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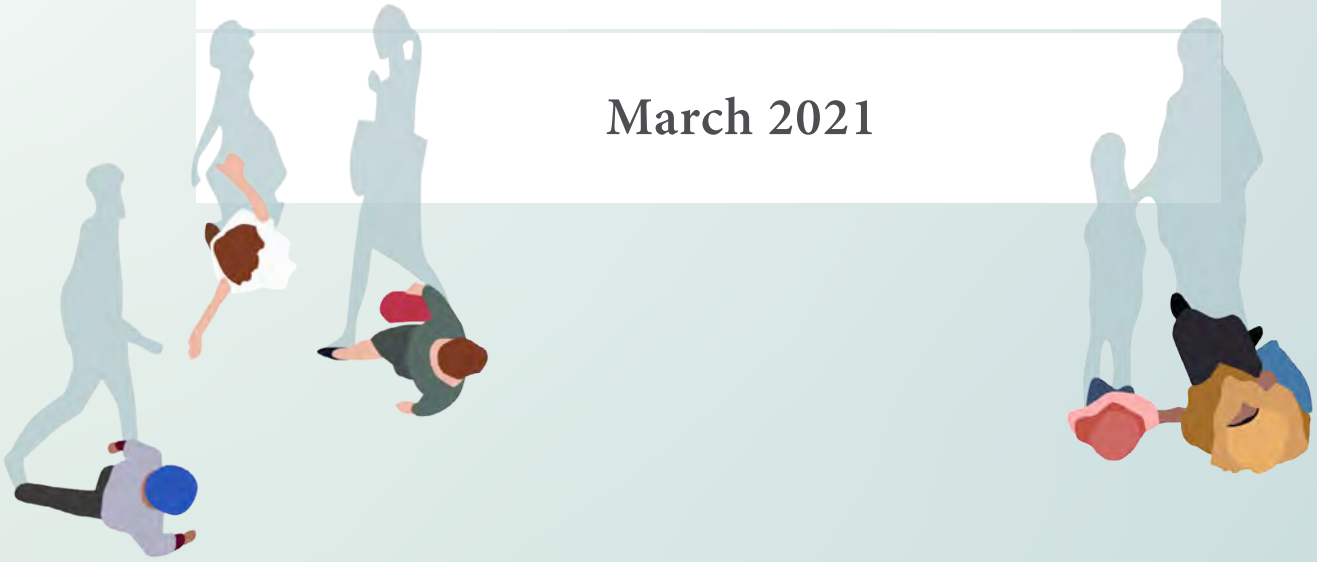
What Works *for* Children's Social Care

HAPPIER, HEALTHIER PROFESSIONALS: SMALL SCALE INTERVENTIONS TO IMPROVE SOCIAL WORKER WELL-BEING

March 2021



What Works *for* Children's Social Care

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About What Works for Children's Social Care

What Works for Children's Social Care seeks better outcomes for children, young people and families by bringing the best available evidence to practitioners and other decision makers across the children's social care sector. We generate, collate and make accessible the best evidence for practitioners, policy makers and practice leaders to improve children's social care and the outcomes it generates for children and families.

To find out more visit the Centre at: whatworks-csc.org.uk, or CASCADE at: sites.cardiff.ac.uk/cascade

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FOREWORD

Social work is a difficult job - managing high caseloads, the complexities and nuances of working with families and children during difficult times, and a huge amount of responsibility. Social workers do vital, often underappreciated work. It's perhaps unsurprising then that social workers leave the profession at an alarming rate - some 50% higher than teachers.

Retaining more social workers in the profession is an ambition with potential to make a big difference; it can reduce caseloads, or money spent on recruitment and agency staff; it means that children and families experience fewer changes in worker, and that relationships - critical to successful social work - can flourish and be maintained. Beyond these reasons, there is a moral imperative to support social workers. They are public sector workers, doing difficult and important work - and they are human beings - they deserve to feel happy and respected in their chosen career.

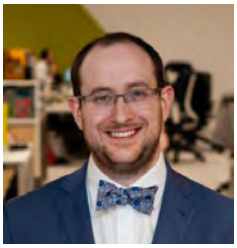
It was with this in mind that we launched the "Happier, Healthier Professional" programme when I joined What Works for Children's Social Care in 2019. I knew from the academic literature in behavioural science that light-touch interventions can make a difference when the conditions are right, and that they have the virtue of being scalable and fairly straightforward to implement. I also knew that at the time we had a narrow window of opportunity to get projects up and running.

This report describes the results of the first three randomised trials we conducted as a part of this programme. These trials were not without their challenges - not least the onset of the Coronavirus Pandemic - but no study ever is.

The results, to my mind, teach us two important things. First, there is value in some of these light touch interventions. Despite the challenges, I find the results of our symbolic recognition study promising, and that taking the time to provide feedback and to thank social workers is worth the effort. As I have written elsewhere, these small acts of kindness are an important part of public service.

Second, light touch interventions cannot have an impact in an environment where they cannot take root. As was shown by the low take-up of the goal setting tool - a tool which had an existing evidence base behind it and which was created in response to social worker demand. If social workers do not have the time or headspace to engage, no intervention can be effective.

Overall, what have we learned? That we should never fail to be kind - and that if we are to improve social workers wellbeing and retention, larger changes to their working environments are likely to be needed.



Dr Michael Sanders

Chief Executive
What Works for Children's Social Care

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EXECUTIVE SUMMARY

In this report we describe findings from three studies conducted as part of the Happier, Healthier Professionals (HHP) research programme at What Works for Children's Social Care (WWCSC), launched in January 2019. This programme of research was launched to build evidence around social worker well-being, which was identified as one of the key research priorities of WWCSC in its start-up phase.

The three trials reported here were developed and designed by consulting with 35 local authorities across England between January and March 2019, with trials going live between April and October 2019. Final data collection concluded in March 2020, with some of the data collection interrupted due to the impact of the Covid-19 pandemic on local authorities.

The three trials which were implemented were:

- An online Goal-Setting programme,
- A personalised letter of recognition to staff from senior management ('Symbolic Awards'), and
- Access to free tea and coffee in the office.

Social Worker Goals and Well-being Programme

Building on a goal-setting programme designed by researchers at Royal Holloway University - and which was shown to be effective with participants from a civil service workforce, we developed the 'Social Worker Goals and well-being Programme'. The 6-week online programme aimed to motivate social workers to be more likely to complete work tasks by making use of explicit planning and intention-setting through a series of exercises, thereby improving their work-life balance.

The central finding from the trial was that uptake among participants was very low - around 20% of the treatment group engaged with the intervention at any time, and fewer than 2% actually completed each of the six weekly modules. Subsequently, no differences were observed in our four outcome measures. While the implementation was not successful, the study provides us with valuable insights into how future interventions might be designed and framed for the workforce.

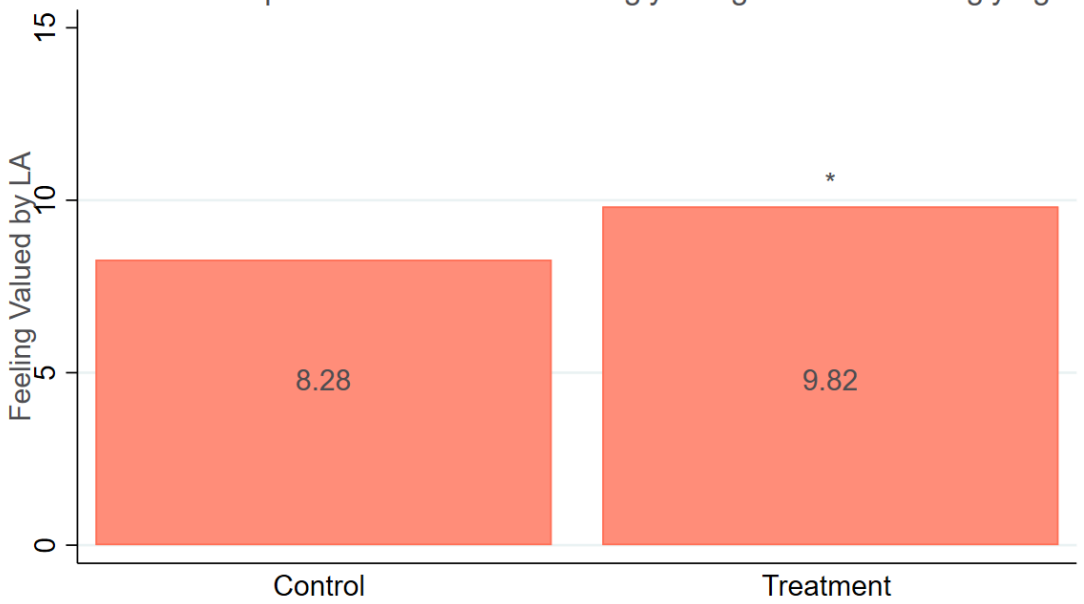
Symbolic Awards - Letters of Recognition

This intervention aimed to increase social workers' sense of feeling valued and recognised by sending them a symbolic award - specifically, a letter from a senior-level figure in the local authority expressing gratitude for their hard work and commitment, which was also personalised with two lines of positive feedback coming from their direct line manager.

We found that the intervention positively impacted social workers' sense of feeling valued, while other observed measures such as subjective wellbeing, motivation and sense of belonging also showed positive directional changes, though outside of the conventional thresholds for statistical significance. Due to the Covid-19 pandemic, only three of our five participating local authorities were able to launch the trial, and it is possible that with a larger sample these thresholds might have been met.

Perceived Social Worth and Symbolic Recognition

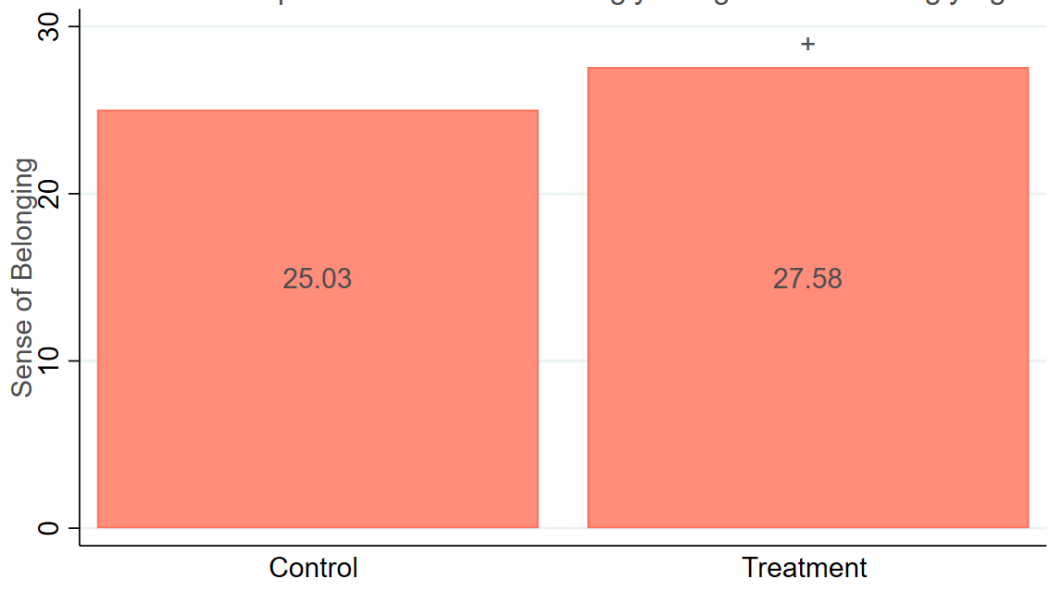
3 items on a 7 point scale from 1 = Strongly disagree to 7 = Strongly agree



Final Analysis Conducted by WWCSC in September 2020
N = 66, 3 local authorities,+ p<0.2 ++ p<0.1 * p<0.05 ** p<0.01
Figures derived from AR(1) Linear Regressions

Belonging and Symbolic Recognition

6 items on a 7-point scale from 1=Strongly disagree to 7=Strongly agree



Final Analysis Conducted by WWCSC in September 2020
N = 66, 3 local authorities,+ p<0.2 ++ p<0.1 * p<0.05 ** p<0.01
Figures derived from AR(1) Linear Regressions

Access to Free Coffee and Tea

We installed coffee machines and provided supplies of tea and coffee to seven social worker office buildings across Kent with the aim of understanding whether a small, material display of recognition from their local authority could increase social workers' sense of feeling recognised and appreciated, and thus contribute to overall well-being. The machines were accompanied by a laminated message of thanks addressed to social workers from senior management.

Although the trial was interrupted by the pandemic, we were able to collect administrative data on sickness and absence from the local authority, though this indicated that there was no difference between the treatment and control groups. Short interviews conducted earlier this year did however indicate that the machines were well-received by social workers in Kent. The social workers interviewed reported that the intervention was seen by some to add to staff's sense of feeling valued, and even contributed to a sense of community as team members would congregate around the coffee machine to talk.

Implications of findings

While some elements of our evaluation of the three wellbeing interventions were disrupted by events in 2020, this report nevertheless highlights several valuable findings which can be used to inform both how senior management at local authorities can support their staff, and also areas of promise for future research in this area.

Our symbolic awards trial provides evidence that employers can, with relatively little time or cost, positively influence employees' sense of feeling valued and supported by their local authority. Insights taken from our coffee trial, while limited, further support the view that staff might respond positively to non-monetary signals of appreciation. Perhaps equally important is the finding from our goal-setting experiment that the degree of time-pressure experienced by social workers is such that some types of intervention are unlikely to be effective. This further highlights the pressing need for interventions to address these challenges, and perhaps implies they might be more effectively implemented at the level of the team or the organisation.

INTRODUCTION

Background

Employee health and well-being is increasingly recognised as a core ingredient in achieving any organisation's goals, and social work in particular faces significant challenges in relation to worker well-being, sickness absence and turnover rates. More than most professions, the emotional nature of social work means that the sector faces particularly acute challenges with employee stress. The role is client-based, involving complex social situations and requiring high levels of emotional involvement - all factors which can contribute to low job satisfaction and burnout. High workloads and time-pressure, also common in the social work profession, are also related to negative work-related outcomes such as stress.

Social workers' average caseload is 16.9 cases per worker, though this figure varies significantly between local authorities, with the Department for Education reporting figures varying between 12.1 (Kensington and Chelsea) and 32.7 (North East Lincolnshire). High caseloads can cause strain to social workers' day-to-day working lives. The 2018 Social Worker Health Check Survey revealed that 50% of respondents felt that their current workload prevents them from being able to dedicate appropriate time to tasks, and a third of respondents felt that their caseloads were not manageable. Moreover, one quarter of social workers surveyed reported having to cancel meetings with service users and other professionals at least once a week to meet their work demands. Thus, the high number of caseloads held by social workers may reduce the time as well as cognitive bandwidth that social workers have available to dedicate to families and children, and potentially risk the quality of services being provided.

Moreover, social workers often report working significantly more than their contracted hours. A longitudinal study of social workers conducted by the DfE in 2019 found that a staggering 84% of social workers who are contracted to work between 31-35 hours reported that they worked unpaid overtime, with an average actual working hours of 42 hours. Additional research revealed that child and family social workers in particular reported working on average more than 12 hours per week more than they are contracted to. A study which examined the well-being and working conditions of UK social workers found that the demands placed on social workers' time on the job was related to increased levels of stress, intentions to leave the job, job satisfaction, and presenteeism - all factors which contribute to poor well-being.

The combination of these factors means that social work is widely recognised as one of the most stressful occupations in the UK. The profession experiences high levels of turnover (16.1%) - the equivalent of 5,300 full-time employed children and family social workers - as well as high sickness absence rates (3.1% national average, with some local authorities recording rates as high as 6-7%). Employees working in service occupations such as social work consistently have the highest sickness absence rates out of any occupational group in the UK.

In 2018, the Department for Education reported that the average vacancy rate across the country was 16.4% (the equivalent of 6,000 FTE social workers), and agency worker rates - the recruitment of temporary social workers to fill vacancies - is at an average of 16%. Social worker turnover is likely to be a highly consequential issue, impacting as it does on the experience of the children and families they work with.

A survey conducted on the well-being of 2,263 children and young people from 16 LA areas found that two thirds of young people (aged 11-18 years old) surveyed had more than one social worker during the past year, and qualitative data suggested that frequent changes of social worker was one of the main reasons of concern voiced by young people. The researchers also found a significant relationship between the lack of trust reported by looked after children, and their having had three or more social workers in the past 12 months. If a child does not feel they have trust within the relationship, they are less likely to discuss issues openly with their social worker, potentially constraining the therapeutic relationship. Furthermore, within many studies, children state their need for fewer changes in their social worker. We therefore have strong reason to suspect that the instability within the social work workforce is adversely affecting the experience of children in care.

Staff well-being is an important outcome in and of itself, but with social workers being key to supporting some of the most vulnerable people in our society, it is particularly important that these employees are provided with appropriate support and optimal working conditions to reduce stress and promote well-being.

Wider Policy Implications

There is evidence to suggest that employee well-being could impact organisational outcomes, such as turnover, sickness absence rates and performance. In recent years, UK policy-makers and organisational leaders have become increasingly interested in the topic of employee well-being in part due to the negative impacts of burnout and stress on organisational outcomes. In 2018, 17.5 million working days were lost due to stress, depression and anxiety. A report commissioned by the UK government estimated the costs of lost productivity due to poor mental health and well-being of employees were equivalent to £42 billion annually, which is equivalent to approximately 2% of the UK's Gross Domestic Product in 2016.

Research Aims

With this in mind, we launched the HHP research programme in January 2019. The programme aims to test the effectiveness of a series of light-touch interventions, inspired by insights from behavioural science, in partnership with LAs across England. To carry out this research, we collaborated with academic researchers from the Harvard Business School and King's College London to draw on the latest insights from the field and to develop and implement interventions aimed at increasing the overall well-being of social workers across England, as well as examine the potential downstream effects of employee well-being for organisations, including decreased turnover and sickness absence rates.

We measured these administrative outcomes for each of our three studies to determine whether our interventions had any effect on wider organisational outcomes. The project also aimed to identify ways to improve a wide range of work-related outcomes that contribute to overall well-being - such as burnout, motivation and perceived social worth. We tested the interventions through the use of randomised controlled trials (RCTs), a research design which is considered the 'gold standard' in social science research in being able to determine that any effects detected in outcomes of interest (e.g. well-being) were the result of the intervention in question.

Recruitment and Co-Design Phase

Recruitment of LAs began in January of 2019 with a public call for LAs with children's social care teams who were interested in being involved in behavioural interventions focused on improving social worker well-being, and continued until June 2019, with more local authorities added after the initial launch dates of the interventions.

With the above goals in mind, between January and March 2019 we embarked on a co-design phase which involved consulting

with social workers and social work leaders from participating local authorities. During this time, our research team spoke to senior leaders and children's social workers from 35 local authorities across England to help understand the challenges they were facing, and to get feedback on the early ideas for interventions which had emerged.

We then embarked on a co-design phase with 15 local authorities, which also involved prototyping some potential interventions. We narrowed our interventions down to three that fit our criteria for intervention choices. Our criteria specified that the interventions should be:

1. **Inexpensive** (i.e. the costs were not high enough that the intervention could not be implemented by LAs in future);
2. **Deliverable** (i.e. the LAs we spoke to agreed that the intervention design and the methods we outlined were feasible);
3. **Scaleable** (i.e. the proposed intervention would be applicable across different LAs and different contexts);
4. **Light-touch** (i.e. did not require a significant amount of time and/or effort on the part of the LA or of the individual social workers).

During the consultation process, which involved focus groups and semi-structured interviews conducted with children's social workers and meetings with senior leaders (findings seen in Appendix 2A), several key contributing factors to poor well-being amongst social workers emerged:

1. **Time pressure and challenging environment for time planning** - social workers experience significant challenges with their work schedule, juggling high caseloads with a heavy administrative burden which includes strict statutory deadlines for reporting, and are also often required to adjust their schedule due to unexpected events such as emergency case visits. The resulting pressure to meet work goals leads to social workers often working overtime, which was perceived as having a negative impact on work-life balance. Social workers also reported that they would welcome support and/or training from the LA to manage their time and schedules effectively.
2. **Lack of recognition and feeling undervalued** - social workers reported that their daily efforts, often made amid the significant emotional strains associated with the profession, often went unrecognised by senior management who themselves had many competing demands on their time and attention. Similarly, senior leaders and management expressed the need for more mechanisms to provide positive feedback and recognition to their social workers outside of increased pay or other prohibitively expensive rewards.
3. **Administrative burden** - social workers repeatedly referred to the high volume of administrative tasks that they were required to complete, which they felt contributed to their well-being and stress levels. Social workers must adhere to strict statutory deadlines to write-up and submit reports, which can be very time-intensive, and reported that they feel that as a result they often do not have enough time to meet their workload. There was also reference to a lack of resourcing and support to assist with administrative tasks; while LAs previously outsourced a significant amount of administrative work to business support, most LAs are no longer able to provide this support to social workers due to budget constraints.
4. **Supervision and management** - the extent to which social workers felt they had adequate supervision and supportive management varied significantly, and the relationship between social workers and their team manager was seen to significantly impact their overall sense of well-being.

5. **Disconnection to the impact of social work** - several social workers noted that the nature of their interactions with children and families does not allow them to see the positive impacts of their work, which are often felt only after they have stopped working with their clients. They suggested that a feedback mechanism might be a positive source of well-being and also an opportunity to learn what parts of their practice have been effective.

Partner local authorities were matched with interventions that seemed to suit local conditions. It is noted that this may decrease the external validity of the work, as participating LAs may have expended more time making the interventions work or had more enthusiastic senior leadership teams. In total, 35 local authorities (23% of all English local authorities), responded to our Call for Partners (see Appendix 1A) and were involved in a consultation.

Study Methods and Outcomes

We conducted randomised controlled trials (RCTs) to evaluate the effectiveness of each intervention. While most commonly used in medicine to understand whether a particular treatment works, RCTs are increasingly widely used in the social sciences. This method involves randomly assigning half of the study participants to receive the intervention, and not the other half, and comparing the outcomes of both groups to determine whether there was any difference. Random assignment attempts to ensure that the two groups are on average the same in all characteristics which might influence the outcomes in question, and therefore any difference in results between the groups can confidently be ascribed to the intervention itself given a sufficiently large sample.

We decided upon a series of primary and secondary outcomes as well as mediators for each of the three interventions (see Table 1 below). The choice of these outcomes and mediators depended on the nature of the intervention in the trial and the types of impacts we hypothesised they might have. For example, in the symbolic awards trial, our primary outcome was subjective well-being since we did not expect turnover or sickness absence to be significantly impacted by our intervention.

Table 1: Happier, Healthier Professionals Trials - Primary and Secondary Outcomes

Trial	Primary Outcome	Secondary Outcomes and Mediators
Social Worker Goals and well-being Programme	Sickness absence	**Secondary Outcomes:** ▪ Turnover ▪ Subjective well-being **Mediators:** ▪ Time pressure ▪ Workplace efficacy ▪ Sense of purpose ▪ Sense of feeling supported by manager
Symbolic Awards (Letters of Recognition)	Subjective well-being	**Secondary Outcomes**: ▪ Sickness absence **Mediators:** ▪ Perceived social worth (i.e. sense of feeling valued and recognised by the organisation) ▪ Perceived organisational support and affective commitment (i.e. sense of belonging) ▪ Intrinsic and prosocial motivation
Symbolic Awards (Access to Free Coffee and Tea)	Sickness absence	**Secondary Outcomes:** ▪ Subjective well-being **Mediators:** ▪ Intrinsic and prosocial motivation ▪ Perceived organisational support and affective commitment (i.e. sense of belonging)

Trial Protocols and Pre-Registration

The plan for study design, methodology and analysis for each of the three trials were published as trial protocols on the WWCSC website prior to intervention launch (links below):

1. Social Worker Goals and well-being Programme
2. Symbolic Awards (Letters of Recognition)
3. Symbolic Awards (Access to Free Coffee and Tea)

In line with the principles of open science, our studies were also pre-registered via the Open Science Framework website, with sample sizes, study designs, methodology and analysis plans all available publicly (links below):

1. Social Worker Goals and well-being Programme
2. Symbolic Awards (Letters of Recognition)
3. Symbolic Awards (Access to Free Coffee and Tea)

Data Collection

We collected administrative data from LAs on staff key demographics (e.g. role, team, gender, contract type) as well as sickness absence and turnover rates at various time points, including pre-, mid- and post-intervention. For self-reported data on subjective well-being and our other proposed mediating outcomes, we administered tailored well-being surveys both at pre- and post-intervention for two of the three trials (we administered a pre-intervention survey only for the Access to Free Coffee and Tea study, as the post-intervention survey was halted due to the Covid-19 pandemic).

We worked closely with LAs to ensure that all data was being collected in a consistent manner across all research partners, by providing the LAs with specific, detailed instructions for how to collate and return administrative datasets and distribute well-being surveys. We also communicated key time points and deadlines to LAs to ensure that study timelines were the same across different LAs, regardless of the different intervention launch date at each LA.

Impact of Covid-19 Pandemic on Data Collection

The implementation and data collection for the trials were impacted by the Covid-19 pandemic in March 2020. We outline below how our trials were impacted below:

- **Goal-Setting Intervention:** Implementation of the trial was halted after interim administrative data collection in five LAs, though full data collection was completed in three LAs where the trial had launched earlier.
- **Symbolic Awards (Letters of Recognition) Intervention:** Implementation of the trial in two LAs (City of Bradford Metropolitan District Council and London Borough of Southwark) was cancelled due to the Covid-19 pandemic in March 2020. As a result, we completed implementation and full data collection in 3 out of the intended 5 LAs.
- **Access to Free Coffee/Tea Pilot:** By March 2020, we had implemented the trial in Kent County Council, and had conducted interim administrative data collection. However, endline well-being and administrative data was not collected. The implementation of the trial in London Borough of Southwark was also cancelled due to the pandemic. As a result, we report only baseline and interim administrative data collection in one LA (Kent), and do not report on well-being data for the pilot study. Qualitative insights were gathered in early 2021 and are reported below to provide some indication of how the intervention was received by social workers.

STUDY 1: SOCIAL WORKER GOAL-SETTING

Background

Challenging caseloads, unpredictable work schedule, and overtime can lead public-sector workers to experience chronic feelings of time pressure (i.e. time stress) and high levels of conflict between work and home priorities. Some studies show that time stress - the feeling of not having enough time to do everything one wants to do or has to do - can have a stronger negative effect on life satisfaction than being unemployed. Time stress further undermines work productivity: when employees feel like they have too much to do and not enough time to do it all, they tend to increase their work pace, shorten their time spent on any one activity, or multi-task - behaviors that not only deepen their feelings of time poverty but also undermine work productivity and happiness. Prolonged exposure to time poverty can therefore result in burnout, exhaustion, and de-motivation, all of which can increase rates of sickness absence and turnover.

Our consultations with social workers in the development phase of the project suggested that a key contributor to low levels of social worker well-being is likely to be the time pressure they experience as a result of their work. Social workers often hold high numbers of complex cases, meaning they are subject to time pressure and often struggle to balance priorities at work and at home. For some areas of social work, such as assessment, statutory deadlines also add to the time pressure. This pressure can lead to burnout and exhaustion, which in turn contributes to increased rates of sickness absence and staff turnover.

Research indicates that setting aside dedicated time to plan out goals as well as to reflect on progress towards personal or work-related goals promotes well-being and can decrease time pressure through increased task completion. For instance the use of implementation intentions, i.e. the setting out of when, where and how during goal striving, have been applied with great success across a wide variety of policy issues. The goal-setting strategy has been used to effectively increase voter turnout, improve student exam performance, and flu shot rates.

Intervention

Building on a goal-setting programme designed by researchers at Royal Holloway University - and which was shown to be effective with participants from a civil service workforce - we developed the 'Social Worker Goals and well-being Programme' (see Appendix 2B for full goal-setting materials).

The programme was hosted on an online platform, and materials included a variety of goal-setting and reflection exercises (see Figure 1 below). The programme was delivered over a 6-week period with a specific schedule of programme activities (see Figure 2 below). The intervention was designed to increase social workers' self-efficacy, sense of autonomy and work-life balance, by prompting them to prioritise and plan out specific actions and goals, both in and outside of work. (See Appendix 2F for a logic model outlining the hypothesised causal pathways for the intervention.)

Managers of teams in the treatment group were sent a set of 'flashcards' (Appendix 2D) explaining the rationale for the intervention and asking them to discuss with their teams how and when to make best use of the programme. Managers were also sent the link to the course and an accompanying email to forward on to their teams to mark the start of the intervention.

Social workers in the treatment group were sent an email from the principal social worker, or other senior leader in the local authority, informing them that they were part of the programme and would soon receive the materials. In the introductory email from their managers, social workers were prompted to identify a weekly protected 30-minute slot in which to complete the programme materials.

Figure 1: Goal-Setting Programme

Figure 2: Goal-setting Programme Schedule

WEEK 1	Module 1 - Making Goals	30 mins
	Module 2 - Imagining Achieving Goals	30 mins
WEEK 2		
	Module 3 - Planning to Achieve Goals	30 mins
WEEK 3	--- Time to try out plans ---	
WEEK 4	Module 4 - Overcoming obstacles	30 mins
WEEK 5	Module 5 - Putting it all into practice	30 mins
	--- Time to try out plans ---	
WEEK 6	Module 6 - Review	30 mins

Participants

Participants (N = 1,315) were recruited at 8 LAs, including London Borough of Bromley, Central Bedfordshire Council, London Borough of Greenwich, Kent County Council, London Borough of Lambeth, North Tyneside Council, Telford and Wrekin Council, and The City of Wolverhampton Council.

The intervention concluded for the three LAs in early 2020: North Tyneside Council, Telford and Wrekin Council, and The City of Wolverhampton Council. Thus, we report here on full well-being data for only these LAs (n = 66) and full administrative data for these LAs and Central Bedfordshire, whose trial also ended before the start of the pandemic (n = 486). We also report on interim administrative data which includes two additional LAs (Kent County Council and London Borough of Bromley) who had provided this (n = 1468).

Sample Characteristics

Role and Length of Service:

The sub-sample (n = 65) who responded to the survey consisted of 55 children's social workers, 6 student social workers, 1 senior practitioner, 2 managers, and 1 social worker assistant. The mean length of employment indicated by survey respondents was 57.08 months (SD = 84.45), ranging from 0 to 430 months. Thus social workers in our sample who responded to this question were employed in the LA for an average of 4.75 years.

Age and gender:

The mean age indicated by participants who responded to the question (n = 23) was 41.87 (SD = 12.74). The sample was predominantly female (n = 52); thus, 80% of the sample was female.

Marital status and children:

For the participants who responded to the question on marital status (n = 23), 6 participants stated that they were single / never married, 1 participant was divorced, 16 participants were married / had a domestic partner. For the participants who responded to the question regarding having children who currently live at home with them (n = 25), 8 participants indicated that they currently had dependent children living at home.

General health, overtime worked and caseload:

For the participants who responded to the question regarding their general health (n = 25), 4 participants rated their health as "good", and 16 participants rated their health as "fair", and 5 participants rated their health as "poor".

For the participants (n = 25) who responded to the question regarding the number of hours they worked beyond their contracted hours on average per week, 16 participants reported working 5 or more hours, 3 participants reported working 4 hours per week, 3 participants reported working 3 hours, 2 participants reported working at least 1 hour, and 1 participant reported that they did not work overtime hours.

For the participants who responded to the question regarding caseload (n = 5), "Do you feel your caseload is manageable?" (on a 7-point scale where 1 = not at all, 7 = completely), respondents rated this on average at 4.04 (SD = .38).

Figure 3: Data Collection Across LA Partners

Goal-setting trial: Data collection					
Local Authority	Baseline administrative	Baseline wellbeing	Interim administrative	Endline administrative	Endline wellbeing
Bromley					
Central Bedfordshire					
Greenwich					
Kent					
Lambeth					
North Tyneside					
Telford and Wrekin					
Wolverhampton					
Total	**1492**	**297**	**1468**	**486**	**65**

Method and Design

The study was a clustered randomised controlled trial, with the randomisation taking place at the team level. We collected administrative data on staff demographic information and a measure of sickness days over the past 12 months to use as control variables in our analysis, and to randomise participants.

Administrative data was also collected at interim (3 months after the launch of the intervention) and endline (6 months after), including rates of sickness absence and turnover for that time period. A short wellbeing survey was also administered at 3 months to collect information on our other three secondary outcomes: social workers' subjective well-being, sense of time-pressure and sense of self-efficacy.

Trial type and number of arms		Clustered randomised controlled trial, two-armed
Unit of randomisation		Team
Stratification variables (if applicable)		Team average attendance in the last 12 months (split into quartiles)
Primary outcome	**Variable**	Sickness absence
	Measure (instrument, scale)	Participant sickness absence in the past 6 months (administrative data, number of days)
Secondary outcome 1	**Variable**	Staff turnover
	Measure (instrument, scale)	Binary measure, coded as 1 if the staff member has left the LA or 0 if not (administrative data, binary measure)

Secondary outcome 2	**Variable**	Subjective well-being
	Measure (instrument, scale)	Overall Life Happiness scale (survey data, scale of 0-10); Cantril Ladder (survey data, scale from 0-10); Schedule for Positive and Negative Affect scale (survey data, scale of 1-5)
Secondary Outcome 3	**Variable**	Mechanism 1: Time pressure
	Measure (instrument, scale)	Material and Time Affluence Scale (survey data, scale of 1-7)
Secondary Outcome 4	**Variable**	Mechanism 2: Workplace efficacy
	Measure (instrument, scale)	Work-Related Basic Need Satisfaction Scale (survey data, scale of 1-7)

Outcomes of Interest

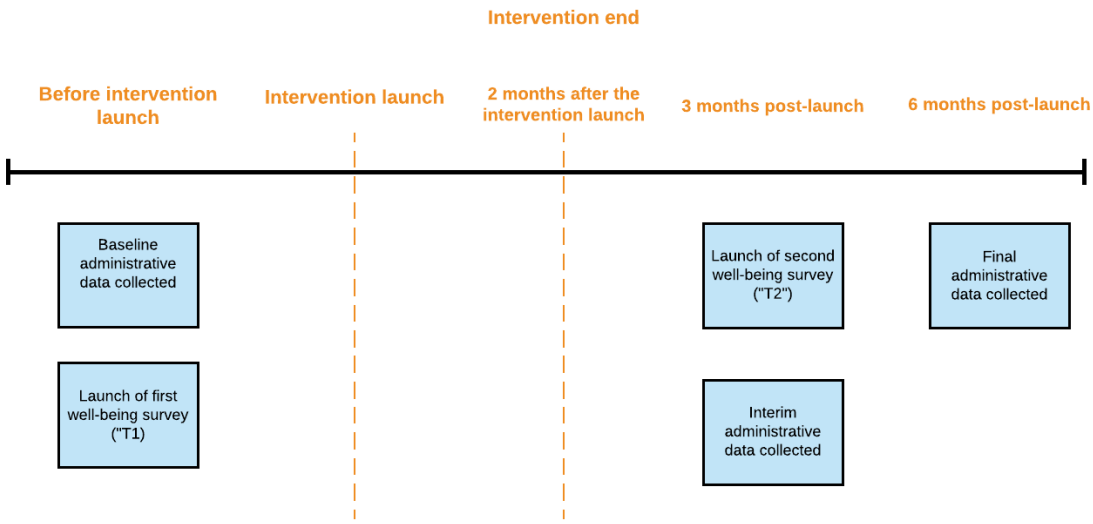
Our primary outcome measure was focused on the priority of the LAs we were working with, which was the reduction of sickness absence rates amongst staff. This had the advantage of being both an objective measure and one for which we hoped to see an effect size larger than our originally calculated minimum detectable effect size in the trial protocol.

We measured turnover (via administrative data), and subjective well-being (via survey data) which were included as secondary outcomes. We also tested a range of secondary mechanisms through which we hypothesised social worker well-being may be boosted: individuals' sense of time pressure; workplace efficacy; sense of purpose and feeling supported by their manager. See Appendix 2C for well-being survey measures.

Timeline for Data Collection

We collected administrative data three times; at pre-intervention, at interim (3-months post launch), and at endline time points (6-months post launch). Well-being survey data was collected directly prior to the launch of the intervention (T1), and again after the intervention ended 6 months later (T2). See Figure 4 below.

Figure 4: Timeline for Data Collection



Randomisation

This was a clustered randomised controlled trial with teams as the clusters because of the risk of spillover within teams and the role of team managers to encourage their team members to set aside time for the goal-setting programme.

Team-level randomisation was conducted using baseline data provided by LAs before the start of the trial and was stratified by quartiles of baseline average team attendance. In total, 290 team clusters that consisted of 1315 social workers were randomised across the 8 LAs who started the trial. As we were unable to guarantee balance on individual-level characteristics (due to the finite number of teams), we also controlled for these as part of our regression specification. Balance checks were conducted for the role of the social worker using a chi-squared test; and the length of service at that LA in years using a t-test.

Findings

All regression table outputs are included in Appendix 2E.

Primary Outcome: Sickness Absence

Interim:

For our primary outcome attendance (measured via sickness absence rates), we conducted a linear regression for the total number of participants for whom we had interim administrative data (n = 1,468). There was a non-statistically significant increase in attendance rates for participants in the intervention group (n = 712, M = 47.24, SE = .85) compared to the control group (n = 756, M = 43.29, SE = .92), p = .39. This a non-significant 8.7% increase in attendance rates for participants who received the treatment. See Appendix 2E for the regression table.

Endline:

For our final analysis of attendance rates, we conducted a linear regression for the total number of participants for whom we had endline administrative data (n = 486). There was a non-statistically significant decrease in attendance for participants in the intervention group (n = 225, M = 109.28, SE = 1.4) compared to the control group (n = 261, M = 111.65, SE = 1.04), p = .39. This a non-significant 2.1% decrease in attendance rates for participants who received the treatment. An analysis on the impact of the intervention on City of Bradford Metropolitan District Council scores was also conducted on participants from LAs where absence spells information was recorded, and no effect was detected - see Appendix 2E.

Figure 5: Interim Attendance and Goal-Setting

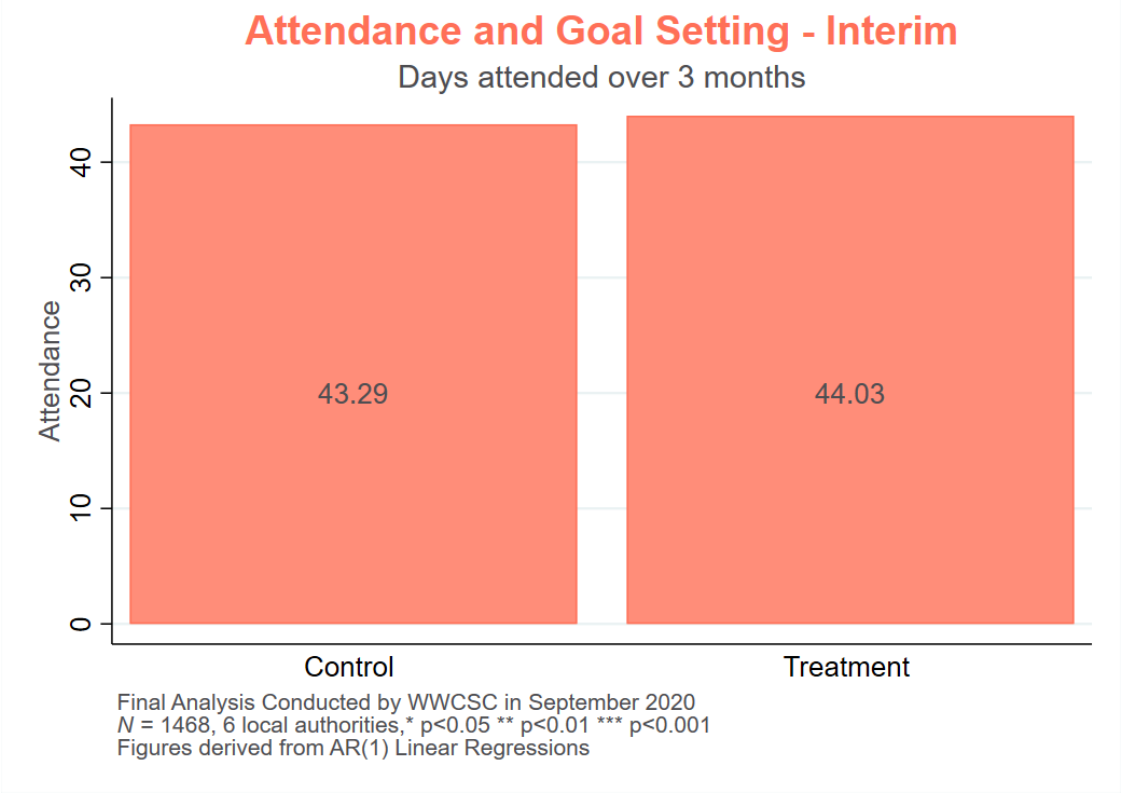
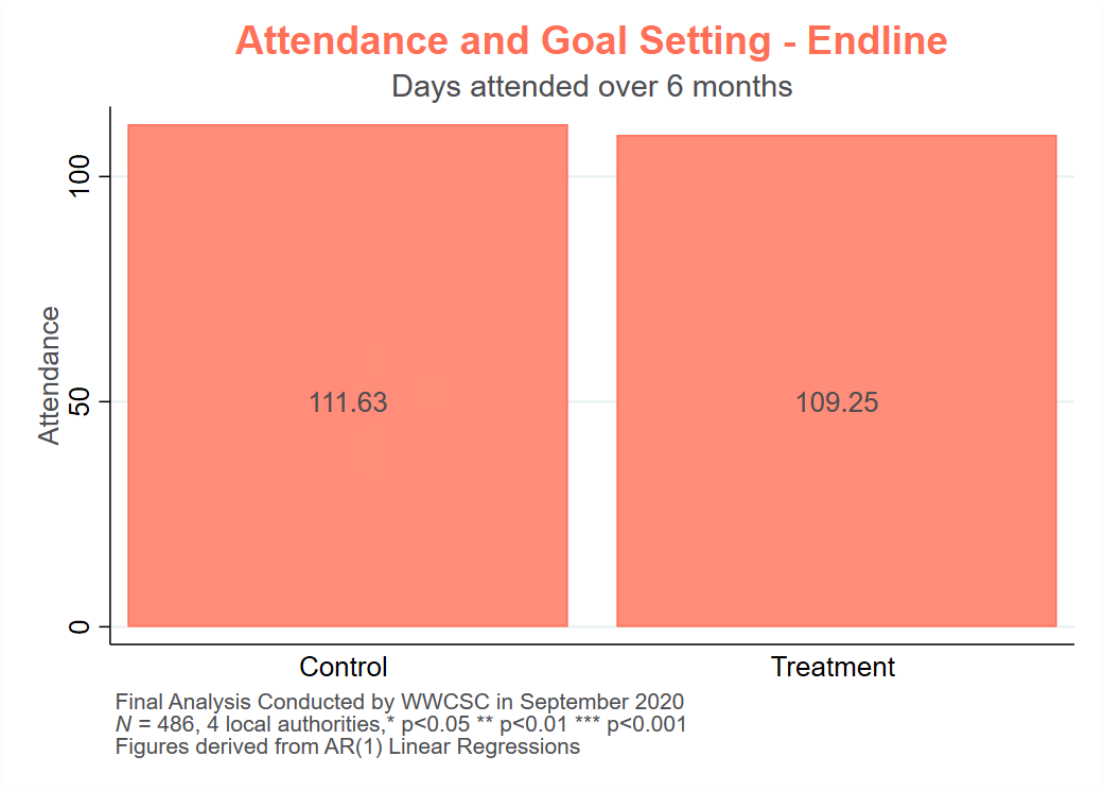


Figure 6: Endline Attendance and Goal-Setting



Secondary Outcome 1: Turnover

Interim:

For our secondary outcome turnover, we conducted a linear regression for the total number of participants for whom we had interim administrative data (n = 1,468). Turnover rates for participants in the intervention group (n = 712, M = .037, SE = .007) were slightly higher (though non-significant) compared to the control group (n = 756, M = .036, SE = .007), p = .39.

Endline:

For our final analysis of turnover rates, we conducted a linear regression for the total number of participants for whom we had endline administrative data (n = 486). There was a small, non-statistically significant decrease in turnover rates for participants in the intervention group (n = 225, M = .05, SE = .014) compared to the control group (n = 261, M = .06, SE = .014), p = .63.

Figure 7: Interim Turnover and Goal-Setting

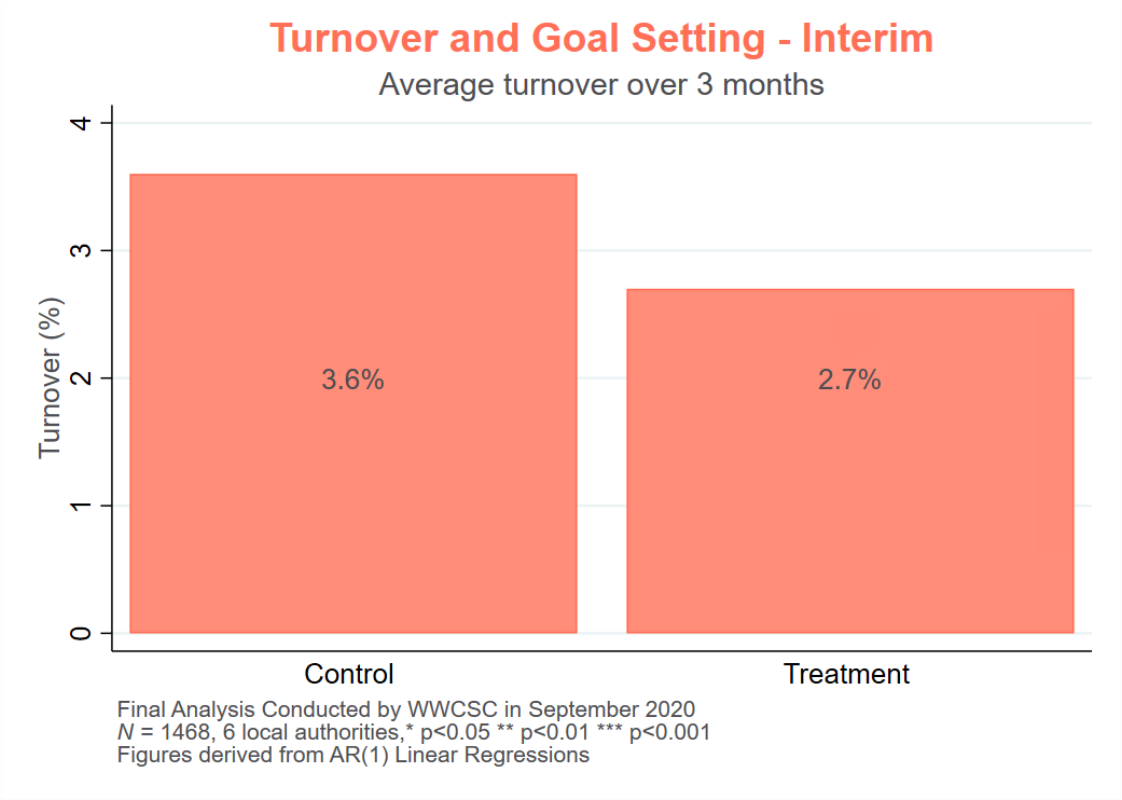
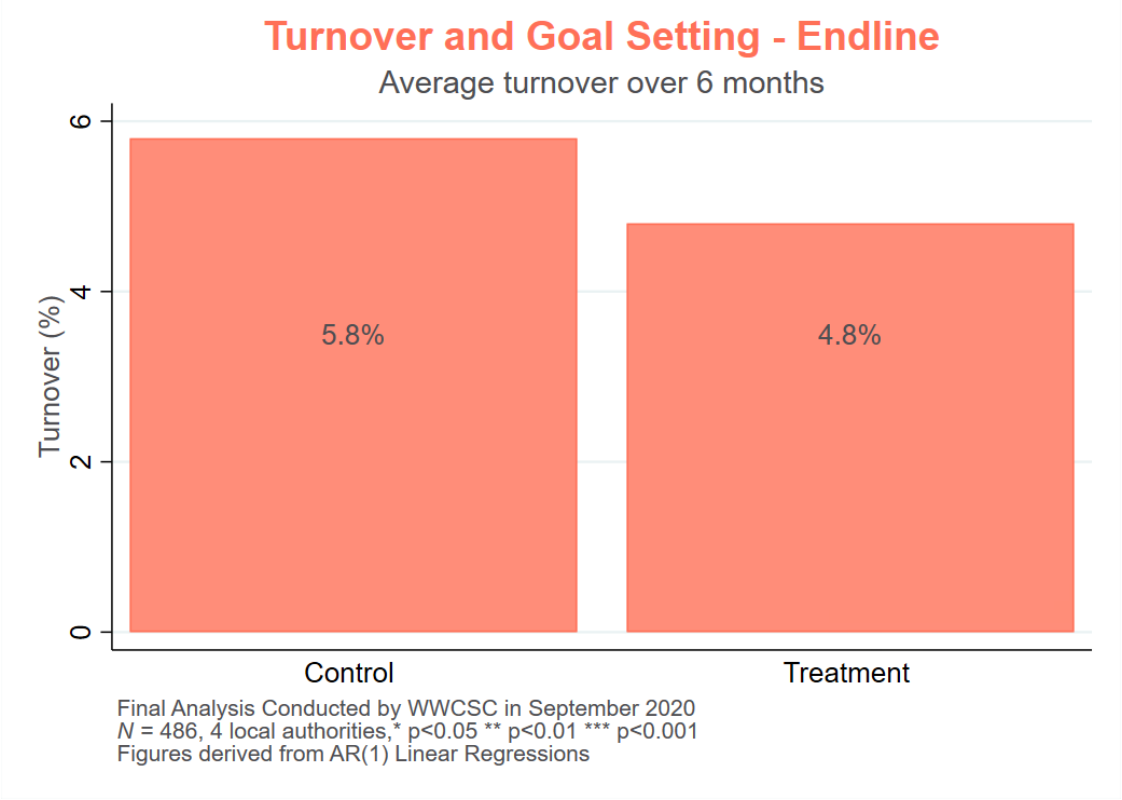


Figure 8: Endline Turnover and Goal-Setting



Secondary Outcome 2: Subjective Well-being

For our primary outcome, subjective well-being, we conducted a linear regression for the total number of participants for whom we had survey data (n = 66). There was a non-statistically significant decrease in well-being for participants in the intervention group (n = 30, M = .003, SE = .04) compared to the control group (n = 36, M = .02, SE = .04).

Secondary Outcome 3: Time Pressure

For our secondary outcome (mediator) time pressure, we conducted a linear regression for the total number of participants for whom we had survey data (n = 66). There was a non-statistically significant increase in time pressure for participants in the intervention group (n = 30, M = 1.61, SE = .28) compared to the control group (n = 36, M = 1.28, SE = .23), p = .17.

Secondary Outcome 4: Self-Efficacy

For our secondary outcome (mediator) self-efficacy, we conducted a linear regression for the total number of participants for whom we had survey data (n = 66). There was a non-statistically significant decrease in self-efficacy for participants in the intervention group (n = 30, M = 6.14, SE = 1.09) compared to the control group (n = 36, M = 5.41, SE = .96), p = .13.

Figure 9: Subjective Well-being and Goal-Setting

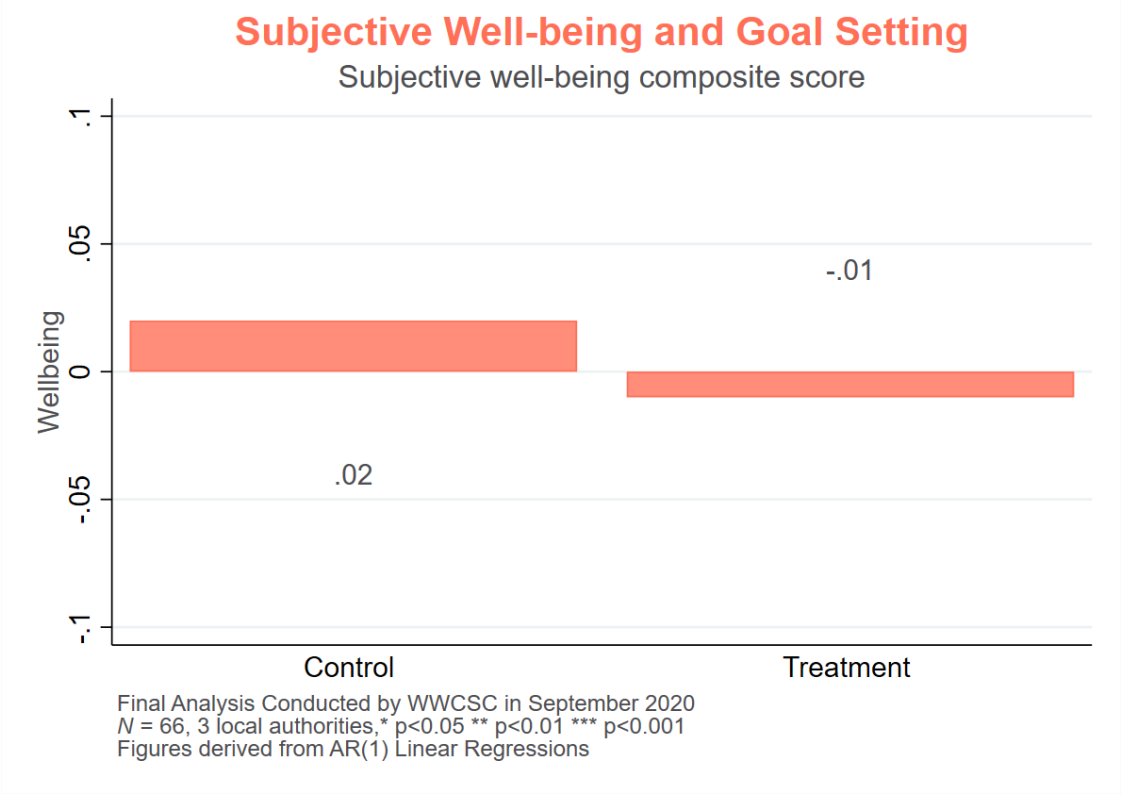


Figure 10: Time Pressure and Goal-Setting

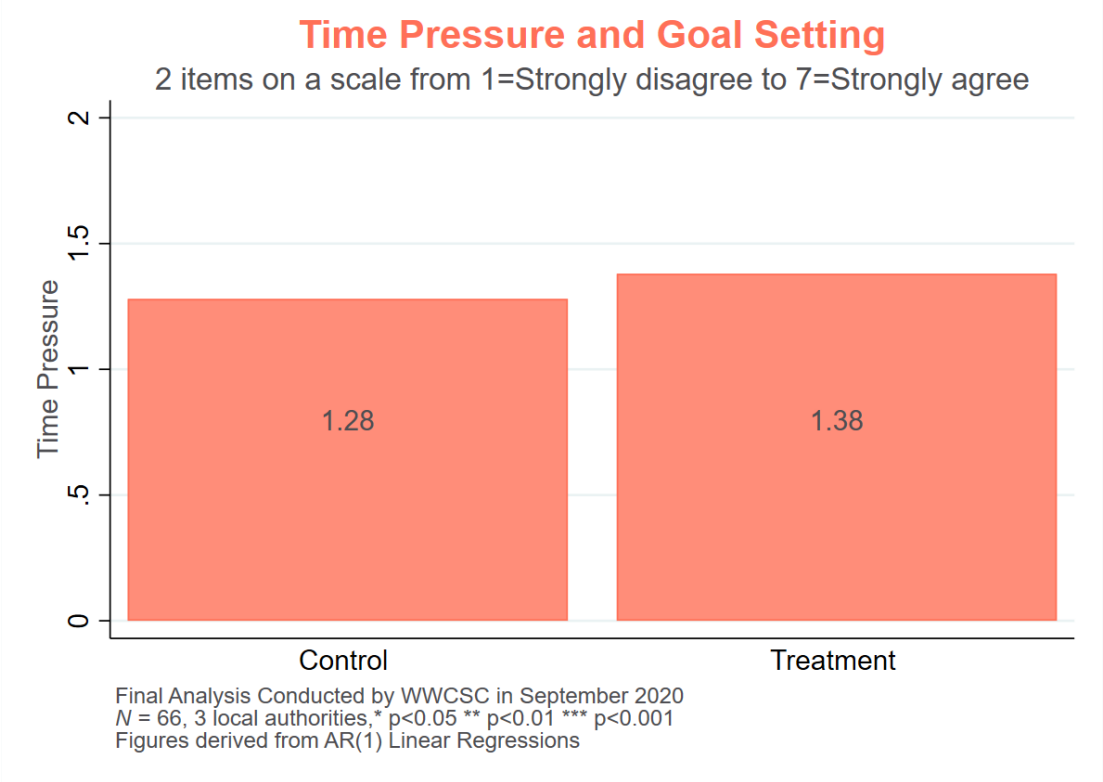
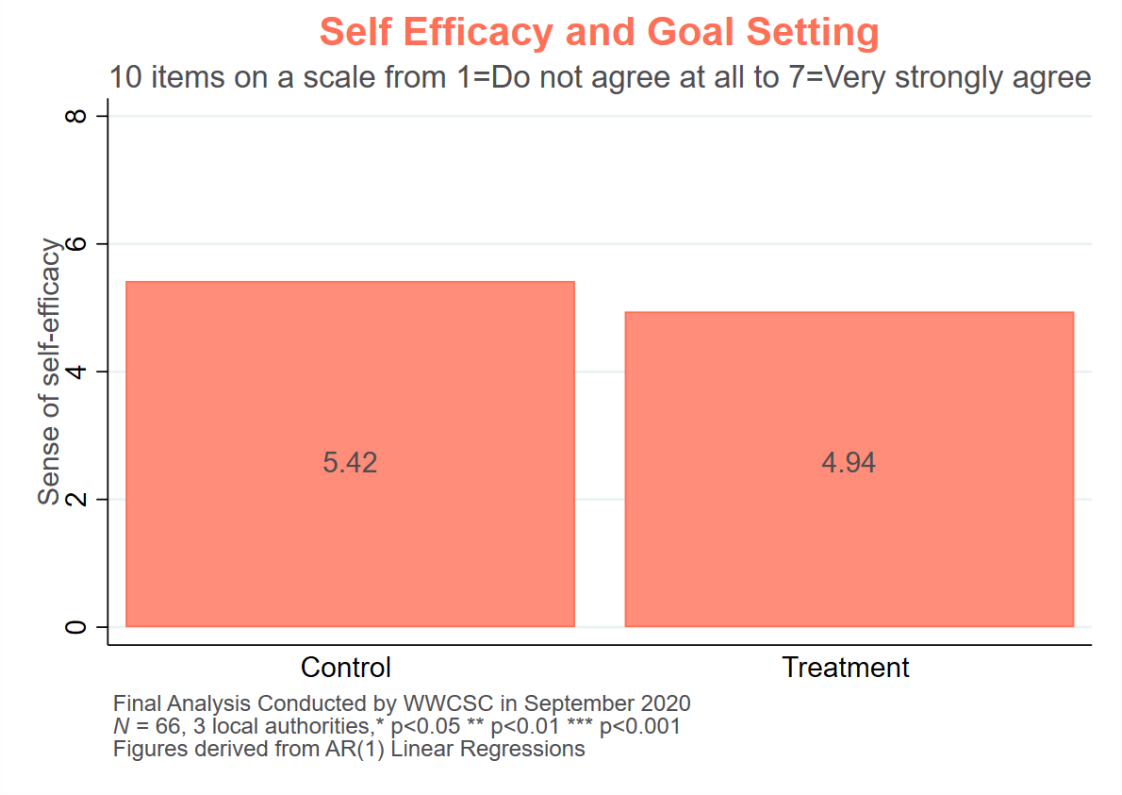


Figure 11: Self-Efficacy and Goal-Setting



Uptake across LAs

Perhaps the most notable finding from this study was the level of uptake, which was far lower than we had hoped at the start of the project. Only 20% of individuals who were assigned to the intervention logged in at least once, while only 10 participants out of a possible 712 assigned to the treatment group (1.4%) completed the full 6-week programme (as tracked by looking at log-in rates with rates of over 6 log-ins). This somewhat limited any impact we could expect to find in our pre-specified outcome measures.

However, several additional questions were included in our endline surveys to help us understand the success of the implementation, reasons for potential low uptake and how social workers used their protected time, if at all. We also conducted a focus group in Bromley with participants in the treatment group which provided us with some additional understanding as to why uptake of the intervention was so low. These insights each provide us with potentially valuable insights when designing interventions of this type in the future. Key findings from these survey measures and the focus group are outlined below:

a. Manager buy-in and role in implementation

Findings from our survey questions and focus group highlighted the pivotal role of team managers in the successful implementation of the programme. Managers were provided with an email detailing information about the programme and a link to the resources to send on to their teams, but our survey results suggested this process did not reliably succeed in ensuring the treatment group received the intervention. Of the 30 people in the treatment group who had responded to the endline well-being survey:

- **11** indicated that they did not recall receiving the invitation to participate in the goal-setting programme,

- **9** stated that they were not sure if they had received it, and
- **10** indicated that they had received the invitation.

This indicates that there may have been issues regarding communication of the programme (e.g. social workers did not read/notice the email, and/or managers did not send the email to their team members). When participants in the treatment group were asked if they had worked with their manager to book a weekly block of time in their calendars for goal-setting, only 3 (10%) reported that they had done so. Additionally, of the 29 people in the control group who had responded to the survey, 4 participants indicated that they had received the intervention, which indicates that there may have been accidental spillover (e.g. managers/ social workers forwarding the email invitation to colleagues, or LA contacts incorrectly emailing managers in the control group regarding the distribution of the invitation).

The responses indicating that social workers in the treatment group did not receive or did not recall receiving the invitation were surprising, despite an earlier email sent by LA contacts to social workers highlighting that they could expect to receive the programme materials, as well as an email from their manager with the goal-setting programme instructions. This highlights the need for future light-touch interventions to ensure that communications regarding the intervention are well-managed.

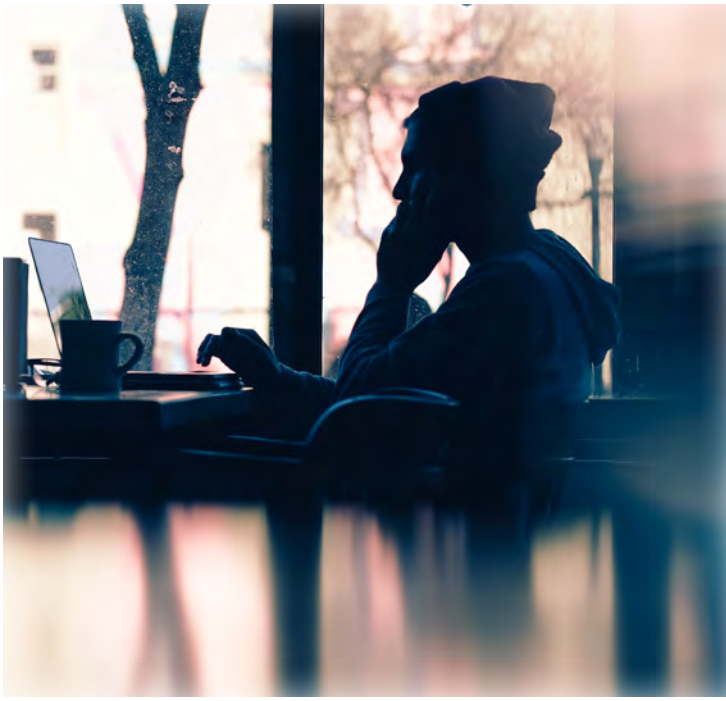
These responses also highlighting the value of obtaining buy-in for the intervention, not only at the senior leadership level but also with team managers - who are themselves likely to have busy schedules and competing priorities (of which the programme was only one), but whose investment in the implementation of team-level well-being interventions likely contributes significantly to their overall success.

b. Time poverty / difficulty protecting time

Despite being encouraged to agree "protected" time slots in their calendars with their managers, only 3 (10%) of the treatment group reported that they had done so in the endline survey. Those that did reported that it was difficult to protect such slots due to the unpredictability in their schedules.

Though participants understood the rationale for the programme, and considered it a potentially useful exercise, many reported having to manage several competing priorities they perceived as more urgent at that moment than a goal-setting exercise, meaning that the slots were repeatedly shifted to a different time and often eventually not used at all. When asked why they had not participated in the goal-setting programme, respondents to our survey noted:

- ***"I started this but then couldn't find the time to carry on"***
- ***"I could not dedicated a protected time slot"***
- ***"There is no point, something always comes up that prevents attendance at these types of things"***



In the open-ended question for further comments, two participant responses further highlighted the perceived challenge with respect to workloads:

- ***"I have been a social worker for 10 years and find that the processes continue to be repetitive and long-winded. Desks work 80% time with young people less than 5%.***
- ***"The reason I manage is because I undertake work on weekends on a regular basis."***

It is therefore important to understand how we can better promote goal-setting or similar interventions so that time-poor social workers perceive more positive benefit in prioritising them, even during busy periods.

c. Framing / description of programme materials:

It was suggested by social workers in our focus group that while the materials were potentially beneficial, the framing of the materials (i.e. as a "programme" with "modules" - see Appendix 2B) might signal that this is a formal or academic course which requires significant cognitive effort and attention - which social workers did not feel motivated to invest in particularly given their busy schedules.

Future research might therefore test different strategies to ensure that the framing of such goal-setting exercises is perceived more positively. Alternatively, social workers could be prompted to complete the goal-setting exercises as part of their teams (e.g. at the same time and on the same day), which could encourage uptake as well as have potential prosocial benefits for coworkers.

STUDY 2: SYMBOLIC AWARDS (LETTERS OF RECOGNITION)

Background

Social workers make incredibly important contributions to society which are often insufficiently recognised, despite the best efforts of management teams. This can result in social workers feeling demotivated, undervalued, and a sense that their organisation does not care about them and their daily efforts. Research suggests that symbolic gestures and awards that have no objective monetary value which recognise an employee for their hard work and efforts can enhance the subjective well-being and motivation felt by employees, as well as potentially increase retention and performance. Moreover, recognising employees with positive verbal feedback can increase intrinsic motivation since it affirms an individual's sense of competence.

Research also suggests that employees' feelings about how their work is valued by others (i.e. perceived social worth) is a key motivator, and when employees feel that their individual efforts at work are valued and recognised, they are more motivated to contribute to their work.

A field experiment involving voluntary contributors to Wikipedia found that non-monetary symbolic awards had a sizable effect on the retention of new volunteers. The share of newcomers who remained active in the month after the award date was 7 percentage points higher for the treatment group (42%) than for the control (35%, $p < 0.001$). These results indicated that symbolic awards can be effective even when they have no added financial benefit or impact on the volunteers future career opportunities.

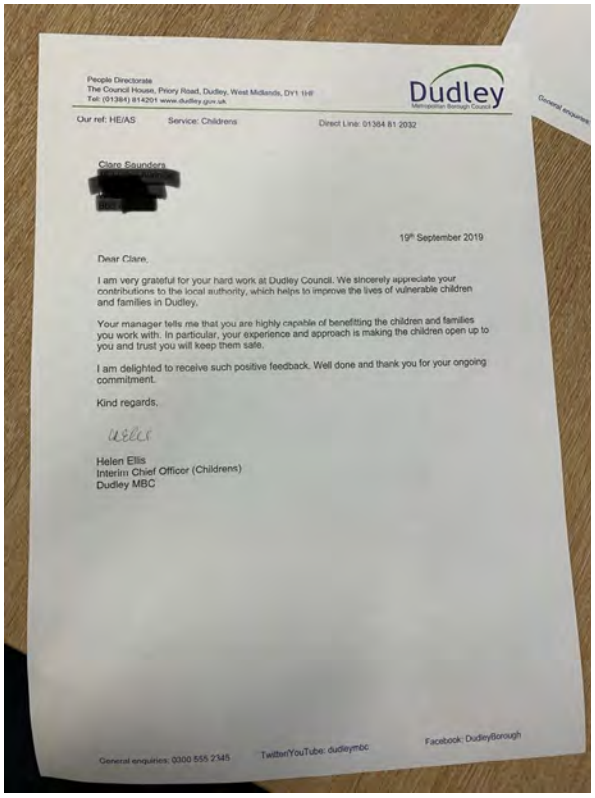
Additionally, symbolic awards can affect the loyalty relation between employee and management. Managers presenting awards may establish an implicit relational bond, and employee's accepting an award signals approval of, and support for, an organisation's values and goals.

Subsequently, we designed an intervention which was aimed at increasing the sense of value and recognition felt by social workers via sending them a symbolic award - specifically, a letter from a senior-level figure in the local authority expressing gratitude for their hard work and commitment in service of the children and families in their local authority.

Intervention

The symbolic award intervention was delivered in the form of short, personalised letters addressed to individual social workers at their home addresses. The letters contained the social worker's first name, two lines of personalised lines of positive feedback directly from each social worker's team manager and sent from a senior-level figure identified by the LA, for example the Director of Children's Services or Chief Officer for Children's Services (see Figure 12 below). (See Appendix 3F for a logic model outlining the hypothesised causal pathways for the intervention.)

Figure 12: Letter of Recognition (sample of letter sent at Dudley Metropolitan Borough Council)



People Directorate
The Council House, Priory Road, Dudley, West Midlands, DY1 1HF
Tel: (01384) 814201 www.dudley.gov.uk

Dudley
Metropolitan Borough Council

Our ref: HE/AS Service: Childrens Direct Line: 01384 81 2032

[redacted]

19th September 2019

Dear Clare,

I am very grateful for your hard work at Dudley Council. We sincerely appreciate your contributions to the local authority, which helps to improve the lives of vulnerable children and families in Dudley.

Your manager tells me that you are highly capable of benefitting the children and families you work with. In particular, your experience and approach is making the children open up to you and trust you will keep them safe.

I am delighted to receive such positive feedback. Well done and thank you for your ongoing commitment.

Kind regards.

Helen Ellis
Interim Chief Officer (Childrens)
Dudley MBC

General enquiries: 0300 555 2345 Twitter/YouTube: dudleymbc Facebook: DudleyBorough

Participants

We recruited participants (N = 391) at three LAs: Bracknell Forest Council, Dudley Metropolitan Borough Council, Shropshire Council. The intervention was launched in the first three of these LAs between September and November 2019, and outcome data collected in early 2020.

We had recruited a further 947 participants at London Borough of Southwark and City of Bradford Metropolitan District Council; however, launch of the intervention at both LAs was delayed and ultimately canceled due to the Covid-19 pandemic, and thus we do not report on findings here for these two LAs.

Sample Characteristics

Role and Length of Service:

The sub-sample (n = 66) who responded to the survey consisted of 49 children's social workers, 5 senior practitioners, 5 NQSW, 2 student social workers, 1 manager, and 4 employees listed as "other". The mean length of employment indicated by survey respondents (n =57) was 52.58 months (SD =75.60), ranging from 0 to 437 months. Thus social workers in our sample who responded to this question were employed in the LA for an average of 4.38 years.

Age and gender:

The mean age indicated by participants who responded to the question (n = 23) was 42.17 (SD = 11.49). In terms of the gender balance indicated by participants who responded to the question (n = 58), we had a majority female sample (n = 50).

Marital status and children:

For the participants who responded to the question on marital status (n = 27), this was roughly balanced, with 14 participants single and 13 participants married.

For the participants who responded to the question regarding having children who currently live at home with them (n = 27), 16 participants indicated that they currently had dependent children living at home.

General health, overtime worked and caseload:

For the participants who responded to the question regarding their general health (n = 27), 23 participants rated their health as "good" or "excellent", and 4 participants rated their health as "fair" or "poor".

For the participants who responded to the question regarding the number of hours they worked beyond their contracted hours (n = 27), 14 participants reported working 5 or more hours, 8 participants reported working 3 or more hours, 3 participants reported working at least 1 hour, and 2 participants reported that they did not work overtime hours.

For the participants who responded to the question regarding caseload (n = 27), "Do you feel your caseload is manageable?" (on a 7-point scale where 1= not at all, 7= completely), respondents rated this on average at 4.52 (SD = 1.63).

Method and Design

The study was a randomised controlled trial, with the randomisation taking place at the individual level. We collected administrative data on staff demographic information and a measure of sickness days over the past 12 months to use as control variables in our analysis, and to randomise participants. Administrative data was also collected after 2 months, including rates of sickness absence for that time period. A short wellbeing survey was administered around a week after the launch of the intervention to collect information on social workers' subjective well-being (our primary outcome), and their motivation, sense of belonging to the organisation, and sense of feeling valued.

Trial type and number of arms		Randomised controlled trial, two-armed
Unit of randomisation		Individual
Stratification variables (if applicable)		N/A
Primary outcome	**Variable**	Subjective well-being
	Measure (instrument, scale)	Overall Life Happiness scale (survey data, scale of 0-10); Cantril Ladder (survey data, scale from 0-10); Schedule for Positive and Negative Affect scale (survey data, scale of 1-5)
Secondary outcome 1	**Variable**	Staff sickness absence
	Measure (instrument, scale)	Participant sickness absence in the past 2 months (administrative data, number of days)

Secondary outcome 2	**Variable**	Mechanism 1: Motivation
	Measure (instrument, scale)	Intrinsic and Prosocial Motivation scale (survey data, scale of 1-7)
Secondary outcome 3	**Variable**	Mechanism 2: Sense of belonging
	Measure (instrument, scale)	Affective Commitment and Perceived Organisational Support scale (survey data, scale of 1-7)
Secondary outcome 4	**Variable**	Mechanism 3: Sense of feeling valued and recognised by the LA for one's work
	Measure (instrument, scale)	Perceived Social Worth scale (survey data, scale of 1-7)

Outcome Measures

Our primary outcome measure was focused on a priority of the LAs we partnered with which was to increase the subjective well-being of social workers. Choosing this as our main outcome of interest was based on the rationale that subjective well-being is the outcome variable that we expect the largest increase from baseline scores as a result of our intervention. We hypothesised that our primary outcome, subjective well-being, could lead to a reduction in social worker sickness absence (an administrative, objective measure), which we included as a secondary outcome.

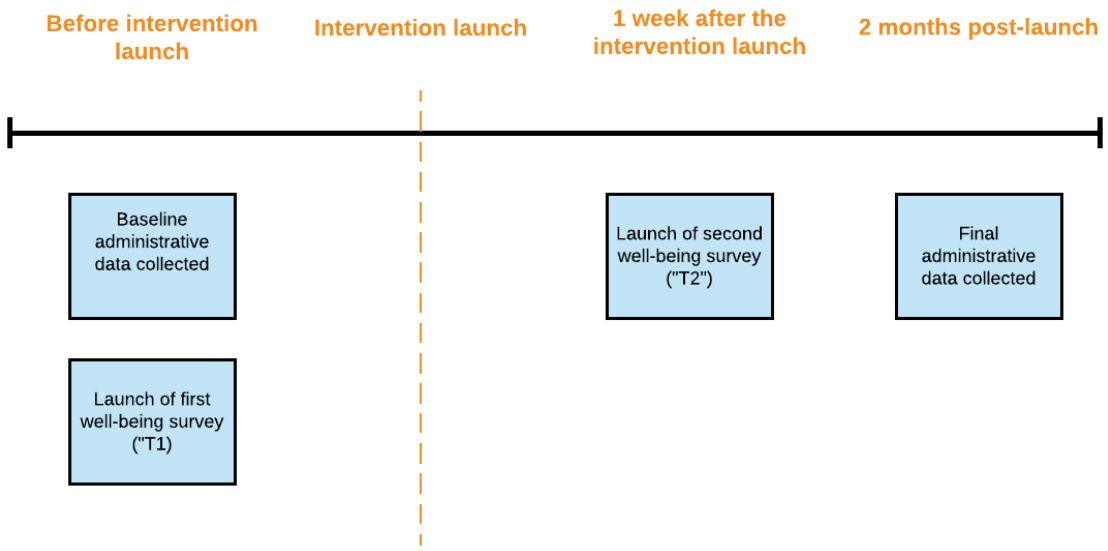
We also tested a range of secondary mechanisms through which we hypothesised social worker well-being may be boosted. Scales were therefore included to measure participants' sense of intrinsic and prosocial motivation; sense of organisational support and affective commitment (i.e. sense of belonging to their organisation); perceived social worth (i.e. sense of feeling valued and recognised for their work). These were included in order to test the hypothesised causal pathways and because they represent features of a positive workplace environment in and of themselves. See Appendix 3A for full survey measures.

Results from a range of exploratory measures (organisational support, prosocial impact, burnout, job satisfaction and turnover intentions) are included in Appendix 3G.

Timeline for Data Collection

We collected administrative data twice; once at pre-intervention, and again 2 months post-intervention. well-being survey data was collected directly prior to the launch of the intervention (T1), and again after the intervention ended 2 months later (T2). See Figure 13 below.

Figure 13: Timeline for Data Collection



Randomisation

Randomisation was conducted at the individual level using baseline data provided by LAs prior to commencement of the trial, whereby half of social workers at each LA were randomised to receive the letter, and the other half were allocated to a control group, where they received the letter after the intervention ended. In total, 345 social workers were included in the randomisation (not including participants who had left the LA by the beginning of the trial, or those for whom we had not received feedback from direct line managers). As social workers would receive the letters at their home, we decided that the risk of spillover biasing our treatment estimate was outweighed by the benefit provided by an individual-level randomisation, which increased our statistical power for the study.

Findings

Significance thresholds

The volume of completed wellbeing surveys contributing to our outcome measures for this trial was substantially lower than we initially anticipated. In total, only 65 participants from three local authorities returned surveys, less than a quarter of the number we had hoped to collect (276). This was due to a lower response rate (19%) than the 30% rate included in our original power calculations, and also the cancellation of the launch of the intervention in two additional local authorities - London Borough of Southwark and City of Bradford Metropolitan District Council - due to the pandemic, meaning that only three of the local authority partners were included in our analysis.

In the graphs below, we therefore include additional indicators for where the difference between the treatment and control groups is significant at a 10% or 20% level. However, while it is possible that lack of outcome data is a reason the results did not reach conventional significance levels, it should be noted that these are indicative only and the adjusted significance thresholds should not be treated as robust evidence for the intervention's effectiveness.

All regression table outputs are included in Appendix 3E.

Primary Outcome: Subjective Well-Being

For our primary outcome subjective well-being, we conducted a linear regression for the total

number of participants for whom we had survey data (n = 66). There was anincrease in well-being for participants in the intervention group (n = 30, M = .24, SE = .34) compared to the control group (n = 36, M = -.30, SE = .29), p = 0.23.

A paired t-test demonstrated that participants in the treatment group (M = .24, SD = 1.86) reported higher subjective well-being compared to the control group (M = -.30, SD = 1.74), though this increase, 0.54, was not statistically significant, $t(64) = 1.21$, p = .23.

Secondary Outcome 1: Attendance

For our secondary outcome attendance (measured via sickness absence rates), we conducted a linear regression for the total number of participants for which we had interim administrative data (n = 275). There was a non-statistically significant decrease in sickness absence rates for participants in the intervention group (n = 132, M = 37.02, SE = .63) compared to the control group (n = 143, M = 37.31, SE = .57), p = 0.67. This a small 0.78% reduction in sickness absence rates for participants who received the treatment.

A paired t-test demonstrated that participants in the treatment group (M = 37.02, SD = 7.29) had lower levels of sickness absence rates compared to the control group (M = 37.31, SD = 6.78), and this decrease, 0.30, was not statistically significant, $t(273) = 0.35$, p = .72.

Secondary Outcome 2: Motivation

For our secondary outcome (mediator) intrinsic and prosocial motivation, we conducted a linear regression for the total number of participants for whom we had survey data (n = 66). There was a non-statistically significant (though trending towards significance) increase in motivation for participants in the intervention group (n = 30, M = 47.57, SE = .91) compared to the control group (n = 36, M = 44.47, SE = .87), p = .17. This a 6.7% increase in motivation for participants who received the treatment.

A paired t-test demonstrated that participants in the treatment group (M = 47.57, SD = 4.97) reported higher motivation levels compared to the control group (M = 44.47, SD = 5.23), and this increase, 3.09, was a statistically significant difference, $t(64) = 2.45$, p = .017.

Figure 14: Subjective Well-being

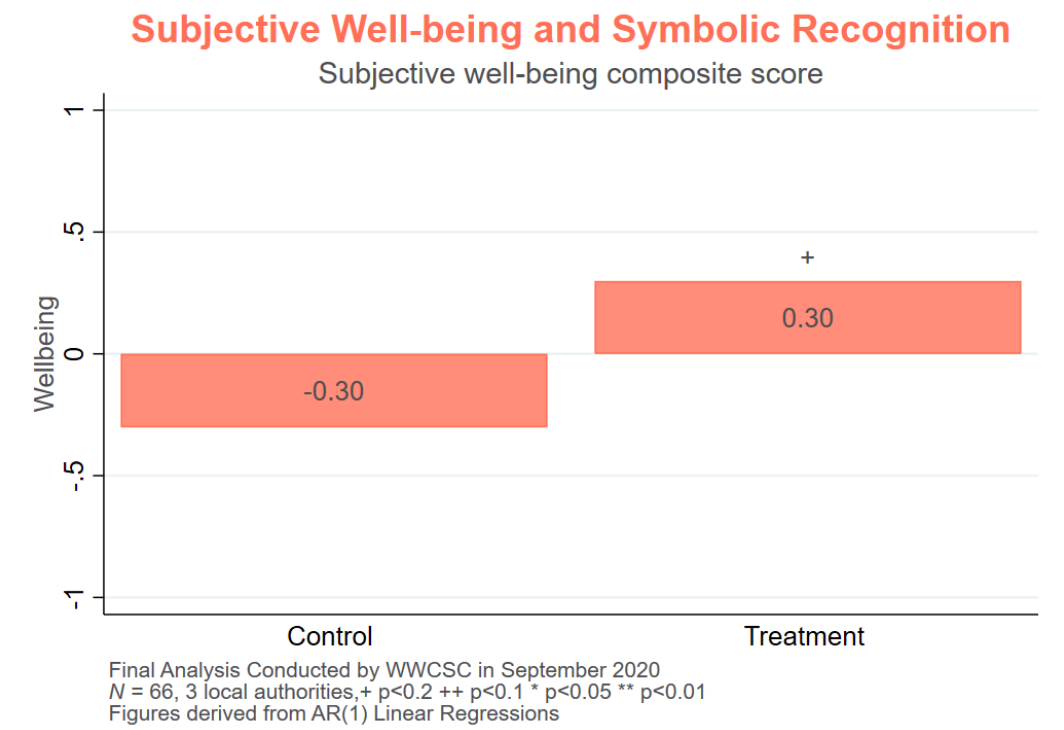


Figure 15: Attendance

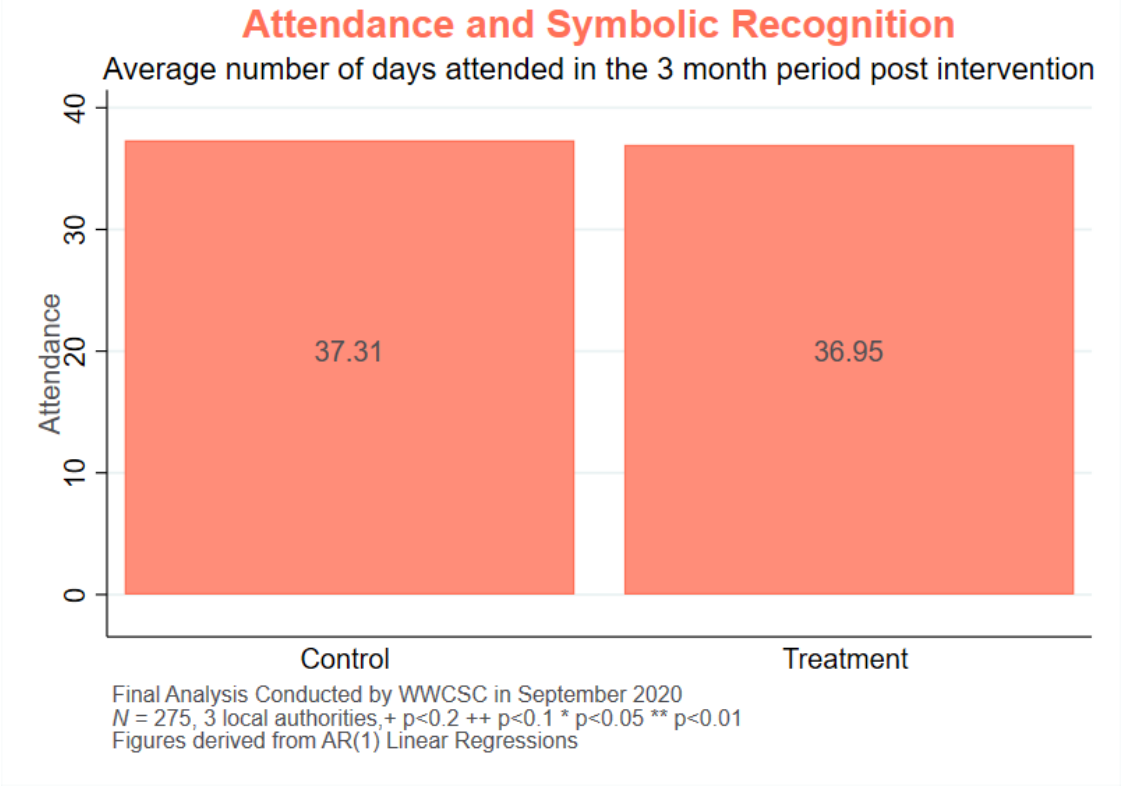
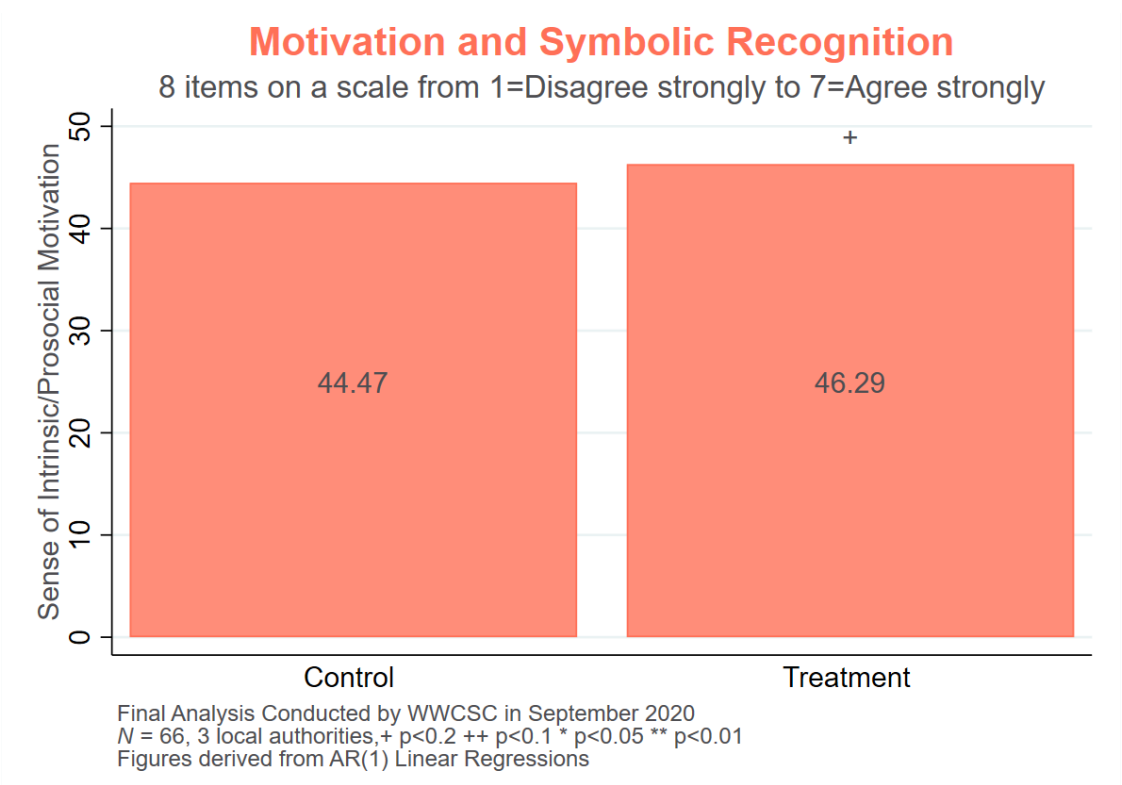


Figure 16: Intrinsic and Prosocial Motivation



Secondary Outcome 3: Sense of Belonging

For our secondary outcome (mediator) sense of belonging, we conducted a linear regression for the total number of participants for whom we had survey data (n = 66). There was a non-statistically significant (though trending towards significance) increase in belonging for participants in the intervention group (n = 30, M = 29.43, SE = 1.09) compared to the control group (n = 36, M = 25.03, SE = 1.19), p = .15. This a 16% increase in belonging for participants who received the treatment.

A paired t-test demonstrated that participants in the treatment group (M = 29.43, SD = 6.00) reported higher belonging levels compared to the control group (M = 25.03, SD = 7.15), and this increase, 4.4, was a statistically significant difference, $t(64) = 2.68$, p = .009.

Secondary Outcome 4: Perceived Social Worth (sense of feeling valued and recognised by the LA)

For our secondary outcome (mediator) perceived social worth, we conducted a linear regression for the total number of participants for whom we had survey data (n = 66). There was a statistically significant increase in perceived social worth for participants in the intervention group (n = 30, M = 10.0, SE = .54) compared to the control group (n = 36, M = 8.28, SE = .48), p = .03. This a 1.7% increase in perceived social worth for participants who received the treatment.

A paired t-test demonstrated that participants in the treatment group (M = 10.0, SD = 2.98) reported higher levels of perceived social worth compared to the control group (M = 8.28, SD = 2.90), and this increase, 1.72, was a statistically significant difference, $t(64) = 2.37$, p = .02.

Figure 17: Sense of Belonging (Affective Commitment)

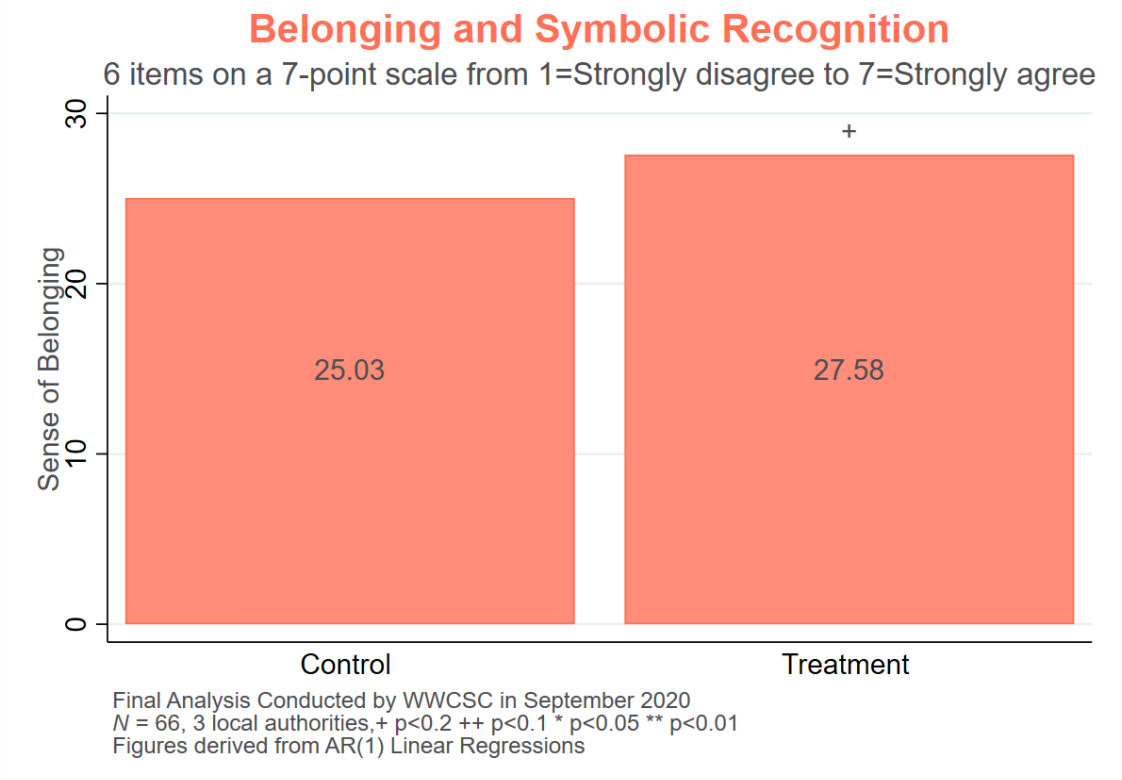
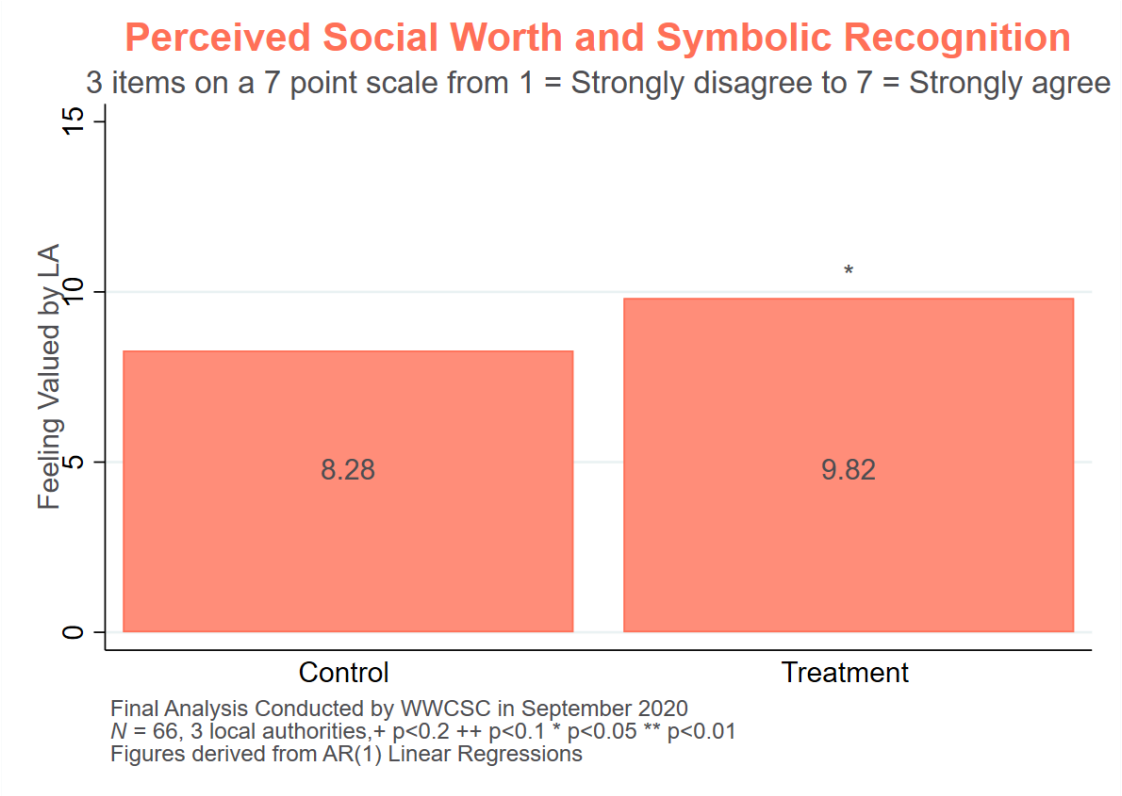


Figure 18: Perceived Social Worth



Implementation Issues/Attrition

One key issue faced relative to this intervention was seeking manager feedback. We had to rely on our LA contacts in order to reach out to managers and collate manager feedback (see Appendix 3B and 3C for outreach materials to managers) and not all participants were provided with feedback, meaning that they did not receive the intervention. These individuals were included in the analysis as this was an intention-to-treat design which may have diluted our treatment effect, but we wanted to replicate conditions as they would be were local authorities to implement the intervention themselves.

We also faced significant attrition from baseline to endline, and despite an original sample of 345 participants, only 66 responded to the endline survey. This likely substantially impacted the robustness of our findings. Several of our outcome measures show directional changes, though these fall below the conventional thresholds for statistical significance, possibly as a result of collecting less outcome data than we had planned due to the survey response rates, as well as the impact of the pandemic forcing two participating LAs to withdraw.

STUDY 3: ACCESS TO FREE COFFEE AND TEA

Background

Social workers make hugely important contributions to society which are often not reflected in additional workplace rewards due to budget constraints, which can result in demotivation over time. Research has shown that material rewards which emphasise recognition for employees' efforts can produce disproportionately large effects on well-being given the monetary cost .

In site visits to speak to local authorities participating in the wider Happier Healthier Professionals programme, social workers often highlighted the discrepancy in the seriousness of the challenges they face, as well as the time pressure associated with high and complex caseloads, and how they feel they are perceived as a workforce from within and outside the field. The absence of any kind of 'perks' in their work environment - exacerbated by council budget-cuts - were seen as symptomatic of this wider issue. This perceived lack of recognition can lead to increased stress, which in turn contributes to increased rates of sickness absence and staff turnover. Well-being is also important in and of itself - all workers, perhaps especially those doing a public good - deserve to be in environments that promote their well-being.

This pilot study aimed to explore whether providing social workers with a small, material display of recognition from their local authority - namely, access to high-quality free coffee and tea at work - could increase social workers' sense of feeling recognised and appreciated by their local authority, and thus contribute to overall well-being.

Intervention

The coffee machines and coffee/tea supplies were installed in LA buildings assigned to the treatment group and were accompanied by a laminated message addressed to social workers from senior management, emphasising that the coffee machine and supplies were a small token of appreciation for the dedication and hard efforts of social workers to their work (see Figure 19 below). The machines were free for the LAs to keep following the 6-month trial period. (See Appendix 4E for a logic model outlining the hypothesised causal pathways for the intervention.)

Figure 19: Coffee Machine Installation

Participants

380 participants were recruited from one LA, Kent County Council. The council had 13 buildings which housed at least 25 children's social workers, which was the minimum number for a building to be included in the trial.

Challenges in recruitment

A number of additional LAs were interested in taking part in the trial, but there was some initial concern that providing the machines to some of their workforce rather than others would produce a negative reaction among their staff, and several ultimately decided not to proceed for this reason. One additional local authority was due to launch the intervention, but the Covid-19 pandemic forced them to withdraw.

Subsequently, recruitment for the trial was lower than initially hoped. In addition to this, the need to randomise at a building level to preserve the integrity of the treatment and control groups meant that the trial was substantially unpowered, and we therefore classified it as a pilot study and use adjusted thresholds to designate what we believed would constitute indicative evidence of impact in our outcomes.

Method and Design

The study was a clustered randomised controlled trial, with randomisation taking place at the building level. We collected administrative data on staff demographic information and a measure of sickness days over the past 12 months to use as control variables in our analysis. Administrative data was intended to be collected at interim (3 months after the launch of the intervention) and endline (6 months after), including rates of sickness absence for that time period. A short wellbeing survey was also due to be administered at 3 months to collect information on our other three secondary outcomes: social workers' subjective well-being, motivation and sense of belonging. However, for the reasons outlined above only interim administrative data was available for analysis.

Trial type and number of arms		Clustered randomised controlled trial, two-armed (pilot)
Unit of randomisation		Building
Stratification variables (if applicable)		Number of social workers situated in the building
Primary outcome	**Variable**	Sickness absence
	Measure (instrument, scale)	Participant sickness absence in the past 6 months (administrative data, number of days)

Secondary outcome(s)	**Variable**	Subjective well-being
	Measure (instrument, scale)	Overall Life Happiness scale (survey data, scale of 0-10); Cantril Ladder (survey data, scale from 0-10); Schedule for Positive and Negative Affect scale (survey data, scale of 1-5)
	Variable	Motivation
	Measure (instrument, scale)	Intrinsic and Prosocial Motivation scale (survey data, scale of 1-7)
	Variable	Belonging
	Measure (instrument, scale)	Affective Commitment and Perceived Organisational Support scale (survey data, scale of 1-7)

Outcomes of Interest

Our primary outcome measure was sickness absence, which had the advantage of being an objective measure routinely recorded by LAs. Subjective well-being was included as a secondary outcome, and although we may expect this measure to be more easily influenced by the intervention, we were conscious of the challenges in obtaining sufficient survey completion rates to sufficiently measure this, as described above. We also included measures to test three mechanisms we believed might influence the two measures described above: organisational / affective commitment; and sense of belonging and motivation. See Appendix 4A for the full survey measures.

Timeline for Data Collection

We had planned to collect administrative data three times; at pre-intervention, at interim (3-months post launch), and at endline time points (6-months post launch). However, due to the Covid-19 pandemic, we were only able to collect administrative data at pre-intervention and interim time points. Well-being survey data was collected directly prior to the launch of the intervention (T1), and we had planned to administer the second well-being survey 6 months later (T2), but similarly this was halted due to the onset of the pandemic. See Figure 20 below.

Randomisation

This was a cluster randomised trial, conducted as a pilot evaluation, with buildings as the clusters due to the need to install the machines by building, recognising the infeasibility of preventing participants in the control group from using coffee machines installed in their building. Thus, randomisation was conducted at the building-level (whereby 13 whole buildings of 380 eligible employees were randomised to either receive or not receive the intervention), using baseline data and team location information provided by LAs before the commencement of the trial. We also stratified on the number of social workers situated in each building to ensure that there were roughly balanced samples in both the intervention and control groups. 6 buildings were assigned to treatment and 7 to the control group.

Figure 20: Timeline for Data Collection

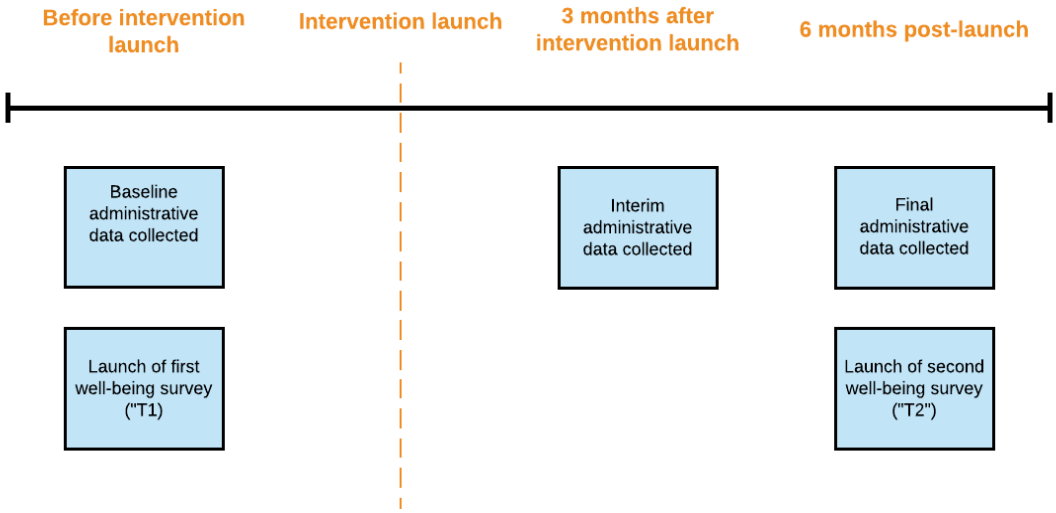
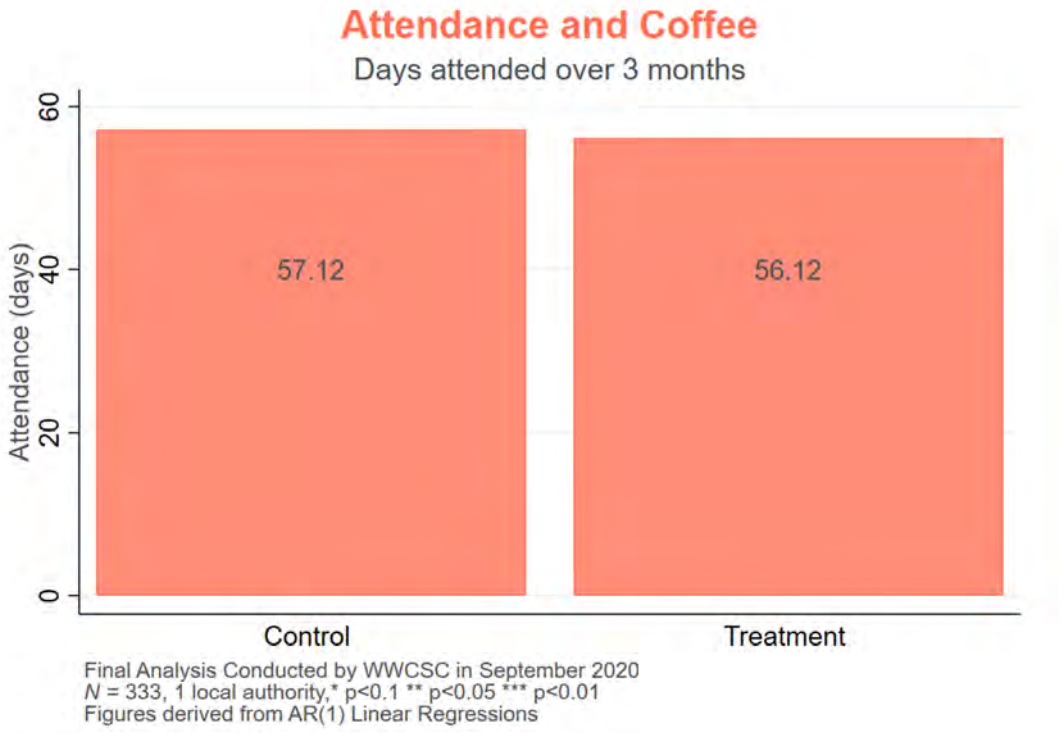


Figure 21: Attendance and Coffee



Findings

Primary Outcome: Sickness Absence

To determine the impact of the intervention on attendance, we conducted a linear regression for the total number of participants for whom we had interim administrative data (n = 333).

There was a non-statistically significant decrease in days attended in for participants in the intervention group (n = 190, M = 56.12, SE = 1.20) compared to the control group (n = 143, M = 57.12, SE = 2.31), p = 0.41. This a 1.75% decrease in days attended for participants who received the treatment. The regression table is included in Appendix 4C.

Secondary Outcomes: Subjective Well-being, Motivation and Belonging

Given that we were unable to collect endline well-being data at Kent due to the Covid-19 pandemic, we conducted a follow-up interview in early 2021 with a service manager and two business support employees who were responsible for coordinating the implementation of the intervention in the buildings. We summarise these insights below.

A service manager at Kent said that initially there was a mixed reception from social workers regarding the intervention, in particular around the use of money, with some feeling that council funding should be spent directly on children and families rather than on staff 'perks'. This highlights a further challenge in designing interventions to promote social worker well-being in the workplace. Social workers are keenly aware of the hardships experienced by the families they work with and the scarcity of funds to help improve their circumstances, and therefore any public money spent on what they perceive as 'unnecessary' extras is deemed to be misspent.

However, the manager also said that the intervention helped to ease a pre-existing inequality as a result of the particular office the LA's social workers worked from - some of which were seen to be a substantially better working environment and have 'perks' such as discounted coffee and tea. Thus, it appeared that the intervention helped to make social workers in the less well-furnished buildings feel they were not excluded from the perks enjoyed by working in other council buildings.

A business support employee reported that overall feedback from social workers regarding the access to free coffee/tea was very positive. She stated,

> ***"It was really communal - social workers would congregate around the coffee machine and ended up having a competition on who made the best coffee."***

She also reported that given that there is generally no availability of such free work perks and that they do not always have the best working conditions, it was something that added to people's sense of feeling valued.

Several social workers commented that it was nice to feel appreciated. She stated:

> ***"LAs have lots of commitments in terms of funding, so it was nice to show some appreciation and some people made comments about how it was nice to get a little extra - it felt like a reward and it recognised that they were working hard."***

Overall, she said that she thought that the intervention helped to improve morale and created a sense of community - team members would tend to congregate around the machine to talk:

> ***"They would all go to the coffee machine together, they would have a debate about how many spoons of coffee to put in and it was a bit of a bonding experience. Also social workers are not very good at taking breaks, so it helped them to take breaks a bit better since it takes longer to make coffee and gave the opportunity for people to talk and catch up."***

When asked about what social workers caught up about, she said that it was usually a mixture of work and personal chat - varying from discussing how they were doing personally, to using the time to discuss a particular case. She said:

> ***"The face-to-face element does so much more the world of good than all of the other resources combined - personal relationships with colleagues is the thing that gets social workers through hard times."***

This was supported by the service manager, who said that people used their coffee breaks as an opportunity to talk about their well-being, while another business support employee reported that social workers felt more supported by their employers as a result of the access to free coffee and tea.

GENERAL DISCUSSION

Study 1: Goal-Setting

The central finding from this trial was that uptake among participants was very low - around 20% of the treatment group engaged with the intervention at any time, and fewer than 2% actually completed each of the six weekly modules. Subsequently, no differences were observed in our four outcome measures.

Survey questions and qualitative data suggest that part of the reason for low uptake was likely to be implementation failure as a result of team managers not sharing the resources with their teams. 66% of survey respondents in the treatment group (n=30) reported either not receiving the programme, or not being sure that they had. Many participants who were interviewed and who did receive the materials from their managers reported that they felt they were too busy to make use of the programme, even though they understood it was designed to save them time in the long run. There were also suggestions that the description of weekly 'modules' made the programme seem potentially onerous and likely to require significant time and effort to complete, which may have been a further barrier to engagement with the intervention.

Although the implementation was not successful, the study provides us with valuable insights into how future interventions might be designed and framed for the workforce. Our findings imply that future interventions should focus time on creating buy-in with both social workers and managers, ensuring both parties understand the rationale for why such an intervention could be effective and how it could benefit them. Future research might also consider interventions which entail more substantial changes in team or local authority processes, which could avoid asking time-pressured individuals to undertake an additional task during their day, which is likely to be de-prioritised given the many competing demands on their attention.

Study 2: Symbolic Awards (Letters of Recognition)

We found that the symbolic awards intervention had a significant positive impact on social workers' sense of feeling valued and recognised by one's local authority. Three of our other outcomes (subjective well-being, sense of belonging, motivation) also showed positive directional impacts, though these were not significant at conventional levels. However, it is possible that this was a result of lower levels of data collection than anticipated due to the pandemic and our survey response rates.

This provides tentative yet exciting evidence to suggest that such letters could be successful in increasing subjective well-being amongst social workers in their workplace, and could be used as part of a well-being toolkit by local authorities to promote social worker well-being. Moreover, this is an easy-to-implement, light-touch intervention that requires little work on the part of local authorities, and that can result in improved well-being.

As the surveys were administered a short time after the intervention, future work could investigate the longer-term impact of such an intervention, for example by delivering interventions of this type more than once over longer periods of time (e.g. over 3 months and 6 months) rather than a one-off letter. A longer-term intervention could also provide the opportunity to examine the impact of symbolic awards on other potential outcomes that matter to organisations, such as productivity and performance.

Moreover, future interventions could also examine the effectiveness of the messenger of such letters. Past work has examined the effectiveness of letters of recognition coming from direct beneficiaries of one's work (service users in the social worker context), and while there are logistical issues associated with contacting service users to request feedback, this is a potentially important and unexplored avenue of research that could have a higher impact on well-being than having the letter come from a senior-level figure. Messages coming from service users could help to create a feedback mechanism and reconnect social workers with their intrinsic goals and prosocial motivation for entering the social work profession, by reminding them of the positive impact of their work on others, an element which can often get lost in the environment of their day-to-day child protection work.

Study 3: Access to Free Coffee/Tea

Coffee machines and tea and coffee supplies were installed in 7 buildings across one local authority in October 2019, with final data collection due to take place in March 2020. However, due to the disruption to the LA caused by the Covid-19 pandemic, neither the survey nor the administrative data was provided at this time-point. We did, however, collect interim administrative data on rates of sickness absence, though this indicated that there was no significant difference between the treatment and control groups.

Short interviews conducted earlier this year did however provide some indication of how the machines were received by social workers in Kent. The social workers and business managers interviewed reported that the impact on the teams they worked in was ultimately very positive. As the profession does not tend to have access to free resources in the office environment, or the 'perks' that might be more common to other professions, the interviewees reported that the feedback they received from social workers was that the intervention made them feel more valued by their employer, which was a key mechanism the intervention had aimed to influence. Social workers also reported that the introduction of the coffee machines had cultivated a sense of community and feeling of social connectedness, as team members would congregate around the coffee machine to take a break and catch up with their colleagues while they waited for the coffee to brew, something they were unlikely to have done in regular circumstances.

While the amount of data we were able to collect was substantially impacted by the disruption caused by the Covid-19 pandemic, these qualitative insights might nevertheless provide LAs reason to consider the often intangible benefits of making a modest investment in their office environments. In this case, the machines somewhat unexpectedly provided a nudge for more informal conversations between team members which would not have happened in the absence of an excuse to leave their desks for a short break, and which we might expect to strengthen bonds between employees.

Challenges

A key challenge in the evaluation of our interventions was survey uptake. Response rates to well-being surveys was low, approximately 17.7% on average across the two studies in which they were administered. This resulted in a substantial decrease in our ability to detect an effect of the intervention across each of the studies. Future evaluations should aim to make use of existing processes to implement surveys where possible, for instance prompting employees to fill out surveys in person during team meetings, or identify alternative means of administering surveys such as time at the start of team meetings or via text message. Equally, evaluations could focus more heavily on administrative data which is likely to be available for all participants, though this may necessitate a more substantial type of intervention or a larger sample size to be able to detect any effect, as these outcomes tend to be harder to impact.

Conclusions and Directions for Future Research

While some elements of our evaluation of the three wellbeing interventions were undermined by the disruption to data collection as a result of the Covid-19 pandemic, this report nevertheless highlights several valuable findings which can be used to inform both policy decisions made by senior management at local authorities around what can be done to support their staff, and also areas of promise for future research in this area.

Our symbolic awards trial provides evidence that employers can, with relatively little time or cost, positively influence employees' sense of feeling valued and supported by their local authority. While this was not reflected in data on staff sickness absence rates, this trial demonstrates that social workers' relationship to their employer has the potential to be meaningfully improved, and local authorities can consider this intervention as an example of the types of policies they might implement to produce sustained changes in employer-employee relations. Insights taken from our coffee trial, while limited, further support the view that there might be organisational benefits to making non-monetary signals of appreciation for staff.

Perhaps equally important is the finding from our goal-setting experiment that the degree of time-pressure experienced by social workers is such that they are unlikely to be motivated to engage in interventions which ask them to take any additional time out of their schedules, even if its purpose is to counteract that very problem. This suggests that interventions should not expect widespread upfront engagement from staff, and arguably also highlights the pressing need for more substantial interventions, perhaps technological or structural, which effectively address the root cause of these challenges.

Analytical Decisions

Due to the issues regarding data collection and implementation as a result of the Covid-19 pandemic, there were a number of strategic and analytical decisions we had to make in order to ensure that we were able to proceed with analysis of the trials, while ensuring that we remained as close as possible to the details outlined in the original trial protocols. There were also a small number of analytical decisions taken in the process of preparing the data for analysis to respond to issues which were not anticipated in the initial research design, and therefore not detailed in the trial protocols. These deviations or additions to the strategies outlined in the trial protocols are detailed in the Table below.

Table 2: All trials

All trials	
Decision	**Detail**
Cost-benefit analysis (CBA)	We did not conduct a CBA as indicated in the trial protocol, since the finding for our primary outcome subjective well-being was not significant.
Creation of 'days attended' outcome measure rather than 'days of sickness absence'	In the symbolic awards trial protocol, we specify that we will compute a 'days attended' measure from the data reported by LAs to use as an outcome measure, rather than days of 'sickness absence' as described in the other trial protocols. We decided to adopt this strategy for each of the analyses, as this allowed us to include social workers who leave their posts over the course of the trial - these individuals are classified as absent every day after they leave. Excluding these participants from the absence analysis would risk biasing the results, as we suspect that individuals' likelihood to leave is correlated with their rate of sickness absence.
Pro-rata imputation of baseline sickness absence for new staff at LAs	When writing the trial protocols we did not consider how to impute baseline sickness absence for social workers who were new to the local authority and therefore did not have a full 12 months of data to use as a control variable. We therefore decided to null impute for those social workers who had been at the LA for less than three months, and to use a pro-rata calculation for those who had been employed for between 3 and 11 months.
Null imputation of other control variables	We decided to consolidate our imputation strategy for the three trials so that missing data for our control variables was null imputed rather than employ mean or multiple imputation, as stated in the trial protocols: ▪ In the symbolic awards trial protocol, we did not indicate how we will impute missing data for control variables. ▪ In the goal-setting trial protocol, we indicated that we will use multiple imputation for control variables. ▪ In the coffee trial protocol, we indicated that we will use multiple imputation for control variables. The trial protocols were written sequentially while the WWCSC statistical guidance was in development, resulting in differing strategies in each, and we therefore decided to adopt the same strategy in our final analyses so that it coheres with the updated organisational guidelines.
Categories of participant 'role' in LAs	In our trial protocol we say that we will categories participants as one of five types of role for analysis. However, we did not consider the role of 'social work assistant', some of whom are included in the sample in some LAs. We therefore created a new category for these participants to include them in the analysis.

Goal-setting trial	
Decision	Detail
Cost-benefit analysis (CBA)	We did not conduct a CBA as indicated in the trial protocol, since the number of participants in the treatment group who actually followed through on completion of the goal-setting programme was so low.
Access to Free Coffee/Tea trial	
Decision	Detail
Cost-effectiveness analysis (CEA)	We did not conduct a CEA as indicated in the trial protocol, as we found no effect of the intervention across any of our outcome measures at interim and we were unable to gather any endline data to conduct analysis.
City of Bradford Metropolitan District Council score analysis not included	We were unable to conduct this analysis as the participating LA did not record absence spells information
'Part-time' control variable in regression	We were unable to include this variable as a control in our regression as it was not information recorded by the participating LA.
Imputation	We used null imputation instead of the following strategies outlined in the trial protocol to handle missing data: ▪ Removing the data and only using complete cases. ▪ Using a Heckman selection model. ▪ Multiple imputation using the available covariates.

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APPENDIX 1

Appendix 1A: Call for Partners

Flagship research programme aims for happier, healthier professionals

The What Works Centre for Children's Social Care is inviting local authorities in England to collaborate with us in one of our flagship projects for 2019 that aims to help support social workers and their managers to be happier and healthier at work.

The call follows feedback from over 25 partners who we have worked with over the last two months in designing the programme of research, which involved shortlisting research interventions informed directly by discussions with current local authority partners.

With these partners and in collaboration with Harvard Business School and University College London, we have designed a series of light touch, low cost or free interventions based on behavioural science. This includes interventions that help boost the motivation of workers, as well as to increase the strength and relationships within children's social work teams, and to provide social capital and support.

The programme will focus on employee well-being (e.g. happiness, stress); sickness and absence; and retention and the overall themes of the interventions we will be researching with the successful partners are:

- Increasing access to training and development opportunities
- Increasing resilience
- Reducing feelings of time pressure
- Increasing capacity for work-life balance
- Making social workers feel valued and recognised for their work.

Researcher Shibeal O'Flaherty said: "We have had a very enthusiastic response to our first-round call for expressions of interest, and have been grateful to have had valuable insights directly from local authorities to inform our research design."

She added: "At this stage we have designed a variety of behavioural interventions which we are excited to launch in collaboration with partners during this next phase."

"Over the course of the next six months we will be working to conduct a series of randomised controlled trials with local authorities. These will provide us with the best possible information about what works when it comes to increasing the health and happiness of social worker professionals which will ultimately allow them to succeed in their work, and have positive outcomes for those around them."

Michael Sanders, Executive Director of the What Works Centre for Children's Social Care, said: "Social Workers have intensely challenging jobs, bearing a great deal of responsibility, often with little societal recognition of the benefits of their work.

"In 2017, turnover rate amongst social care workers was 15% and more than 220,000 days were lost to sickness and absence. Social workers spend their professional lives working with the complex and traumatic lived experiences of families, which impacts on social worker well-being, which is exacerbated by a challenging climate for local government more generally. In this context, social workers often struggle to take care of themselves alongside working to improve the lives of the children and families they work with. This creates a vicious circle, with workloads increasing for those social workers that remain, leading to higher stress and increasing dependency in some authorities on agency workers.

"The What Works Centre is therefore pleased that our programme to help support social worker and their managers to be happier and healthier is one of our flagship projects in 2019."

Interested authorities are invited to submit their applications by Monday 18 March with a view to launching the intervention research projects in April or May this year lasting for approximately six months.

Partners new to this research programme, can complete the application form here.

We will be in contact with partners involved in the co-design phase with information on how to take part in this next research phase separately.

All research projects will be published on the What Works Centre's website and the Centre will work to spread best practice to a wide audience. The research will be overseen by the ethics committees of University College London and Harvard Business School.

Appendix 1B: Administrative Dataset Template Sent to LAs

	A	B	C	D	E	F	G	H
1								
2	Please enter the data related to each children's social worker below and return to us by emailing wwcprogrammes@nesta.org.uk by **Friday 3 May, 2019** In accordance with GDPR, please ensure that you use anonymised unique IDs only (please let us know if you need us to provide these). Do not include names of any individuals. It is very important that you keep a record of which staff IDs relate to which individuals until the end of the project in January 2020 (but please do not share this information with us). It is essential that the same IDs are used for the same staff members when returning the data each time (at the mid-point and end of the project) to allow us to track individual outcomes.							
3								
4	**Local Authority:**							
5	**Date data retrieved:**							
6								
7						**Over the last 12 months:**		
8	**Unique Staff ID**	**Team ID** (Please use a unique identifier for each team)	**Role** (Please select the option which best describes the role)	**Gender**	**Length of employment at LA (months)**	**Overall absence, incl. holiday (no.of days)**	**Illness related absence (no. of days)**	**Number of illness related spells of absence**
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								

Appendix 1C: Survey Consent Form

Thank you for taking part in this survey! This contributes to exciting research led by What Works for Children's Social Care (WWCSC, hosted by Nesta) in collaboration with your local authority to help us improve wellbeing amongst social workers.

The purpose of the survey "Daily Experiences of Social Workers" is to understand more about your unique experience as a social worker, how this impacts on individual wellbeing, and from this exploring ways to improve social worker wellbeing.

We are only requesting data that is necessary for the purposes of this research. Your survey responses are anonymous, and will be matched via a unique code so that we can match your responses before and after the programme. Your unique code will also allow us to match your responses to administrative data. The WWCSC will be unable to identify you from your answers. Your answers will be analysed by the research team at the WWCSC, and all data will be deleted 12 months after analysis and quality assurance is complete.

If you have any questions after you have completed the survey, and/or later decide that you do not want to participate in this research, and/or you would like your responses to be deleted or rectified, please contact the research team by emailing Shibeal O' Flaherty, Researcher at the WWCSC: shibeal.oflaherty@nesta.org.uk.

The WWCSC can be contacted at:

What Works for Children's Social Care
58 Victoria Embankment
London
EC4Y 0DS

Email: wwccsc@nesta.org.uk
Telephone: 02073601208

Clicking on the "agree" button below indicates that:

You have read the above information
You voluntarily agree to participate in the research

Note: If you do not wish to participate, please decline participation by clicking on the "disagree" button.

Agree to participate in the research
Do not agree to participate in the research

Appendix 1D: Emails to Staff Regarding Well-being Survey

Suggested Title: Action required: Short survey for our research into social worker wellbeing

Dear all,

As you may know, [LA name here] are participating in some exciting research into staff wellbeing with the What Works Centre for Children's Social Care. In the coming months, we'll be trialling a new intervention across around half of the workforce and measuring its impact on wellbeing. For this to work, we need **all staff** to complete a short survey, once at the start and once again at the end of the project. This is the first of those surveys.

The survey (link below) will take around **5 minutes to fill out,** and if your whole team completes it **you will be entered into a prize draw to win £140 of vouchers for the team!**

Just to note too that your survey responses cannot and will not be individually traced back to you - your responses will be stored anonymously by the What Works Centre for Children's Social Care.

We're asking for **all responses by [agreed date here]**

Please find your unique link to the survey here:

Best

NB: Please ensure that you complete the survey using your individual link above - do not share this link with colleagues.

Survey First reminder

Title: Reminder: Wellbeing survey

From: Team managers
To: Social workers

Subject: Reminder: Complete Wellbeing Survey

Hi team,

Just a reminder to those of you who haven't already to please complete the "Daily Experiences of Social Workers" survey you received on **June 7th**. It takes around **5 minutes** to fill out, and if the whole team completes it you will have the chance to win **£140 of vouchers** for the team!

Your link to complete the survey can be found in the initial email, which was sent on (insert date). The deadline to complete the survey is **June 28th**.

Thanks,
…

APPENDIX 2 - GOAL-SETTING MATERIALS

Appendix 2A: Key Quotes from Focus Group Sessions

Question Theme	Quote
Time division/control over working week and tasks	"Appointments in calendar, urgent things come up, there is a juggle - I get caught up in interesting bits, and the important things I need to be doing goes to the wayside" "There are too many things to fit in really so you can't possibly do everything you need to do. For me it's a priority issue. I feel like I don't have a good system to manage this workload. I have been in my current job for 1 year 1 month and I feel like I'm just now getting to grips with it." - Social worker interview at Lambeth
Work-life balance	"Social work is said to be a 9 to 5 job - when you apply you are told this. It's about the cognition of working after hours. It's declared you work 9 to 5 but it's undeclared when you work outside those hours. [Resultingly, social workers are] vocal about coming in late, silent about staying late." - Focus group at Lambeth
Work week structure	"[I am] in and out of the office, other days might be spent in office – it's varied. [There is a sense of] not knowing how your day is going to go. When there is an emergency to go and see a family - you don't know what time you're going to be finished." - Focus group at Lambeth
Work-life balance	"Nobody tells you to, but you take ownership of your workload. iPhones are good but your work is visible and you don't switch off. It becomes accepted that the job is bigger than can be fitted in to a working day, you need to accept it. You have got to be comfortable with having lots of things on your to-do list." - Focus group with early help workers at Kent
Work week structure	"[The work involves] juggling priorities as they come up; often dealing with unreliable families who aren't engaging. Also managing limited resources (high caseloads)... Variety of the day isn't necessarily a bad thing – [just involves] thinking on your feet." - Focus group with early help workers at Kent

Appendix 2B: Goal-Setting Programme Materials

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Worksheet 1.1

Making a List of Goals

The first step is to make a list of goals - things that you would like to have happen in the future and that you want to work towards. It doesn't matter how small you think the goal is, or whether it relates to work or the rest of life. Any goal that seems positive and important to you is good.

Goals can relate to different areas of your life:

- Work
- Self-development
- Health
- Relationships
- Money
- Leisure

Goals can also be for:

- the near future (e.g. tomorrow, next week)
- the distant future (e.g. next year, the next 5 years)

Write your goals below. They do not have to be in any particular order or in great detail. These are just ideas for now.

Goal 1	
Goal 2	
Goal 3	
Goal 4	
Goal 5	
Goal 6	

You might like to save or print this worksheet to refer back to.

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Worksheet 1.2
Refining Goals

From your list of goals in Worksheet 1.1, pick the top two goals you want to work towards achieving over the next few weeks.

When deciding on your top two goals, it might help to revisit these questions:

- Are they **approach** goals (things to work towards, not get away from)? *Ensure you only choose approach goals.*
- Are they **self-concordant** (thing you want to achieve because you enjoy them and they matter, not things that someone else wants you to achieve)?
- Are they **realistic** goals that you can see how to take steps towards achieving in the next few weeks? You don't have to actually achieve the goals but you need to be able to see steps that you can start to take.

Chosen Goal 1	
Chosen Goal 2	

You might like to save or print this worksheet for your records.

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Worksheet 2
Effective Visualisation

1. **Relaxation**
   Take time to relax. Find a comfortable body position, either standing, sitting or lying down. Take a few deep breaths in and out, if it feels okay to do so.

2. **Realism**
   Take **one of your chosen goals** from Worksheet 1.1. For 3-5 minutes, project yourself into the future in your mind and imagine that your goal has been achieved. To make your images feel real, try to be as creative and imaginative as you can by filling these with colours, sounds, smells, textures, and tastes. Keep your visualisations positive and make sure they appeal to you!

3. **Reinforcement**
   How does having achieved your goal make you feel? Write down your thoughts and feelings below.

Thoughts	
Feelings	

4. **Regularity**
   Repeat stages 1-3 above regularly, preferably once each day. Having practised on one chosen goal, repeat for your other chosen goal too.

You might like to save or print this worksheet for your records.

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Worksheet 3
Developing action plans

Good action plans should be:

Specific, which means including:

- ✔ Days;
- ✔ Times;
- ✔ Locations;
- ✔ Any other detailed information about how these are going to be achieved.

Realistic, so where possible:

- ✔ Test them for a trial period;
- ✔ Adjust if unrealistic (e.g. too ambitious or too cautious).

Use the tables overleaf to make actions plans for each of the top two chosen goals you identified in the last worksheet from the previous module: Worksheet 1.2: Chosen Goals.

Try to identify at least some action steps that can be carried out over the next week.

You might like to save or print this worksheet for your records.

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Worksheet 4.1 Identifying Obstacles

List below the sorts of obstacles that have prevented you from taking the planned steps towards your chosen goals. If you have not experienced any recent obstacles, widen it out to things you know have prevented you from taking steps to achieve goals in the past.

For each obstacle, decide whether it was:

Easy to anticipate – when you made the action plan, if you had thought about potential obstacles, this one seemed likely

Hard to anticipate – when you made the action plan, even if you had thought about potential obstacles, you would not have predicted this one

	Description of obstacle	Easy or Hard to anticipate?
1		
2		
3		
4		
5		
6		

You might like to save or print this worksheet for your records.

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Worksheet 4.2
Dealing with Obstacles

Select some **action steps** for your chosen goals that you have not yet implemented and use the tables overleaf to note down solutions to the obstacles that may prevent you from carrying out the steps.

The more difficult a step is to implement the more you will need to identify obstacles and specific solutions.

Remember your solutions will need to be **specific** to help you overcome your obstacles successfully. Make sure to include details about:

- ✔ What;
- ✔ How;
- ✔ Where;
- ✔ When;

You might like to save or print this worksheet for your records.

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Worksheet 4.3 Pros & Cons of Next Step

For one of your chosen goals, take a **planned step** that you have **not yet implemented**. Fill in the table below, outlining the pros and cons for doing your planned step. Then reflect on your planned step and write out a conclusion, indicating whether the step is something you want to carry out or not.

Planned step:	

Pros:
☐
☐
☐

Cons:
☐
☐
☐

Conclusion:	

You might like to save or print this worksheet for your records.

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Worksheet 5
Review of Progress

Below is a summary of all the skills and tips we have covered throughout the programme.

Take a few minutes to go through the summary and consider how each stage in the goal and action-planning process worked for you over the last few weeks.

1. Making goals

Make a list of goals

- Goals in different areas: Work, self-development, health, relationships, money…
- Goals for different timeframes: next week, next month, next year, in 5 years

Refine your goals

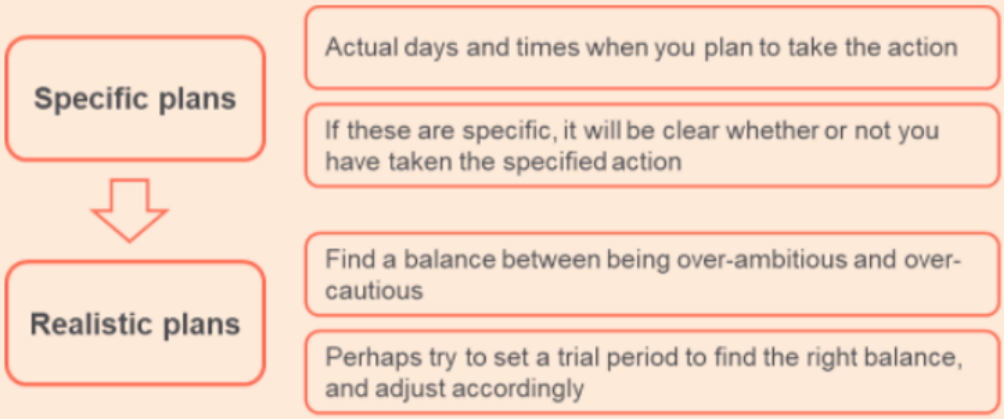
- Approach goals: ones to works *towards* (not avoiding!)
- Self-concordant goals: ones *you* want to achieve (not for anyone else!)

Select your goals

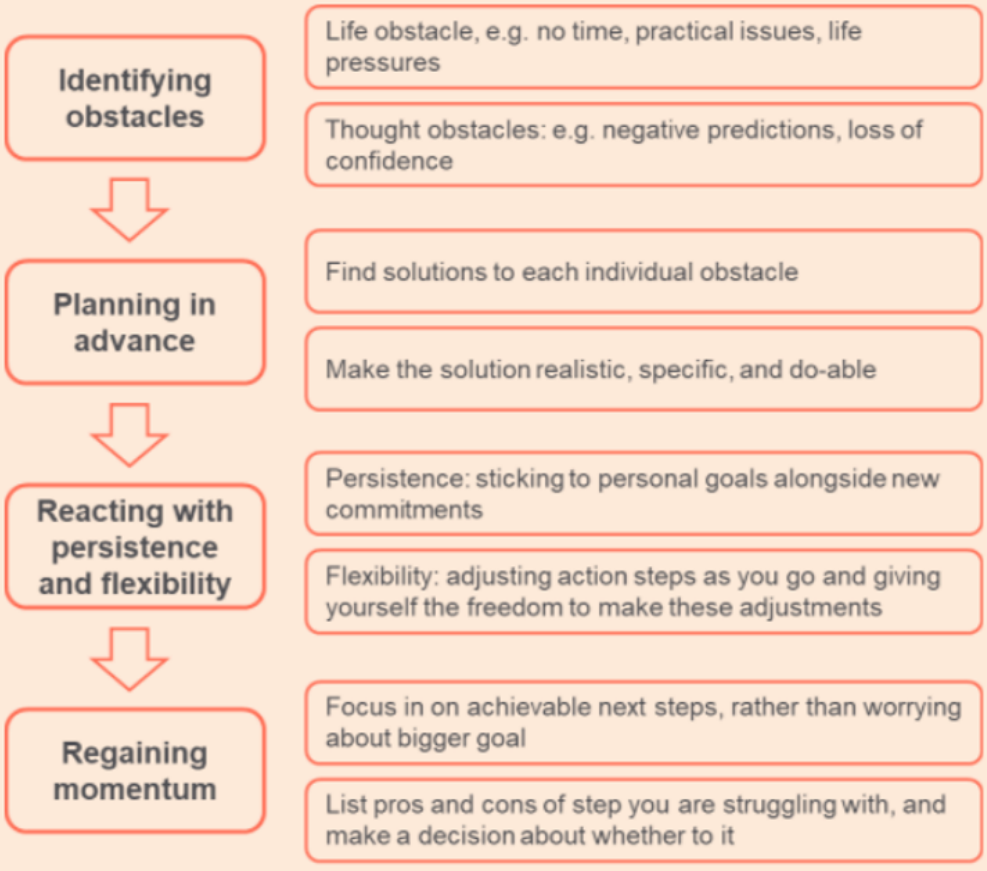
- Ones you *most want* to work on (e.g. most self-concordant, important or fun!)
- Ones that you can start to make progress on soon, even if goal is long-term

2. Visualising goals

3. Planning to achieve goals



4. Overcoming obstacles



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Worksheet 6 Maintaining and developing these skills

There are three key things to help maintain progress towards chosen goals:

Accessibility: easily seeing your plans will help you remember what you are working towards! Why not stick it up on your fridge door?

Accountability: telling others about your plans and goals will help you stick to your plan!

Reward yourself: Reward yourself when you implement a difficult step to help maintain motivation and enthusiasm throughout the process!

Further points to bear in mind when working towards goals:

Any progress is better than none. Sometimes you will do a lot and sometimes a little, sometimes with success, sometimes without. The key is to be moving forward with your plans. When your steps are not successful, consider why not, then plan for it next time.

Thought is no substitute for action. The good feelings that come from thinking about goals and planning for them are likely to be short-lived without action as a follow-up.

Motivation can be re-gained. If you start to lose motivation use the visualization exercise, or weigh up the pros and cons of your next step to help you decide if the goal is still important to you and worth working towards.

Finally, to maintain and develop your goal and action-planning skills, you could make a plan towards that specific goal. Something like:

Goal: 'To feel confident in using goal-setting and planning techniques by [*set a date*, e.g. 3 months from now?]'

As you will know from Module 1, only choose to work towards that goal if it is something you really want to achieve (self-concordant). You may need to work on the wording to make it specific and realistic for you.

Thank you and wishing you the best of luck with all your future goals!

Appendix 2C: Goal-Setting - well-being survey

Title: Daily Experiences of Social Workers

Q1. Subjective Well-Being

Overall life happiness (1-item)[1]

Taking all things together, how happy would you say you are?

0	1	2	3	4	5	6	7	8	9	10
Not at all										Extremely

Cantril Ladder[2]

Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. Suppose we say that the top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.

If the top step is 10 and the bottom step is 0, on which step of the ladder do you feel you personally stand at the present time? (Please circle your response).

0	1	2	3	4	5	6	7	8	9	10
Bottom Step										Top Step

PANAS (Schedule for Positive and Negative Affect)[3]

Please think about what you have been doing and experiencing during the past four weeks. Then report how much you experienced each of the following feelings, using the scale below. For each item, select a number from 1 to 5, and indicate that number on your response sheet.

1	2	3	4	5
Very rarely/never	Rarely	Sometimes	Often	Very often/always

Positive
Negative
Good
Bad
Pleasant
Unpleasant

Q2. Turnover Intentions[4]

Indicate to what extent you agree with the following statements. Use the following scale to record your answers.

1 Jowell, R. (2007). European Social Survey 2006/2007. Round 3: Technical Report. City University, Centre for Comparative Social Surveys, London.
2 Cantril, H. (1965). Pattern of human concerns. New Brunswick, NJ: Rutgers University Press.
3 Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D. W., Oishi, S., & Biswas-Diener, R. (2009). New well-being measures: Short scales to assess flourishing and positive and negative feelings. Social Indicators Research, 97(2), 143-156.
4 Cohen, A. (1993). Work commitment in relation to withdrawal intentions and union effectiveness. *Journal of Business Research*, 26, 75-90.

(7-point scale: Do not agree at all 1, Very Slightly Agree 2, Slightly Agree 3, Moderately Agree 4, Mostly Agree 5, Strongly Agree 6, Very Strongly Agree 7).

1. I think a lot about leaving the organization.
2. I am actively searching for an alternative to the organization.
3. As soon as possible, I will leave the organization.

Q3. Job Satisfaction[5]

Below are two items with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item. Please circle the relevant number with each question.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
In most ways, my job is close to my ideal.	1	2	3	4	5	6	7
I am satisfied with my job.	1	2	3	4	5	6	7

Q4. Work-Related Basic Need Satisfaction[6]

The following statements concern your experiences at work DURING THE PAST FOUR WEEKS. Please indicate to what extent you agree with these statements. (1 = Do not agree at all, 2 = Very slightly agree, 3 = Slightly agree, 4 = Moderately agree, 5 = Mostly agree, 6 = Strongly agree, 7 = Very strongly agree)

1. I feel like I can be myself at my job.
2. The tasks I have to do at work are in line with what I really want to do.
3. I feel free to do my job the way I think it could best be done.
4. I really master my tasks at my job.
5. I feel competent at my job.
6. I am good at the things I do in my job.
7. I have the feeling that I can even accomplish the most difficult tasks at work.
8. At work, I feel part of a group.
9. At work, I can talk with people about things that really matter to me.
10. Some people I work with are close friends of mine.

Q5. Burnout[7]

Please think about your experience at your job during the past four weeks. Then, indicate how much you experienced each of the following states, using the scale below.

5 Adapted from Diener, E. D., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49(1), 71-75.

6 Van den Broeck, A., Vansteenkiste, M., De Witte, H., Soenens, B., & Lens, W. (2010). Capturing autonomy, competence, and relatedness at work: Construction and initial validation of the Work-related Basic Need Satisfaction scale. *Journal of Occupational and Organizational Psychology*, 83(4), 981-1002.

7 Bacharach, Samuel B., Bamberger, Peter, & Conley, Sharon. (1991). Work-home conflict among nurses and engineers: Mediating the impact of role stress on burnout and satisfaction at work. *Journal of Organizational Behavior*, 12(1), 39-53. doi: 10.1002/job.4030120104

	Never 1	Very rarely 2	Rarely 3	Occasionally 4	Frequently 5	Very frequently 6
Periods of fatigue when you couldn't 'get going'						
Being tired						
Being physically exhausted						
Being emotionally exhausted						
Feeling 'burned out'						
Being 'wiped out'						
Feeling 'run down'						
Being weary						

Q6. Time Pressure[8]

Thinking about the PAST FOUR WEEKS, please read each of the following statements carefully. Use the scale provided to indicate how much you agree with each statement: (1 = Strongly disagree, 2 = Disagree, 3 = Disagree slightly, 4 = Neutral, 5 = Slightly agree, 6 = Agree, 7 = Strongly agree)

1. There have not been enough minutes in the day.
2. I have felt like things have been really hectic.

Section 2: Demographics

Q1. Age

How old are you? (insert number)

Q2. Marital status

What is your marital status?

- Married/domestic partner
- Widowed
- Divorced
- Separated
- Single/never married
- Prefer not to say

8 Kasser, T., & Sheldon, K. M. (2009). Time affluence as a path toward personal happiness and ethical business practice: Empirical evidence from four studies. *Journal of Business Ethics*, 84(2), 243-255.

Q3. Number of children

How many children do you have who currently live at home with you?

- 0
- 1
- 2
- 3
- 4 or more
- Prefer not to say

Q4. General Health

In general, how would you rate your health?[9]

- Excellent
- Good
- Fair
- Poor

Q5. Contract Length

On which of the following basis are you employed?

- On a permanent contract
- On a fixed term or temporary contract
- Via an agency

Q6. Overtime Worked

On average, how many extra hours (above your contracted hours) do you work per week? (Insert number from 0)

If so, how many on average per week?

Q7. Caseload

Do you feel your caseload is manageable? Please use the scale provided to indicate your answer. (7-point scale where 1=not at all, 7=completely)

Q8. Additional Comments

Thank you for your time. If you have any thoughts about the study, you can provide them in the space below.

Questions Related to Goal-Setting Tasks (only included in endline survey)

1. During the past six months, did you receive an invitation from your local authority to sign up to a 'Social Worker Goals & well-being Programme'?*

- Yes
- No
- Not sure

2. Did you work with your manager to choose a weekly protected time slot?*

- Yes
- No
- Yes but I did not use the protected time slot

3. If you did not work with your manager to choose a weekly protected time slot, why not? Please

9 DeSalvo, K. B., Fisher, W. P., Tran, K., Bloser, N., Merrill, W., & Peabody, J. (2006). Assessing measurement properties of two single-item general health measures. *Quality of Life Research*, 15(2), 191-201.

note you may choose multiple options.

- My manager did not encourage it
- I did not have enough time
- I did not find the goal-setting materials useful
- Other: _____

4. What kind of activities did you complete during your time slot? Please note you may choose multiple options.

- Planning
- Reflecting
- Administrative tasks (e.g. case notes)
- Completing the programme materials
- Other: _____

5. To what extent would you rate the tasks you completed during the protected time slot as urgent? (1 = Not urgent to 5 = Very urgent)

6. To what extent would you rate the tasks you completed during the protected time slot as important? (1 = Not important to 5 = Very important)

Appendix 2D: Goal-setting manager flashcards

The Social Worker Goals and Wellbeing Programme

Research has shown that people with high levels of wellbeing have been found to have clear personal goals and have effective plans of action for achieving those goals.

The Social Worker Goals and Wellbeing Programme is a six-week course designed for people with busy jobs and who face the challenge of balancing priorities at work and at home. Tailored specifically for social workers by the What Works Centre for Children's Social Care team, it aims to promote wellbeing by encouraging social workers to set clear goals and make concrete plans to work towards them.

Your team will be encouraged to identify goals relating to their role as a social worker or to other aspects of their lives. Any goal that seems positive and important can have an impact on overall wellbeing.

How do goals and plans relate to wellbeing?

Having goals and plans can contribute to wellbeing in two main ways:

- **the process of goal-setting itself** can create a sense of purpose, giving us more direction in what we do on a day-to-day basis and the feeling that we are making progress
- **the increase the likelihood** of actually progressing towards and achieving things that are important to us

Trialling goal-setting for social workers

The programme is designed to support your team to take some time out of their week to set some personal goals, work related or otherwise, and sometimes keeping track of progress by reflecting at the end of the week on what they have achieved. Of course, planning and goal setting are an integral part of the work social workers do with families, but busy lives mean it can be challenging to apply the same principles to themselves.

The programme has been shown to be effective in a trial involving a civil service workforce. Participants reported improved wellbeing (greater life satisfaction, more positive emotions, less negative emotions, and a greater sense of purpose) five weeks after starting the programme and three months later. This trial represents an exciting opportunity to see if this type of programme might also be effective in a social care field.

Timetable

There is no set timetable – the programme is designed to be flexible to fit around busy lives. There are six modules, each containing information and exercises to do. Each module takes about 30 minutes in total, but does not all have to be done at once. Some modules ask particpants to go away and try things for a week before progressing to the next module. Here's a suggestion, included in the programme, for where your team might want to schedule time into their diaries.

WEEK 1	Module 1 - Making Goals	30 mins
	Module 2 - Imagining Achieving Goals	30 mins
WEEK 2		
	Module 3 - Planning to Achieve Goals	30 mins
WEEK 3	--- Time to try out plans ---	
WEEK 4	Module 4 - Overcoming obstacles	30 mins
WEEK 5	Module 5 - Putting it all into practice	30 mins

WEEK 6	Time to try out plans ---	
	Module 6 - Review	30 mins

What we need from you

The programme is designed to be completed without much need for support from you or from us, but there are ways that you can help your team to embed it into their routine, to make sure they get the most out of it.

We would like to you to encourage your team to set aside a regular slot of 'protected' time of around half an hour each week to use for the programme. You can do this by agreeing an appropriate time with your team members individually and marking this by sending a diary invitation, with the understanding that more urgent tasks will take precedence should they arise. We hope this acts as a placeholder - reminding the team that they have licence to spend time on planning and goal-setting. The training is designed to be accessed in short bites to fit around high workloads and other life commitments - so they can always come back to it later in the week if they miss the slot.

At the end of the programme, you might encourage your team to continue to make use of their protected time to continue the practice if they have felt it has been beneficial to them.

And finally...

A massive 'thank you' from everyone at the What Works Centre for making the extra effort to encourage your team to take part in the programme.

When we have the results of the trial, we will know whether this kind of intervention can improve social workers' wellbeing, as well as rates of staff sickness and turnover. We hope that these findings, and those from our other trials, can help make a positive impact for children's social workers across the country.

Appendix 2E: Goal-Setting regression tables

Table 1: Regressions for administrative outcomes

Table 1
Goal-setting intervention impact on administrative outcomes

	attendance_int	turnover_int	attendance_end	turnover_end
treatment	0.735	-0.00856	-2.379	-0.00979
	(0.86)	(-0.94)	(-1.38)	(-0.48)
female	0.567	-0.00413	-3.195	0.00801
	(0.47)	(-0.32)	(-1.31)	(0.28)
missingfemale	3.273	0.0360	0	0
	(0.81)	(0.83)	(.)	(.)
role	0.514	-0.00314	0.695	-0.0118
	(0.86)	(-0.49)	(0.59)	(-0.84)
missingrole	0	0	0	0
	(.)	(.)	(.)	(.)
agency	-5.398**	-0.0127	0	0
	(-2.88)	(-0.63)	(.)	(.)
missingagency	-12.51	0.0526	-8.346***	0.0804**
	(-0.77)	(0.30)	(-3.68)	(2.97)
employment	-0.0117*	-0.0000682	0.00715	-0.0000457
	(-2.21)	(-1.20)	(0.66)	(-0.35)
missingemployment	-24.75***	0.718***	0	0
	(-4.17)	(11.26)	(.)	(.)
1.feLA	0	0	0	0
	(.)	(.)	(.)	(.)
2.feLA	-2.858	0.0589**	3.585	0.0193
	(-1.58)	(3.04)	(1.23)	(0.56)
3.feLA	10.07	0.0144	4.552	-0.0627*
	(0.62)	(0.08)	(1.79)	(-2.06)
4.feLA	14.52	-0.0275	0	0
	(0.89)	(-0.16)	(.)	(.)
5.feLA	-51.17***	-0.00793		

	(-27.91)	(-0.40)		
6.feLA	3.314	0.0000493		
	(0.20)	(0.00)		
7.feLA	6.004	-0.0593		
	(0.37)	(-0.34)		
8.feLA	15.01	-0.0184		
	(0.92)	(-0.10)		
0.missingfeLA	0	0	0	0
	(.)	(.)	(.)	(.)
_cons	52.10***	0.0236	117.2***	0.0319
	(20.63)	(0.87)	(27.64)	(0.63)
N	1468	1468	486	486

Note: t-statistics in parentheses; * p<0.05, ** p<0.01, *** p<0.001

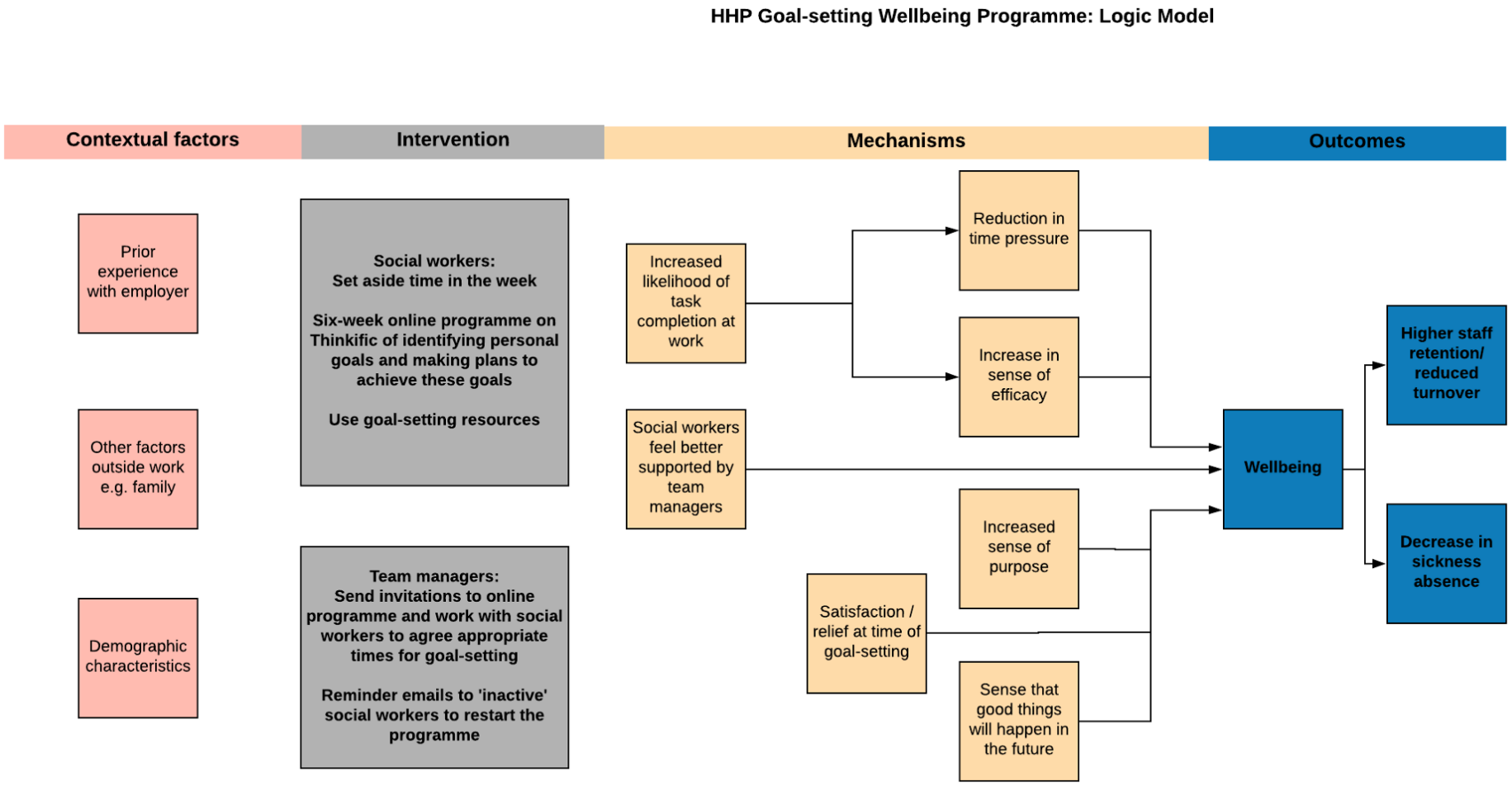
Table 2: Regressions for subjective well-being and mediator outcomes

Table 2
Goal-setting intervention impact on well-being outcomes

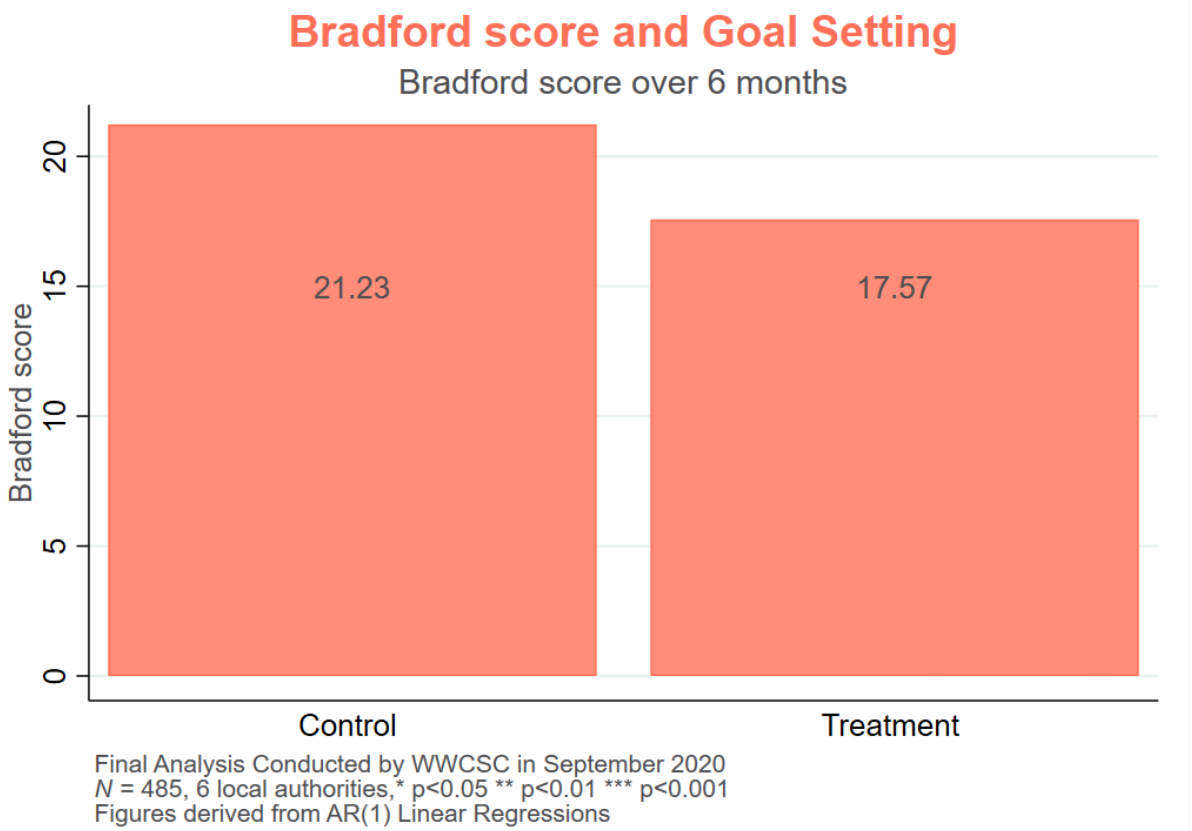
	attendance_int	turnover_int	attendance_end	turnover_end
treatment	0.735	-0.00856	-2.379	-0.00979
	(0.86)	(-0.94)	(-1.38)	(-0.48)
female	0.567	-0.00413	-3.195	0.00801
	(0.47)	(-0.32)	(-1.31)	(0.28)
missingfemale	3.273	0.0360	0	0
	(0.81)	(0.83)	(.)	(.)
role	0.514	-0.00314	0.695	-0.0118
	(0.86)	(-0.49)	(0.59)	(-0.84)
missingrole	0	0	0	0
	(.)	(.)	(.)	(.)
agency	-5.398**	-0.0127	0	0
	(-2.88)	(-0.63)	(.)	(.)
missingagency	-12.51	0.0526	-8.346***	0.0804**

	(-0.77)	(0.30)	(-3.68)	(2.97)
employment	-0.0117*	-0.0000682	0.00715	-0.0000457
	(-2.21)	(-1.20)	(0.66)	(-0.35)
missingemployment	-24.75***	0.718***	0	0
	(-4.17)	(11.26)	(.)	(.)
1.feLA	0	0	0	0
	(.)	(.)	(.)	(.)
2.feLA	-2.858	0.0589**	3.585	0.0193
	(-1.58)	(3.04)	(1.23)	(0.56)
3.feLA	10.07	0.0144	4.552	-0.0627*
	(0.62)	(0.08)	(1.79)	(-2.06)
4.feLA	14.52	-0.0275	0	0
	(0.89)	(-0.16)	(.)	(.)
5.feLA	-51.17***	-0.00793		
	(-27.91)	(-0.40)		
6.feLA	3.314	0.0000493		
	(0.20)	(0.00)		
7.feLA	6.004	-0.0593		
	(0.37)	(-0.34)		
8.feLA	15.01	-0.0184		
	(0.92)	(-0.10)		
0.missingfeLA	0	0	0	0
	(.)	(.)	(.)	(.)
_cons	52.10***	0.0236	117.2***	0.0319
	(20.63)	(0.87)	(27.64)	(0.63)
N	1468	1468	486	486

Appendix 2F: Goal-setting logic model



Appendix 2G: Goal-setting and City of Bradford Metropolitan District Council scores



APPENDIX 3 - SYMBOLIC AWARDS (LETTERS OF RECOGNITION) MATERIALS

Appendix 3A: Symbolic Awards - Letter Template

Letter from Senior-Level Figure in Local Authority to Individual Social Worker

The letter below will be populated with the social worker's first name and the corresponding two lines of feedback provided for them by their manager (as requested in the feedback request emails through the feedback form).

Letter text:

Dear (Social Worker First Name, e.g. Anna),

I am very grateful for your hard work at (LA Name, e.g. Shropshire). We sincerely appreciate your contributions to the local authority, which help to improve the futures of vulnerable children and families in (LA name, e.g. Shropshire).

While we haven't worked together directly, your manager tells me that (insert 2 lines of feedback from manager to social worker).

Your work makes a huge difference to in order to give families and children the best chance to fulfil their potential.

Kind regards,

Photocopy of Signature

Name (e.g. Sonia Johnson)
Position (e.g. Director of Children's Services)

Appendix 3B: Symbolic Awards - Manager Feedback Form

What Works for Children's Social Care

MANAGER INSTRUCTIONS:

1) Enter your details under "Manager" below.
2) Enter details for your team members under "Team Members" below.
3) Choose two lines of feedback: Line 1 to be chosen from specific list; Line 2 is an additional line of your own choosing (examples below).

Feedback Line 2 Examples:

"In particular, you work hard to create a friendly atmosphere for children"
"In particular, you are reliable and helpful and can always be depended on by your team"

MANAGER

First Name	Last Name	Position	Team (e.g. Safeguarding, Child Social Care)	Email Address

TEAM MEMBERS

First Name	Last Name	Position (e.g. Child Social Worker)	Feedback Line 1 (choose from dropdown list)	Feedback Line 2 (choose your own line)

Appendix 3C: Symbolic Awards - Emails to Managers

First Email:

Dear team managers,

We need your help! We are asking **all team managers** to fill out **the attached very short form** (no longer than 5 minutes) to provide short feedback for your team members. Please send this on to (insert name) at (insert email) no later than **12pm on Friday, August 9th**.

The purpose of this feedback is to feed into research we are conducting looking at ways to improve the recognition and sense of value felt by our social workers.

Please do not hesitate to reach out with any questions.

Regards,
(insert name)

Reminder Email:

(Forward First Email)

Dear all,

A reminder that the below feedback form is due by tomorrow at …

Please let us know if you have any questions.

Regards,
(insert name)

Appendix 3D: Symbolic Awards - well-being survey

Title: Daily Experiences of Social Workers

Section 1: Subjective well-being Questions

Q1. Subjective Well-Being

Overall life happiness (1-item) [1]

Taking all things together, how happy would you say you are?

0	1	2	3	4	5	6	7	8	9	10
Not at all										Extremely

Cantril Ladder[2]

Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. Suppose we say that the top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.

If the top step is 10 and the bottom step is 0, on which step of the ladder do you feel you personally stand at the present time? (Please circle your response).

0	1	2	3	4	5	6	7	8	9	10
Bottom Step										Top Step

PANAS (Schedule for Positive and Negative Affect)[3]

Please think about what you have been doing and experiencing during the past four weeks. Then report how much you experienced each of the following feelings, using the scale below. For each item, select a number from 1 to 5, and indicate that number on your response sheet.

1	2	3	4	5
Very rarely/never	Rarely	Sometimes	Often	Very often/always

Positive
Negative
Good
Bad
Pleasant
Unpleasant

1 Jowell, R. (2007). European Social Survey 2006/2007. Round 3: Technical Report. City University, Centre for Comparative Social Surveys, London.
2 Cantril, H. (1965). Pattern of human concerns. New Brunswick, NJ: Rutgers University Press.
3 Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D. W., Oishi, S., & Biswas-Diener, R. (2009). New well-being measures: Short scales to assess flourishing and positive and negative feelings. *Social Indicators Research*, 97(2), 143-156.

Q2. Turnover Intentions[4]

Indicate to what extent you agree with the following statements. Use the following scale to record your answers.

(7-point scale: Do not agree at all 1, Very Slightly Agree 2, Slightly Agree 3, Moderately Agree 4, Mostly Agree 5, Strongly Agree 6, Very Strongly Agree 7).

1. I think a lot about leaving the organization.
2. I am actively searching for an alternative to the organization.
3. As soon as possible, I will leave the organization.

Q3. Job Satisfaction[5]

Below are two items with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item. Please circle the relevant number with each question.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
In most ways, my job is close to my ideal.	1	2	3	4	5	6	7
I am satisfied with my job.	1	2	3	4	5	6	7

Q4. Burnout[6]

Please think about your experience at your job during the past four weeks. Then, indicate how much you experienced each of the following states, using the scale below.

	Never 1	Very rarely 2	Rarely 3	Occasionally 4	Frequently 5	Very frequently 6
Periods of fatigue when you couldn't 'get going'						
Being tired						

4 Cohen, A. (1993). Work commitment in relation to withdrawal intentions and union effectiveness. *Journal of Business Research*, 26, 75-90.

5 Adapted from Diener, E. D., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49(1), 71-75.

6 Bacharach, Samuel B., Bamberger, Peter, & Conley, Sharon. (1991). Work-home conflict among nurses and engineers: Mediating the impact of role stress on burnout and satisfaction at work. *Journal of Organizational Behavior*, 12(1), 39-53. doi: 10.1002/job.4030120104

Being physically exhausted
Being emotionally exhausted
Feeling 'burned out'
Being 'wiped out'
Feeling 'run down'
Being weary

Q5. Motivation[7]

Intrinsic and Prosocial Motivation (1=disagree strongly to 7=agree strongly)

Why are you motivated to do your work at your organization?

- Because I enjoy the work itself.
- Because it's fun.
- Because I find the work engaging.
- Because I enjoy it.
- Because I care about benefiting others through my work.
- Because I want to help others through my work.
- Because I want to have positive impact on others.
- Because it is important to me to do good for others through my work.

Q7. Affective Commitment and Perceived Organizational Support (including Sense of Belonging)[8]

Rated on a 7-point Likert scale from "strongly disagree" to "strongly agree"

Affective Commitment
I feel strong sense of belonging to my organization.
I feel personally attached to my work organization.
I am proud to tell others I work at my organization.
Working at my organization has a great deal of personal meaning to me.
I would be happy to work at my organization until I retire.
I really feel that problems faced by my organization are also my problems.

Perceived Organizational Support
My organization really cares about my well-being.
My organization strongly considers my values and goals.
My organization shows little concern for me. (R)
My organization cares about my opinions.
My organization is willing to help me if I need a special favor.
Help is available from my organization when I have a problem.
My organization would forgive a mistake on my part.
If given the opportunity, my organization would take advantage of me. (R)

7 Grant, A. M. (2008). Does intrinsic motivation fuel the prosocial fire? Motivational synergy in predicting persistence, performance, and productivity. *Journal of Applied Psychology,* 93(1), 48.

8 Rhoades, L., Eisenberger, R., & Armeli, S. (2001). Affective commitment to the organization: The contribution of perceived organizational support. *Journal of Applied Psychology*, 86(5), 825.

Perceived Prosocial Impact[9]

Rated on a 7-point Likert scale from 1=disagree strongly to 7= agree strongly

1. I am very conscious of the positive impact that my work has on others.
2. I am very aware of the ways in which my work is benefiting others.
3. I feel that I can have a positive impact on others through my work.

Perceived Social Worth[10]

Rated on a 7-point Likert scale from 1=disagree strongly to 7= agree strongly

1. I feel that my local authority appreciates my work.
2. I feel that my local authority values my contributions at work.

Section 2: Demographics

Q1. Age

How old are you? (insert number)

Q2. Marital status

What is your marital status?

- Married/domestic partner
- Widowed
- Divorced
- Separated
- Single/never married
- Prefer not to say

Q3. Number of children

How many children do you have who currently live at home with you?

- 0
- 1
- 2
- 3
- 4 or more
- Prefer not to say

Q4. General Health

In general, how would you rate your health?[11]

- Excellent
- Good

9 Grant, A. M. (2008). Employees without a cause: The motivational effects of prosocial impact in public service. *International Public Management Journal*, 11(1), 48-66.

10 Adapted from Grant, A. M. (2008). The significance of task significance: Job performance effects, relational mechanisms, and boundary conditions. *Journal of Applied Psychology*, 93(1), 108.

11 DeSalvo, K. B., Fisher, W. P., Tran, K., Bloser, N., Merrill, W., & Peabody, J. (2006). Assessing measurement properties of two single-item general health measures. *Quality of Life Research*, 15(2), 191-201.

- Fair
- Poor

Q5. Contract Length

On which of the following basis are you employed?
- On a permanent contract
- On a fixed term or temporary contract
- Via an agency

Q6. Overtime Worked

On average, how many extra hours (above your contracted hours) do you work per week?
(Insert number from 0)

If so, how many on average per week?

Q7. Caseload

Do you feel your caseload is manageable? Please use the scale provided to indicate your answer. (7-point scale where 1=not at all, 7=completely)

Q8. Additional Comments

Thank you for your time. If you have any thoughts about the study, you can provide them in the space below.

Appendix 3E: Symbolic Awards regression tables

Table 1: Regressions for subjective well-being and mediator outcomes

Table 1
Symbolic recognition intervention impact on well-being outcomes

	wellbeing_t2	LA_t2	org_t2	motivation_t2	belonging_t2	prosocial_t2
wellbeing_t1	0.306					
	(1.32)					
missingwellbeing_t1	-0.0180					
	(-0.04)					
treat	0.601	1.543*	4.329	1.815	2.552	0.975
	(1.35)	(2.20)	(1.94)	(1.41)	(1.47)	(1.67)
female	-0.246	0.499	-0.274	-0.420	0.507	0.991
	(-0.37)	(0.49)	(-0.09)	(-0.23)	(0.21)	(1.16)
missingfemale	-1.774	-2.338	-11.74	-10.13	-9.412	-2.340
	(-1.55)	(-0.71)	(-1.16)	(-1.64)	(-1.19)	(-0.85)
0.role	2.986	1.901	5.015	2.996	3.467	
	(1.94)	(0.77)	(0.66)	(0.69)	(0.54)	
1.role	0.962	1.215	1.316	3.804	-1.697	
	(0.81)	(0.68)	(0.24)	(1.14)	(-0.39)	
2.role	2.506*	-0.246	2.133	-0.630	-2.243	
	(2.65)	(-0.18)	(0.51)	(-0.24)	(-0.68)	
3.role	0	0	0	0	0	
	(.)	(.)	(.)	(.)	(.)	
4.role	-0.0974	-7.577*	-19.75*	0.690	-12.02	
	(-0.05)	(-2.49)	(-2.09)	(0.12)	(-1.64)	
5.role	4.739**	0.407	3.272	4.962	1.736	
	(3.08)	(0.18)	(0.46)	(1.16)	(0.31)	
role						-0.0809
						(-0.21)
agency	-0.396	0.152	0.884	2.183	1.465	2.635
	(-0.37)	(0.09)	(0.17)	(0.74)	(0.37)	(1.87)
employment	-0.000115	-0.00672	-0.0192	-0.00688	-0.00766	-0.00395

	(-0.04)	(-1.36)	(-1.25)	(-0.70)	(-0.64)	(-0.94)
1.feLA	0	0	0	0	0	0
	(.)	(.)	(.)	(.)	(.)	(.)
2.feLA	-0.984	0.190	-0.0694	-0.0877	0.181	0.443
	(-1.31)	(0.17)	(-0.02)	(-0.04)	(0.07)	(0.52)
3.feLA	-0.994	-1.705	-4.187	-1.617	0.581	-0.104
	(-1.68)	(-1.84)	(-1.45)	(-0.93)	(0.26)	(-0.14)
LA_t1		0.722**				
		(3.35)				
missingLA_t1		6.725**				
		(2.85)				
missingrole		0	0	0	0	0
		(.)	(.)	(.)	(.)	(.)
missingagency		2.632*	1.309	-2.001	1.766	-0.558
		(2.05)	(0.33)	(-0.85)	(0.56)	(-0.52)
missingemployment		-1.064	-1.142	1.401	1.893	1.845
		(-0.39)	(-0.14)	(0.27)	(0.29)	(0.80)
missingfeLA		0	0	0	0	0
		(.)	(.)	(.)	(.)	(.)
orgsupport_t1			0.603**			
			(3.12)			
missingorgsupport_t1			18.52**			
			(2.92)			
motivation_t1				0.455		
				(1.78)		
missingmotivation_t1				19.35		
				(1.59)		
belonging_t1					0.845***	
					(3.72)	
missingbelonging_t1					24.39***	
					(3.66)	
prosocial_t1						0.262

						(1.33)
missingprosocial_t1						4.021
						(1.16)
_cons	-1.571	2.310	10.99	27.10*	4.185	11.62**
	(-1.45)	(0.82)	(1.38)	(2.29)	(0.56)	(3.28)
N	66	66	66	66	66	66

Note: t-statistics in parentheses; * p<0.05, ** p<0.01, *** p<0.001

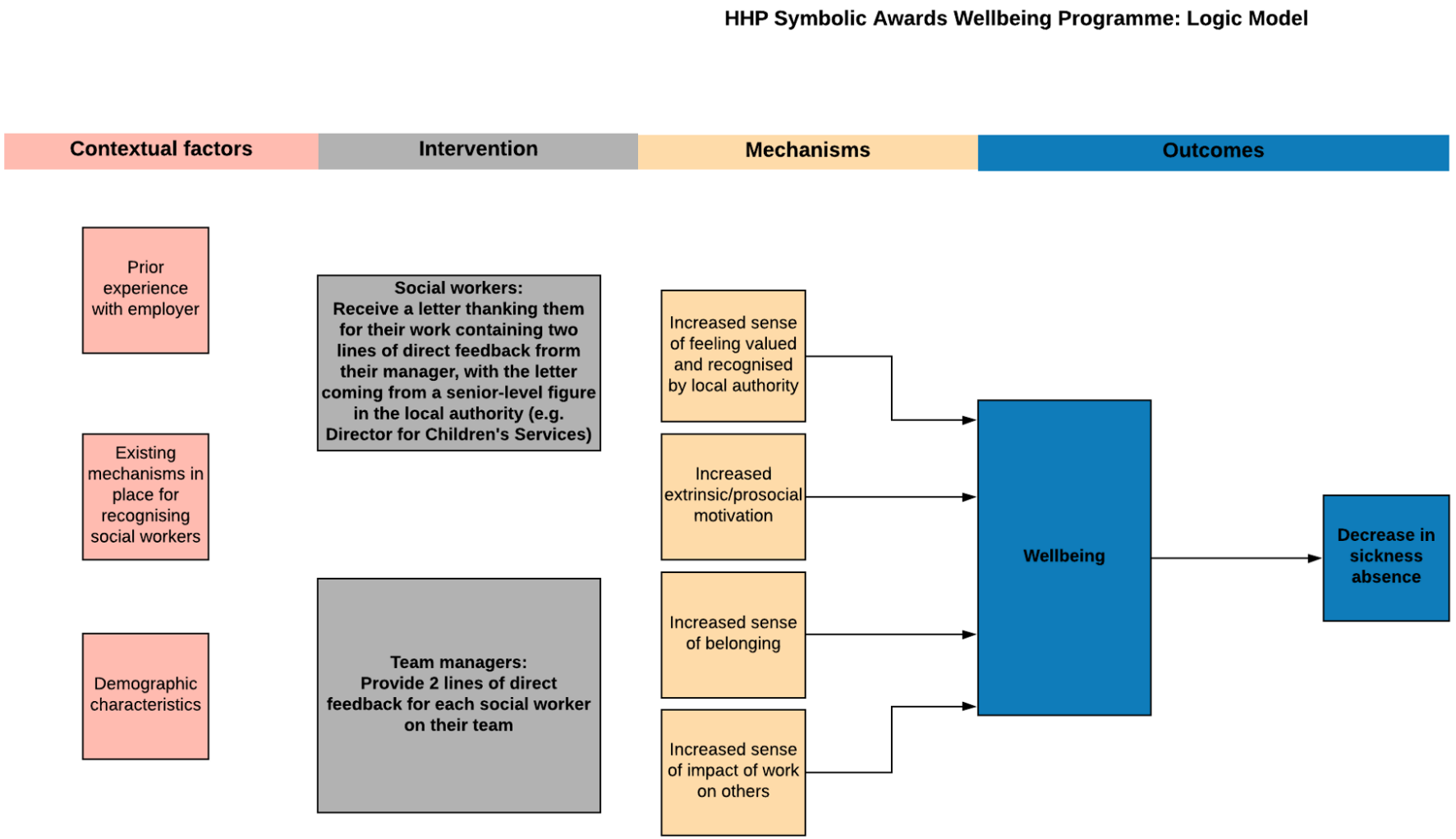
Table 2: Regressions for administrative outcomes

Table 2 Symbolic recognition intervention impact on administrative outcomes	
	Endline attendance
treatment	-0.359
	(-0.42)
female	1.346
	(0.94)
missingfemale	6.917*
	(2.00)
role	-0.803
	(-1.46)
missingrole	0
	(.)
agency	0.0901
	(0.06)
missingagency	1.890
	(0.27)
employment	0.0105
	(1.68)
missingemployment	-2.724
	(-0.94)
1.feLA	0

	(.)
2.feLA	-3.974**
	(-3.26)
3.feLA	0.0939
	(0.08)
missingfeLA	0
	(.)
_cons	38.61***
	(20.28)
N	275

Note: t-statistics in parentheses; * p<0.05, ** p<0.01, *** p<0.001

Appendix 3F: Symbolic Awards logic model



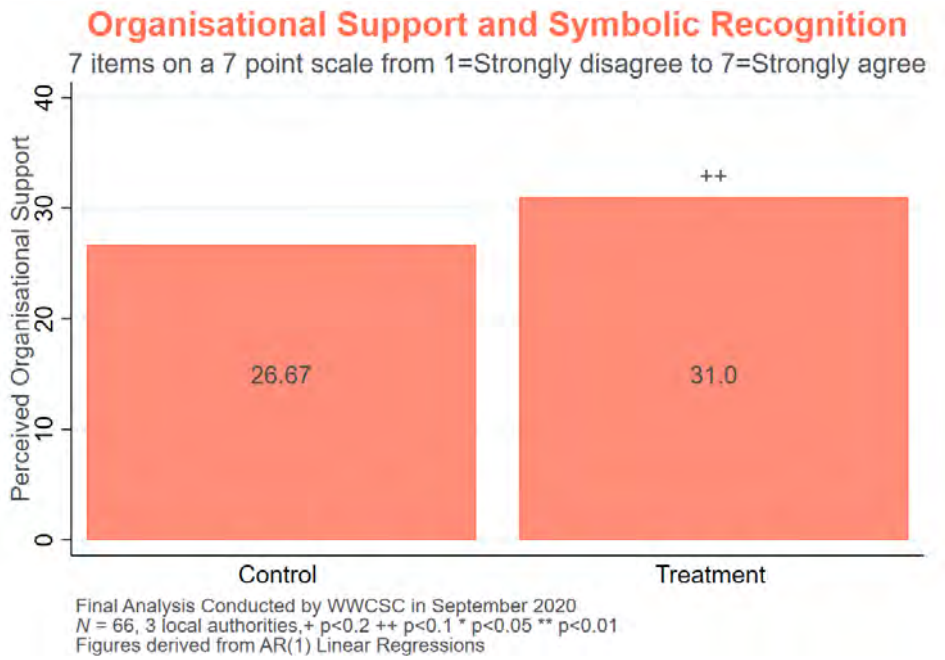
Appendix 3G: Symbolic Awards exploratory outcomes

Exploratory Outcome 1: Organisational Support

For our exploratory outcome organisational support, we conducted a linear regression for the total number of participants for whom we had survey data (n = 66). There was a non-statistically significant (though close to significant) increase in organisational support for participants in the intervention group (n = 30, M = 31.97, SE = 1.70) compared to the control group (n = 36, M = 26.67, SE = 1.40), p = .058. This a 18% increase in organisational support for participants who received the treatment.

A paired t-test demonstrated that participants in the treatment group (M = 31.96, SD = 9.3) reported higher levels of organisational support compared to the control group (M = 26.67, SD = 8.41), and this increase, 5.3, was a statistically significant difference, $t(64) = 2.43$, p = .018.

Figure 3G.1: Perceived Organisational Support

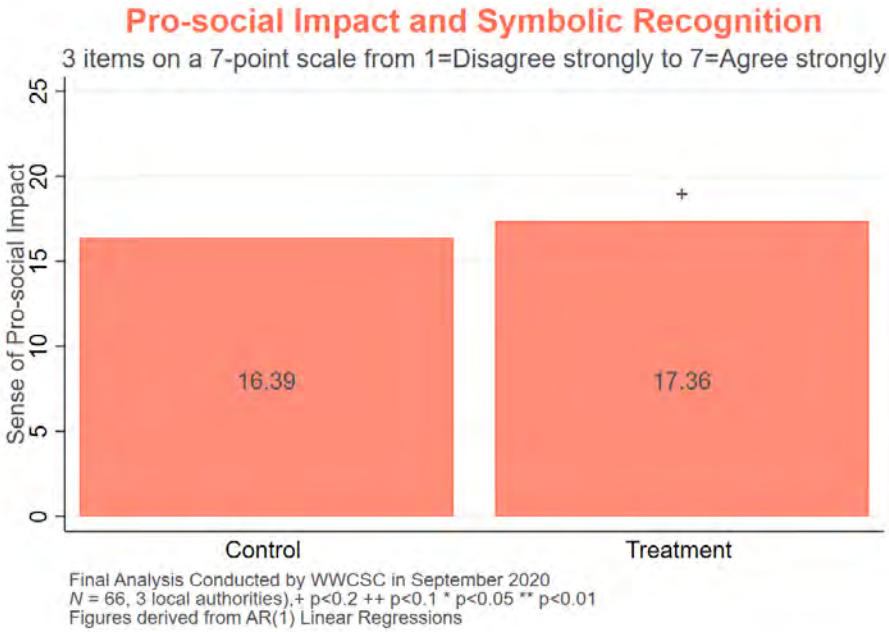


Exploratory Outcome 2: Prosocial Impact

For our exploratory outcome prosocial impact (i.e. the sense that one' work has a positive impact on others), we conducted a linear regression for the total number of participants for whom we had survey data (n = 66). There was a non-statistically significant (though trending towards significance) increase in for participants in the intervention group (n = 30, M = 17.33, SE = .42) compared to the control group (n = 36, M = 16.39, SE = .36), p = .102. This a 5.58% percent increase in prosocial impact for participants who received the treatment.

A paired t-test demonstrated that participants in the treatment group (M = 17.33, SD = 2.32) reported higher levels of prosocial impact compared to the control group (M = 16.39, SD = 2.14), and this increase, 0.94, was not statistically significant difference, $t(64) = 1.72$, p = .09.

Figure 3G.2: Prosocial Impact

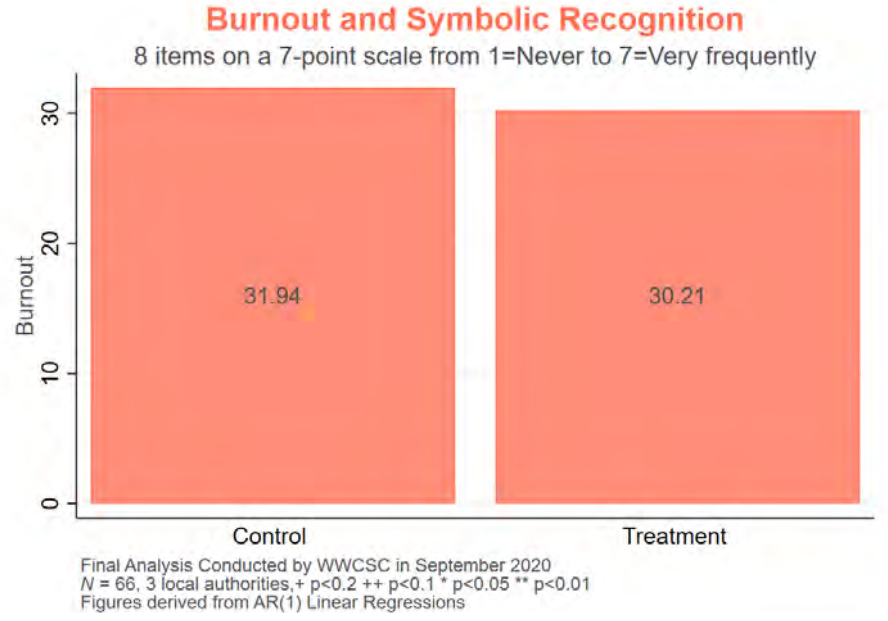


Exploratory Outcome 3: Burnout

For our exploratory outcome burnout, we conducted a linear regression for the total number of participants for whom we had survey data (n = 63). There was a non-statistically significant decrease in burnout for participants in the intervention group (n = 28, M = 30.21, SE = 1.64) compared to the control group (n = 35, M = 31.94, SE = 1.56), p = 65. This a 5.57% reduction in burnout for participants who received the treatment.

A paired t-test demonstrated that participants in the treatment group (M = 30.21, SD = 1.64) reported lower levels of burnout compared to the control group (M = 31.94, SD = 9.22), and this increase, 1.73, was not statistically significant difference, $t(61)$ = 0.76, p = .45.

Figure 3G.3: Burnout

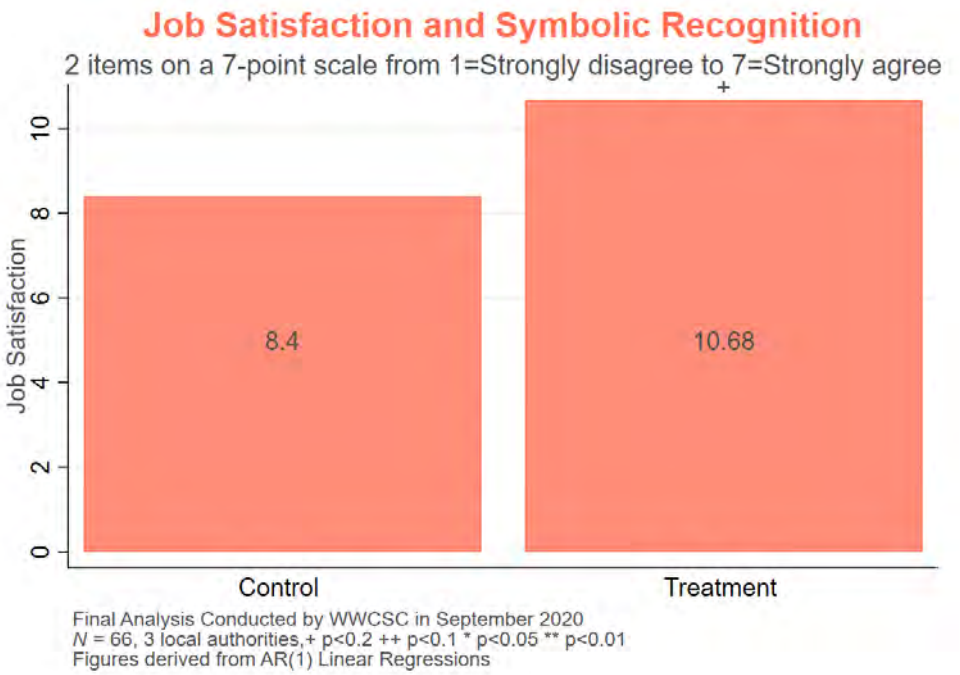


Exploratory Outcome 4: Job Satisfaction

For our exploratory outcome job satisfaction, we conducted a linear regression for the total number of participants for whom we had survey data (n = 27). There was a non-statistically significant increase in job satisfaction for participants in the intervention group (n= 28, M= 11.33, SE= 1.02) compared to the control group (n= 15, M= 8.4, SE= 1.02), p = .16. This a 29.7% increase in job satisfaction for participants who received the treatment.

A paired t-test demonstrated that participants in the treatment group (M = 11.33, SD = 3.52) reported higher levels of job satisfaction compared to the control group (M = 8.4, SD = 3.96), and this increase, 2.93, was a not statistically significant difference, although it was approaching significance, $t(25) = 2.0$, p = .0558.

Figure 3G.4: Job Satisfaction

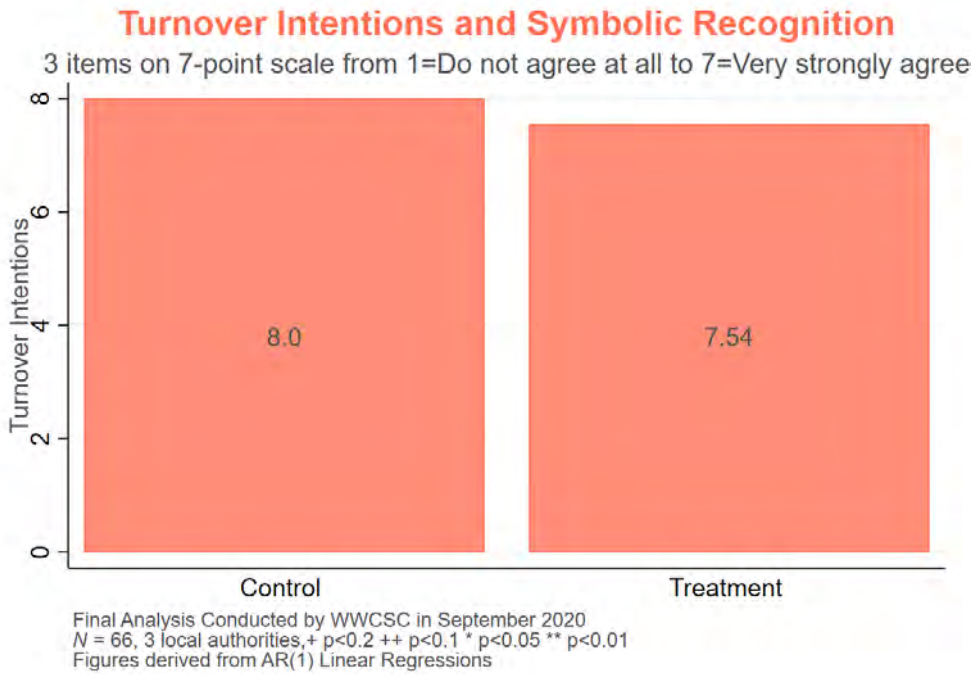


Exploratory Outcome 5: Turnover Intentions

For our exploratory outcome turnover intentions, we conducted a linear regression for the total number of participants for whom we had survey data (n = 66). There was a non-statistically significant decrease in turnover intentions for participants in the intervention group (n= 30, M= 7.2, SE= .93) compared to the control group (n= 36, M= 8.0, SE= .82), p = .73. This a 10.5% decrease in turnover intentions for participants who received the treatment.

A paired t-test demonstrated that participants in the treatment group (M = 7.2, SD = 5.10) reported lower levels of turnover intentions compared to the control group (M = 8.0, SD = 4.92), and this decrease, 0.8, was not statistically significant, $t(64) = 0.65$, p = .52.

Figure 3G.5: Turnover Intentions



APPENDIX 4 - SYMBOLIC AWARDS (ACCESS TO FREE COFFEE/TEA) MATERIALS

Appendix 4A: Note Attached to Coffee Machine in Buildings

Dear [team manager name] and your team,

This coffee machine is just a small token of thanks for your hard work to improve the futures of the most vulnerable children and families in Kent. Your compassion, integrity and dedication make a huge difference to these families every day and gives our children and young people the best chance to fulfill their potential.

Thank You

Appendix 4B: Access to Free Coffee/Tea - well-being survey

Title: Daily Experiences of Social Workers

Section 1: Subjective well-being Questions

Q1. Subjective Well-Being

Overall life happiness (1-item) [1]

Taking all things together, how happy would you say you are?

0 Not at all	1	2	3	4	5	6	7	8	9	10 Extremely

Cantril Ladder[2]

Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. Suppose we say that the top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.

If the top step is 10 and the bottom step is 0, on which step of the ladder do you feel you personally stand at the present time? (Please circle your response).

0 Bottom Step	1	2	3	4	5	6	7	8	9	10 Top Step

PANAS (Schedule for Positive and Negative Affect)[3]

Please think about what you have been doing and experiencing during the past four weeks. Then report how much you experienced each of the following feelings, using the scale below. For each item, select a number from 1 to 5, and indicate that number on your response sheet.

1	2	3	4	5
Very rarely/never	Rarely	Sometimes	Often	Very often/always

Positive
Negative
Good
Bad
Pleasant
Unpleasant

1 Jowell, R. (2007). European Social Survey 2006/2007. Round 3: Technical Report. City University, Centre for Comparative Social Surveys, London.
2 Cantril, H. (1965). Pattern of human concerns. New Brunswick, NJ: Rutgers University Press.
3 Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D. W., Oishi, S., & Biswas-Diener, R. (2009). New well-being measures: Short scales to assess flourishing and positive and negative feelings. *Social Indicators Research*, 97(2), 143-156.

Q2. Turnover Intentions[4]

Indicate to what extent you agree with the following statements. Use the following scale to record your answers.

(7-point scale: Do not agree at all 1, Very Slightly Agree 2, Slightly Agree 3, Moderately Agree 4, Mostly Agree 5, Strongly Agree 6, Very Strongly Agree 7).

1. I think a lot about leaving the organization.
2. I am actively searching for an alternative to the organization.
3. As soon as possible, I will leave the organization.

Q3. Job Satisfaction[5]

Below are two items with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item. Please circle the relevant number with each question.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
In most ways, my job is close to my ideal.	1	2	3	4	5	6	7
I am satisfied with my job.	1	2	3	4	5	6	7

Q4. Burnout[6]

Please think about your experience at your job during the past four weeks. Then, indicate how much you experienced each of the following states, using the scale below.

	Never 1	Very rarely 2	Rarely 3	Occasionally 4	Frequently 5	Very frequently 6
Periods of fatigue when you couldn't 'get going'						
Being tired						

4 Cohen, A. (1993). Work commitment in relation to withdrawal intentions and union effectiveness. *Journal of Business Research*, 26, 75-90.

5 Adapted from Diener, E. D., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49(1), 71-75.

6 Bacharach, Samuel B., Bamberger, Peter, & Conley, Sharon. (1991). Work-home conflict among nurses and engineers: Mediating the impact of role stress on burnout and satisfaction at work. *Journal of Organizational Behavior*, 12(1), 39-53. doi: 10.1002/job.4030120104

Being physically exhausted						
Being emotionally exhausted						
Feeling 'burned out'						
Being 'wiped out'						
Feeling 'run down'						
Being weary						

Q5. Strong and Weak Ties[7]

Please think about all of the coworkers that you know who you work with. Each person might be either a strong tie or a weak tie.

A strong tie is someone you are very close to, someone who you know really well and knows you really well, someone who you confide in or talk to about yourself or your problems (e.g., a good friend).

On the other hand, a weak tie is someone you are not very close to, who you don't know very well and who doesn't know you very well, someone who you consider a friend, but would be unlikely to confide in (e.g., a casual friend, an acquaintance).

Don't include someone who is an absent tie: Someone you don't recognize or who probably doesn't recognize you. It could be someone that you've met, but haven't really talked to.

Please estimate the number of strong ties you have at your work:

Now, please estimate the number of weak ties you have at your work:

Q6. Motivation[8]

Intrinsic and Prosocial Motivation (1=disagree strongly to 7=agree strongly)

Why are you motivated to do your work at your organization?

- Because I enjoy the work itself.
- Because it's fun.
- Because I find the work engaging.
- Because I enjoy it.
- Because I care about benefiting others through my work.
- Because I want to help others through my work.

7 Adapted from Sandstrom, G. M., & Dunn, E. W. (2014). Social interactions and well-being: The surprising power of weak ties. *Personality and Social Psychology Bulletin*, 40(7), 910-922.

8 Grant, A. M. (2008). Does intrinsic motivation fuel the prosocial fire? Motivational synergy in predicting persistence, performance, and productivity. *Journal of Applied Psychology*, 93(1), 48.

- Because I want to have positive impact on others.
- Because it is important to me to do good for others through my work.

Q7. Affective Commitment and Perceived Organizational Support (including Sense of Belonging)[9]

Rated on a 7-point Likert scale from "strongly disagree" to "strongly agree"

Affective Commitment
I feel strong sense of belonging to my organization.
I feel personally attached to my work organization.
I am proud to tell others I work at my organization.
Working at my organization has a great deal of personal meaning to me.
I would be happy to work at my organization until I retire.
I really feel that problems faced by my organization are also my problems.

Perceived Organizational Support
My organization really cares about my well-being.
My organization strongly considers my values and goals.
My organization shows little concern for me. (R)
My organization cares about my opinions.
My organization is willing to help me if I need a special favor.
Help is available from my organization when I have a problem.
My organization would forgive a mistake on my part.
If given the opportunity, my organization would take advantage of me. (R)

Section 2: Demographics

Q1. Age

How old are you? (insert number)

Q2. Marital status

What is your marital status?
- Married/domestic partner
- Widowed
- Divorced
- Separated
- Single/never married
- Prefer not to say

Q3. Number of children

How many children do you have who currently live at home with you?
- 0
- 1
- 2
- 3
- 4 or more
- Prefer not to say

9 Rhoades, L., Eisenberger, R., & Armeli, S. (2001). Affective commitment to the organization: The contribution of perceived organizational support. *Journal of Applied Psychology*, 86(5), 825.

Q4. General Health

In general, how would you rate your health?[10]

- Excellent
- Good
- Fair
- Poor

Q5. Contract Length

On which of the following basis are you employed?

- On a permanent contract
- On a fixed term or temporary contract
- Via an agency

Q6. Overtime Worked

On average, how many extra hours (above your contracted hours) do you work per week? (Insert number from 0)

If so, how many on average per week?

Q7. Caseload

Do you feel your caseload is manageable? Please use the scale provided to indicate your answer. (7-point scale where 1=not at all, 7=completely)

Q8. Additional Comments

Thank you for your time. If you have any thoughts about the study, you can provide them in the space below.

10 DeSalvo, K. B., Fisher, W. P., Tran, K., Bloser, N., Merrill, W., & Peabody, J. (2006). Assessing measurement properties of two single-item general health measures. *Quality of Life Research*, 15(2), 191-201.

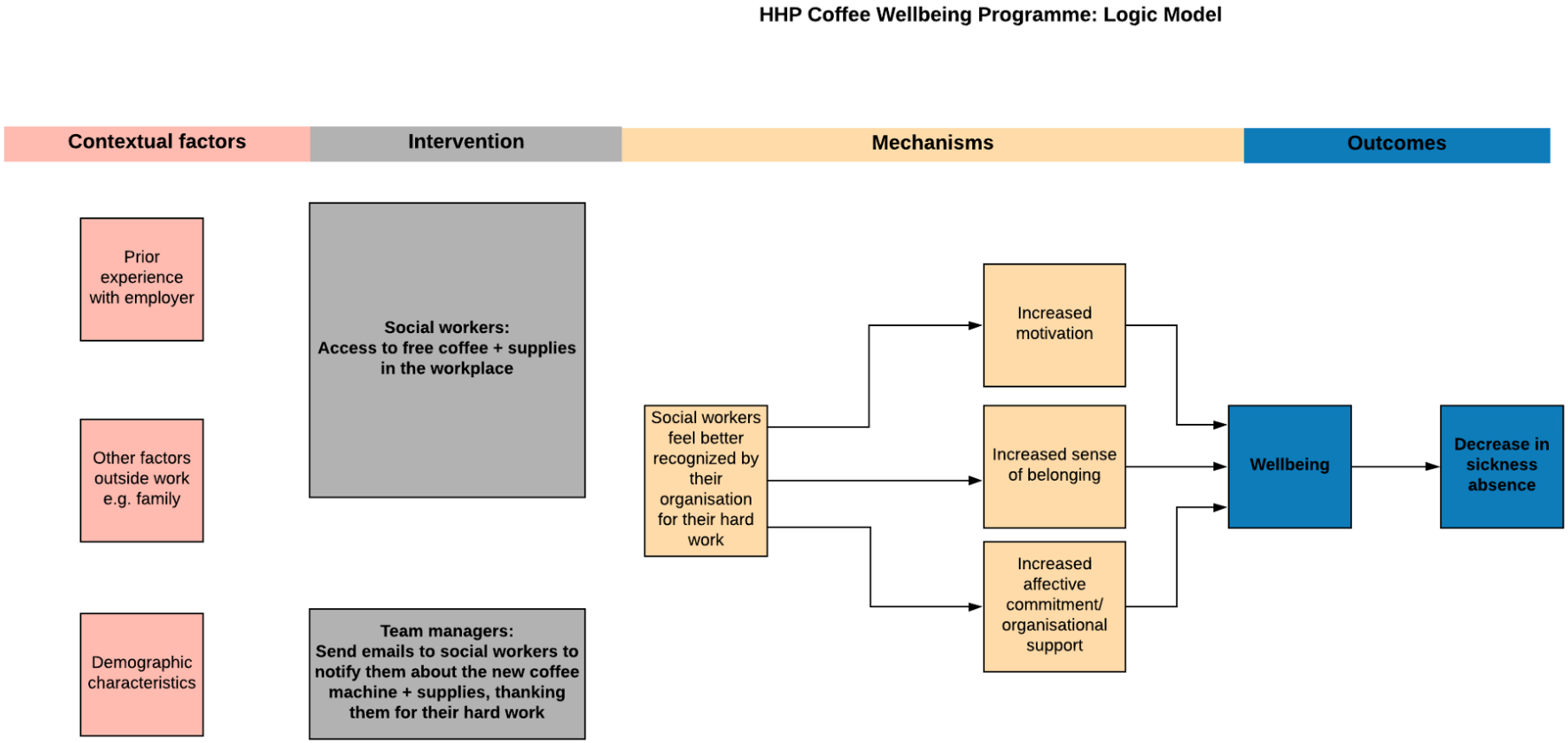
Appendix 4C: Free tea and coffee regression table

Table 1: Regressions for interim administrative outcomes

Table 1 Coffee intervention impact on interim administrative outcomes	
	attendance_int
treatment	-0.996
	(-0.82)
female	2.473
	(1.42)
role	0.686
	(1.53)
employment	-0.00366
	(-0.51)
goalsetting	0.211
	(0.18)
absence_base	-0.0718**
	(-2.66)
_cons	54.29***
	(23.45)
N	333

Note: t-statistics in parentheses; * p<0.05, ** p<0.01, *** p<0.001

Appendix 4D: Free tea and coffee logic model



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