done in the future? Both in terms of support from within school, from local authority, children's social care or in terms of resources or government policies?

29. The supervision has happened during fairly exceptional circumstances of the pandemic and school disruptions. Do you think the supervision has been more/less effective or more/less useful during this period, compared to if it had happened during a "normal" period?

a.   [Probe for both practical implication and change of needs and support requested]

Future

30. How do you think the programme could be improved in potential future versions of the programme?

31. Would you recommend other schools/DSLs to sign up for future versions of the programme? Why?

32. Would you want to continue receiving supervision and support by your SSW? Why/why not?

33. Anything else?

Topic guide – supervising social workers (SSWs)

Thank you so much for participating in this interview. My name is [X] and I am a researcher at the National Institute of Economic and Social Research. Myself and colleagues at NIESR are evaluating the programme providing supervision for DSLs on behalf of the WWCSC. As part of the independent evaluation, we are interviewing each of the supervising social workers. The aim of the interview is to explore your experiences of the programme, and how schools have engaged with it. The interview will last around 45 minutes.

Everything we discuss will be confidential to the evaluation team at NIESR, and all the findings will be reported anonymously, and it will be analysed and presented so that neither you or your Local Authority, or any of the schools or DSLs, will be identifiable in any reports or publications resulting from the research.

To ensure that the research is as informative as possible, we would encourage you to be open and honest on how delivery has progressed and the successes and difficulties encountered so far.

With your permission, the interview will be recorded and transcribed, and kept at secure servers only accessible to the research team. Your participation is voluntary, so you are free to withdraw at any stage without giving a reason.

Please can you confirm you are happy for this interview to be recorded, and that you are willing to take part in this research? [obtain consent]. Do you have any questions before we start?

About you

1. What was your role before the start of the programme? How did you get recruited into the role as DSL supervisor, and why were you interested?

2. To what extent do you feel supported to perform the role as DSL supervisor? [prompt for]:

   - Time to perform the role;

   - Support, e.g. support from LA, Community of Practice sessions with other SSWs;

   - Support from LA: What team are you located within the LA? Where do you think the role should be located?

   - What are your other responsibilities, if any, outside the programmes? Have these changed since the programme began?

3. Do you have any pre-existing relations with your schools and DSLs? [if yes]: To what extent has this affected implementation?

Implementation

4. Do you know how the individual DSLs were selected for each school? Do you think you are supervising the right staff member in the school? [probe: DSL, Deputy DSLs, pastoral team, SLT?]

5. How did you experience the process of getting schools started with the programme, and organising the first sessions? What have been the barriers and facilitators to buy-in?

    a. Probe: how many schools did not start the supervision? Do you know why?

Supervision and support

6. Can you describe what type of support you are giving and offering to the schools?

About one-to-one sessions

7. How would you describe the one-to-one supervision sessions? How have you generally structured the sessions and what has been the main focus?

8. Is there anything that has been particularly beneficial for schools in terms of support? Or not beneficial?

9. Did you generally do the supervision sessions face-to-face or online? What are the benefits/disadvantages?

About additional/different support

10. To what extent has your support differed compared to what was supposed to be offered and delivered? [type of support, amount of support, what was done during supervision sessions, who support was given to]

    a. How has this evolved over the time that the programme has been delivered?

    b. Have you offered group DSL sessions? Have you offered drop-in sessions? Have you offered supervision to other staff members than the DSL? Have you connected DSLs from within the local authority? [probe: how did these arise, benefits, limitations]

    c. Why did you make these decisions to adapt the support provided?

Time and costs

11. How much time is required for the DSL in between sessions? (e.g. preparation, actions)

12. How much contact do you have with DSLs in between sessions (e.g. ad hoc calls, support in addition to individual sessions). [probe: is this effective? does it limit your ability to carry out your other responsibilities?]

13. Were there any unanticipated costs, monetary or non-monetary, for you as a SSW or for LA that was not anticipated as part of the programme?

Other activity to support DSLs

14. How do you feel this programme fits alongside any other existing programmes/school-based initiatives provided?

15. Are you aware of any activities within control group schools? Has the LA been doing anything with these schools? Or done any activities that have benefited all schools in LA?

DSL engagement

16. How would you broadly describe the DSLs' engagement during the intervention so far? That is, to what extent would you generally say the DSLs in your schools have engaged with the supervision sessions and used it to inform practices?

17. Are there any particular parts of the support DSLs are engaging more/less with than others?

18. What have been the facilitators and barriers to engagement? Do you feel there are any patterns of what types of DSLs or schools are most or least engaged?

19. How many schools have withdrawn, or become disengaged, after having started supervision sessions? Do you know why? What were the barriers?

20. How do you think COVID has affected the programme? [probe for both practical implications and change of needs and support requested]

Outcomes and impact

21. To what extent do you think DSLs have changed or improved their approaches, or how they perform the role as DSL, as a result of the programme? In what ways? [provide examples]. [probe for, and ask why/who not?:]

    a. Reduction in inappropriate contacts to CSC? Better-quality information provided to CSC at point of contact and referral? Better understanding of thresholds?

    b. Better understanding of roles and responsibilities between schools and CSC?

    c. Better understanding of multi-agency working?

    d. Increase in Early Help plans?

    e. Better understanding of difficulties faced by children and families?

    f. Better relationships and interaction between schools and families, and earlier and more effective support provided to families?

    g. Greater confidence among DSLs?

    h. Any improvements in mental wellbeing? Decreasing stress, anxiety, burnout?

9. What are the barriers and facilitators for DSLs to change and improve their approaches? [time, enough staff, COVID, support from senior leadership]

   a. Prompt: How has COVID and school disruptions impacted delivery? Do you think the exceptional circumstances of COVID and school disruptions had made the programme more/less useful or more/less effective for schools and DSLs, compared to if the programme had been delivered during more normal circumstances?

10. To what extent are those improvements seen for other DSLs in the school? Why/why not? [probe more generally on how the programme has been cascaded to others in the school, including wider safeguarding team]

Your development as social worker and benefit for CSC

11. To what extent is the programme developing your skills as a social worker? [Probe for better understanding of the challenges faced by DSLs and schools]

12. To what extent do you think CSC will be able to use, or have already used, these insights to improve the support and relations with schools in the future? How? Please describe.

Future

13. Do you think the programme should be continued in the future, or rolled out on a larger scale with more Local Authorities?

   a. Is it important for schools to continue the programme? Why/why not?

   b. Is it important for CSC to continue the programme? Why/why not?

   c. Has your LA made any plans or considered continuing the programme in the future? Please explain.

   d. Would you personally like to continue in this role in the future? Why/why not?

      During the programme, have you ever had any considerations about leaving the role? Why/why not?

14. How do you think the programme could be improved in the future?

15. Do you see any adaptations that would be needed if the programme were to be rolled out, to make it more feasible or to improve it?

16. Is there anything you cannot provide DSLs in terms of support and guidance, which could need another programme/training/support?

17. Anything else?

Thank you!