June 2025 | **Report**

Implementation and process evaluation

EVALUATION OF MULTI-AGENCY SAFEGUARDING HUBS (MASH)

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What Works Centre for Children & Families

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[1] See https://www.ucl.ac.uk/impact/research-excellence-framework-2021
[2] See https://www.ucl.ac.uk/news/2023/sep/ucl-named-university-year
[3] For more information see https://www.ucl.ac.uk/ioe/departments-and-centres/ucl-social-research-institute

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GLOSSARY OF TERMS

Abbreviation / acronym / terms	Description
Child protection services	Child protection services are statutory interventions provided by local authorities when there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm. These services aim to protect children from abuse, neglect, and/or exploitation and are governed by Section 47 of the Children Act 1989, which requires authorities to investigate such cases and take appropriate action to safeguard the child's welfare.
Children	We use the term 'children' throughout to refer to children and young people up to age 18.
Children in Need	Children in Need are defined under Section 17 of the Children Act 1989 as children who are unlikely to achieve or maintain a reasonable standard of health or development without local authority services, or whose health or development is likely to be significantly impaired without such services, or who are disabled.
CMO	Context-Mechanism-Outcome – realist domains for understanding interventions, used in the Normalisation Process Theory Coding Manual.
Early Help and Family Help	Early Help comprises non-statutory services provided to families who need additional support but don't meet the threshold for statutory social care intervention. These services aim to prevent problems from escalating to crisis point by providing targeted support to families facing challenges, which may include parenting support, counselling, housing advice, or help accessing other services. The 2022 Independent Review of children's social care recommended that Early Help services be combined with Child in Need services (see above) and called 'Family Help' The government has confirmed Family Help as national

	policy, with Family help including targeted early help and Child in Need services under Section 17 of the Children Act 1989.
Front door	First point of access for all safeguarding referrals to the local authority. Sometimes referred to as integrated or multi-agency front door (see 'MASH' description below).
LA	Local authority
MASH	Multi-Agency Safeguarding Hub
Ofsted	Office for Standards in Education, Children's Services and Skills
Ofsted inspection	Ofsted inspects education, childcare/early years settings, and local authority children's social care in England. Ofsted grades these services using four categories: Outstanding, Good, Requires Improvement, or Inadequate. At the time of this report's publication, Ofsted is in the process of reviewing and consulting on potential changes to inspection frameworks for education and early years/childcare settings. Ofsted inspects children's services through Inspections of Local Authority Children's Services (ILACS), focused visits and Joint Targeted Area Inspections (JTAIs, with the other inspectorates). Ofsted's inspection framework and inspector workforce will be attuned to children's social care reforms, including the changes being made through the Families First Partnership Programme and measures in the Children's Wellbeing and Schools Bill.
Parents	Throughout this report, the term 'parents' is used as an inclusive term to refer to all adults with parental responsibility for children, including biological parents, legal guardians and carers. When discussing our Public Involvement and Community Engagement work, we

	occasionally distinguish between mothers and fathers where their specific perspectives differed, but otherwise use the umbrella term 'parents' for consistency.
Practitioners	The term practitioners is used in this report to refer to those working directly with children, young people, and families, building relationships and providing support. It refers to social workers, senior practitioners, family support workers, multi-disciplinary and multi-agency practitioners, such as those working in health or the police, and those with expertise in specific fields such as domestic abuse, mental health, and substance misuse (this is not an exhaustive list).
Referral	A referral is a formal request made to a local authority's children's social care services for assistance or intervention concerning a child or young person who is suffering, or is likely to suffer, significant harm, inside and outside of the home, including from abuse, or neglect and exploitation, or whose wellbeing may require assessment and support. Referrals are typically initiated by practitioners (e.g. teachers, health workers, police) or members of the public (e.g. family members, neighbours). In front-door services (known as Multi-Agency Safeguarding Hubs or MASH in some areas), referrals are received and triaged by a dedicated multi-agency team. This team assesses the information provided, determines the level of risk, and may recommend or decide on the appropriate response, which may include: 'No further action' (if the concern does not meet the threshold for social care intervention); signposting to early help or universal services (e.g. family support, health services); or initiating a social work assessment under Section 17 (Child in Need) or Section 47 (Child Protection) of the Children Act 1989.
Safeguarding partners	The Children Act 2004, as amended by the Children and Social Work Act 2017 (specifically in Section 16E), establishes three statutory safeguarding partners: the local authority, police and clinical commissioning groups/integrated care boards (health). These partners have a legal duty to make arrangements to work together to safeguard and promote the welfare of children in their area. Some local authorities have broadened their front-door multi-agency arrangements to incorporate additional partners such as education, domestic

	abuse services, youth justice teams and early help services. The composition of local authorities' multi-agency front-door teams varies with regard to partner agency participation.
Statutory services	Statutory children's services are social care services that local authorities in England are legally required to provide under various laws including the Children Act 1989 and Children Act 2004. These include child protection, support for children in care, services for disabled children and support for families in crisis.
Steering Committee	A working group who brings expertise to a project or study and who may guide direction at specific points.
Strategy discussions	Strategy discussions are a part of statutory safeguarding procedures in which statutory safeguarding practitioners decide whether to conduct a single or joint agency child protection assessment, identify if any urgent action is required to keep the child safe, and agree whether any legal or medical action is required.
Terms used to describe different levels of MASH cases	These terms indicate differing severity and concern and therefore urgency – linked to timelines of MASH. Sometimes they are referred to by practitioners as RAG ratings. • Tier 1: Universal services; • Tier 2: Children who may require support or signposting to other agencies from Early Help; • Tier 3: Children in need who require statutory intervention or specialist support (Section 17, Children Act 1989); • Tier 4: Children considered at risk of or suffering significant harm, who require statutory child protection intervention (Section 47, Children Act 1989). • Green: Referrals rated as Green are considered to be low risk and meaning there may be need for additional support and signposting from Early Help; • Amber: Referrals rated as Amber are considered to be medium risk meaning there are significant

	concerns, but they do not require immediate action from MASH; • Red: Referrals rated as Red are considered to be high risk meaning they require immediate action from MASH.
Triaging	Reviewing referrals, assessing the risk and allocating to MASH or Early Help/Family Help pathways.

EXECUTIVE SUMMARY

Introduction

The Department for Education has highlighted the importance of multi-agency practitioners working together for children and young people [for the purposes of this report, we will use the term 'children' throughout to refer to both children and young people] and families following a referral into children's social care (i.e. at the 'front door' of the local authority children's services). These multi-agency front-door services are often referred to as 'MASHs' (Multi-agency Safeguarding Hub) but are also known as Integrated Front Doors, Single Points of Access or other names. In this report, we use the term 'MASH' as a shorthand for all multi-agency front-door services.

A recent survey sent to all 152 upper tier local authorities in England in 2023 found that 93% (n= 103) of 111 responding local authorities had a MASH or other multi-agency front door and 60% (N=61/103) called their service a 'MASH' (see introduction for citation).

The fundamental principle of all MASH is to bring key practitioners together so they can share information about a child and family rapidly. We know that MASH vary across England and there is only a small amount of research telling us about how and why MASH work to support practitioners, children and families. This makes it difficult to describe the key components of MASH in England, to know if one way of implementing MASH is better than another and if any extra guidance might be helpful to local areas who are running or innovating their MASH. The Child Safeguarding Practice Review Panel recommended an evaluation of MASH in its Child Protection in England review (2022). The previous Government committed to evaluating MASH in its children's social care reform strategy, Stable Homes Built on Love, in 2023; the Department for Education has funded our study to provide research evidence in this area.

Objectives

The overarching objective of this study was to use accounts and views from MASH practitioners to develop understanding of how MASH work, for whom and in which contexts (i.e. develop a programme theory).

We had six research questions which were agreed with the National Cross-Government Steering Committee[4] set up by the Department for Education to input into this study:

[4] The National Cross-Government Steering Committee included representatives from the Department for Education, the Department of Health and Social Care, the Home Office, the Police, the National Police Chiefs' Council, Ofsted, Children's Social Care, local authorities, MASH Communities of Practice, and the NHS.

1. What are the common components, functions, or features of a MASH?
2. What are the main mechanisms (processes) by which we expect MASH to work?
3. What is the perceived impact and for whom does MASH work/not work and why?
4. In what contexts will MASH work/not work, and why?
5. What is the place of feedback loops, audits, and quality improvements?
6. If MASH works, what outcomes will we see?

Methods

University College London Social Research Institute and the Population Health Sciences Institute at Newcastle University conducted this research between February 2024 and January 2025.

We analysed: existing research about MASH from 2010 to 2022 (from a previous scoping review), information about 106 MASH in England from a 2023 survey and conducted focus groups for conceptual development. We undertook interviews in three local authorities (which remain anonymous in our study), and a workshop to explore and sense-check findings. Overall, we collected data from in total 103 MASH practitioners who worked in 58 (38%) of the 153 local authorities in England. We included more than one practitioner from some areas. These methods reflect a broad (existing scoping review, existing national survey, focus groups), deep (local authority case studies), broad (workshop) approach to allow sense-checking and contextualisation in the wider picture of MASH in England. We undertook Public Involvement and Community Engagement with parents, six mothers and four fathers, who had experience of involvement of children's social care for their children, gaining their feedback and insights on our results at two time points in the study.

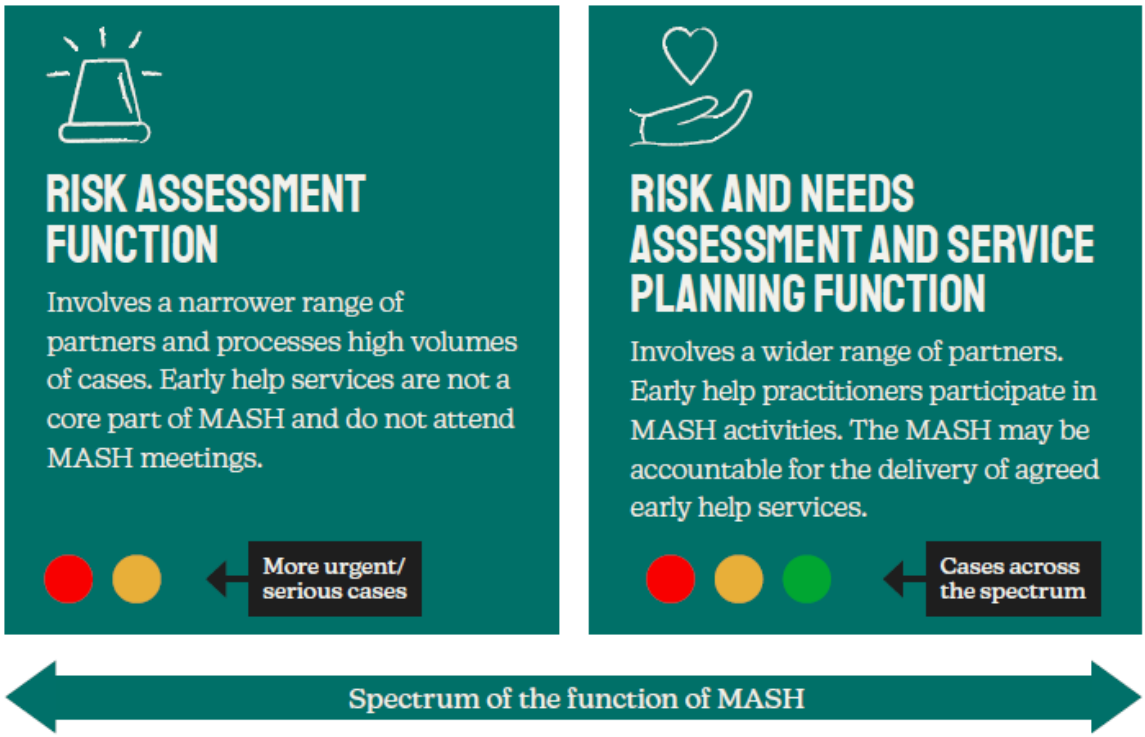
Key findings

We identified two empirically based models of MASH as implemented in England which were differentiated by their strategic priorities and remit: MASH with a primarily risk assessment function and MASH that also include a need assessment and service planning function (figure 1). The models we describe are theoretical – i.e. to represent the internal logic of the two different approaches to implementing MASH and show how the differing objectives connect logically to certain MASH features and intended outcomes. However, our results suggest that in reality the separation between the models is not so 'clean' and that MASH on the ground exist along a spectrum where the needs assessment and service planning objective was more or less locally visible or strategically prioritised.

In our workshop our theorised models of MASH resonated with the 40 MASH represented by participating practitioners. Workshop participants also reported that their MASH are commonly prioritising a needs assessment and service planning function alongside a risk assessment function (i.e. the most common MASH were in the middle of the spectrum) with fewer examples of MASH at either end of the spectrum. Using an online voting tool, the 40 workshop participants reported on the key features of their local MASH: only two participants reported characteristics consistent

with a 'pure risk assessment' MASH. It is not clear how far these results indicate that the represented MASH were *aspiring* to prioritise a needs assessment and service planning function and how far they were able to *implement* this function.

Figure 1. The two strategic functions of MASH (go to accessibility text)



RQ 1: What are the common functions, components, or features of a MASH?

Although much of the structure and day-to-day activity was similar between the two models of MASH, as figure 1 shows there were some key differences:

- The breadth of families going through MASH process: needs assessment and service planning MASH responded to the whole spectrum of family need, but risk assessment MASH focused on cases with higher but uncertain risk
- Number of core partners: higher in a needs assessment and service planning MASH
- Role of Early Help: more central in a needs assessment and service planning MASH
- Whether needs assessment and service planning were perceived as inside (needs assessment and service planning MASH) or outside (risk assessment) the MASH processes.

Practitioners expressed that this collaborative approach in a MASH enhanced their decision making and ultimately led to better safeguarding practice for individual children and families. At the same time, practitioners saw that a MASH could provide assurance when making difficult

decisions about families, which provided them with a greater sense of protection within this challenging area of practice. Parental consent for information sharing was consistently highlighted as a confusing and difficult issue for MASH practitioners. Despite existing guidance, practitioners reported uncertainty particularly in complex cases where additional information was needed to determine whether the threshold of significant harm had been met (noting that consent is not required when the significant harm threshold *is* met), creating tension between information-gathering needs and consent requirements.

In our theorised models of MASH, a MASH which prioritises a needs assessment and service planning function will focus on getting services to families earlier in their journey to prevent an escalation of problems, and will by default include a risk assessment function and, in some cases, will create accountability for delivery of agreed Early Help services. These MASH may be more resource intensive. A risk assessment MASH has a narrower focus of making sure no harm or risk of harm is missed, usually in the context of high volumes of children with complex cases referred into children's social care.

Although both risk assessment and needs assessment and service planning models of MASH were recognised by practitioners and parents, in both groups there was stronger support in principle for the latter. However, practitioners also acknowledged that a needs assessment and service planning MASH may not be practical in areas facing serious operational challenges.

RQ 2: What are the main mechanisms by which we expect MASH to work (or not)?

We identified two key mechanisms through which MASH operates effectively: strong practitioner relationships fostered by co-location practices and the expertise and stability of practitioners.

Practitioners consistently reported that co-location, even in a hybrid setup, serves as the 'gold standard' for promoting informal knowledge sharing, mutual respect and collaborative decision making. When colleagues from various agencies work alongside one another in shared office spaces, practitioners told us they can readily exchange 'softer' information, strengthen practitioner bonds, and engage in spontaneous discussions about cases, which they felt contributed to better, timely multi-agency decision making and improved outcomes for families.

The second crucial mechanism was a stable, skilled, and experienced workforce. Based on parental accounts, staff retention may be able to avoid changes in key workers for families, which significantly undermined trust in individual practitioners and agencies. A stable workforce may also allow practitioners to develop expertise in selecting and analysing information that is necessary, relevant, and proportionate, which was of high importance to parents (see below). This skill is also needed for sharing single-agency information in a way that colleagues from other agencies can interpret.

We identified challenges around seeking parental consent for information sharing, with practitioners often expressing uncertainty about requirements and best practice in complex situations. We found parents were concerned about the way that practitioners shared information,

particularly 'historic' data on parents reaching back decades and which parents thought was not relevant to their child's current situation. Parents also described how poor communication from practitioners and staff turnover affected trust and relationship building. Practitioners consistently told us that social workers hold ultimate decision making authority in MASH, particularly for statutory child protection decisions, challenging the concept of fully joint decision making. However, we found that clear understanding of safeguarding thresholds, well-defined agency roles, and strong cross-agency relationships facilitate valuable multi-agency informed decision making. This collaborative approach enhances social work decisions and builds consensus on appropriate interventions, even as local authorities retain their statutory responsibility.

RQ 3: What is the perceived impact and for whom does MASH work/not work and why?

We identified impacts of MASH for children, families and practitioner practice. Across all sites, practitioners reported MASH could help keep children 'safe' through enhanced risk identification. In locations with a needs assessment and service planning model, we heard that MASH could enable earlier intervention and preventive support for children below the threshold for statutory intervention. Practitioners also reported that MASH offered them assurance and protection in their difficult safeguarding work through rigorous processes and experienced management, enabled better service coordination, and supported practitioner wellbeing through opportunities to debrief with colleagues. Some practitioners told us that the MASH structure helped prevent services from becoming overwhelmed by inappropriate referrals and facilitated better filtering of cases.

In our parent workshops, we found significant concerns about MASH's impact on families. While we found practitioners viewed MASH as enhancing safety and enabling earlier intervention, parents expressed feeling under surveillance and excluded from the information-sharing processes that could follow a referral into children's social care.

MASH was used primarily for two groups of children (and therefore was seen as particularly useful for these groups): children with uncertain risk based on referral information alone and, in needs assessment and service planning models, families who could benefit from early preventive assistance. We identified specific operational challenges for certain groups, including care leavers aged 18 to 25 who fell outside standard MASH processes, families with no recourse to public funds, and newly arrived migrant families who had only limited contact with health, education, children's social care or other services in England and therefore had generated less service knowledge and information for MASH to draw on to form a picture of the family. In our workshops, fathers particularly reported feeling marginalised and viewed as peripheral to their children's lives rather than as important stakeholders.

RQ 4: In what contexts will MASH work/not work and why?

We found that essential enabling contexts included clear threshold guidance understood by all parties, which reduced disagreements and facilitated decision making. Developing these threshold documents through collaborative work among MASH partners was particularly valuable in

fostering shared understanding. While we found effective information-sharing infrastructure and systems were crucial, we noted these IT solutions still required skilled practitioners to transform data from single agency IT systems into meaningful and proportionate information to be shared.

We identified that contextual challenges of capacity constraints and resource issues significantly impacted MASH operations. Co-location practices, while fundamental for MASH effectiveness, often needed to shift to hybrid working arrangements due to workforce preferences and funding constraints. We heard from practitioners that resource constraints may lead some MASH teams to narrow their focus primarily to risk assessment functions. We also heard that a well-functioning MASH relies not solely on internal resources but also on the capacity of broader local services: a MASH may see repeat referrals if there are inadequate services to offer children and families once risk has been assessed and/or needs identified.

RQ 5: What is the place of feedback loops, audits, and quality improvements?

We found both formal and informal approaches to monitoring and improving MASH quality. Formal oversight was provided through strategic groups conducting regular audits and reviews, while quality improvement also occurred through informal channels, with practitioners identifying and solving issues through established relationships. The MASH management teams used adherence to internal timelines for case processing as a key measure of how well their MASH was functioning.

RQ 6: If a particular MASH works, what outcomes will we see?

Practitioners told us that they saw re-referral rates of children and families as indicators of MASH performance, with high rates of repeatedly referred families understood to be evidence of service failure requiring investigation. We heard that quality improvement efforts often focused on collaborating with referring agencies to enhance referral quality and appropriateness, primarily through targeted training and support. This involved reviewing referral patterns from specific services and working with partners to improve their understanding of thresholds and processes.

Participants commonly reported that if a MASH is working well, we would see: timely and relevant information sharing between practitioners; informed multi-agency decision making by children's social care; a reduced likelihood of missing or underestimating risk; swift needs assessment; and enhanced practitioner confidence and wellbeing. Participants across all MASH models saw that one function of a MASH is to protect children from harm.

In addition, we identified distinct additional outcomes from different MASH models, as perceived by practitioners. In needs assessment and service planning MASH, we saw potential for reducing the demand on child protection services through early intervention and preventing repeat referrals. These MASH also reported working to improve family experiences by offering earlier support and fostering trust in services. In contrast, we found risk assessment MASH to be perceived by practitioners as particularly effective in managing high volumes of complex cases within short

timelines. In our parent workshops, participants described potential negative outcomes when MASH mechanisms were not functioning effectively, including increased family mistrust in services and distress caused by poor communication or inappropriate timing of interventions.

Recommendations and next steps

The implications of these findings

Our framework of two main models of MASH can act as a basis for developing shared understanding of the variation in MASH in England and might underpin principles for MASH (or MASHs). MASH with a needs assessment and service planning appear to be more acceptable to practitioners and to parents conceptually and are broadly consistent with the multi-agency Family Help front-door services set out in new policy from the Department for Education. However, this model is likely more difficult to implement and may not be feasible in local areas with operational difficulties without significant extra resource and/or organisational change. The contextual challenges of safeguarding partner finances, resource, workforce and geographical boundary issues are significant. If difficulties within the local authority or wider agencies mean that key mechanisms of MASH cannot feasibly be achieved, we cannot assume that implementing any form of MASH will help staff, the service, or parents.

We show the importance of a) thinking beyond MASH components (e.g. timelines for activity) to look at the strategic purposes of MASH in relation to local contexts, and b) considering MASH within the wider system in which it sits (e.g. resourcing and quality of Early Help and locality assessment team).

Local MASH practitioners and parents are likely to benefit from national guidance about parental consent in multi-agency front-door services, taking into account experiences of parents.

Limitations of the study

A small number of case studies affects the weight of evidence and generalisability of the findings. Although we mitigated this by collecting data from 103 practitioners from 58 local authorities, most of this was through one workshop which was relatively light touch, and our programme theory needs to be explored against more case studies across England. Although our participants included MASH practitioners from multiple services, this study took the perspective of MASH as part of children's social care services within the local authority. Further work is needed to explore what multi-agency front-door services look like from the perspective of the police, for different parts of the health system, and for the education system. We have not fully explored the factors that drive design of MASH, and this needs further work with a wider set of case studies. Finally, our findings theorise MASH based on data collected in 2024 and cannot be assumed to apply to MASH as they evolve over time. Our 2023 survey suggests that MASH evolve over time and this evolution may be accelerated as children's social care reform is implemented throughout 2025 and

beyond. This reflects a common challenge, where the evidence base must continually adapt to policy and practice developments that can outpace research timelines.

Research recommendations

- Researchers should take a broader view of MASH and multi-agency front-door services, to include the functioning of the wider system in which they sit, for example in relation to the new multi-agency child protection teams.
- Further qualitative research should describe other MASH in detail and test our findings in order to extend our proposed framework. Detailed case study work is needed to get beyond surface accounts by practitioners. A future focus could be on MASH that have recently moved from a risk function to a needs assessment and service planning model including as a response to new (2025) policy expectations and/or MASH in local areas that have made changes over time.
- Further research should test these models at scale across a broader sample of local authorities to establish how consistently they apply nationally, as MASH evolve over time in the changing policy landscape and to identify any additional factors that might refine our programme.
- A dedicated study on parental consent and multi-agency front-door services in children's social care could helpfully be conducted to help identify good practice in different scenarios, including from the point of view of parents and older adolescents and across the spectrum of contact with children's social care.
- Researchers should collect detailed accounts of multi-agency working, including at the front door of children's social care, from the perspective of the police, different parts of the health service, and education settings across multiple areas of England.

INTRODUCTION

In 2023, the Department for Education laid out its vision for transforming children's social care in England under the previous Conservative government's 'Stable Homes, Built on Love' strategy (DfE, 2023a, p. 17). This was in response to the findings and recommendations of the Independent Review of Children's Social Care (MacAlister, 2022a), the Child Safeguarding Practice Review Panel's (2022) Child Protection in England review into the murders of Arthur Labinjo-Hughes and Star Hobson, and the Competition and Markets Authority's Children's Social Care Market Study (2022). Both the Independent Care Review and 'Stable Homes, Built on Love', placed emphasis on multi-agency collaboration as a key part of creating robust safeguarding and child protection systems, an approach that received strong support during practitioner consultations which were conducted for the 'Stable Homes, Built on Love' policy document (DfE, 2023a, p. 17). In 'Stable Homes, Built on Love', multi-agency front-door services within children's social care were presented as an important and promising example of multi-agency working to safeguard children.

Frequently, these multi-agency front-door services are called 'MASH' (Multi-Agency Safeguarding Hubs), but similar structures are also known as Integrated Front Doors, Single Points of Access, or Children and Family Hubs. Our survey of all 152 local authorities in 2023 found that 93% (n=103) of 111 responding local authorities had a MASH or other multi-agency front door and 60% (N=61/103) called their service a 'MASH' (Mendez Pineda et al., 2025). In total, we learned about 106 MASH from the survey (operating across a total of 111 local authorities). In our survey, we found that most of the multi-agency front-door services were established between 2011 and 2016 (Mendez Pineda et al., 2025). In this report, we use the shorthand 'MASH' to talk about the whole range of multi-agency front-door models.

In 2022, the Child Safeguarding Practice Review Panel (2022, para.13.34) made national recommendations to evaluate MASH. To better understand MASH, the Department for Education committed to commissioning research through its children's social care strategy (DfE, 2023a, p.25). Our rapid (12-month) study was commissioned by the Department for Education as this evaluation of MASH. The timing of the study was planned so that the findings could inform planned cross-government work on a revision of the Working Together guidance about multi-agency child safeguarding at the front door of children's social care for practitioners (HM Government, 2023). The Department for Education set up a Cross-Government Steering Committee to ensure the study design and presentation of findings aligned with evidence needs in government.

Since the study was commissioned in November–December 2023, the policy landscape in England has evolved rapidly in the context of a change in government in July 2024 following the general election. The Department for Education published its vision for Children's Social Care reform in November 2024, including plans for legislative change to enact these reforms (DfE, 2024a). The legislative changes are proposed in the Children's Wellbeing and Schools Bill (DfE, 2025), along with other proposals for improving the provision of education to children. This Bill is currently

being discussed in Parliament. Some of the proposed legislation would impact multi-agency working at the front door of children's social care, perhaps most significantly a new duty on the three statutory safeguarding partners (the local authority, NHS integrated care board and police) to establish new multi-agency child protection teams and nominate a social worker, health practitioner, a police officer or police staff, and someone with experience in education to form the team's minimum membership. The Bill also seeks to amend the Children Act 2004 to make it a requirement for safeguarding partners in each local area to include education and childcare agencies as mandatory participants in their multi-agency safeguarding arrangements. The Bill also contains multi-agency information sharing measures including an information sharing duty that provides a clear legal basis to share information for the purposes of safeguarding and promotion of welfare, and provision to enable the specification of a consistent identifier (also known as 'Single Unique Identifier') (DfE, 2025a, 2025b).

Simultaneously, a new model of Family Help has been designed and tested in the Families First for Children Pathfinder programme (HM Government, 2025), which was started under the previous conservative government's strategy (DfE, 2023a) and has been continued by the current Labour government (Daby, 2024). One aim of the pathfinders is to 'establish local multi-disciplinary Family Help services' including integrated front doors (HM Government, 2025). In March 2025, the Department for Education released the Families First Partnership (FFP) programme guidance which sets out expectations of safeguarding partners and other agencies to implement Family Help and multi-agency child protection, and increase the use of Family Group Decision Making, underpinned by strong multi-agency working across this reformed system (DfE, 2025b). Family Help will include targeted early help and Child in Need services under Section 17 of the Children Act 1989 with a policy aim of increasing and expediting preventive and supportive work with families, reducing an escalation of crisis and care entry. This guidance also has a section on 'front-door arrangements' which acknowledges that multi-agency working can be flexibly implemented (e.g. local areas can choose whether their multi-agency front door is physically or virtually co-located, or a hybrid arrangement) but also sets the expectation that local areas have a multi-agency front door if they do not already which includes or works closely with Early Help (DfE, 2025b). The FFP guidance shares examples of some local areas that have integrated family hubs – a community-based model of providing Early Help – and Family Help, with family hubs providing the physical co-location space for Family Help teams. It is intended that such community-based Early Help settings will play a key role in the early identification of family need and ensuring appropriate referrals into targeted support. The FFP guidance makes clear that each local area will need to review their local offer to ensure it works with the reformed system, which includes the new multi-agency child protection teams and Family Help.

Our results are relevant to some of the reforms to children's social care and Family Help and we have presented our results and discussed them with policy colleagues in the Department for Education (March – June 2025).

The introduction of multi-agency front-door services within children's social care were mentioned in the Munro Review of Child Protection (Munro, 2011): "Because of the complexity of assessing

why a child has problems or how serious they are, many areas are developing some form of multi-agency team for responding to referrals and deciding which type of help, if any, is needed."

Our review of the literature on MASH (Mendez Pineda et al., 2025) identifies several purposes of this service model, primarily centred around threshold and risk assessment as the Munro Review implies and also services planning. Objectives of multi-agency front-door services reported in the literature largely relate to improving service processes including conducting accurate risk assessments, offering appropriate and coordinated services, providing early help interventions, and enabling information sharing between agencies. The literature suggests that the ultimate goal of MASH is to improve timely access to appropriate support, reducing the need for repeated assessments across different agencies, ensuring children do not fall through the gaps in service provision, and enhancing overall safety and wellbeing of children. However, what remains unclear is the extent to which these goals and processes coexist within individual local authorities' front door, whether certain functions receive greater emphasis than others and if so, in which contexts and with what implications for the service design of MASH and service responses to children, young people, and families.

MASH are highly variable in their local implementation, and there are no centrally held records of whether there is a MASH in each local area of England, when it started, or its key characteristics. Since the inception of MASH in local authorities, there have been calls to evaluate this approach to child safeguarding (Munro, 2011; DfE, 2023a, p. 25). Due to the number of agencies involved in MASH, the skills and expertise required by each practitioner and the variability in implementation across England, MASH can be considered a 'complex intervention' (Pawson et al., 2005; Murray et al., 2010; Moore et al., 2015; Skivington et al., 2021). Part of evaluating a complex intervention is to go beyond investigating whether an intervention works in the sense of achieving its intended outcome, and asking a broader range of questions. This includes theorising *how* the complex intervention works, taking account of how it interacts with the context in which it is implemented and how it contributes to system change (Pawson et al., 2005; May et al., 2018; Skivington et al., 2021). In our study, we aimed to generate a theory about how MASH works, for whom, and how and in which contexts, known as 'programme theory'.

INTERVENTION

The information presented in this chapter comes from the published literature on MASH collected as part of a separately funded systematic scoping review conducted in 2022 and survey conducted in 2023 (Mendez Pineda et al., 2025). The 2022 scoping review included 29 publications about multi-agency front-door services within children's social care in England published between 2004 and 2022 (Mendez Pineda et al., 2025). To make sure we hadn't missed any important studies published since 2022, we re-ran the same searches form the scoping review in Web of Science, SCOPUS, and checked the scoping review sources for grey literature until March 2025. In this update, we found 18 publications that referenced front-door work, but none of these focused specifically on multi-agency working at the front door of children's social care (Baginsky & Manthorpe, 2022; Baginsky et al., 2022; MacAlister, 2022b; Muirden & Appleton, 2022; Bacon et al., 2023; Clare & Jackson-Blott, 2023; Firmin & Lloyd, 2023; Lamph et al., 2023; Owens & Lloyd, 2023; Purcell et al., 2023; Tyldesley-Marshall et al., 2023; Bennett et al., 2024; Firmin, 2024; Firmin et al., 2024; Haworth et al., 2024; Martin et al., 2024; Westlake et al., 2024; Mayrhofer et al., 2025). We also included the Ofsted (2023) report based on Joint Targeted Area Inspections (JTAIs) which provides valuable insights into multi-agency working at the front door of children's social care. This report, while not academic research evidence, offers important policy evidence about how multi-agency safeguarding hubs (MASHs) function across different local authorities, noting that "quality of information and decision making varied between each area's multi-agency safeguarding hub (MASH) or equivalent" (Ofsted, 2023). While there undoubtedly will be much to learn from the evidence base about multi-agency working within children's social care, we focus our introduction on what we know about multiagency working *at the front door* of children's social care, or to use the phrase from the Munro review "a multi-agency team for responding to referrals".

Why is MASH needed?

The first known MASH was implemented in Devon in 2011 (Golden et al., 2011). This intervention was developed in response to several high-profile cases of fatal child abuse and neglect, where investigation revealed that "poor coordination and a failure to share information" between practitioners had contributed to these tragic deaths (DfES, 2003). The fundamental principle of all MASH is to bring key practitioners together into a single team and share information rapidly: MASH have been described as a 'sealed intelligence hub' for children and families who are referred to children's social care (Mendez Pineda et al., 2025).

A key purpose of MASH, identified in the literature, is to enable more efficient and accurate risk assessments through collaborative information sharing among practitioners (Mendez Pineda et al., 2025). Based on these assessments, the team determines the most appropriate level of support for each child and family. This support may come through universal services (such as schools and

health visitors), Early Help and Child in Need services,[5] or, when necessary, statutory child protection services.

Who receives a MASH assessment?

There is relatively little information available about which children go through the MASH process across England – i.e. whether all children referred to children's social care go through the MASH process or only specific groups of children. In our 2023 survey (Mendez Pineda, 2025), 90% of responding local authorities who said they had a multi-agency front-door service reported a single referral pathway into children's social care. Most (80%) of the 106 MASH teams that answered our survey reported that their MASH also acted as a front door to Early Help. These survey results suggest that MASH processes in England are commonly used for every child and young person referred to children's services, whether the referrer intended the referral as Family Help, Child in Need, or Child Protection. However, we also found in the survey that MASH exist in areas with multiple pathways into children's social care (10%), meaning that these MASH teams will likely only assess a proportion of children referred to children's social care in these areas. In some local areas, there are separate pathways for accessing Early Help, not involving MASH processes. In areas with separate pathways to Early Help, MASH teams may assess a subset of children with more serious or complex problems than in other areas.

Based on our 2023 survey, around three-quarters of responding MASH focused only on children, while a quarter (26%) also responded to adult safeguarding referrals (Mendez Pineda, 2025).

What happens in a MASH?

MASH in England are highly variable in implementation, components, tailoring, and contexts, with all elements interacting to influence service delivery and outcomes. The context in which MASH models work will vary across local areas of England, with differences in risk and need in local populations, infrastructure (e.g. information systems), safeguarding partners, and wider support services for families. A 2014 Home Office study on MASH reported that despite differences in form and structure, MASH appeared to share the same three common principles: information sharing, joint decision making, and coordinated intervention (Home Office, 2014) and these three principles are evident in the MASH literature since 2014 (Mendez Pineda et al., 2025). This 2014 Home Office report remains the largest and most detailed study of MASH in England, with interviews in 37 local areas, expert panels, and questionnaires of practitioners (Home Office, 2014; Mendez Pineda et al., 2025). Although there is a growing evidence base on the operations of MASH

[5] In this report, we refer to Early Help and Children in Need as this was the way in which the practitioners from whom we collected data talked about their services. However, the Independent Review of Children's Social Care recommended that targeted Early Help and Child in Need services be integrated and known as 'Family Support' (MacAlister, 2022a) and this has now been confirmed as government policy.

in England, few accounts or studies investigate MASH across locations and none aim to make sense of the variation across England or to generate programme theory about MASH (or MASHs).

Who is part of MASH?

The existing literature and our 2023 survey of 106 MASH evidence high variation in the number and type of core partners in MASH teams (Mendez Pineda et al., 2025). In our survey, the majority of MASH we surveyed reported under 10 core partners in their MASH, with a minority (13%) reporting over 10 core partners – and 57% of those with MASH reported Children's Social Care, Health, Police, and Education as part of their core partner agencies. The MASH who reported dealing with adult *and* child safeguarding referrals most often had more staff, perhaps because the team also included representatives from adult services.

What are the barriers and facilitators of a MASH?

Our scoping review (Mendez Pineda et al., 2025) identified several key barriers to effective MASH operation, including communication challenges between multidisciplinary team members (Jahans-Baynton & Grealish, 2022), incompatible IT systems hampering information sharing (Centre of Excellence for Information Sharing, 2015; McCoig & Durán, 2020), issues accessing information for 'out of area' children (Shaw & Greenhow, 2021), and complexities around confidentiality and consent (Jahans-Baynton & Grealish, 2022). Organisational barriers include limited health representation in some MASH as reported in Joint Targeted Area Inspection reports (which was found both in our scoping review and in Ofsted research (2023), resource constraints affecting staffing and IT development, and different agency thresholds creating tensions (Centre of Excellence for Information Sharing, 2015). Facilitators of MASH success identified in the literature included co-location of staff, robust information sharing agreements, multi-agency engagement (McCoig & Durán, 2020), well-designed information-sharing tools (Driscoll, 2021), strong governance arrangements (Home Office, 2014),integrated IT systems, practitioner experience and consistency of staff, inclusion of education sector representatives, and comprehensive monitoring and evaluation processes (Centre of Excellence for Information Sharing, 2015).

OBJECTIVES

This implementation and process evaluation aims to identify and explain how and why MASH could contribute to better outcomes for children, young people, and their families. This evidence can be used to inform principles of best practices for implementing, adapting, or innovating MASH locally. An implementation and process evaluation such as ours can facilitate a more 'realist' perspective on evaluation – i.e. helping us not just to answer the question of 'what works' but also understanding for whom, why, and in which contexts (Murray et al., 2010; Humphrey et al., 2016; EIF, 2019; Huddlestone et al., 2020; Skivington et al., 2021; May et al., 2022). This study will add to the evidence base on multi-agency working at the front door of children's social care which may be relevant for wider work on children's social care reform This study will also inform the methods of a separately funded proof-of-concept retrospective quantitative evaluation of MASH for example by determining primary outcome measures (Mendez Pineda, 2025).

Research objectives

Objective 1

To develop an initial programme theory and a logic model (i.e. a graphic representation of programme theory) through a reanalysis of our recent scoping review of MASH in England and survey responses from MASH practitioners working in 106 MASH across 111 local authorities (Mendez Pineda et al., 2025).

Objective 2

To test and refine the programme theory and logic model through an analysis of: practitioner and service manager perceptions and experiences of implementation processes, contextual factors, resources, and mechanisms (Moore et al., 2015; Skivington et al., 2021), that enabled or hindered MASH in their local area and consultation with parents who have relevant lived experience.

Objective 3

To explore and sense-check the findings of our study through consultation with MASH practitioners from multiple local authorities in a workshop.

We have structured our research on six questions, adapted from (ex)Public Health England guidance on realist evaluations, the Medical Research Council's process evaluation literature, and Humphrey et al.'s handbook on implementation and process evaluation (Moore et al., 2015; EIF, 2019; Mercer & Lacey, 2021).

Evaluation questions

1. What are the common components, functions, or features of a MASH? (Context and Mechanisms)
2. What are the main mechanisms by which we expect MASH to work? (Mechanisms)
3. What is the perceived impact and for whom does MASH work/not work and why? (Outcomes)
4. In what contexts will MASH work/not work, and why? (Context)
5. What is the place of feedback loops, audits, and quality improvements? (Mechanisms)
6. If a particular MASH works, what outcomes will we see? (Outcomes)

METHODOLOGY

Research design

Programme theory describes how an intervention is expected to lead to its effects and under what conditions (Pawson & Tilley, 1997; Pawson et al., 2005). It articulates the key components of the intervention and how they interact, the mechanisms of the intervention, the features of the context that are expected to influence those mechanisms, and how those mechanisms might affect the context (Skivington et al., 2021). When we started this study, there was no programme theory (also known as theory of change) for MASH, even though MASH is widely implemented. The largest and most in-depth study of MASH – which identified common principles (purposes or activities) of MASH, facilitators and barriers, and possible outcomes across many MASH in England – is now more than 10 years old (Home Office, 2014).

This current study aims to generate programme theory for MASH (or different MASHs) by providing an empirically based description of what MASH are and how they are thought to work – the essential elements to produce a MASH programme theory.

We used an implementation and process evaluation design to answer our research aims (Moore et al., 2015; Humphrey et al., 2016; Skivington et al., 2021; Youth Endowment Fund, 2022).

Protocol overview

The evaluation protocol was registered with the Open Science Framework [6] and published on the Foundations website on 21 August 2024.[7]

In this protocol we proposed to conduct an implementation and process evaluation (IPE) and collect qualitative data from practitioners and families to answer questions about the key features of MASH and how (different) MASH work. This qualitative study collects and analyses interviews, national focus groups, national practitioner workshops, and observational data from practitioners, parents, and young people in England. We proposed that our main data collection occur in three local areas of England. These would be sampled according to key characteristics of MASH which we identified in the literature, the survey of MASH in England (Mendez Pineda et al., 2025), and from national focus groups. The sampling framework would be guided by the views and priorities of the National Cross-Government Steering Committee with whom we are working as part of this study.

Although most of our qualitative data would be collected from three local areas in England, our evaluation takes a broad-deep-broad approach. We start with a broad analysis of all published

[6] See https://osf.io/
[7] See https://foundations.org.uk/our-work/current-projects/an-implementation-and-process-evaluation-of-multi-agency-safeguarding-hubs-mash/

literature since 2010 and an analysis of data from our 2023 survey and scoping review, and focus groups (Objective 1). Then, we conduct a deep dive into three local authority sites, theoretically sampled from our learning from Objective 1, to test and refine the programme theory developed in Objective 1 (Objective 2). Then, we broaden out again by taking our refined programme theory to a workshop with practitioners and local leaders who were not part of our previous three-site sample (invited through our networks, Objective 3). This broad-deep-broad structure of the study would allow us to collect in-depth data from a small number of sites while placing those sites in the wider picture of England and using the workshop to explore and sense-check findings.

In this study, we take a 'realist' perspective on evaluation, i.e. aiming to not only answer the question of 'what works' but also understand for whom and why. To embed a realist approach to our analysis, we proposed to use Normalisation Process Theory and REAIM (Reach, Effectiveness, Adoption, Implementation, Maintenance), both of which provide a structure for evaluating implementation.

Deviations from the protocol

1. Our initial protocol proposed three focus groups with practitioners working in MASH in England. For these initial focus groups, we managed to recruit practitioners in children's social care, health, and police. These practitioners told us about the key role of education and Early Help practitioners who were not present. Therefore, we conducted two further focus groups specifically for Early Help and Education practitioners, with targeted recruitment.
2. We had planned to undertake 12 one-to-one interviews with children, young people, parents, and carers, asking about their own experiences of coming into contact with children's social care and their views on the role of different practitioners in their lives. However, as the study progressed, we felt it more appropriate to conduct Public Involvement and Community Engagement with parents rather than in-depth qualitative data collection. The rationale for this was: (i) interviews about their own experiences of children's services may be triggering and cause undue upset to young people, parents, and carers; (ii) the 12 interviews we planned may not have been enough to draw out meaningful findings across a heterogeneous sample (young people, parents, and carers with different types and severity of family problems). For these reasons, we partnered with two charities who supported parents and who facilitated two workshops with mothers and two with young fathers who had experience with children's social care involvement for their children. In these workshops, participants discussed our emerging findings. We considered the themes from the four parent workshops as 'results' and they are reported in the Findings chapter.
3. We planned to observe MASH meetings in each case study site (n=3) but one site could not identify any relevant meeting for us to attend during a period of two weeks, yet initially provided researcher availability across a two-month time frame.
4. We planned to recruit participants from across agencies for our workshop but the workshop was mainly attended by health and police practitioners (few social workers and no education or Early Help practitioners). Due to the rapid timelines of this study, and as we

had already elicited views from education, Early Help and social workers in our focus groups (including through targeted recruitment) and case studies, we decided to proceed without further targeted recruitment for the workshop.

5. We planned to use Normalisation Process Theory and REAIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) as frameworks for data analysis. However, to keep to rapid timelines we focused exclusively on Normalisation Process Theory, which is widely applied in process evaluations and health interventions in the UK (May et al., 2018; Huddlestone et al., 2020).
6. Our original protocol stated that Objective 3 would "explore the generalisability of this programme theory with a workshop with MASH practitioners". However, peer review comments have prompted us to reconsider this objective in terms of how aligned it is with the methods we propose. To test generalisability we would need to conduct extensive sampling across local authorities in England. Given the workshops limit on number of attendees and that this was planned as relatively light-touch data collection, we have reworded this objective to make clear that we meant sense-checking and exploring our findings with a wider group of practitioners, rather than a systematic and comprehensive testing of generalisability as our wording may have implied.

Data collection

Practitioners

To understand 'what' MASH looks like and how it functions, we gathered the views and experiences of practitioners working in MASH across England.

Our implementation and process evaluation was not designed to quantify the impact of MASH on any child and family outcomes. Qualitative data is inherently in-depth rather than broad: we adopted a case study approach by collecting data from three local authority case study sites in England, each having its own MASH. To contextualise our findings from the three case studies within a broader national perspective, we gathered additional insights through five focus groups involving 32 MASH practitioners and a separate workshop attended by 35 practitioners (table 1). In total, we collected data from participants from 58 (38%) of the 152 local authorities in England which allowed us to incorporate a national perspective in our findings.

Table 1. Number of participants and unique local authorities represented in our data, by data collection method

	Social Care	Police	Health	Education	Early Help	Other	Total participants	Unique local authorities represented
Focus groups	5	5	9	6	6	1[1]	32	18

	Social Care	Police	Health	Education	Early Help	Other	Total participants	Unique local authorities represented
Site 1 interviews	4	2	1	1	1	[1][2] ;[1][3];[1][4];[1][5]	13*	1
Site 2 interviews	3	2	2	2	2	[1][1]	12	1
Site 3 interviews	4	1	2	1	1	[1][5];[1][6] ;[1][7];[1][8]	13	1
Workshop	3	16	16				35	40[9]
Total	**19**	**26**	**30**	**10**	**10**	**10**	**104***	**58**

[1] Strategic; [2] Domestic Violence; [3] Community Safety – LA; [4] Strategic partnerships; [5] Youth Justice; [6] LADO; [7] Frontline advisor manager; [8] Strategic – Safeguarding Children Partnerships; [9] Participating practitioners in some cases covered overlapping local authorities, particularly within health trusts and policing sectors where individual practitioners represented several local authorities.

*Education and Youth Justice were represented by one practitioner, so although the addition of represented practitioners adds to 105 it was in reality 104.

Parents

We conducted Public Involvement and Community Engagement with parents, specifically mothers and fathers, who had experience of involvement of children's social care for their children. Public Involvement and Community Engagement is recognised as an important factor in research to ensure it is relevant and reflective of those with lived experiences of systems and services. Incorporating the views and perspectives of individuals with lived experience may add cultural relevance and a more nuanced understanding of the research topic, which may enhance the findings of the research and ensure they are relevant and appropriate and more likely to impact and inform policy and practice (Brett et al., 2014).

The purpose of our engagement with parents was to discuss and gain feedback on findings at two time points to contextualise findings from the data we collected from practitioners.

In collaboration with two charity partners, we undertook two separate workshops with a group of mothers and a group of fathers in September to October 2024 and two additional workshops with the same mothers and fathers in December 2024 to January 2025. The development and organisation of these groups was supported by our charity partners who have established networks and offer support to mothers and carers (Birth Companions) and fathers (North East Young Dads and Lads). A convenience sampling was adopted for our PICE workshops, directed by our charity

partners who had in depth knowledge of mothers and fathers' experiences and engagement with children's social care. Each of the parents involved in our workshops were identified from charity partners lived experience teams and approached by either Birth Companions or North East Young Dads and Lads for participation. Parents were invited to take part in our Public Involvement and Community Engagement workshops if they met the following criteria: a) their children having been referred to children's social care (i.e. potential contact with MASH processes) within the last year; b) being in a position where involvement in the research would be feasible and appropriate (e.g. family is not crisis); and c) participation would not create additional difficulties for the families. All parents approached to take part were over 18 years old and were known to and working with, our charity partners.

Six mothers and four fathers each attended two workshops (four workshops in total). Each workshop lasted 1.5 to 2 hours. Workshops were undertaken either online using video conferencing software (Microsoft Teams) or in person, by our researchers with community involvement experience (CS, RMP). All of the parents involved in our workshops had lived or living experience of children's social care involvement, with some also having involvement when they were themselves children. Mothers involved in the workshops had experiences with their children being referred to children's social care as recently as just a few weeks previous to our workshops and one mother reported over two decades of experience with children's social care. All fathers who participated in these workshops were under the age of 25 years and had experience of children's social care involvement in their children's lives. Some fathers were themselves care leavers. Within each workshop a representative from each charity partner was present to support mothers and fathers before, during, and after the workshop.

All workshop participants were reimbursed for their time in line with National Institute for Health and Care Research INVOLVE guidelines (NIHR, 2024) at the rate of £75 per workshop. We also reimbursed our charity partners for the costs of setting up and running the workshops, which comprised administrative work, identifying and recruiting parents, organising parents' attendance at each workshop, and supporting parents before and after the workshops. This included work to make sure parents understood what participation meant and could give truly informed consent, which was collected in both written and verbal form from each parent.

Within each workshop we presented the emergent findings of our study as 'themes' to the parents at both an earlier stage (Sept/Oct 2024) and a later stage (Dec 2024/Jan 2025) of analysis. We then asked parents to discuss and reflect on the themes. After the workshop, one researcher (CS) wrote up notes and key points which were then synthesised and included in this report.

Objective 1: Develop an initial programme theory and a logic model

We developed initial programme theory and a logic model based on the existing evidence-base about important and common characteristics of MASH, drawing on our previously conducted scoping review of relevant literature published between 2010 and 2022 and our 2023 survey of 106 MASH in England (Mendez Pineda et al., 2025). In addition, we conducted five virtual focus

groups with 28 MASH practitioners (1) in order to test and extend what we knew from the scoping review literature and survey and further understand the perceived benefits and impacts of MASH and how these might be achieved. Our approach is consistent with guidance on developing initial programme theory, which recommends collecting data from practitioners rather than programme users (i.e. families) as a first step (Greenhalgh and Manzano, 2022).

For the focus groups, we invited practitioners through emails to the 106 MASH managers who responded to our 2023 survey (Mendez Pineda et al., 2025) and wider networks of the research team, funder and members of the National Cross-Government Steering Committee. We invited practitioners from across the core partners (children's social care, health, police, education, and Early Help practitioners), aiming for geographical coverage across England. See table 1 for details of participants' practitioner role across focus groups.

We transcribed and analysed the focus group data, though analysis was only in preliminary stages when we drew up the initial logic model.

The purpose of the initial programme theory and logic model was to communicate our emerging thinking to the National Cross-Government Steering Committee at an early stage of the study, to make sure our case study data collection was based on empirical evidence and to identify the unanswered questions about programme theory after analysing the existing literature, survey results and focus group data.

This initial logic model indicated that our understanding of MASH at this point (month 4 of the study) remained high level, relying on top-line phrases such as "timely and appropriate decision making" and "right time, right child, right services". We didn't yet have much detail about what these concepts looked like in operation on the ground for different local areas or different groups of children and families. Our initial logic model and the unanswered questions it highlighted is presented in appendix B.

Objective 2: Test and refine the initial programme theory and logic model

In order to test and refine the initial programme theory and logic model, we continued our analysis of the focus group data and also conducted a case study of MASH in three local areas in England. In these case studies, we collected data through interviews with practitioners working in the MASH.

Inclusion criteria: choosing our three case study sites

We undertook a purposive sampling approach, which means we chose our case study sites to reflect specific key characteristics of MASH (Palinkas et al., 2015). This was possible because we had data on some key aspects of variability between 106 MASH in England from our 2023 survey. This included information on: number and type of core partners, inclusion of Early Help in the MASH (or not), single or multiple referral pathways into MASH, and whether the MASH included adult as well as child and young person safeguarding referrals (Mendez Pineda, 2025).

We used these 2023 survey results to generate the sampling framework for selecting our case study sites (methods explained further in appendix A). We applied the following inclusion criteria to the sampling framework to identify which of the 106 MASH we should approach to participate in our case studies.

Inclusion criteria

1. Children's social care, police, health, and education all reported to be 'core partners'
2. A higher number of partner agencies (=8)
3. Physical co-location
4. One system referral pathway into children's social care
5. Within a local authority which Ofsted had rated as Good or Outstanding in the most recent inspection at 31 March 2023 (Ofsted, 2025)
6. Not within a local authority which was a 'Families First for Children Pathfinder's' area (HM Government, 2025). These are local authorities funded to 'test and learn' from their approach to service reform within children's social care, which includes participating in research study.[8]

These inclusion criteria were developed in collaboration with the National Cross-Government Steering Committee. Criteria 1–4 were designed to help us identify well-functioning MASH, reflecting the National Cross-Government Steering Committee's position that more would be learned about programme theory from MASH which worked well than MASH which were struggling. Inclusion criteria 5 was designed to broaden the range of local areas in England contributing to the evidence base about service models within children's social care. Our inclusion criteria mean that our case study sites are, by design, likely to be examples of 'good' MASH.

The Steering Committee also highlighted the importance of sampling case studies with a range of area-level deprivation.

Based on the survey results, nine MASH met inclusion criteria 1–5 (see appendix A for more details). We selected our three case study sites from these nine MASH, avoiding the 'Pathfinder' local authorities (inclusion criteria 6) and aiming for maximum geographical variation in our final sample.

To recruit case study sites, we first approached MASH managers by email to the MASH inbox. All but one MASH manager that we approached agreed to participate (i.e. we had to approach four MASH to successfully recruit three sites).

Given our other inclusion criteria, we were not able to sample a range of area-level deprivation in our three case study sites: all three were among England's 40% most deprived local areas (MHCLG, 2019).

[8] For further information see https://www.gov.uk/government/publications/families-first-for-children-ffc-pathfinder-programme/families-first-for-children-ffc-pathfinder-programme-and-family-networks-pilot-fnp

Case study interviews

We developed our interview topic guide based on results from Objective 1 and incorporating relevant Normalisation Process Theory constructs (see Analysis section, table 3, and appendix E).

In each of the three case study sites, we started by interviewing the MASH manager, who we then asked to identify additional practitioners. In each site we aimed to interview at least one MASH practitioner from each of children's social care, police, health (the statutory safeguarding partners), and education, as well as a senior staff member in the local authority with strategic responsibility for MASH. We achieved this with the exception of Site 2 where we did not recruit a senior strategic participant (table 1).

We conducted a total of 38 interviews across the three case study sites: 13 interviews in Site 1, 12 in Site 2, and 13 in Site 3. This included nine interviews with social workers, six interviews with police colleagues, five with health, five with education, and four with Early Help practitioners. See table 1 for a description of the numbers and role of interviewees across case study sites.

Three researchers (RMP/CG/CS) conducted interviews, mainly in person in the MASH offices. Four (of the 38) interviews were done using MS Teams due to practitioner availability. We observed two MASH meetings (Sites 1 and 2). All interview recordings were transcribed and anonymised. Three researchers (SB/CS/RMP) undertook data coding on transcriptions of the interviews, with RMP and SB double-coding five and nine interview transcripts, respectively, for coder reliability.

Characteristics of case study sites

In line with our inclusion criteria, all three sites had a recent Ofsted rating of Good or Outstanding, had reported in our 2023 survey that practitioners in their MASH were physically co-located, had a one-system referral pathway, and had eight or more MASH partners. Consistent with our sampling aims of geographical spread, each of the three case study sites were located in a different region of England. All three sites had relatively higher rates of deprivation compared to other parts of England and were in urban areas, which was not by design but a consequence of our other sampling criteria. Table 2 presents key statistics for each case study site, based on publicly available data.

Based on these statistics, there appeared to be differences between the local areas of the three case studies, with Site 1 from the London region standing out as different to the other two.

Sites 2 and 3 had a similar number of children in their local areas (≈42,000 children), whereas Site 1 had a higher child population (≈62,000 children, 2). Compared to the other two sites, Site 1 had a much higher volume of referrals into children's social care, a lower rate of child protection plans, and in the middle range between the three sites for children in need, with a rate of 811 per 10,000 children (table 2). Although the volume of referrals for Site 1 was triple that of Site 3, Site 1's total reported expenditure on children and people's services was only 34% higher (table 2).

Table 2. Data collection Site and National average – selected statistics regarding children's social care (2023)

	National	Site 1	Site 2	Site 3
Child population estimates	11998646 ⇑	62102 ⇓	42307 ⇑	43064 ⇑
LA children and young people services funding – total net expenditure	£12,242,290,143 ⇑	£67,606,022 ⇑	£54,424,809 ⇑	£50,583,809 ⇑
Referrals in the year	640430 ⇓	5015 ⇓	2897 ⇓	2247 ⇑
Referral rates	538.8 ⇑	805.5 ⇓	691.9 ⇓	531 ⇑
Re-referrals within 12 months of a previous referral (%)	22.4 ⇑	22.8 ⇑	27.7 ⇑	17.8 ⇑
Referrals which resulted in an assessment and the child was assessed not to be in need (%)	29.9 ⇑	24.2 ⇓	2.7 ⇑	31.2 ⇑
Referrals which resulted in no further action (%)	7.1 ⇓	7.7 ⇓	0 ⇒	3 ⇓
Median days for assessments	33 ⇑	26 ⇒	19 ⇑	29 ⇒

	National	Site 1	Site 2	Site 3
Rate of children with an episode of need at any point during the year per 10,000 children aged under 18 years	599.6 ⇓	811 ⇑	956.3 ⇓	673.2 ⇑
Rate of child protection plans taking place at any point in the year per 10,000 children aged under 18 years	96.5 ⇓	92.5 ⇓	114.9 ⇓	126.7 ⇑
Deprivation quintile*	n/a	2	2	2
Region		London	South East	Midlands
Urban/Rural		Urban	Urban	Urban
Single front door	90%	Yes	Yes	Yes
Child and adult front door	73%	Yes	Yes	Yes

All data in the table is from 2023 https://explore-education-statistics.service.gov.uk/find-statistics/children-in-need, except for net expenditure obtained from DfE Official Statistics LA and school expenditure https://www.gov.uk/government/statistics/la-and-school-expenditure-2022-to-2023-financial-year

ONS mid-year population estimates – children aged 0–17 years.

Total Safeguarding Children and Young Peoples Services expenditure funding financial year, example 2023=2022/2023.

The duration of an assessment is calculated as the number of working days between the start and end dates.

*Deprivation quintile obtained from accredited official statistics – English indices of deprivation 2019 https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

The national estimates for 'Single front door' and 'Child and adult front door' refer to a national picture compiled from 111 local authority responses to the 2023 MASH survey.

⇑ This implies an increase compared to the previous year, ⇓ a decrease compared to the previous year, ⇒ or no change compared to last year.

Objective 3: Exploring the generalisability and sense-checking findings

We explored and sense-checked findings of our programme theory and logic model from Objective 2 through a single online workshop with 35 practitioners – mostly from health and police, three from children's social care, and no representation from education or Early Help – who worked across 40 MASH (table 1). To recruit participants, we cascaded a flyer about the workshop through our networks and the members of the National Cross-Government Steering Committee. We collected expressions of interest from practitioners, including their roles, local authority sites, and partner agencies they belong to, as well as emails to contact them. We invited all 69 practitioners who expressed interest, and 35 attended the workshop in December 2024.

In the online workshop, we asked practitioners to tell us how far our findings reflected their own MASH and to discuss our emerging findings in the context of their local areas. This workshop included three parts: first, we presented our findings; second, participants used online polls to tell us if their local authority front-door services were similar or different from our results and whether certain aims or features were prioritised in their local MASH; and third, we split into five breakout rooms where participants discussed how far our key findings resonated with their own MASH and their views on what a MASH can do and how.

Analysis

We used Normalisation Process Theory to embed a realist approach and framework to our study (May et al., 2022) and ensure data collection and analysis were theoretically informed (May et al., 2022). While primarily using a deductive analytical approach guided by this theory, we also incorporated inductive coding to enhance the robustness of our findings (Bingham, 2023).

What is Normalisation Process Theory?

Normalisation Process Theory is an explanatory model concerned with the social organisation of work (implementation), making practices routine elements of everyday life (embedding), and sustaining embedded practices in their social contexts (integration). It is a theory of implementation that focuses on what individuals and groups do rather than what they believe or intend. It has been developed through studies of practice in many different complex interventions and healthcare systems (May et al., 2018). Normalisation Process Theory has been used in previous research as a framework to describe, assess, and enhance implementation potential in complex interventions (Murray et al., 2010; May et al., 2018). Research using Normalisation Process Theory has been applied to complex healthcare interventions in the UK (May et al., 2018; Huddlestone et al., 2020), digital health interventions in England and Scotland (Quayle et al., 2024), health visiting services in England (Ikioda & Kendall, 2016), and implementation of a National Surgical

Quality Improvement Program in five hospital sites in Canada (Schroeder et al., 2022), among others (Engeltjes et al., 2022; Svedin et al., 2023).

Normalisation Process Theory originally consisted of four constructs: (i) coherence: the sense-making work people do, individually and collectively when faced with operationalising new practices; (ii) cognitive participation: the relational work people do to build and sustain a community of practice around the new complex intervention; (iii) collective action: the operational work people do to enact the new practices; and (iv) reflexive monitoring: the appraisal work people do to understand the ways the new practices affect them and others. We used the updated framework which contains 12 constructs and 24 subconstructs, described in table 3 (May et al., 2022).

How did we incorporate a Context-Mechanism-Outcome approach?

The Context-Mechanism-Outcome approach to describing programme theory provides a framework for understanding complex interventions by identifying what works for whom, how, and under which circumstances (Pawson et al., 2005; De Souza, 2013; Lacouture et al., 2015; Wong et al., 2016; Shearn et al., 2017; Weger et al., 2020; Skivington et al., 2021; Greenhalgh & Manzano, 2022). The Context-Mechanism-Outcome framework serves as a foundation for generating and refining programme theories. The Medical Research Council guidance states that a refined programme theory is a principal aim in evaluation when none exist and will inform the transferability of interventions across settings, helping to produce evidence and understanding that is useful to decision-makers (Moore et al., 2015; Skivington et al., 2021; May et al., 2022).

In our analysis we used Normalisation Process Theory within a Context-Mechanism-Outcome framework based on May et al.'s (2022) updated Normalisation Process Theory coding manual (see table 3 for definitions of concepts in each framework). This meant our analysis could benefit from the detailed Normalisation Process Theory coding structure and theory and we could present our results in the Context-Mechanism-Outcome structure, which we thought would be more familiar to readers. Appendix C gives a detailed description of the concepts in Context, Mechanism, and Outcomes and in Normalisation Process Theory, as applied to our research.

We argue that Context-Mechanism-Outcome can provide an overarching structure within which Normalisation Process Theory's constructs can be positioned. We adapted existing descriptions and examples of Normalisation Process Theory constructs and to make the framework as relevant as possible to our research objectives, drawing largely on work by May et al. (2022), Finch et al. (2012), Murray et al. (2010) and Huddlestone et al. (2020). We then organised the Normalisation Process Theory constructs and subconstructs into a Context-Mechanism-Outcome structure, shown in table 3 and described in more detail in appendix C.

Table 3. CMO domains, Normalisation Process Theory construct, coding tool examples

Context-Mechanism-Outcome domain	The 12 Normalisation Process Theory constructs	Coding tool focus	Descriptions and illustrative questions
Implementation contexts: Contexts are patterns of social relations and structures that unfold over time and across settings. They make up the implementation environment. **How does the environment shape the interventions?**	C1. Strategic intentions	Aim, Why?	Description: How do contexts shape the formulation and planning of interventions and their components?
			Is the context focusing on assessing risk and timely information sharing into statutory services?
	C2. Adaptive execution	Conditions affecting implementation	Description: How do contexts affect how users can find and enact workarounds that make an intervention and its components a workable proposition in practice?
			How does the justification for information sharing affect implementation by the different partner agencies?
	C3. Negotiating capacity	Capacity for implementation	Description: How do contexts affect how an intervention and its components can fit, or be integrated, into existing ways of working by their users?

Context-Mechanism-Outcome domain	The 12 Normalisation Process Theory constructs	Coding tool focus	Descriptions and illustrative questions
			What is the role of physical space/virtual connection and IT and technology resources in generating capacity for implementation?
	C4. Reframing organisational logics	How they work collectively	Description: How do existing social structural and social cognitive resources shape the implementation environment?
			How does MASH work with strategic roles and through strategic partnerships and relationships with the locality's social workers?
Implementation mechanisms: Mechanisms are revealed through purposive social action – collaborative work – that involves the investment of personal and group	M1. Coherence building*	Building a shared ethos, meaning and sense-making by participants	Description: How do people work together in everyday settings to understand and plan the activities that need to be accomplished to put an intervention and its components into practice?

Context-Mechanism-Outcome domain	The 12 Normalisation Process Theory constructs	Coding tool focus	Descriptions and illustrative questions
resources to achieve goals. **What is the work of enacting interventions?**			*Differentiation* – Do stakeholders see this as a new way of working? *Individual specification* – Do individuals understand what tasks the intervention requires of them? *Communal specification* – Do all those involved agree about the purpose of the intervention? *Internalisation* – Do all the stakeholders grasp the potential benefits and value of the intervention?
	M2. Cognitive participation*	Act of coming together commitment, and engagement by practitioners	Description: How do people work together to create networks of participation and communities of practice around interventions and their components? How does consent affect implementation?

Context-Mechanism-Outcome domain	The 12 Normalisation Process Theory constructs	Coding tool focus	Descriptions and illustrative questions
			Enrolment – Do the stakeholders believe they are the correct people to drive forward the implementation? *Initiation* – Are they willing and able to engage others in the implementation? *Activation* – Can stakeholders identify what tasks and activities are required to sustain the intervention? *Legitimation* – Do they believe it is appropriate for them to be involved in the intervention?
	M3. Collective action*	Action performed together, the work participants do to make the intervention	Description: How do people work together to enact interventions and their components?

Context-Mechanism-Outcome domain	The 12 Normalisation Process Theory constructs	Coding tool focus	Descriptions and illustrative questions
		function or to enact the new practice	*Interactional workability* – Does the intervention make it easier or harder to complete tasks? *Skill set workability* – Do those implementing the intervention have the correct skills and training for the job? *Relational integration* – Do those involved in the implementation have confidence in the new way of working? *Contextual integration* – Do local and national resources and policies support the implementation?
	M4. Reflexive monitoring*	Reflections/Appraisal – The work inherent to formal and informal appraisal of	Description: How do people work together to appraise interventions and their components?

Context-Mechanism-Outcome domain	The 12 Normalisation Process Theory constructs	Coding tool focus	Descriptions and illustrative questions
		new practice, to enable assessment of advantages and disadvantages, developing users' comprehension of the effects of a practice	*Systemisation* – Will stakeholders be able to judge the effectiveness of the intervention? *Individual appraisal* – How will individuals judge the effectiveness of the intervention? *Communal appraisal* – How will stakeholders collectively judge the effectiveness of the intervention? *Reconfiguration* – Will stakeholders be able to modify the intervention based on evaluation and experience?
Implementation outcomes: The practical effects of implementation mechanisms at work. **How do things change when interventions are implemented?**	O1. Intervention performance	Practice change/ reproduced	Description: What practices have changed as the result of interventions and their components being operationalised, enacted, reproduced, over time and across settings?
			What do daily strategy meetings look like?
	O2. Relational restructuring	How people work together because of collective action (M3).	Description: How have working with interventions and their components changed the ways people are organised and relate to each other?

Context-Mechanism-Outcome domain	The 12 Normalisation Process Theory constructs	Coding tool focus	Descriptions and illustrative questions
			How have different practitioners from different partner agencies changed/adjusted their practice within the MASH? How did the locality and national policy support/hinder this implementation?
	O3. Normative restructuring	Norms/Rules	Description: How have working with interventions and their components changed the rules and resources governing action?
			What role do thresholds have within decision making, and how do different partner agencies discuss different opinions?
	O4. Sustainment (normalisation)	Normalised/Routine practice	Description: How have interventions and their components been incorporated into practice?
			What does day to day practice look like?

*The mechanism constructs each have four further subconstructs, presented in italics in the last column – these were also used for coding – this means in total we used 24 codes.

How did we apply Normalisation Process Theory?

We applied Normalisation Process Theory to our data collection, to generate our focus group and interview topic guides and to structure the practitioner workshop (appendix D and appendix F). We used the Normalisation Process Theory coding guide to code our data deductively.

When qualitative data is analysed deductively, researchers have a list of codes (themes, concepts, or constructs) before they start data analysis and then systematically apply those codes to the data (Bingham, 2023). This means that deductive analysis can be used to organise data into predetermined categories from literature or theory, which in our case was Normalisation Process Theory (Bingham, 2023). In practice, we went through each transcript from the focus groups and interviews, coding our data with one or more of the 24 subconstructs from Normalisation Process Theory (May et al., 2018, 2022) (subconstructs shown in table 3).

Four researchers systematically coded the data (CS, SB, CG, RMP) using a cloud version of NVivo 14 software. RMP double-coded nine transcripts which were first coded by CS, SB, and CG to ensure robustness and coder reliability: first and second coding was discussed in team meetings to develop shared team thinking. We also held in-person team analysis workshops (four whole-day workshops including project leads) to review coding and discuss emerging findings. In addition, we held regular shorter team meetings online to discuss methods and emerging results.

Inductive coding

In addition to applying codes from Normalisation Process Theory, we coded inductively. This meant we identified and coded themes in the data not using any framework or predefined list of codes. This identified themes such as consent, Early Help integration, hybrid working, and the importance and use of IT systems. We then mapped these themes from the inductive analysis onto the Normalisation Process Theory and Context-Mechanism-Outcome framework. This approach of including inductive coding within a primarily deductive approach can increase robustness of the analysis (Bingham, 2023).

Reporting our analysis

Following our structured coding, we organised our Normalisation Process Theory codes and concepts under the six research questions and this is how we present the results. To aid the non-technical reader, we have not used the language of Normalisation Process Theory in the Findings chapter, although our results are underpinned by this theory.

Data management and processing

Prior to data collection, each local authority case study site signed a Data Sharing Agreement with Foundations and UCL. We obtained written informed consent from each focus group, interview, and workshop participant before all data collection began. We audio recorded the focus groups, one-on-one interviews, and practitioner workshops. The recordings were transcribed and anonymised before analysis, which was conducted using NVivo 14. All analysis was performed on

anonymised transcripts. The study was registered with UCL Institute of Education and Society's data protection team, and all identifiable data was stored securely in UCL's Data Safe Haven until June 2025, when it will be securely deleted (Data protection number: z6364106/2024/04/14).

Working with the National Cross-Government Steering Committee

During the 12-month study, we met with the National Cross-Government Steering Committee at four key points: months two, four, six, and nine. We met with them to discuss the direction of the study and inform them of emerging results and our interpretations. As explained in Objective 1, the Steering Committee prioritised selection criteria for the three local authority sites based on our proposed sample framework obtained from the scoping review and 2023 MASH survey. The Steering Committee membership included professionals and practitioners from different sectors and departments, including the Department for Education, the Police and National Police Chiefs' Council, the Home Office, Children's Social Care, local authorities, the Department of Health and Social Care, MASH Communities of Practice, and the NHS.

Ethics

An ethics application was submitted to and approved by UCL Institute of Education's Ethical Approval Committee on 23 April 2024 (REC1973) for all aspects of data collection (focus groups, 1:1 case site interviews, observation of MASH meeting, and practitioner workshop). An amendment to the Ethics application was approved on 1 July 2024 to incorporate the involvement of lived experience workshops with our charity partners (Birth Companions and North East Young Dads and Lads). Data Protection Protocol's and Agreements were signed off by each case site local authority who participated in the study. (UCL data protection registration: Z6364106/2024/04/14.)

Privacy statements were shared with all participants (including parents) who gave informed consent for their involvement in the study and also for practitioners who sent expressions of interest for the focus groups and workshop (but who did not necessarily participate in the end).

FINDINGS

We have organised our findings to demonstrate how they address each of our six research questions, synthesising results across our study components for each research question.

As described in the methods, we do not report our findings using Normalisation Process Theory even though this was the basis for our detailed coding of data during analysis (table 3).

We also present our programme theory in the form of two logic models which incorporate a Context, Mechanism, and Outcomes framework (figures 5 and 6).

Research question 1: What are the common functions, components, or features of a MASH?

A framework to describe MASH, based on strategic function

The strategic function of MASH was 'latent' in our data, meaning that it was largely discernible through analysis of underlying meaning and implied function rather than explicitly stated, even when we asked practitioners why they needed a MASH (case studies and focus groups). This indicated to us that practitioners found it more difficult to articulate the strategic purpose of their MASH than to talk about their MASH processes and components. This was supported by the workshop discussions where participants agreed that the strategic intention of MASH was often not clear.

In our three case studies, we found that identification of risk and harm to children was a function of all the three MASH but that one MASH focused more narrowly on risk assessment, while the other two were designed to have a broader remit to including needs assessment (Sites 2 and 3) and multi-agency service planning (Site 3). In Site 3, service planning was for children below the statutory threshold for intervention (i.e. Early Help) and involved a meeting between relevant practitioners (decided and invited by children's social care) to holistically assess the needs of the whole family, based on information gathered by each agency represented and discussion about which agency could best support the family and how. There would then be a commitment from the MASH practitioner from this agency to make sure these services were offered by their agency.

These differences in strategic function and remit appeared to explain why some MASH were designed to have more (or fewer) core partners and to include Early Help in all MASH functions (or not).

From our three case studies we identified two models of MASH, differentiated by strategic function and remit (depicted in figure 2). Our focus group and workshop data largely supported this framework for describing MASH (detailed below in exploring the generalisability and sense-checking findings section below). Our data across the study suggests that MASH across England

exist on a continuum between a narrower focus on risk assessment and a broader focus to include needs assessment and service planning for children and families at the Early Help end of the spectrum:

1. The risk assessment function: MASH aimed to accurately assess risk in referrals where a child or young person might be at risk of significant harm but risk was unknown or uncertain. These were cases where the child or young person might meet thresholds for child protection assessment and intervention but it was not clear to the social worker who looked at the initial referral information. In this type of MASH, we heard that needs assessments for children, young people, and families and planning of services was located within other parts of children's social care services such as locality assessment teams, outside of the MASH remit.
2. The needs assessment and service planning function: MASH aimed to assess the holistic needs of all children or young people and their families who are referred to children's social care, across the whole spectrum of risk. In cases with a strong needs assessment function, this included multi-agency service planning for children below the threshold for statutory safeguarding intervention. By default, a risk assessment function was included in the holistic needs assessment and service planning. This type of MASH had a wider remit than those with a primarily risk assessment function.

The difference between the two models of MASH is not *whether* needs assessment and service planning take place for children and young people in the local authority but *where* in the system this takes place (inside or outside the MASH). Where needs assessment took place outside the MASH, we saw that there could be strong connections between the locality's assessment team and MASH, with the locality assessment teams involved in core MASH processes (Site 1). In Site 1 this was achieved through practitioners from the locality assessment teams attending all the MASH meetings in which information and analysis was shared about families, which could then contribute to their own needs and risk assessment if the family was passed onto their team (see appendix G for visual representation).

In the focus groups, case study interviews, and in the workshop, practitioners told us that the MASH process gave them assurance about difficult decisions and a sense of professional protection from the spectre of serious incidents or child deaths. In our case studies, this sense of professional protection was strongest in the case study site where the MASH prioritised the risk assessment function (Site 1).

The strategic risk assessment function

The MASH in case study Site 1 exemplifies a MASH with a strong risk assessment function, in which the key aim was to avoid 'missing' any child who might need to be protected from harm. In both Site 1 and in focus groups, this was often framed as preventing Child Practice Safeguarding Reviews (formerly known as Serious Case Reviews). Child Practice Safeguarding Reviews are reviews into child death or serious injury to explore how services and practitioner practice can be improved to prevent future incidents. In other words, participants implied that the key priority of

some MASH was to avoid child death and serious injury following underestimation of risk by their service and we describe these as risk assessment MASH.

In Site 1, there were fewer routinely included partners in the MASH compared to the other two sites. We could not ascertain from the focus group data or the workshop how far this finding was more generalisable (because strategic function of MASH was 'latent' in our data and required deep case study analysis triangulating multiple accounts and observations about a single MASH). However, we hypothesise that lower numbers of core participants likely characterise MASH with a dominant risk assessment function because this is consistent with their purpose: information sharing at speed between a small cohesive group of practitioners about complex and/or uncertain cases in order to avoid 'missing' any serious risks to a child.

In Site 1, only cases initially triaged by the senior social worker as 'amber' or 'red' went through the MASH process: these were cases where the social worker judged that more information about the child or family was needed to ascertain whether the child might meet thresholds for child in need (amber) or child protection (red) assessment and intervention (figure 2). Cases where the senior social worker was confident that the referral did not meet thresholds for a child in need or child protection assessment or intervention were diverted directly to Early Help practitioners: these were described by Site 1 practitioners as 'green' cases. Cases where the senior social worker was confident that the referral met thresholds for child in need or child protection assessment bypassed MASH and went through the relevant child protection processes outside MASH.

The strategic needs assessment and service planning function

Case study Sites 2 and 3 exemplified MASH with a strategic needs function. As well as needs assessment, Site 3 also had a very strong focus on multi-agency service planning and could hold services accountable for delivering agreed Early Help support. When contextualised in all our data, this suggests that Site 3 was particularly far towards the needs assessment and service planning end of the MASH spectrum.

The needs assessment and service planning MASH had a key aim of offering earlier and fuller Early Help support to children and families below the thresholds for statutory assessment or intervention to prevent escalation of problems and reduce the need for any later safeguarding or child protection intervention. The needs assessment and service planning MASH by default included risk assessment for children.

In Sites 2 and 3, MASH processes were used for the whole spectrum of children referred to the front door of children's social care (figure 2). This included families who may only need relatively light-touch extra support, for example those which were known in Site 2 as 'Tier 2' cases:

> "I always think of Tier 2 as like universal with a cherry on the top, in the sense that it's just you need that bit more advice. Sometimes it's just because parents need more clear signposting, they need kind of a little bit more of a robust response, and actually for some families they just respond better if there's a bit of

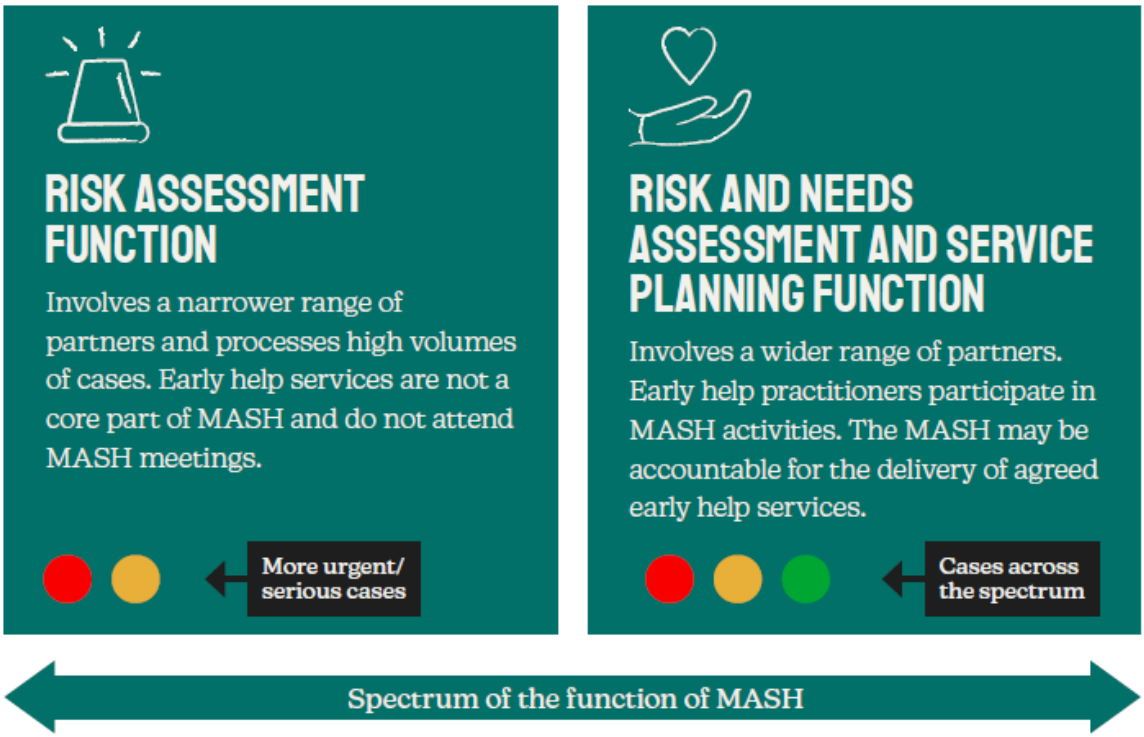
a clearer plan around things. If they themselves kind of don't do well with seeking the support themselves, or knowing where to go…" (S2, ID14)

Alongside 'Tier 2' cases, the MASH in Site 2 dealt with children and families who may need child in need, child protection or youth justice services ('Tiers 3 and 4'). As one practitioner in Site 3 put it, these types of MASH "go from Early Help up until child in care" (S3, ID33).

In Sites 2 and 3, there were a higher number of routinely included partners in the MASH than in Site 1 and Early Help was included in all MASH processes (unlike in the risk assessment MASH). This was particularly the case in Site 3 which had the most explicit and dominant needs assessment and service planning function among our three case study sites.

The information gathered and shared about children and families tended to be wide ranging in these MASH, particularly in Site 3 where information was gathered not only on the child and parents but also for all siblings.

Figure 2. The two strategic functions of MASH (go to accessibility text)



Exploring the generalisability and sense-checking of the framework

We used our workshop with 35 MASH practitioners to explore and sense-check the findings of our framework. Using online voting, the workshop practitioners agreed that their MASH performed the functions of needs assessment and service planning (most commonly reported), and that a MASH could give assurance when making difficult decisions about families, which provided them with a greater sense of protection within this challenging area of practice (figure 3, rows 1–4). When

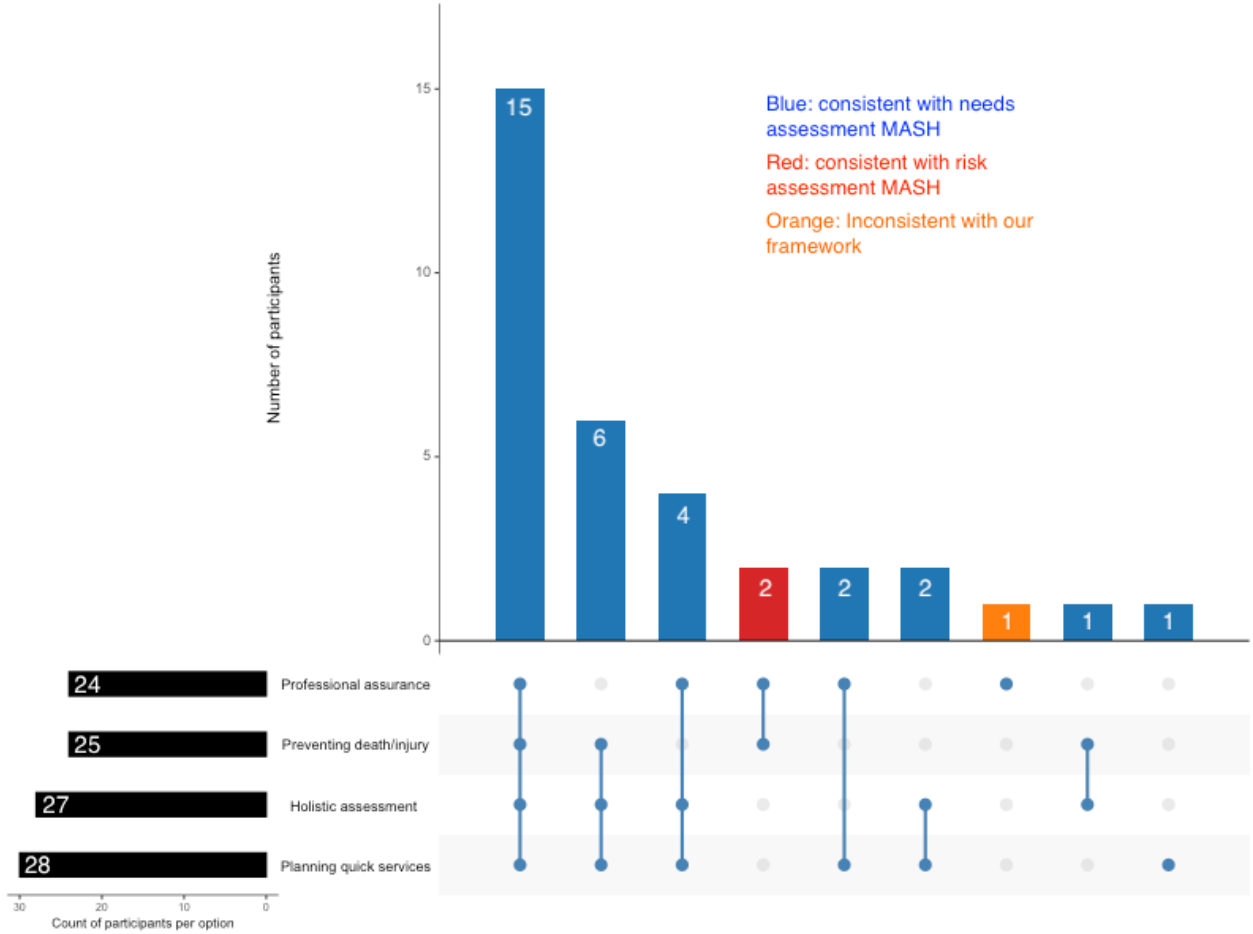
practitioners reported that their MASH prioritised one function over another, this tended to be planning services (N=15/35; 43%). However, just over a quarter of workshop practitioners (N=9/35; 26%) reported that their MASH prioritised the prevention of harm or death to children i.e. a risk assessment function.

Figure 3 shows the combinations of responses about prioritised strategic functions of their MASH from our workshop practitioners (columns). Almost half the practitioners who responded to this question in the workshop (N-15/34; 44%) reported that their MASH performed *all* of these strategic functions (column one). As figure 3 shows, the combination of responses about prioritised function was largely consistent with our theorised needs assessment and service planning model of MASH (blue columns N=31) but also with two practitioners giving responses consistent with a theorised risk assessment function (red colour columns N=2). Although nine (26%) practitioners reported that their MASH prioritised a risk assessment function, only two practitioners (6%) reported that their MASH *only* had risk assessment function.

These workshop findings indicate that our framework appears generalisable to the 40 MASH represented by the practitioners in our workshop. It also suggests that MASH in England are commonly prioritising (or perhaps aspiring to prioritise) a needs assessment and service planning function alongside a risk assessment function (i.e. in the middle of the spectrum) with fewer examples of MASH at either end, particularly at the risk assessment end which was last commonly reported by workshop practitioners.

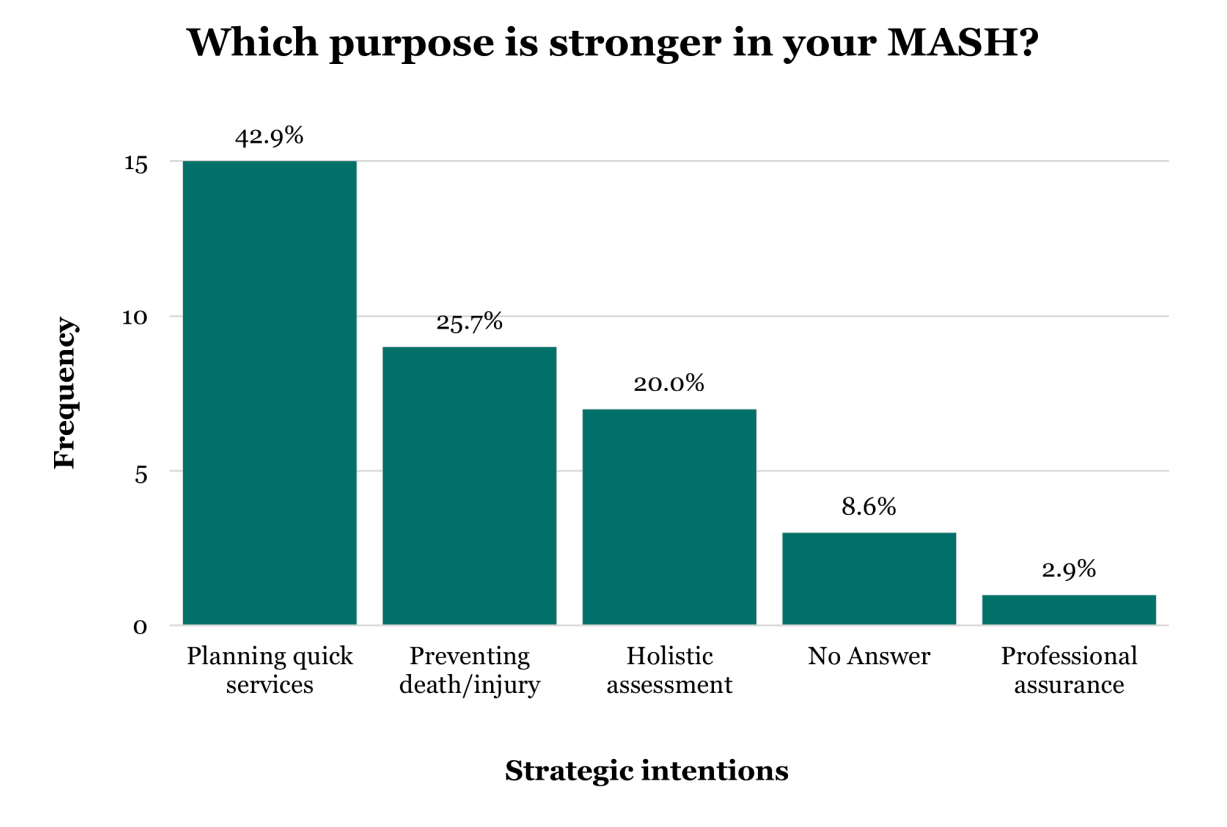
The voting by the practitioner who indicated that the main priority of their MASH was 'professional assurance' (N=1, orange column in figure 3) is not consistent with our framework. We were not able to explore this response in the workshop but it could be that that this MASH has a prioritised risk assessment function because this is (most likely) how professional assurance is achieved (by not missing or underestimating risk to a child).

Figure 3. Strategic intention (purpose) of MASH reported in workshop (options not mutually exclusive) (go to accessibility text) (link to raw data)



Professional assurance: Professional assurance and protection; Preventing death/injury: Preventing cases of death or serious injury (preventing safeguarding practice reviews); Holistic assessment: Holistic needs assessment of child and family members; Planning quick services: Planning services for a child so they can be provided quickly; *Although 35 practitioners attended the session, only 34 answered this question.

Figure 4. Practitioner workshop results – Which strategic intention (purpose) of their own MASH is stronger? (go to accessibility text) (link to raw data)



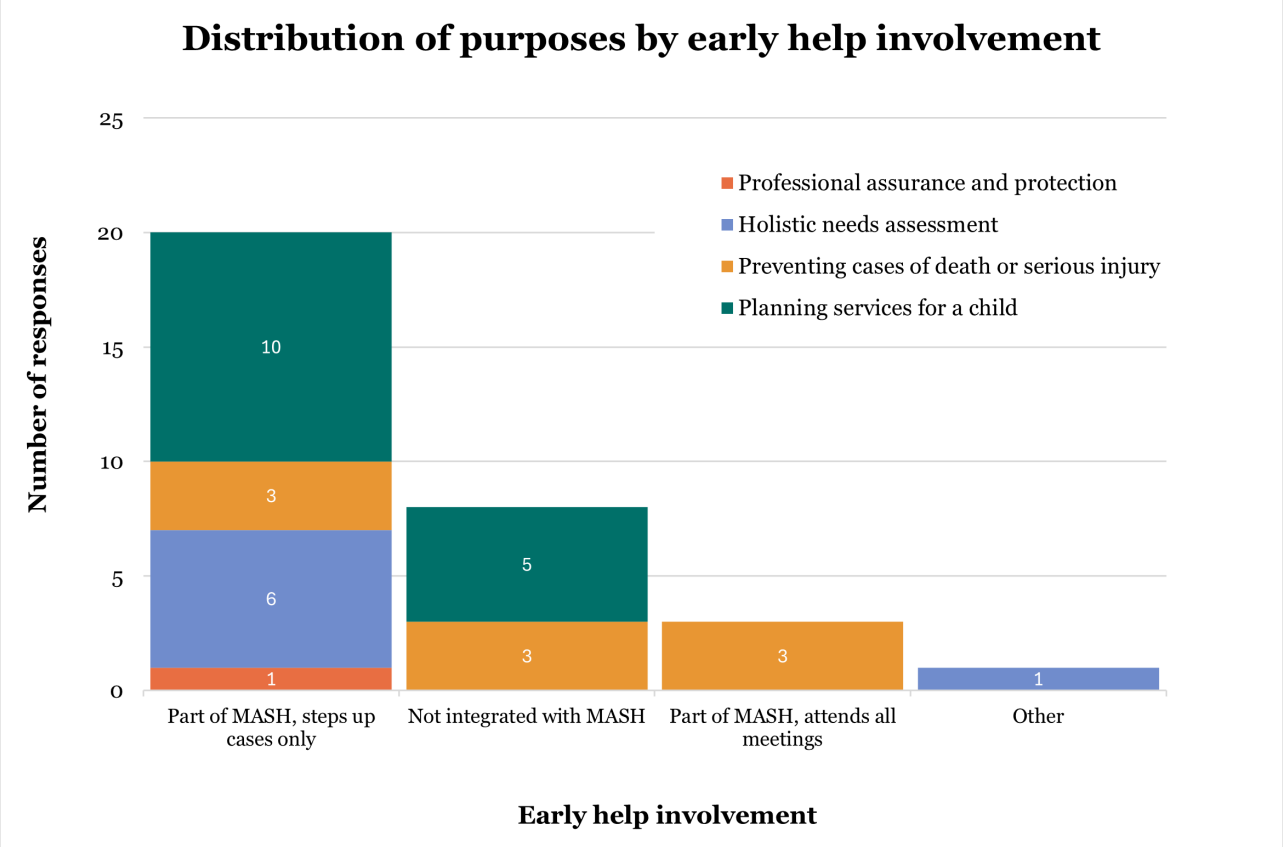
In the workshop discussions, the concept of a 'pure' risk assessment MASH (with little needs assessment or service planning function) was controversial in some breakout groups. A few practitioners argued that a pure risk assessment function in a MASH might represent "institutional defensiveness", i.e. protecting the interests and needs of the service rather than prioritising the needs of families. The concept of a needs assessment and service planning model of MASH was consistently supported in workshop discussions through arguments about the importance of early intervention and prevention in the trajectory of family problems. However, several practitioners also highlighted that it might not always be feasible to implement as it was a resource intensive way of working.

Overall, the workshop results supported the two models of MASH that we identified from focus groups and case studies and strongly supports the finding that MASH exist on a continuum between a pure risk assessment model and a very strong needs assessment and service planning model.

However, some of the workshop results were not fully consistent with our two models of MASH along a spectrum. Figure 5 shows that the online voting about the role of Early Help in their MASH

and their MASH's priority purpose was not what we would expect from our theorised models. As figure 5 shows, among the 21 practitioners who indicated that Early Help can step up cases to MASH but was not a part of MASH in their area, 77% also reported that their MASH prioritised a needs assessment or service planning function. Equally, the three practitioners who indicated that Early Help was a full part of their MASH attending all meetings, all also indicated that the prioritised purpose of their MASH was to prevent child death and serious injury. Taking into account the rest of our data, including the workshop discussions, we suggest that practitioners in the workshop may have found it difficult to characterise the primary strategic function of their MASH in the online voting.

Figure 5. Practitioner workshop results – Prioritised strategic intention (purpose) of MASH by reported role of Early Help (go to accessibility text) (link to raw data)



Acceptability of risk and needs assessment and service planning functions to parents

Parents involved in our workshops understood from their own experience that when a child was referred to children's social care, practitioners might share information with each other. Across the workshops, parents thought that this happened when there were concerns about a child being

abused or neglected and that the purpose was to keep these children 'safe'. This view is consistent with our risk assessment model of MASH. However, the parents also told us that services had a responsibility to work together to identify areas where families may require further support and to get those support services in place. This view is consistent with the aims of a needs assessment and service planning MASH. In principle, there was stronger support among parents for a model of service that got support services earlier to families rather than just assessed risk, but parents did not comment on where needs assessment and service planning should come within the system (i.e. within or outside of MASH remit). In summary, the risk assessment function and the needs assessment and service planning function of information sharing at the front door of children's social care were both broadly acceptable to the parents in our workshops.

However, although multi-agency work in theory was largely supported by the parents, they often described how they felt information sharing between agencies was disproportionate to concerns about their child and they couldn't make sense of how it was fair and relevant. This is discussed in our later section on 'consent'.

Common features and components of MASH

Across both models of MASH (risk assessment function and needs assessment and service planning function), we found some common features and components.

All the focus groups, case studies, and workshop practitioners viewed health, police, and education as the minimum essential partners in MASH alongside children's social care. The message that education practitioners had a critical and unique view of the child came across particularly strongly in the focus groups. However, we also heard from the focus groups that participation in MASH was more difficult for education practitioners as their classroom teaching roles made it difficult to supply information in short time frames and to attend MASH meetings.

The following section details the features and components of MASH that were shared across our three case study sites (we were not able to collect this level of detail on individual MASH in the focus group and workshop).

Shared features and components of MASH across the three case study sites

Initial triage by a social worker

Referrals came into children's social care from the public (including anonymously) and from practitioners and professionals. These referrals were triaged by experienced social workers for seriousness and certainty about risk to child and complexity and level of need in the family, based on the information in the referral. This triage was a single-agency activity. This initial social work triage determined whether or not a case went through a MASH process and with what urgency and speed.

Certain types of cases bypassed the (full) MASH process

If a child already had an allocated social worker, the referral information would be passed directly to the allocated social worker and the team manager without triggering any MASH activity.

If initial triage by a social worker identified reasonable cause to suspect actual or likely significant harm (i.e. meeting thresholds for statutory child protection intervention), the case would move straight to a strategy discussion without going through a full MASH process (see Glossary). It was difficult for us to determine from the data whether practitioners considered these strategy discussions a part of MASH activity or as beyond the front door, and therefore outside of MASH activity. This ambiguity may be because the strategy discussions were attended by some MASH practitioners and key aspects were similar to MASH (specifically, information sharing).

Timelines for information gathering and sharing within MASH

Although sites had differing timelines for MASH activity, they followed a similar pattern:

- Very short timelines of 2 to 4 hours for children who might need a statutory child protection response, known as 'Red cases' (Site 1), 'Tier 4' (Site 2), or 'Acute' cases (Site 3)
- Medium timelines of 24 to 36 hours for children who may need statutory child in need services
- Longer time frame of up to 10 days for children who may need non-statutory services such as Early Help or Family Support (Site 1 MASH did not deal with these cases).

Information gathering, analysis, and sharing

At the request of the MASH social worker, MASH practitioners would gather the information that was known to their agency about a child and family, to the short, medium, or long timeline specified by the initial social worker triage. Each MASH practitioner would then select, interpret and frame this information to produce an analysis from a single-agency perspective.

A key part of both information gathering and analysis was careful documentation and recording of activity, practitioner thinking, and decisions.

Additional activity

In all three sites, MASH activity went beyond multi-agency working on specific cases. There was substantial time and effort from practitioners across agencies and at more senior level put into creating shared policies and shared understanding of the MASH and into building a shared ethos and coherent team.

Note: in addition to the shared features and components listed here, our inclusion criteria specified that all the case studies have MASH with children's social care, health, police, and education as core partners, <8 core partners, physical co-location of MASH practitioners, and operate within a single referral pathway.

Key differences in the features and components of MASH

However, we also found important differences between MASH in the three case study sites: who MASH processes are used for, the role of Early Help, and the number of partners in these MASH processes. These three features appeared to be a key differentiator in our case studies and connected to how far the MASH was performing a risk assessment (Site 1) or needs assessment and service planning function (Sites 2 and 3, figure 2).

Who MASH processes are used for

In Site 1, only cases where the social worker judged that more information was needed to assess risk to the child went through the MASH process ('red' and 'amber' cases) and these cases were brought to daily meetings were MASH practitioners shared their information and analysis. This means that cases that were triaged as below statutory thresholds ('green' cases) did not go through the MASH processes and were passed straight to the Early Help practitioners after initial triage.

In Sites 2 and 3, all families referred to the local authority for further support were subject to a MASH process. In Site 3, the social worker requested information gathering by practitioners that they judged to be of relevance to the referral (i.e. not all the MASH practitioners) and this information and analysis was submitted as a written record to the MASH social worker via their shared IT system. Meetings in Site 3 MASH were primarily used for deeper needs assessment and multi-agency service planning for cases below threshold for statutory intervention, with only practitioners from relevant support services attending.

Role of Early Help

Although Early Help practitioners in Site 1 described themselves as "in the MASH team", they did not attend the MASH meetings where information and analysis was shared about 'amber' and 'red' cases. Early Help practitioners did not therefore participate in the verbal but structured information sharing with other MASH colleagues in Site 1. The role of Early Help appeared to be to communicate with core MASH colleagues outside of the formal MASH meetings, particularly to make sure the core MASH partners had considered whether Early Help could support any of the 'amber' or 'red' cases. However, the interviewees in Site 1 described a porous interface between Early Help, and Early Help practitioners explained that they could challenge the initial triage and trigger a full MASH process for that child and family:

> "If a Green came through to me and I feel that I'm curious and there's too much missing and I think this could do with a MASH then I will flip it over to Children's Social Care and say, 'Look, I feel this needs a MASH.' And they'll MASH it. I'll put my rationale … and they'll MASH it." (S1, ID22)

This porous interface between Early Help and MASH may have been the reason that Early Help practitioners described themselves as "in the MASH team" and/or or it may have been because they sat in the same office as other MASH practitioners.

In our workshop, 60% (21/35) of participants indicated that in their MASH, Early Help had a similar role to Site 1 (Early Help was 'part of MASH' but did not routinely attend MASH meetings) and nine workshop participants (26%) indicated that Early Help was not a part of their MASH at all (figure 5).

In Sites 2 and 3, Early Help was more involved in MASH processes, including attending MASH meetings for families below the statutory threshold to discuss identified family need, plan services for the family, and (in Site 3) get those services put in place. The central role of Early Help in the Site 3 MASH was facilitated by having a single manager for MASH and Early Help (and edge of care services). In our workshop, only 9% of participants (3/35) indicated that Early Help was part of their MASH *and* attended all MASH meetings.

Range of partners in MASH

As might be expected from their narrower focus on risk assessment, Site 1 had fewer MASH practitioners and MASH partners than the other sites, particularly compared to Site 3 which had the strongest needs assessment and service planning function (see appendix G for a visual representation of each site process).

Research question 2: What are the main mechanisms by which we expect MASH to work (or not)?

Strong practitioner relationships built on expertise and shared ethos

Participants consistently highlighted that strong relationships and respect between MASH colleagues and a shared ethos with clear roles were the key mechanisms through which MASH could work to improve the way services operate.

Physical co-location in a shared office space for at least some of the week and high skill and experience of practitioners appeared to be important factors in allowing these relational mechanisms to take place.

Conversations (facilitated by co-location within a hybrid working model)

Working alongside colleagues from other agencies in-person and sitting in shared office spaces on the same days of the week was described as the gold standard practice for MASH in our focus group, workshops, and case studies. Participants described how being present at the same time in a shared office space could facilitate a shared ethos and mutual respect, peer support, and the building of relationships between individuals and the agencies involved in MASH.

> "MASH needs to be co-located as far as possible. I do think that could be the difference between a good and an outstanding MASH, when you can actually build some of those personal relationships, know who to go to, whose brains to pick. You don't have those challenges with feeling so remote and … you're always talking – that's so important in MASH … it feeds in so much to our decision making … I really feel that co-location is vital as far as possible." (S2, ID14)

> "I think when you are together then you see things from other people's point of view more. I think the greater the distance you get, you get back into your own agency way of thinking. So, I think it's very much beneficial when you are seeing the good work people are doing as opposed to the things that they say on the phone, they can't do. You know, in a day, if we just get the call saying, 'Oh, no, it doesn't meet the threshold' then we're like, oh, right, okay. But if you've actually sat in the room and seen everything, they have done that day, then you take it better." (S3, ID29)

In combination with strong working relationships and high staff expertise, co-location allowed colleagues to informally share what was known about a family outside of the daily MASH meetings, which may include 'softer' intelligence:

> "I sit next to the police, I've got the safeguarding and education team right in front of me and then the rest are spread around me, so you hear bits from each agency as well. Or if you've got a query for your police colleague, you could be talking about some things, someone else hears that name and before long it's shared within a hub … I think it's that softer intelligence as well, I think when you're in the office, and we do a hybrid as well, but I think that softer intelligence that you get when you're in the office that you might get missed in an email or a telephone call because things just … they fly about." (FG1, ID05)

Some participants explained that the same benefits were not achieved by co-location in the same building with separate offices or having a shared office space which wasn't well used or where MASH colleagues came into the office on different days.

While in-person working was seen as positive for relational practice and sharing expertise, practitioners shared an understanding that hybrid working was the most practical model, including for staff recruitment and retention and issues with office space:

> "So it's trying to get this balance that's right because I … can't run a service with no staff and if I can't recruit because they only want hybrid then we've got to just think about how we can do it in the best way we can possibly do it. So in the main they are in the office but they've got certain days where they could be working at home. And in the main that's working okay." (Site 3, ID30)

> "Since Covid we moved to a county council building … I think that has impacted on joined up working however, our working relationship with police is still very, very good. We also sit in the same room as health and also community services …

> We base ourselves … 40% in the office, 60% at home. But there's always someone from health, community and social care in the same room. I think we're working towards being in the same room as police again but as with everything, following Covid, [it] takes some time." (FG3, ID 22)

MASH teams who worked with a wide range of partners such as domestic abuse practitioners, drug and alcohol services, housing teams and youth justice told us that this was easier to do virtually because these additional partners are not in the same office even if the core partners were physically co-located:

> "[An] enquiry comes in and the virtual partners may or may not be able to contribute, they will be part of that, but they're not an actual partner within the building. We have drug and alcohol services, we have probation, we have youth offending services, housing, there's an IDVA [Independent Domestic Violence Advocate], CAMHS [Child and Adolescent Mental Health Services] as well, part of our health information we contribute to GP information and children's services information, but we also provide secondary mental health information for the adults as well." (FG1, ID01)

Some MASH practitioners involved in our focus groups described working in 'unitary local authorities' whereby they worked across a number of MASH teams and where co-location would therefore be impossible for them:

> "As health MASH we cover three local authorities which have complexities in its own because they don't sit together, they don't all have the same processes." (FG3, ID19)

Skilled and experienced practitioners and a stable team

For selecting and analysing information

Across our case study interviews, participants explained that much of their MASH work involved gathering, filtering, analysing, and careful framing of information known to their agency about a child and family in order to share with either the MASH social worker (needs assessment and service planning model) or all their MASH colleagues (risk assessment model). This means that the 'information' that was being shared went beyond facts about service contact with the child or family members to include an *analysis* of risk and/or need in the family from a single-agency point of view. Across sites, practitioners were aware that the analysis must be tightly anchored to the 'live' referral, so that the information shared was relevant and proportionate to the decision in question.

In each site, information was gathered and analysed independently by each of the MASH practitioners we interviewed, often for high volumes of information, across family members and at speed. This was a significant amount of work for MASH practitioners.

It appeared that experience and skill was necessary for practitioners to select, analyse, and interpret information for colleagues from other agencies while also keeping the information sharing relevant, proportionate, and tightly tied to that which would support decision making for a particular case. Many practitioners from our case study sites felt that they had the necessary skill and experience to do this:

> "I think sometimes there's a view that, if you're looking at the history, well actually you're allowing that to colour your current view. But actually, as professionals, and particularly in the MASH, what we need to be really astute at doing is separating those two things. I'm interested in the history because I want to know what that child's journey has been like. I want to understand exactly how, you know, their kind of life course has been … we have numerous Early Help workers that … are just MASH focused … the phone calls that they make, the work that they unpick, the information they gather, it's just so valuable … because when you don't actually get a chance to have a conversation with the parent or carer … you can't maybe just pick up those extra pieces of information." (S2, ID14)

However, parents were not so confident that services had got the right balance between sharing information to protect children and respecting the privacy and rights of families. The contentiousness of drawing on (and sometimes sharing) historic information about a family was evident in our workshops with parents. There was particular concern from the parents that social care involvement 'sticks' to families and that historic contact or intervention could be brought up many years later. According to parents, this included historic safeguarding referrals for their now adult children being used as relevant information for another much younger child or information about their own childhood. Parents had the view that the legacy of their own childhood trauma and abuse was used against them, as evidence about their own abilities to be a parent. Three of the mothers involved in our workshops shared how notes from psychological counselling sessions, which they had felt were a safe and confidential space, had been used 'against them' in children's social care decision making. Parents reported how they had requested their case files and had learned of the information which had been shared between services.

Gathering information and producing an analysis was described as particularly complex for health practitioners as it required working across different health services and systems, including General Practice, Emergency Departments, Hospitals, Health Visiting, and Mental Health Services.

> "Rather than just thinking that's the proportionate information to share, we think about what health information you need to know to support you with this referral. So, we're looking at multidisciplinary – all the different health systems that we've got available to bring that [fragmented] information together, but not all of it will be relevant." (S1, ID09)

In sites which were performing a needs assessment and service planning function, gathering information and producing an analysis appeared to require most skill and time. This is because the information gathered appeared to be more wide-ranging and across multiple members of the

family, which required more analysis and distilling for relevance and to ensure proportionality. For example, in Site 2 information on the whole family was gathered, distilled, and analysed, even for the urgent cases with short timelines:

> "[W]e do, as health navigators, give an analysis and an opinion of level of need … but giving the analysis can take some thinking really. To actually sort of pick through and decide what's important and what's not … As part of the health navigation … we tend to look at parents. We gather [parents'] health information. What I'm looking for with regards to the parents is any mental health difficulties, any health elements that might impact on their parenting, mobility issues, diabetes, those sorts of things." (S2, ID20)

For practitioner development and building coherence with the MASH team

Participants described how they benefited from the experience and skills of their MASH colleagues outside the formal ways of sharing information (in structured meetings or written analyses put into shared IT systems). We heard how MASH staff would turn to colleagues, often co-located in the same room, not just for *information* but for *expertise and advice*. These informal conversations among MASH colleagues were seen as a valuable way for practitioners to listen to alternative perspectives and sense-check their own professional judgements:

> "[Y]ou bring knowledge and bring your experience, and you share things. And those conversations give you the opportunity to maybe think of something you hadn't thought of. Because even with my colleagues that is the whole point of having conversations, yeah, I can see this and this or that thing where your gut is telling you something, and it's just having that conversation – It's that, can you feel what I'm feeling, is it me that's missing something or does this not seem right, you need to have them [conversations]." (S1, ID11)

> "If I'm questioning my decision making or my recommendation I can just go and sit with them and say this is what I'm thinking, what's your kind of take on it, because children's social care is very different to health." (S2, ID20)

Finally, the reciprocal sharing of expertise and knowledge (in addition to *information*) was perceived as an important tool for multi-agency partner building and collaborative working. It also allowed partner agencies and practitioners to feel that their views and perspectives were valued and considered, particularly those who were not statutory safeguarding partners such as Early Help.

> "I mean, day-to-day, it has a benefit that we do feel that we are treated as professionals, so, if we make a referral, we feel that holds some weight as such." (S3, ID29)

For communicating with parents

These views and experiences of parents suggest that a stable team (low staff turnover and low staff sickness) and high skill and expertise of MASH practitioners is required to communicate well with parents, when needed.

In the workshops, parents described their experiences of the language used by practitioners who contacted them about their child's referral into children's social care. Parents found the language confrontational and difficult to understand (particularly when acronyms were used). Parents felt that practitioners had not considered ways to clearly communicate the processes and interventions being undertaken with their children and the rationale for what was happening was not clear to the parents.

Parents discussed that while language and communication was a barrier for them, it may also be a significant barrier for individuals who were from different backgrounds (both cultural and educational) and that this would particularly impact families where a parent may have a learning disability. Parents outlined the ways in which language and communication from MASH practitioners could hinder their ability to challenge or understand what was being requested of them.

Alongside the way in which MASH practitioners communicated information, parents also discussed about when and how sensitive information was delivered to parents and families. Parents reported that often they were left waiting for communication from practitioners, despite attempting to gain contact with them. In particular, parents found the phone calls delivering sensitive information on Friday evenings left them in distress and having to wait until Monday to access any additional support or explanation from services. They also reported that they had often waited on scheduled phone calls with practitioners that they never received, leaving them feeling anxious and isolated.

Finally, parents reported concerns about consistency among practitioners and how often they had experienced working with many practitioners as staff were regularly unavailable, were on sick leave, or had left the local authority. They said that they were not informed if their key worker(s) were changed or if they were being allocated to a new worker. They reported that this inhibited the rapport and trust they had not only with the practitioner but also the agency they represented.

Consent from parents

Gaining consent from older children, parents, or legal guardians for information sharing *where required* within the MASH was described by practitioners as essential for MASH to work successfully and achieve its aims. However, practitioners also described how difficult it was to determine when consent was required and described consent from parents or older children as difficult, complex, and preoccupying. We heard examples of where MASH activity had ground to a halt because policies and practices on parental consent had not worked across agencies.

Practitioners were acutely aware of the need to remain within the law and that their MASH consent policy and practices would be scrutinised by Ofsted as part of regulatory inspection. In Site 2,

following an Ofsted inspection, an improvement plan was implemented focusing on obtaining and recording consent.

Across all sites, practitioners were clear that where cases clearly did not meet statutory safeguarding thresholds (i.e. were Early Help cases), consent from a parent was required in order to share information between agencies within or outside of MASH processes and that this was the legal basis for the information sharing. This meant that families classified as in need of Early Help could prevent sharing of their information. In these cases, practitioners tried to negotiate consent over time:

> "[I]f … we feel that it's not quite met threshold for Children's Social Care, but Early Help could be of help, [we are] ringing up parents … to say 'we've had this concern, can we come and see you, can we talk about it?' and during that visit we would ask them to give consent for us to share information with school, health, anybody else who's involved. If they choose not to then we're not able to speak to those other agencies as part of our assessment. But sometimes what we might do is re-explore [consent] as the assessment continues." (S1, ID22)

However, in all three of our case studies, much of the MASH activity was focused on cases where a senior social worker had judged that more information was needed to understand risks and needs. This extra information was needed to ascertain whether or not a child was at risk of or suffering significant harm and therefore meeting local thresholds for child protection services. Even in Site 1, where the MASH remit only included children on or around the threshold of significant harm (Section 47) or who might require services as children in need (Section 17), practitioners were not confident about what could and could not be shared without parental consent:

> "[W]e had to kind of keep going back and forth about how much can we share if we haven't made a decision about what's going to happen yet, and if we haven't therefore sought consent in all cases, then how much can we share and who can we share it with?" (S1, ID05)

As this quote suggests, one approach to dealing with this complexity was to seek parental consent for all cases where a statutory assessment had not been ruled out, as was the approach in Site 1.

Across all our data, we heard confusion and contradictions, even within the same case study site, about who had responsibility for seeking parental consent to share information between agencies and in which cases parental consent should be sought. The issue of consent seemed particularly preoccupying and problematic for practitioners in Site 2, and many of our quotes in this section come from Site 2 participants.

Across our case study sites, some practitioners thought that the professional who had referred the child or family into children's social care should be responsible for gaining parental consent, but we didn't hear (and didn't probe about) about what this parental consent should cover. Other participants told us that, while the referrer should talk to the family about the referral and what may happen next, this practitioner was unable to gain consent for information sharing that may only happen after the referral. Practitioners across our three case studies told us that there was a

box to tick on the referral form into children's social care to indicate whether the referrer had gained parental consent. However, in our feedback session to the participating MASH case study sites, we also heard that it was difficult to interpret this box: it was not clear to the MASH social workers what parents had consented to if this box had been ticked or if parents had really been given a chance to understand and give *informed* consent. If consent was indicated on the form, we heard that practitioners may go ahead and share information between relevant MASH colleagues. We did not systematically ask in each site about what happens if this 'consent' box is ticked/not ticked.

In Sites 2 and 3 we heard that practitioners did not always seek parental consent for information sharing and did not always consent for the family to inform them that their child is going through the MASH process. One practitioner in Site 2 explained why this did not sit well with them and how they would prioritise contacting the family themselves:

> "We don't always call the parents when it's in MASH … So that's been a real challenge for me to get my head round, particularly on what's going out of the MASH because I feel that parents have a right to know, so I really struggle if we haven't contacted them and I will quite often add on that additional task … I think we need to speak to parents. I think all MASHs should. It's good practice. If you're working in a strengths-based or restorative way and you say you're based on relationships then you should be from, you know, straight off you should be speaking to parents because we always ask all our referrals or contacts that come in, we say have you spoken to the family and then we don't…" (S2, ID21)

> "We get a lot of pre-birth ones and quite often it's because it's parents have had ACEs [Adverse Childhood Experiences] and really difficult childhoods and we don't speak to them. And then the next thing, they're going to get a knock at the door or a phone call from a social worker saying we need to do a pre-birth assessment for your unborn baby because we're worried. No one's had a conversation in between, you know? So I don't think that starts anyone off on the right foot at all and because we're doing that in the majority of cases, you know, all these families are getting social work intervention without knowing. So we could do a MASH, not contact the family, close it down, and they will never know and that's really like awful." (S2, ID21)

As illustrated by these quotes, practitioner views on contacting families often focused on good relational practice and transparency with families rather than the purpose of gaining consent for information sharing within the MASH. It appeared to us that the gaining consent and informing parents were not always clearly separated in the minds of practitioner, or at least not in the way they spoke.

Gaining parental consent was harder in cases subject to the short MASH timelines. In Site 2 we heard that efforts to gain parent consent had sometimes resulted in cases being reclassified as less urgent, in order to extend timelines available to gain parental consent:

> "Sometimes I've had ones where I've gone, everybody's recommended tier four, why's it come to me at tier 2. But it's because they want to do a little bit more digging and I might need to make that initial phone call and then lay it out that way, then I can escalate it and then that's when sometimes I might say do you, would you consent for me to do a tier 4 assessment? And then they'll say yes. So, then I'll take it back, mum's consented. Then it can go to tier 4. It's a bit of a backwards ways of going around it." (S2, ID18)

For a MASH to work smoothly, policy and practice about parental consent and information sharing needed to be understood by all practitioners and seemed to be a learned part of the MASH's culture:

> "An example I had is that we had some new health triage staff, very, very good, very experienced, but they were still in their induction process, really understanding [our model of front-door services] compared to previous front doors that they might have worked in. So, very topical for partners is consent … suddenly, a decision was made, we've had to go through the right channels, but actually, we're not going to give you the information about the adults, we're just going to give you the information about the children because of consent [the health staff thought that the parental consent obtained did not cover parent information]. Immediately, I had to just convene meetings, call in strategic leaders and go, 'No, you cannot just stop that' from that point of view. But by just stopping it for that very short period of time, it caused a huge disruption. It stopped everything, because social workers were going, 'What do you mean, I can't have the information on the dad? I can't make a decision if I can't have the information on the dad.'" (S3, ID30)

The issue of consent and information sharing was also described as especially complex in certain cases for example those involving domestic violence (including where police were sharing information from a Police Protection Notice), or when information was shared between statutory and non-statutory services or where young people were old enough to give their own consent but were 'technically still a child':

> "So the 16, 17 year olds, for example, I may need to actually update, alert MASH to the fact that I'm currently supporting this service user, even if there's no safeguarding concerns and the young person is safe just to update them that this service user is now being supported by myself … we've had a whole thing, like, a parent asking for what is actually going on, but child not consenting for parent to know, but then there's that blurred line of the fact that 16 is technically still a child, so, yes, it becomes quite challenging." (S1, ID03)

Participants did not provide (and we did not ask for) more detail on the issue of seeking consent for information sharing from older children.

Parents involved in our Public Involvement and Community Engagement workshops reported that they had not been asked for consent for referral to child children's social care or for information sharing following a referral. Given the high levels of involvement with children's social care in the parents we spoke to, this may have been because their cases met statutory threshold for assessment, which would mean that legally practitioners could share information without parental consent. We have no way of knowing whether or not this was actually the case. These parents told us that they were informed or learned from their case notes that information sharing had taken place after the event and that this fuelled mistrust of services.

Shared understanding of roles and responsibilities

Multi-agency informed decision making

Across our three case study sites and focus groups, practitioners consistently told us that social workers were the decision makers:

> "I would say that we [social care] chair the meeting so we would have the responsibility to seek the views of attendees to understand where they're coming from to ask for their rationale to make sure they understand what they're being asked. But yes, the decision would sit with us as the lead agency." (S1, ID05)

> "So the next step is bringing to the table what you have from your field and then at that point, yes the decision is then led by social care and it's almost a bit of a round robin everybody agrees, if there is any sort of dispute it'll be explored, challenged, questioned … it may be reconsidered and discussed but it will still be social care's decision at the end. So very rarely it'll be changed unless there was real information brought that would change that outcome." (FG5, ID31)

Several practitioners reported that they would be able to challenge a social work decision if needed but none of them gave an example of having done so:

> "I don't find a barrier discussing differences of opinion with my colleagues. I'm happy to share what I thought and why I thought it. If somebody then offers me very relevant information from their agency that then lowers the risk I'm very happy to take that on board as well. We usually don't end up needing to have discussions because we know that whatever we suggest in our opinion, the final result may or may not be different." (S2, ID19)

> "[I]f I'm honest, we've got such good relationships that if we do need to challenge, we would just have those conversations and provide a reason as to why we don't agree. But I think, on a day-to-day basis, we're not really included in the decision making because it is the local authority if I'm honest." (FG1, ID01)

This lack of challenge to social work decisions may have reflected an understanding that ultimately the decision was someone else's to make, which was reflected in some comments by Police participants. Alternatively, it could reflect good communication (lots of informal conversations)

between MASH practitioners and a shared understanding of processes and thresholds which helped practitioners navigate any differences in opinion, before they became disagreements.

Research question 3: What is the perceived impact and for whom does MASH work/not work and why?

The impact of MASH for practice and practitioners

There were several ways in which practitioners thought MASH positively affected practice, including coordinating a service response, expediting the process through which families are offered support, promoting practitioner wellbeing, and providing professional safety and protection.

Some practitioners indicated that their MASH ensured that different agencies had collectively agreed on who would take the lead for this family, i.e. a coordination role among services. Practitioners described how this expedited the support they could offer and might prevent families from being "all over the place" or, in other words, being passed from service to service with no single agency taking responsibility which may lead to families falling through the gaps in services:

> "And it makes, for me, that child's journey a little easier and not as fragmented, at least professionals will know where to go. And I'm hoping that if you had everybody under one roof then their issues would be resolved quicker and the young people there wouldn't have, and their parents, wouldn't be all over the place. Every single professional that works with that, I think it would be better, as well, for tighter working." (S1, ID22)

The ability to debrief with other practitioners in MASH was also perceived to support the wellbeing of MASH practitioners, particularly when they were co-located in the same physical space:

> "[W]e find it's helpful for the nurses to have that support, so they're not as isolated when they're dealing with things, because everybody's dealing with, you know, we know that it's a lot of traumatic information that's coming through MASH, so actually for team wellbeing it's felt that it's quite helpful to be that shared experience to be able to debrief quite quickly as well and our partners certainly do like us to be in there as well." (FG1, ID07)

Practitioners also described how MASH provided them with professional safety, through the rigor of its policies, procedures, and expectations, experience and skill of the MASH manager:

> "I guess you feel sort of safe in here, I do, I feel that the managers know what they're doing." (S3, ID32)

Having a centralised repository for records, which detailed planning and decision making, also made practitioners feel protected from the fallout of any future worst-case scenarios for the child:

> "We should all know how to complete records safely, relevantly and with an eye to if somebody else needs to read our records in the future. So, I always make sure that my records are written so that if somebody else did need to read them in the future they could see what I found at the time and what I thought at the time, no matter what happens next … I think it's important those decisions are recorded so any trail or any review of the case, my opinion has been recorded as what it was on that day … I have in the back of my mind if there was a serious case review [i.e. death or serious injury of a child], and my records were looked at…" (S2, ID19)

Although in the starkest instances practitioners described feeling 'safe' and 'covering' themselves, the overall sentiment across the interviews was that feeling assured and safe led to better decision making for children and families. This was especially important where partners judged the level of risk to a child as higher than their social work colleagues did:

> "Our opinions and our recommendations have been taken into consideration and documented so at least, you know, if there was to be a serious case review and it sounds absolutely horrendous that I'm saying you're covering yourself, but you know, I have my opinion to think about and if something did happen to that child at least I can say to myself that the police have actually suggested you know, a higher level of assessment for this family and this child. And again, it's just difficult because children's social care have a very different stance on things than I do, they deal with it day in, day out and it's their bread and butter. And you know, by no means that makes it less risk averse for them but they manage it very differently." (S2, ID20)

We also heard that MASH could prevent children's social care from becoming overwhelmed with referrals that didn't meet their thresholds and which could be filtered or signposted to other relevant agencies, including Early Help:

> "I think within [our area] it was kind of look at the front door and limit things that weren't necessarily safeguarding specific or that could go through partner agencies elsewhere rather than kind of directly overloading the social care teams." (FG3, ID19)

Conversely, we also heard that a MASH could prevent Early Help services receiving a high number of referrals that actually needed a safeguarding assessment and more support than this service could give:

> "So it's stopped a really high volume of families going to Family Help but there has been a piece of work there but everything will have had either a MASH contact or a MASH assessment before it comes to us." (FG5, ID30)

In both these examples, gatekeeping and triaging of cases is a key purpose of MASH to ensure that services are not overwhelmed by cases that would be more appropriately handed to other parts of

the system. This gatekeeping and triaging of cases appeared to explain the phrase "right service, right child" which was commonly stated as both a key purpose and key outcome of MASH.

The impact of MASH for families

Practitioners clearly articulated that families are at the heart of MASH and improving outcomes for families and children was the goal all MASH teams aimed to achieve.

Practitioners across the models of MASH saw that it could keep families 'safe'.

> "It feels like a really safe MASH, so I think if you're being referred in, because a manager is making the first decision it feels really safe. It feels like we hold all the families, and we keep them safe. I think senior managers should be reassured by that, that it is safe, you know? It's really difficult in front door because a lot of things can go wrong really quickly but this is one of the safest I've ever seen because of the structure at the top." (S2, ID21)

Keeping families 'safe' appeared to mean preventing child death or serious injury that may result from underestimation of risk and failure of services to intervene to protect the child:

> "I think a lot of this has come out of the guidance and the legislation around Working Together and how partners communicate more efficiently and effectively, I think previously there's been gaps in those areas that, you know, when children have died, and it's come out of Serious Case Reviews." (FG1, ID05)

In the sites with a needs assessment and service planning model of MASH (Sites 2 and 3), practitioners reported that MASH resulted in families receiving earlier intervention and support, before problems got worse:

> "What can we do early on to really make the difference and meet that need, and stop, you know, children's needs escalating. So yes, that's kind of the message that we have across [our area] and working in that relational and restorative way with families is at the heart of kind of what we do … look[ing] at all of the work that's happening with children and families across the kind of children's social care, targeted Early Help and wider workforce, and make sure that families are achieving outcomes, and the work that we're offering is whole family, holistic." (S2, ID12)

However, the parents we spoke to in the workshops identified some unintended impacts of the front door of children's social care including multi-agency working.

Parents both spoke of the intrusive nature of multi-agency working and the ways in which practitioners gather and share information about children and families. Parents reported that information sharing incited fear. Mothers discussed how they felt they were in surveillance from safeguarding agencies and fathers articulated that they were often on the periphery of involvement, feeling that they were not seen as an important person in their children's lives. Fathers spoke about

how they are less "visible" to children's social care and other services than mothers. There was agreement between parents that they felt excluded as experts in their own families. Parents told us that they did not understand why practitioners were sharing information with each other but they themselves were not asked to share the information they held or to give their views on their own children and the concerns that had been raised.

For whom does MASH work?

We have been able to describe the difference in the range of children and families that go through the MASH process within the two models of MASH that we identified. Our results suggest that MASH is used for two types of cases: first, where risk to the child is uncertain or unknown based on referral information alone (risk assessment and needs assessment and service planning MASH models), and second, where a child and family may benefit from early preventive support (needs assessment and service planning MASH). The fact that these are the cases that go through MASH suggests that these are the children and families that strategic staff and managers see as most able to benefit from MASH.

Participants were also able to identify groups of children for whom MASH did *not* work because they were not eligible to go through the MASH process. A police officer identified that information sharing for 'looked after children' aged 18 to 25 between police and children's social care had to happen outside of their MASH processes. Although the local authority has a statutory responsibility to support these young people as 'care leavers' right up to age 25, this is not the case in the police:

> "I think there is a specific gap for looked after children when they get to 18 … We have no way on our system of knowing if a child has been looked after because it doesn't fit into the police recording of information … we identify them as adults, so we look at them in terms of information sharing for adults. Our statutory information sharing, which is what a lot of the MASH process is, ends at 18, so there is like an overhang of care from children's services that is still ongoing that we no longer feed into because they're 18. So, it then comes down to that worker to chase us for information, so that separate email box that we have, that separate information sharing request that we make, it kind of falls outside of the MASH process … I think potentially there is something missing there." (S2, ID15)

Several participants in one case study (a needs assessment and service planning model of MASH) described challenges for the MASH when working with families who had no access to public funds:

> "So, families that have No Recourse to Public Funds, they're probably the most difficult families because you can't get access to funding … I think if you haven't got legal status in this country you really – It's really, really difficult, you know? And if you've got asylum status, it's really difficult as well. And even refugee status, because although it's – It's not indefinite anymore. So, it gives you a limited amount of time. So those groups of people are really difficult to work with

I think, to be able to get the right resources and things like that. So, I think we do work differently … and it's a lot harder." (S2, ID21)

The no recourse to public funds (NRPF) rule imposes conditions on migrants who are 'subject to immigration control' because they have been granted temporary leave to enter or remain in the UK or who are in the UK unlawfully (Jolly et al., 2022).[9] In England, migrants with No Recourse to Publics funds cannot receive welfare benefits, tax credits, council housing, or homelessness assistance, and, although healthcare is not listed as a 'public fund', an immigration surcharge, prescription costs, and lack of UK recognised ID can act as barriers to accessing healthcare (Jolly et al., 2022). Free school education can be accessed by children who have No Access to Public Funds, as for most children in England (NRPF Network, 2025) and these children are eligible for Free School Meals in England (House of Commons, 2022). Under Section 17 of the Children's Act 1989, local authorities have a duty to safeguard the welfare of a child in need from a no recourse to public funds household (House of Commons, 2022). Although families with no recourse to public funds were only mentioned in one case study site, Jolly and Gupta's analysis of 26 reviews into the injury or death of children (Safeguarding Practice Reviews) also identified systemic barriers impeding effective safeguarding practice with these families, including difficulties in sharing information between local areas when these families move (Jolly & Gupta, 2024).

In one of our observations of a MASH meeting, we also noted that the MASH process of information gathering and sharing did not work well for a family who had recently arrived in England as there was limited information about the family in the English system. Due to limited information in the English system about the family's history, practitioners had to engage additional stakeholders – including teachers, Designated Safeguarding Leads from the children's schools, the locality's assessment team, and Domestic Violence practitioners – to determine appropriate next steps and available support options.

Research question 4: In what contexts will MASH work/not work and why?

In this section we explore the contexts and conditions that affect MASH. This includes how practitioners can find and enact workarounds that make MASH and its components workable in practice. Practitioners described several factors that they perceived as helpful in the implementation of MASH and its processes which included: threshold guidance understanding, joint and collective oversight of MASH, and good information sharing infrastructure and protocols. Practitioners also reported a variety of factors which were less helpful when implementing and working in MASH. These included capacity constraints and resource issues.

[9] See https://www.legislation.gov.uk/ukpga/1999/33/contents

Agreed threshold guidance

The need for clear, agreed threshold guidance generated by each local authority that is understood by all parties within MASH was reported frequently across the data. These agreed threshold documents and guidance were used by MASH practitioners when analysing and communicating the information they had gathered in order to convey their professional judgement. We heard from many participants that using agreed threshold documents in this way reduced disagreements:

> "[T]hey always agree because we're always going from the same threshold document … there have been actually times where it's been the other way around where the manager has given us something and said this is going to be Early Help because they haven't quite looked at it closely enough, and then we've looked at it and gone, no this is going to be social care. They go 'oh sorry, yes, missed that one thank you very much'." (FG5, ID32)

> "I did a referral on my recommendation, sent it back to team leads, team leads will either agree or not agree, 9 times out of 10 they do because how I finish my analysis is I will take the [relevant bits from the] threshold document and put it in my analysis." (Site 2, ID18)

We heard from our case study sites that work was done outside MASH meetings about individual children to make sure that MASH partners had a shared understanding of the threshold documents. In some MASH, social workers developed threshold documents collaboratively with other MASH practitioners or shared early drafts for comment, which was experienced positively:

> "I think there is a shared ethos. External partners helped with the threshold guidance, so, were very much part … health and police were part of that. So, we're all invested in it, if that makes sense. We all know the thresholds, we're all clear on that, all partners." (S3, ID32)

> "A lot of our policies are shared with partners at the draft stage. So, we are actually making sure that yes, they don't have to be the same, but it doesn't grate with what other agencies are doing. So, I think that is something that continually grows, doesn't it? Not from day one, it's about embedding things all the time." (S3, ID29)

Understanding and applying threshold documents were more complex for MASH practitioners who worked across multiple MASH with different thresholds and policies.

> "It is a challenge. The police do exactly the same [as health MASH colleagues], they spread across all three local authorities. We … have a [wider area] MASH operational steering group and we are very much trying to look at thresholds, so the thresholds are the same, the time frames are the same and actually pull everybody in line." (FG3 participant, ID 17)

Information sharing systems

Information sharing systems and infrastructure accessible to MASH practitioners were described as an integral component of MASH. For health practitioners in MASH, IT systems such as Mosaic and SystemOne allowed them to see child and family records from across healthcare on a read-only basis which facilitated quick information gathering. Similar systems (e.g. Liquid Logic) could provide access to basic education records for MASH managers so practitioners knew which school to contact to gather information.

These systems did not replace the need for skill and experience needed to turn health or education records into proportionate and meaningful information to be shared with MASH colleagues.

Again, problems arose when MASH practitioners worked across MASH in different local authorities, each with a different IT system.

Capacity constraints and resource issues

Co-location and in-person working, seen as so beneficial for the functioning of MASH, was often impeded or negotiated as a response to staffing retention problems and funding issues affecting local authorities across England.

For some MASH, insufficient funding meant partner agencies having to negotiate with children's social care on which cases they will prioritise for information gathering and analysis, and which will be taken out of the scope of MASH. One practitioner clearly articulated how lack of resource was moving their MASH towards a risk assessment function.

> "Because of funding issues, we have had to look at how we work, so we will prioritise as health, Section 47s, and we will then work with our partners, well social services predominantly, to see if we can then undertake any of the Section 17 work as well. Any families that are deemed to go for Early Help will be dealt with outside of the MASH forum as well." (FG1, ID07)

Increased workloads coupled with fewer resources threatened the completeness and depth of information gathering by MASH practitioners:

> "The biggest challenge is always with a stretching resource, resources are really stretched at the moment and it's a case of whether are people still thinking of the right things to do or when they haven't got time do they skip to the next thing? I think that's it with most safeguarding, it's gathering all the information and when you're short of time, do you do that? So, I would say the challenges are … generally in workload." (S3, ID29)

Finally, some MASH found themselves dealing with the same families because (as MASH practitioners perceived it) there was insufficient resource for wider services within the locality to assess and support these families:

> "I don't know if sometimes it's about maybe … the locality teams … whether they're more resource-led? Actually, we see the concerns, and we have some families sadly that we see come through the MASH perhaps three or four times a year with very similar concerns … we always send it off for assessment. We always feel that it meets threshold to have a strategy discussion, and the locality will always shut it down. Those are the real challenging ones because they see it from a different perspective to us. And that's not to say they don't identify the harm, but they're looking at it from a different perspective. And I understand they're meeting – Having been there myself, you know, you are meeting all manner of challenges on a daily basis, so yes then when MASH ring up as well and say, 'I've got another one,' they are probably like, 'Oh my God.'" (S2, ID14)

This highlights the importance of capacity in the wider system to deal with risk or need identified by a MASH; having a MASH without further services or support is unlikely to help families.

Research question 5: What is the place of feedback loops, audits, and quality improvements?

Participants described how the process of monitoring and appraising their MASH processes is formally the responsibility of strategic groups – such as the Head of Strategic Partnerships, Head of Family Safeguarding, Independent Chair of Safeguarding, and Service Managers that hold both operational and strategic roles – which rely on good partnership working and buy-in from all MASH agencies:

> "So, that's something else that's really good in the MASH strategic group that partners take ownership, they sort of look at the data and go, oh, what does that mean? … it feels like it's quite a good group where we look at the datasets and try and understand what it's telling us and what we might need to do differently. And what needs to change, or do we need to do an audit in to this, that, and the other to assure ourselves that something's going well or not so well or what we can do differently." (S1, ID10)

> "One of our sub groups … effectively our quality assurance group that will … use multi-agency case file audits … three or four [times a] year." (S3, ID24)

Although practitioners reported formal structures for audit and service improvement, identifying problems and finding solutions to them was also driven by individuals in sometimes informal ways:

> "I'm kind of left to just get on and make improvements, I've got good relationships with assistant directors and heads of service. I will just go to them and highlight [that] this needs looking at. Then we'll have a meeting and put things in place, it could be a new process, it could be mental health services need training on safeguarding. It could be housing are not sure of the safeguarding

process, so it's like let's get out there to the teams, let's deliver our own training as MASH workers … So yes, we see the change and we just keep striving to improve it." (S1, ID06)

Using referral and re-referral rates for quality improvement

Practitioners reported that adherence to their own MASH timelines was a key way in which MASH performance was monitored and judged. We also heard that referral and re-referral rates were used to review if MASH processes were working. MASH practitioners reported that if they received a high number of re-referrals for the same family to MASH, this would indicate a failing in their MASH and that high re-referral rates in MASH would be cause for concern about how the MASH was working. This finding came out particularly strongly in the focus groups:

> "If we see it hasn't worked, we see a lot of duplicate – similar referrals coming in, in regard to that specific child. Particularly the support we put in place isn't done at a correct level or working for that family." (FG3, ID16)

> "I suppose it's easier to think about cases that have gone wrong rather than the ones that go right because [they] just go through, and everything gets solved and investigated or whatever and supported. But it's when you see the same families with the same set of circumstances coming through six, seven times and those, it's not just mistakes – those are service failures." (FG2, ID09)

> "So, we looked at that and those re-referral rates, and we knew that actually we needed to work a bit harder at our step across process to make sure that was really robust, and that families where social workers were identifying that a step across needs to happen, a plan needs to continue at that lower level … that that does happen." (S2, ID12)

Quality improvement in MASH often involved working with other agencies on improving the content or appropriateness of referrals. This was a particularly strong finding in case study 1:

> "[We'll] invite schools to come in, let's have a look at good referrals, speak to us about concerns that you've got around referrals. If you're worried that you're making referrals and they're not going anywhere come and see us we'll have a look, we'll unpick it together, we'll review it. We'll take a second look at it and perhaps it's because key information is not there, or it's not been properly illustrated." (S1, ID05)

> "So we go to Health … into their safeguarding meetings about making a good referral because their referrals are shocking. Sometimes … there's a lot of one liners … I mean we've seen a lot more referrals … coming from Health to Early Help whereas before they all used to go to Children's Social Care when it didn't need to." (S1, ID22)

> "So it could be that actually this month I'm going to be looking at domestic abuse; however, I'm going to change that I'm going to look at health referrals coming in … so in the last month we had 200 referrals from A&E I'm going to sample 20 of them. We'll use different audit templates to go what do we want to gain, what do we want to really understand, what's the purpose of the audit, what do I want to understand about it and actually what's the consistent template that we're going to use for each family that we look at from that point of view." (S3, ID30)

All case study sites mentioned that they had an audit process in place for their MASH.

Research question 6: If a particular MASH works, what outcomes will we see?

Our results suggest that there will be some common outcomes of any MASH, whatever their priority function.

On the service side, these include:

- Relevant and proportionate information shared at speed between MASH practitioners
- Multi-agency informed decision making by children's social care
- Fewer cases where risk has been underestimated or missed after a child has been referred to children's social care but without increasing unnecessary referrals onto the child protection assessment team
- Children's needs are assessed quickly (either in MASH or in the locality assessment team)
- Practitioners feeling confident and protected in their work and that their wellbeing is promoted
- For children, a successful MASH will, as a minimum, help protect them from harm.

We also found some additional impacts that may be specific to each of the two models of MASH.

MASH with a prioritised needs assessment and service planning function have a wider remit, wider activity and a wider range of intended impacts than a risk assessment MASH, including: demand for child protection services is reduced through early intervention; repeat referrals into children's social care are prevented/reduced; and practitioners feel that the MASH way of working aligns with their values. For families: well-working needs assessment and service planning MASH might result in more families feeling that they have been given services soon after their problems started to stop things getting worse and improve experiences of children's social care, potentially improving family trust in this and other services.

MASH with a prioritised risk assessment function may have the specific impact of allowing high throughput of complex and uncertain cases on short timelines.

One practitioner in our focus group summarised much of what we heard about a well-working MASH:

> "So, if a MASH is working well, you'll know it's working well because not only will the people within the MASH be happy and motivated, but you'll also see the productivity … You'll see that the partnership between the partner agencies is working well, and everybody is on the same page really. But … most importantly is we're offering the service to children at the right time and with the right services involved, and that's basically what we're trying to all be wanting to achieve … the majority of the time. There will always be slippages but alongside that is the data … to ensure that there are no delays, that we offer a robust service, and we're also proportionate within our decision making as well." (FG2, ID11)

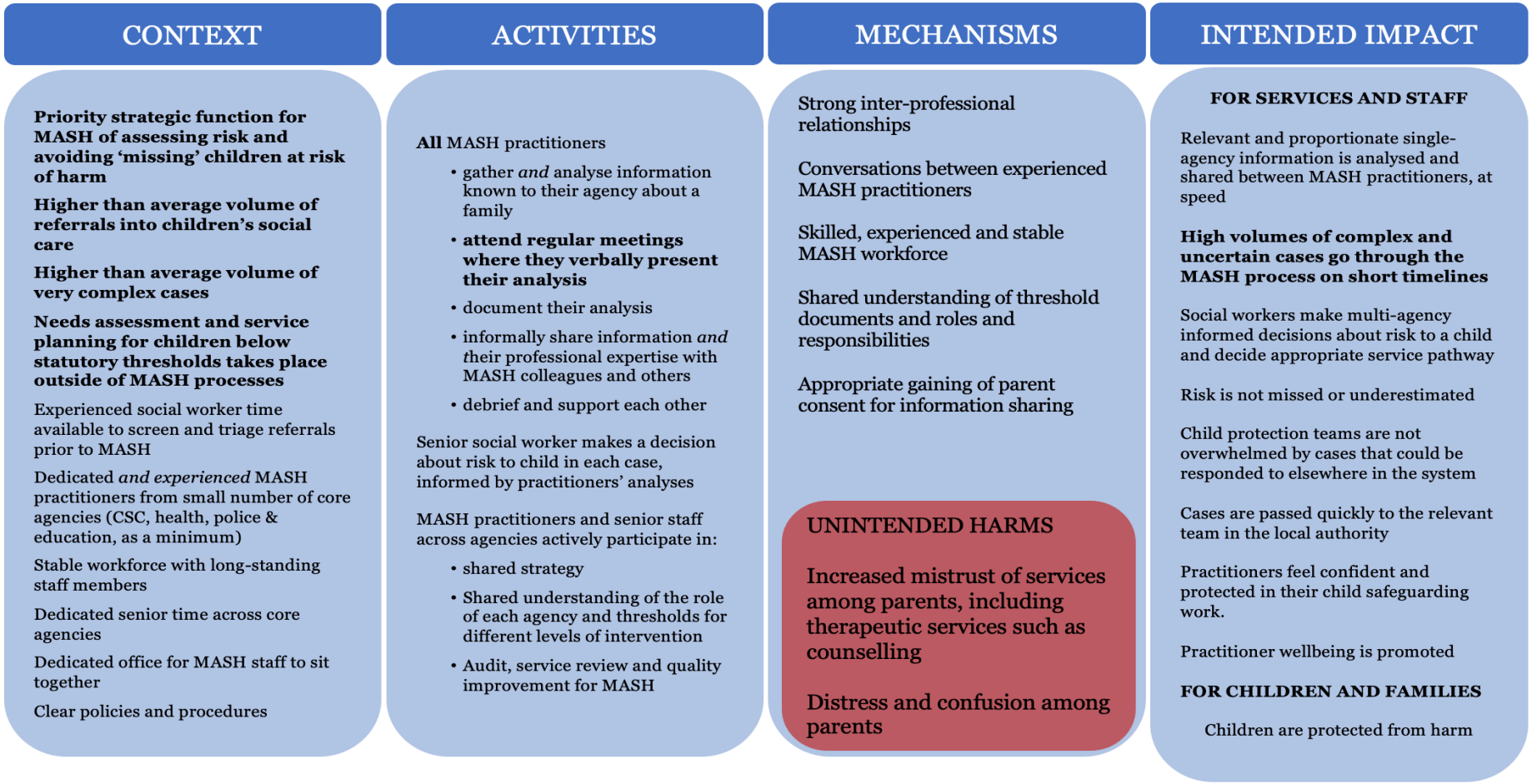
We did not systematically ask practitioners if they routinely measured any of these anticipated benefits of MASH. However, we know from our interview questions about feedback loops and quality improvement that some MASH monitored routine data on re-referrals as an indication of how well their MASH was working, and routinely conducted case note review.

The parents we spoke to identified what might happen when the mechanisms that a MASH needed to work successfully were not in place: fuelling mistrust between families and services (including mental health support services); and distress and confusion caused to parents when process and actions at the front door of children's social care were not delivered accessibly or sensitively.

Programme theory of MASH

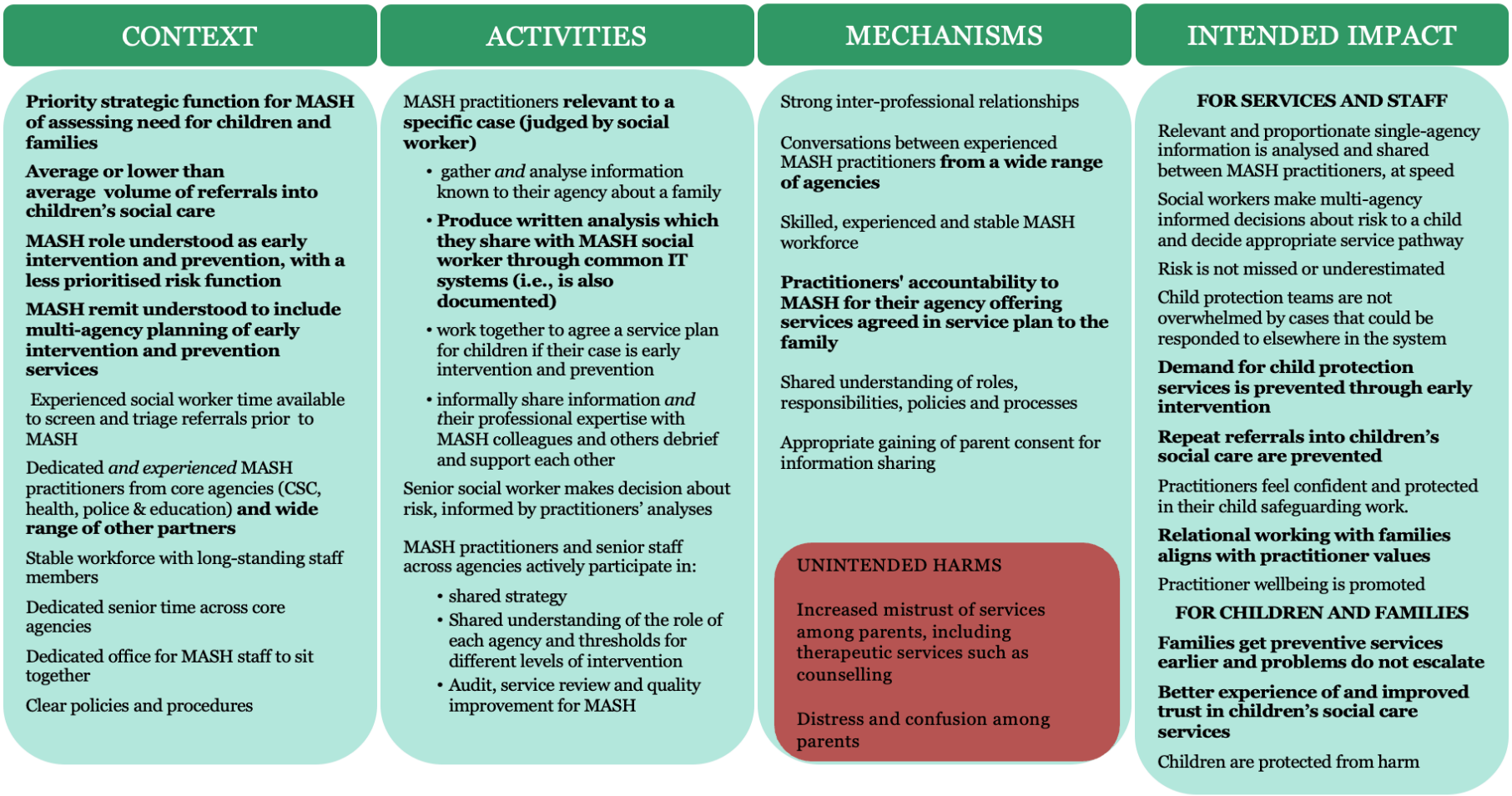
We present our empirically based programme theory for a risk assessment and needs assessment and service planning MASH in figures 6 and 7, respectively (logic models).

Figure 6. Logic model for risk assessment MASH (go to accessibility text)



Text in bold indicates where programme theory differs from a MASH, which prioritises a needs assessment and service planning function. *CSC = Children's social care.

Figure 7. Logic model for needs assessment and service planning MASH (go to accessibility text)



Text in bold indicates where programme theory differs from a MASH, which prioritises a risk assessment function. *CSC = Children's social careDiscussion

Two distinct models of MASH in England, on a continuum

We identified two models of MASH, differentiated by their strategic priorities and consequent remit: the risk assessment MASH and the need assessment MASH.

Although much of the structure and day-to-day activity was similar between these two models of MASH, there were some key differences including: the number of core partners (higher in a needs assessment and service planning MASH), place of Early Help (more central in needs assessment and service planning MASH), and whether needs assessment and service planning was perceived as inside (needs assessment and service planning MASH) or outside (risk assessment MASH) the MASH processes. We developed empirically based programme theory for each of these two models of MASH, which we summarised visually as two logic models.

Our findings suggest that MASH which prioritise a needs assessment and service planning function will focus on getting services to families earlier in their journey to prevent escalation of problems. A central aim of sharing information within needs assessment and service planning MASH will be for relevant MASH partners to plan and agree early intervention services for the family, with some accountability in offering these services. By default, a needs assessment and service planning MASH will also conduct risk assessment. The needs assessment and service planning model of MASH is likely to be the most resource intensive model of MASH and require far-ranging buy-in from services, at strategic and operational level.

In contrast, our findings suggest that a risk assessment model of MASH is characterised by a focus on making sure no harm (or risk of harm) is missed among high volumes of children referred into children's social care. In this theorised model, information is shared primarily to inform the MASH social worker's decision about level of risk and appropriate service pathways.

MASH appeared to exist on a continuum between the risk assessment model and needs assessment and service planning model with MASH adopting a needs assessment and service planning function to varying degrees. We propose that MASH which are furthest towards the needs assessment and service planning side of the continuum have a strong multi-agency service planning function for early preventive services and some soft power to get these preventive services put in place.

The risk assessment MASH was described by one of our participants as a 'traditional' model of MASH. This is consistent with the origins of MASH which was developed over 10 years ago as a grassroots response to service failings identified in reviews of child death (Laming, 2003; Mendez Pineda et al., 2025). As others scholars have noted, there has been a long-standing focus on the information sharing as a way "not to miss signs that a child is being abused or neglected" (Feinstein et al., 2023). It seems that MASH which prioritise a needs assessment and service planning function represent an evolution of MASH that has occurred over time. This is consistent with a 2021 survey in which 132 practitioners from across England reported their MASH had

widened its remit during the covid-19 pandemic to more groups of children (and 83% of these practitioners wanted this new model to be retained) (Driscoll et al., 2021a, p.83, 2021b, 2022).

Workshop participants agreed that these two models of MASH that we have theorised could helpfully be used as a framework to describe MASH across England. However, there was some disagreement in the workshop about which of the two models had the most appropriate remit and function. Our study suggests MASH practitioners most commonly report a prioritised needs assessment and service planning function of their MASH and that, conceptually, there is widespread practitioner support for this type of MASH. This is consistent with views from the parent workshops. Although the parents recognised that services must protect children from harm (risk assessment function), they more strongly argued for the importance of getting preventive services more quickly to families to stop problems getting worse (needs assessment function, including service planning).

However, our study also suggests that it is challenging for practitioners to identify and articulate where their MASH sits on the spectrum of pure risk assessment to strong needs assessment and service planning function. This is likely to be because for two reasons: first, it takes time and conversations for practitioners to understand the detailed model of MASH that we theorise; and second, practitioners often do not know what other MASH look like along the spectrum and so cannot describe their own MASH relative to others. This means that local MASH may need support to characterise their own MASH using our results.

Our interpretation of the Department for Education's Families First Partnership (FFP) programme guide is that it encourages local areas to move towards what we have called a multi-agency 'needs assessment and service planning' front door: "an integrated front door, where contacts and referrals can be triaged to the right level of service; this should include families being connected to universal and community services if required" (DfE, 2025b). It is not yet clear how multi-agency Family Help as presented in the FFP programme guide would affect the way that current needs assessment and service planning models of MASH work.

Our study heard that local areas where the MASH is relatively low resourced but has a high volume of complex cases referred into children's social care, the narrower risk assessment function may be the most appropriate option (or perhaps the only feasible option). It is not clear how far or to what timescale these local areas will be able to implement a needs assessment and service planning integrated model of front-door services, as the Families First Partnership (FFP) programme guide seems to encourage.

We argue that our two models of MASH can help make sense of the otherwise confusing variation within the structure and features of MASH across England. These two models can be used as a basis for understanding how different versions of MASH work to improve services and family outcomes, for which families, and in which contexts. Our programme theory for the two different models of MASH should be investigated, tested, extended, and/or modified through more empirical research, but it provides a good foundation for underpinning guiding principles for multi-agency working at the front door of children's social care.

What are the key things a MASH can achieve?

Within the risk assessment function of a MASH, our empirical data suggests that a well working MASH might lead to social work decisions about risk that are informed by multi-agency information. This in turn might mean that there are fewer instances of risk to a child being underestimated or missed and therefore fewer instances of death or serious harm to children. The risk assessment function of a MASH appears to work best for complex cases that, at the point of referral into children's social care, appear to be near but do not obviously cross thresholds for statutory safeguarding assessments and services – the cases where risk is uncertain or unknown.

Within the needs assessment and service planning function of a MASH, our data suggests that a well-working MASH can enact multi-agency service planning for children and families below the statutory thresholds for intervention and in some cases hold partner agencies to account for delivering these services. In its policy statement 'Keeping children safe, helping families thrive' (DfE, 2024), the government recognised the need to focus on earlier intervention so more children can remain with their families and be safely prevented from entering the care system.

Multi-agency service planning for families with mechanisms to make sure services are accountable for delivering what has been agreed might result in families receiving more preventive services earlier in their trajectory, reducing the likelihood that the family will be referred back into children's social care or need statutory services in the future. Practitioners thought that this may improve the family's experience of working with services and building trust between parents and children's social care services.

It is important to acknowledge, however, that these benefits may not be experienced equally across all population groups. Our findings suggest potential limitations in how effectively MASH structures work for certain vulnerable populations, although these observations emerged from a relatively small number of practitioner accounts. Families with no recourse to public funds (NRPF) may face particular challenges within MASH frameworks, potentially experiencing cumulative inequalities in protection and support – a concern that aligns with broader safeguarding issues identified for this group elsewhere (Jolly & Gupta, 2024). Similar challenges may exist for other population groups such as older children approaching transition to adulthood, a cohort that presents distinct safeguarding complexities due to their developmental stage and the imminent shift in service eligibility (Furey & Harris-Evans, 2021; Alderson et al., 2023; Feather et al., 2024). These nuances warrant further exploration to investigate how MASH models (or the wider system) may be configured to address the needs of all groups of children and families in contact with children's social care.

Across the models of MASH, a well-functioning MASH might be able to make practitioners feel confident, protected, and supported in their difficult safeguarding roles, with potential benefits for practitioner wellbeing.

How does a MASH achieve its intended outcomes?

Many of the key mechanisms that we identified resonate with earlier studies on MASH (Atkinson et al., 2005; Jahans-Baynton & Grealish, 2022; Ofsted, 2023). These include:

- Commitment at a strategic level (e.g. strong leadership, sufficient staffing, quality improvement, and policy generation structures) as well as bottom-up commitment (practitioner commitment to MASH activity and shared ethos)
- A shared understanding of roles and responsibilities, policies, and procedures; open communication, personal relationships
- Opportunities for face to face contact when sharing information, such as co-location
- Making sure the right staff are involved, particularly those with the required level of skill and ability to make decisions.

Additionally, in our study we found that experience and skill of all MASH practitioners and a stable MASH workforce appeared to be a key mechanism by which the information gathering and sharing activity of the MASH could be turned into multi-agency-informed decision making by social workers (risk assessment function) or multi-agency needs assessment and service planning (need assessment function).

A study on multi-agency safeguarding practice in the Probation Service used empirical data to develop a framework for local areas to assess their multi-agency safeguarding arrangements, which was included in Wales' National Independent Safeguarding Board 2023–24 Work Plan (Ball & McManus, 2024). This '12Cs' framework sets out factors which facilitate effective multi-agency practice, which have high overlap with our findings on 'mechanisms'. The 12Cs framework supports the importance of measuring these factors or mechanisms in order to ascertain how effectively multi-agency working has been implemented, as well as indicators such as re-referrals or child and family outcomes.

Our description of information *analysis and framing* prior to sharing in order to achieve MASH outcomes (in both MASH models) adds depth to the concept of 'information sharing' within a MASH. Although IT systems were described as helpful, it also suggests that that the intended outcomes of a MASH are unlikely to be achieved through simply providing MASH practitioners (or the MASH social worker) with access to the child and family records.

We heard that MASH practitioners and parents both thought that only information tightly relevant to the current concern should be shared, and practitioners indicated that skill and experience was needed to achieve the balance between contextualising the family situation with historic information but only sharing relevant information that was proportionate to the current concern or need. However, parents gave accounts about sharing of their historic information from decades ago between practitioners, which they considered irrelevant to their current parenting.

Our finding that decision making about risk within MASH was social work-led but multi-agency *informed*, challenges the concept of "joint decision making" which is often used in the MASH literature (Mendez Pineda et al., 2025). The exception is the 2014 Home Office report on MASH

which acknowledges that social workers hold the single-agency statutory responsibility for making child protection decisions (Home Office, 2014).

There was a consistent view that children's social care, health, police, and education were the minimum core partners that a MASH with a risk assessment function needed in order to achieve intended outcomes and that education practitioners could bring particularly helpful insights. However, we also heard that education practitioners found it harder to participate in MASH because there is no organisation or individual within education who can represent their sector in a MASH (unlike in health and the police). This means that MASH relies on safeguarding leads in individual schools, who (as we heard in our study) spend much of the day in the classroom, cannot meet the tight MASH timelines for information sharing, and largely cannot attend meetings during the school day. These challenges have been recognised by government – the Children's Wellbeing and Schools Bill introduces legislation to ensure that safeguarding partners automatically include education and childcare settings in safeguarding arrangements, to enable representation at operational and strategic level (DfE, 2025a). We also reflect that this contributes to the evidence that a lack of participation of certain agencies or specialisms may lead to barriers in effectiveness, as previously found in our scoping review (Mendez Pineda et al., 2025) and Ofsted (2023) with the case of health representatives, with both studies drawing data from Joint Targeted Area Inspection reports.

In our case studies, education may be the relevant partner that is missing; yet our scoping review, which includes Joint Targeted Area Inspections and Ofsted research (Ofsted, 2023), find that a lack of certain specialisms may also hinder MASH effectiveness.

Our study found that, from the view of practitioners, a MASH needs strong relationships between practitioners from different agencies within a MASH and a shared culture. The majority view was that co-location in a shared office space for at least some of the week was an important way to achieve relationships and a shared ethos, along with co-produced documents and policies to guide practice. Other researchers have argued that while co-location of practitioners from different agencies is widely accepted to increase positive relationships among practitioners, that in itself does not automatically result in effective multi-agency approaches to safeguarding (Ball et al., 2024) and opportunities are needed to meaningfully share knowledge and understanding (Feinstein et al., 2023). For multi-agency partnerships to be successful, practices and processes need to be consistent, embedded into daily practices, and regularly reviewed (Shorrock et al., 2019, 2020).

In all three case study sites, the information gathering and sharing was only a part of the activity performed by MASH practitioners. Most of this 'extra' activity was designed to build relationships between MASH practitioners, create shared understanding and ethos between MASH practitioners from different agencies, and identify and enact service improvements.

Our findings suggest that a smooth, clear, and well-understood policy and process for seeking consent from parents for information sharing was necessary for both the risk assessment and the needs assessment and service planning function of MASH to work well. However, one of our strongest and most consistent findings was that the issue of parental consent for information

sharing was extremely problematic for MASH, whatever their primary strategic function. It is well documented that practitioners lack confidence and understanding when facing decisions about whether to share information with other agencies without consent, particularly when risk of harm to the child is unclear or unknown (Rees et al., 2021; DfE, 2023b).

Research has indicated that both parents and practitioners were broadly supportive of multi-agency information sharing and considered this to be beneficial to the care of families with multiple and complex needs (Smart et al., 2022). However, this support for information sharing was often predicated on a trusted relationship with Early Help practitioners and there were persistent concerns about historical sensitive information being shared.

Limitations

The key limitation of our study is the small number of case studies (N=3) which affects the weight and generalisability of our findings. However, this in-depth work in a few sites provided the insight we needed to theorise MASH within a study with a policy timeline. We addressed the limitations of having just three case sites within our study design by collecting data from 103 practitioners across 58 local authorities to develop the programme theory (focus groups) and explore and sense-check our findings (workshop) and many of our findings were consistent across the different components of our study. However, the data collection from 58 local authorities was relatively light with representatives from 18 local authorities only participating in a single preliminary focus group and representatives from 40 local authorities contributing to a one-time workshop. While the workshop aimed to explore and sense-check findings broadly, we had limited participation from social workers, educators, and Early Help practitioners. Although workshop participants largely reported that our findings resonated with their own views and experiences of MASH, these limitations mean that further work is needed to confirm how far our findings apply to MASH across England.

Although our participants included practitioners from children's social care, health, police, education, early help services, and domestic violence support services, this study took the perspective of MASH as part of children's social care services within the local authority. We have reported how health, police, and education practitioners working within a MASH describe their local MASH and their role within it, but we have not considered the role and experiences of colleagues within each agency and institution. Further work is needed to explore what multi-agency front-door services look like from the perspective of the police force, for different parts of the health system, and for the education system.

We have not fully explored the factors that drive design of MASH and this needs further work with a wider set of case studies which might be sampled according to their MASH's primary strategic intention.

Finally, our 2023 survey suggests that MASH evolve over time and it is likely that this evolution will be accelerated as Children's Social Care reform is implemented throughout 2025 and beyond. Our findings theorise MASH based on data collected in 2024 and cannot be assumed to apply to MASH as they evolve over time.

Conclusions

We propose a theoretical framework comprising two main models of MASH, distinguished by their primary strategic function (risk assessment versus needs assessment and service planning) and with key differences in features. Our results suggest that MASH on the ground may commonly be in the middle of a spectrum or continuum between these two models, with some attempts to include needs assessment and service planning but without fully integrated Early Help. The functions of risk assessment and needs assessment and service planning (sometimes called 'coordinated response') had already been identified in the existing literature (Home Office, 2014). However our study suggests that there are models of MASH that do not enact the full range of functions ascribed to MASH in existing literature and/or where the multiple functions do not occur with equal weight.

The policy expectations set out by the Department for Education in the Families First Partnership programme guide and via the Children's Wellbeing and Schools Bill include local areas establishing a multi-agency Family Help front door, in order to ensure families 'receive the right support, at the right time' with guidance to consider including a range of non-statutory partners and make sure that any separate entry points into the service are working together. This policy vision for a multi-agency Family Help front door is consistent with our needs assessment and service planning model of MASH.

Our results from this study suggest a needs assessment and service planning model may be more aspirational to practitioners and more acceptable to families, in principle. Additionally, our 2023 survey suggests that the direction of travel for MASH on the ground is towards a needs assessment and service planning MASH: most survey respondents reported that their MASH had had at least one overhaul with the most common reasons being incorporation of new partner agencies and/or Early Help, increase in staff and a transition to a single pathway referral system (all of which are commensurate with a move further along the spectrum towards a needs assessment and service planning model (Mendez Pineda et al., 2025)). However, we also heard that a needs assessment and service planning model is likely to be difficult to implement in local areas with relatively low-resourced MASH, high rates of adversity in the population, and high referrals of children with uncertain or unknown risk. Local authorities in these situations may require high additional resource and organisational change to transition to a needs assessment and service planning model of MASH, as set out in policy expectations (DfE, 2025b). We do not currently know how many local authorities in England are at each point of the spectrum between a pure risk assessment model and a needs assessment and service planning model. This information would be useful for understanding baseline 'readiness' for policy change but may may be difficult to collect at scale as there may be a 'pull' to MASH leaders and practitioners reporting a needs assessment and service planning function of MASH, which may or may not be supported by closer analysis of their MASH.

The Children's Wellbeing and Schools Bill will place a new duty on the local authority, NHS integrated care board and police to establish new multi-agency child protection teams in their area to carry out core statutory child protection functions and to advise the wider system. Our findings suggest that some of these intended functions, such as strategy discussions, may overlap with the

remit of risk assessment MASH. More work is needed to investigate and disentangle any overlapping function.

Our theoretical models of MASH remain exploratory and further work is needed to see how far they need to be extended, modified, or reimagined to be useful for describing a much higher number of case study MASH across England and in the context of new policy expectations.

Much of the feedback about MASH from the practitioners we interviewed or consulted with concentrated on the close detail of specific features such as timelines for MASH activity or frequency of MASH meetings. It seems as if a step back may be helpful to look at the strategic purposes of MASH in relation to local contexts.

In order to understand and assess how well MASH are functioning, it is important to consider MASH within the wider system in which it sits. In an area with strong locality assessment and Early Help teams who already achieve successful multi-agency working, we do not know if there is likely to be any additional benefit from a MASH moving further towards a needs assessment and service planning model. Equally, a MASH operating in an area without sufficient high quality Early Help services or without sufficient or well-functioning statutory services is unlikely to make things any better for children, families, or staff.

While Working Together to Safeguard Children (HM Government, 2023) sets out principles for working with children, parents, and carers, and there is non-statutory guidance on information-sharing – such as the guide from the Information Commissioner's Office to sharing information to safeguard children (ICO, 2025) and the DfE's information sharing advice for practitioners providing safeguarding services (DfE, 2024b) – local MASH and parents are likely to benefit from additional tailored national guidance on the issue of parental consent in multi-agency front-door services. This guidance should specifically address the identified confusion between consent requirements and informing parents, while taking into account experiences of parents alongside legal requirements.

Our three case study sites are, by study design, likely to be those that are performing well and less impacted by the resourcing and workforce issues that, as one workshop participant said, can "paralyse" a MASH. The contextual challenges of local authority finances and workforce issues are getting worse and should not be underestimated (ADCS, 2025). Additionally, partner agencies such as health or police have their own operational challenges and cannot always supply enough staff time to a MASH: this was observed to be the case in the national review into the murders of Arthur Labinjo-Hughes and Star Hobson (Child Safeguarding Practice Review Panel, 2022). In many areas, developing a long-standing, skilled, and experienced MASH team with sufficient dedicated practitioner time, a shared office space, and capacity to undertake 'extra' activity to develop shared understanding and ethos may seem very far from what is currently possible. If these 'mechanisms' cannot feasibly be achieved within the local service context, it should not be assumed that implementing a MASH or other multi-agency front door within children's social care will help staff, the service, or parents.

The role of MASH in providing professional assurance and in promoting staff wellbeing in difficult safeguarding work to provide professional protection has not been well documented before but

seems to be a key purpose and outcome. The concept of 'professional protection' should not be confused with 'defensive practice' and/or 'organisational defensiveness'. These concepts refer to professional practices which primarily protect the worker, possibly over and above the welfare of the child or a system whose primary function is to protect itself, again at the possible expense of protecting or supporting the child and family (Munro, 2011; Whittaker & Havard, 2016). Defensive practice has been described as 'fear-based' practice and might lead to overemphasis on documenting practice (rather than helping families) and/or intervening more or less than is needed in order to protect oneself against later being held responsible (Whittaker & Havard, 2016). Within the current evaluation, MASH was found to promote 'assurance-based' practice with practitioners feeling sufficiently protected by the system and process around them so that they could make decisions based upon the best interests of the child and family. It is therefore possible that MASH discourages defensive practice. There may also be wider benefits of creating a system where practitioners feel protected and supported, in terms of staff wellbeing, sickness, and retention. This is something that further research and sector consultation could explore. Participants explicitly describe that the primary goal is to make better decisions and help children and families, and the underlying sentiment in the data is that feeling safe enhances better decision making.

RECOMMENDATIONS AND NEXT STEPS

Research recommendations

- Researchers should take a broader view of MASH and multi-agency front-door services, to include the functioning of the wider system in which they sit and the role and remit of MASH relative to other parts of the local system. Although this will be more complex, artificially separating MASH from other parts of the system may lead to an inaccurate view of what constitutes best practice. It will be important to describe the impacts of the government's children's social care reform on the system as a whole.
- Further qualitative research should describe other MASH in detail and test our findings in order to extend our proposed framework. Detailed case study work is needed to get beyond surface accounts by practitioners and descriptions of the components of a MASH to understanding the (probably latent) strategic intentions and potential differences between aspiration and implementation. A future focus could be on MASH that have recently moved further towards a needs assessment and service planning model in response to policy expectations and/or MASH in local areas that have made changes following an Ofsted inspection of 'requires improvement' (or equivalent in the new system (Ofsted, 2024)).
- To strengthen and refine these initial frameworks, further research should test and apply these models at scale across a wider range of local authorities. Such expanded data collection would help establish a more comprehensive national picture of how consistently these models apply across diverse contexts, and whether additional factors might emerge to confirm or modify our current programme theory. This broader testing is particularly important given the rapidly evolving policy landscape. Further research will be needed to assess how new policy and structures impact MASH strategic intentions, features, components, and perceived benefits (and harms). Part of this work could assess how far our programme theory is still relevant to MASH as they evolve over time.
- A dedicated study on consent from parents and older children and multi-agency front-door services in children's social care would help identify good practice in different scenarios, including from the point of view of parents and older adolescents and across the spectrum of contact with children's social care (Early Help, complex need, safeguarding, child protection).
- Detailed accounts of multi-agency working, including at the front door of children's social care, should be collected from the perspective of the police force, different parts of the health service, and education settings across areas of England (as a minimum). This will likely need separate single agency studies and will provide learning about the ways in which each agency organises itself to participate in MASH and how information and analysis heard in MASH meetings or in conversations with MASH colleagues does or does not get taken back and used within each agency.

Lessons learned

We found that it was more difficult to engage education practitioners and Early Help practitioners in focus groups for the research study and we needed targeted recruitment and sessions held outside of school hours. This is consistent with the difficulties for education practitioners in participating in MASH activity, as described by our study participants.

Despite having many hours of interview data from practitioners explaining the same MASH, we noted how difficult it was for the research team to properly understand a child's journey through MASH and then into other parts of the system and which processes were considered 'in' or 'out' of MASH. When we feedback our results to the study sites, comment from the sites indicated that there were still parts of the system that we did not fully understand in each area. MASH is a complex system within another complex system (children's social care). In this study, our deep and time-consuming case study approach was by far the best way to understand these complex ways of working that vary across local authorities. We would not have been able to produce a framework or even fully understand MASH functions and components simply from the focus groups or workshops (too much variability in the MASH represented that inhibits thorough understanding of any one (or all) of the MASH. We have reflected that any further qualitative research on similarly complex ways of working (or further studies on MASH) would benefit from a case study approach and perhaps ethnographic approaches where observations of practice generate data to analyse. This may be particularly helpful given challenges for practitioners in articulating the strategic function of the MASH (i.e. it may be best observed rather than asked about in interviews).

Working with the Cross-Governmental Steering Committee presented both opportunities and benefits for the study but also challenges. The Steering Committee successfully directed the study towards what was most useful for policy (e.g. characteristics of our three case study sites, see Methodology). However, there was insufficient time with the Steering Committee over the course of the study to communicate the nuance and detail of our findings especially given the diversity of the Steering Committee and different perspectives (i.e. different agencies, different roles within agencies). This would have required more frequent, less formal meetings with more homogeneous groups of stakeholders, in our view.

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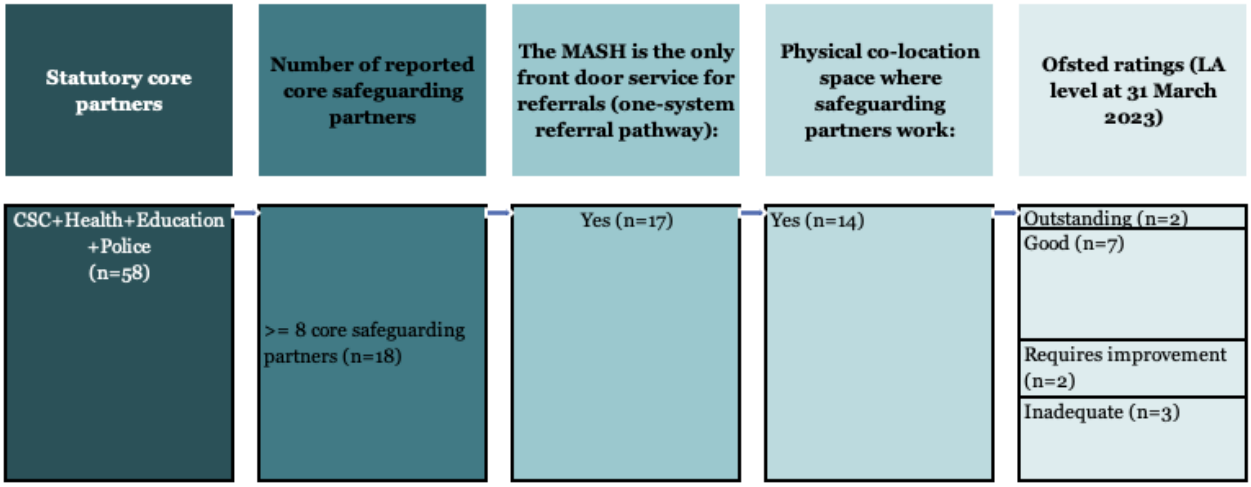
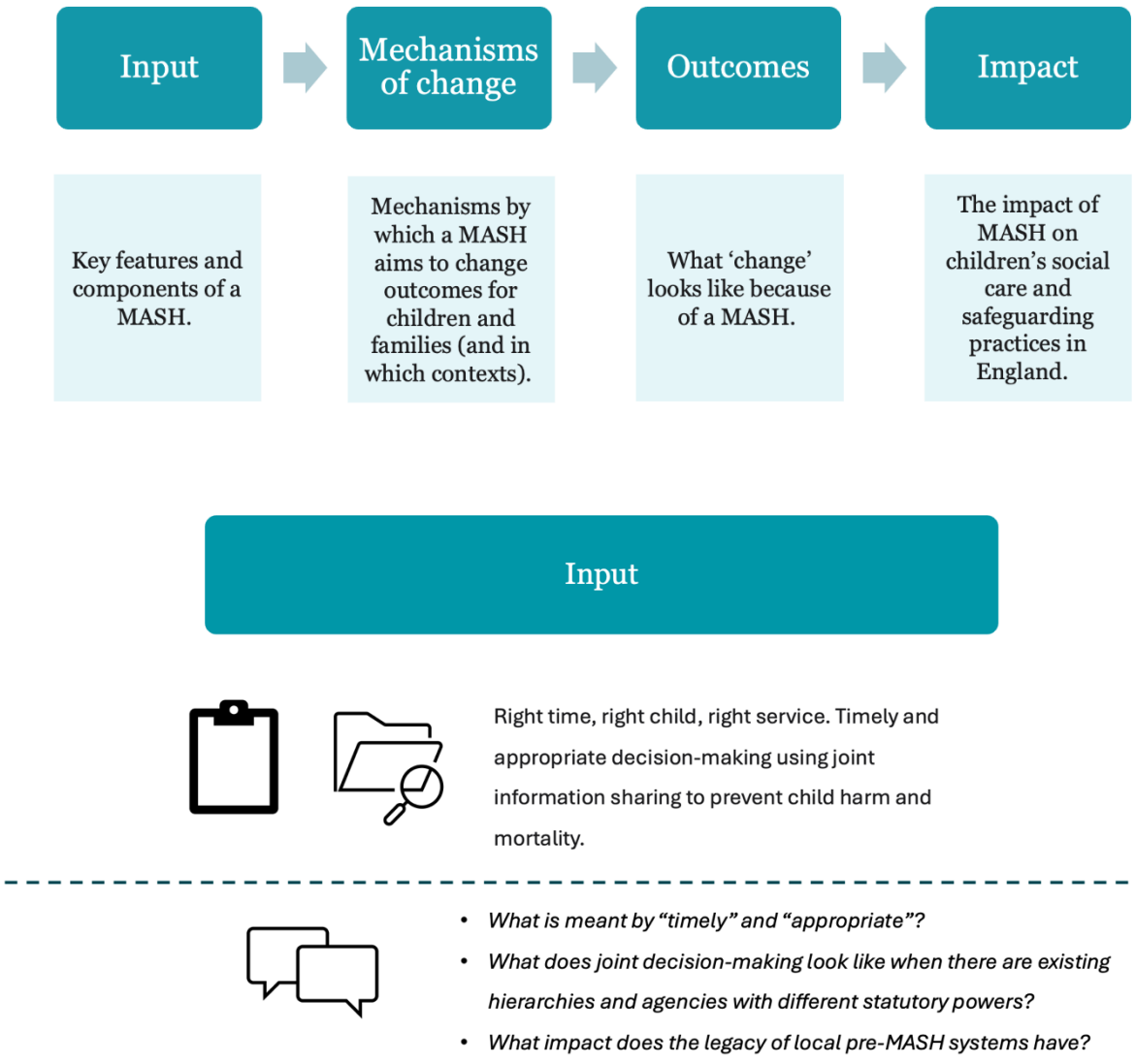
APPENDICES

Appendix A. 2023 MASH survey sample framework considering National MASH Steering Group recommendations

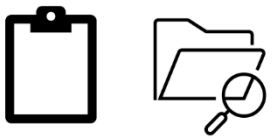


Appendix B. Objective 1 – initial logic model presented to National MASH Steering Group

Logic model



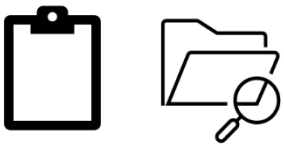
Mechanisms of change



A culture distinct from single agencies. Bringing together partner agencies to a shared space to follow joint procedures to assess front-door contacts, information-share to assess risk, and jointly make decisions on referrals and pathways into services. Shared meetings, trainings, and policies (e.g., threshold documents). Reflexive monitoring (thematic audits, inspections) and service adaptations.

- *What is the process of establishing a shared ethos?*
- *What are the logistics of 'coming together', who is/isn't in the room?*
- *What are the skills/qualities needed for good leadership at a strategic and MASH level?*
- *How does routine monitoring inform service changes?*

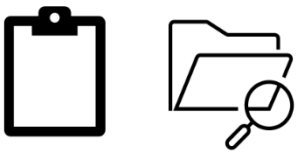
Outcomes



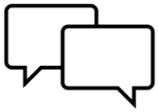
Confidence to share relevant information for safeguarding and greater collaboration with partner agencies (e.g., education, health). Expediated assessment/turn around timescales to assess risk correctly and identify gaps in family need. Improved staff morale and more effective working relationships.

- *Which partner agencies is MASH working for?*
- *How does 'single agency' culture shift?*
- *Can equal partnership exist, what does that look like?*
- *How does perceived, or actual, accountability for cases impact on MASH outcomes?*

Impact



More children and families at less risk of severe harm, and children receiving timely and appropriate services for their needs. Less wastage in the system.



- *Which children and families is MASH working for?*
- *How does MASH (and associated mechanisms) positively impact families?*

What we don't know from the literature:

Input	Mechanisms of change	Outcomes	Impact
What is meant by *timely* and *appropriate*? What does joint decision-making *look like* when there are existing hierarchies and agencies with different statutory powers? What impact does the legacy of local pre-MASH systems have?	What is the process of establishing a shared ethos? What are the logistics of 'coming together', who is/isn't in the room? What are the skills/qualities needed for good leadership? How does routine monitoring inform	Which partner agencies is MASH working for? How does 'single agency' culture shift? Can equal partnership exist, what does that look like? How does perceived, or actual, accountability for cases impact on	Which children and families is MASH working for? How does MASH (and associated mechanisms) positively impact families in practice?

Appendix C. Methods: Normalisation Process Theory and Context-Mechanism-Outcomes

'Contexts' are events in systems unfolding over time within and between settings where implementation work is done (mapping to Normalisation Process Theory constructs: strategic intentions, adaptive execution, negotiating capability, reframing organisational logic). 'Mechanisms' motivate and shape people's work when they participate in implementation processes (mapping to Normalisation Process Theory constructs: coherence building, cognitive participation, collective action, reflexive monitoring). 'Outcomes' are the effects of implementation work in context. They show how practice changes as implementation processes proceed (mapping to Normalisation Process Theory constructs: intervention performance, normative restructuring, relational restructuring, sustainment) (May et al., 2022; Schroeder et al., 2022).

The following sections explain the Normalisation Process Theory subconstructs that we used to analyse our data, structured by Context-Mechanism-Outcomes.

Context

As conceptualised within Normalisation Process Theory, Context encompasses the temporal and spatial patterns of social relations and structures that constitute the implementation environment and shape interventions (May et al., 2022). The Context construct comprises four subconstructs: strategic intentions, adaptive execution, negotiating capacity, and reframing organisational logic.

Strategic intentions address how contextual factors influence intervention formulation and planning, explicitly examining intervention rationale and objectives. Adaptive execution considers the contextual conditions affecting implementation, mainly how users develop and employ practical workarounds to enhance intervention workability. Negotiating capacity examines how context influences the integration potential of interventions within existing work practices. Reframing organisational logic, perhaps the most nuanced subconstruct explores how social structural and cognitive resources collectively shape the implementation environment. This final subconstruct involves legitimising improvements while respecting established practices, exemplified in this intervention through the influence of strategic partnerships.

Mechanisms

Mechanisms, analysed through the Normalisation Process Theory framework, represent the collaborative processes that mobilise individual and collective resources to achieve intervention goals. These implementation mechanisms address the fundamental question: 'What constitutes the work of intervention enactment?' Normalisation Process Theory delineates four key mechanisms subconstructs: coherence building, cognitive participation, collective action, and reflexive monitoring.

Coherence building involves developing shared understanding and planning processes through which stakeholders conceptualise and operationalise the intervention components. Cognitive

participation describes the formulation of participatory networks and communities of practice, specifically focusing on stakeholders' engagement-promoting activities. Collective action represents the operational work undertaken to actualise the intervention. Reflexive monitoring encompasses formal and informal evaluative processes through which participants assess the intervention's efficacy, advantages, and limitations, ultimately developing a comprehensive understanding of its practical implications.

Outcomes

Outcomes in Normalisation Process Theory represent the practical effects of implementation mechanisms, addressing how interventions generate change. The framework delineates four outcome subconstructs: intervention performance, relational restructuring, normative restructuring, and sustainment (normalisation).

Intervention performance captures the evolution and reproduction of practices by operationalising intervention components across temporal and spatial dimensions. Relational restructuring examines how collective action transforms organisational relationships and structures. Normative restructuring addresses modifying governing norms, rules, and resources that shape action. Sustainment, or normalisation, describes how interventions and their components become embedded within routine practice.

Appendix D. Topic guide for MASH Stakeholder Focus Group (Objective 1 – for initial PT and logic model)

Introduction by researcher

Welcome to this focus group. I am part of a team of researchers from UCL and NCL whom the DfE and Home Office have funded through Foundations to identify and explain how and why MASH could contribute to better outcomes for children, young people, and their families to inform principles of best practices for adapting and innovating locally. As you know, the government's Working Together 2023–24 is being worked on. This research is intended to provide your insight into multi-agency arrangements.

Today, we are here to collect/discuss your recent experience working in your MASH. What we want to learn is related to your experiences, understanding, and reflections about working in a MASH, its components, how you would expect MASH to work (or not), in what contexts will MASH work (or not) and why, what is the perceived impact of MASH and for whom, and what is the place for feedback loops and quality improvements.

During this session, we might also ask you to reflect barriers and facilitators to implementation or examples of good practice. Nobody will be identified from this research, we will make sure everything we publish and present is anonymous so neither you, our local areas nor any children can be identified from any details.

So, some last details:

- Everybody's ideas are equally important.
- The group needs to hear everybody's views, so please pitch in.
- The moderator is here to understand your ideas, not to influence you in any direction.
- All comments made today will be anonymised and will remain completely confidential. When we give feedback on our findings, no comments will be attributed directly to any one person.
- The session will be transcribed. Again, transcriptions will be anonymised, remain confidential, and be used to help analyse the results of the focus groups.

Switch on recording in their sight.

Topic guide for researchers

Section 1 – Context (15 minutes)

Why is a MASH needed in your local authority?

What is the 'problem' MASH is targeting?

What is the drive for shared decision making?

What came before MASH?

What impact does the legacy of pre-MASH systems have?

Section 2 – Mechanisms (20 minutes)

What does the MASH in your local authority look like?

Who are the core partners within your local authority's front door?

What are their roles and responsibilities within the MASH?

What about involvement from other agencies?

Who isn't in the room (but maybe should be)?

How does your local authority establish a shared ethos? Probe: What does that look like within your MASH?

How does your MASH operate to support families?

Are you physically/virtually collocated? Probe: What does this look like for you – in your LA, your role, has this helped? etc.

Do you have a shared information sharing system? Probe: Do you also record on other systems? How does this benefit your practice? Do you think this helps when supporting families?

Do you have shared threshold documents? Probe: RAG rating; shared threshold for intervention/referral.

How does routine monitoring inform services changes? Probe: We know that Front Door and MASH evolve continuously, particularly after serious case reviews, how does work?

What does it mean to work collaboratively? Probe: Can you give me an example on how you work collaboratively?

How do you understand the notion of equal partnership? Probe: What does this look like in practice?

How does perceived, or actual, accountability for cases impact on MASH processes (i.e. who is leading) Probe: Shared/partnership decision making? How does that impact on your practice?

What are the skills/qualities of good leadership?

Section 3 – Outcomes (15 minutes)

What would you expect to see if a MASH has (or hasn't) worked as it should? [examples of these]

Probe to enquire beyond semantics (e.g. what are 'timely' referrals? What are 'appropriate' referrals? Are there times when these are at odds with each other?)

Which families are being described in 'success stories', why might this be?

Are there implications for individual professionals, e.g. job satisfaction?

In which ways do you see services benefiting (or not) from MASH?

Reflections

Are there any other comments you would like to make around MASH or your experiences of MASH?

What key messages do you want to share that we might learn from?

Appendix E. Topic guide for case study sites – MASH stakeholder 1-1 interview with practitioners

Introduction by researcher

Thank you for agreeing to take part in this interview. I am part of a team of researchers from UCL and NCL whom the DfE and Home Office have funded through Foundations to identify and explain how and why MASH could contribute to better outcomes for children, young people, and their families to inform principles of best practices for adapting and innovating locally. As you know, the government's Working Together 2023–24 is being worked on. This research is intended to provide your insight into multi-agency arrangements.

Today, we are here to discuss your recent experience working in your MASH. What we want to learn is related to your experiences, understanding, and reflections about working in a MASH, its components, how you would expect MASH to work (or not), in what contexts will MASH work (or not) and why, what is the perceived impact of MASH and for whom, and what is the place for feedback loops and quality improvements.

We are really interested in the way that MASH is set up in your local authority and how these MASH operate to support children, young people, and their families. During this session, we might also ask you to reflect on a particular case or family, and we would appreciate it if you could please avoid mentioning their names. Nobody will be identified from this research, and we won't tell anyone what you have said.

Questions

Could you tell me a bit about your role here in [local authority] and your role in the MASH (or similar front-door service)?

How long have you been in this role?

What is your previous experience?

How does MASH operate in practice? [How was this established from a strategic level]

How is information shared between partner agencies? (e.g. systems, policies, protocols, frameworks)

What does joint decision making look like in your MASH? (e.g. RAG, rating systems; Strategy Meetings, MARAC)

Is it always led by social care? Has there been a case where non-social care partners lead on decision making?

Could you tell me a bit about your MASH and how it's structured? [Safeguarding boards and how they are structured]

Is it physically/virtually co-located?

Has this changed overtime?

Who are your core partners? (e.g. Children's Social Care, Education, Adult Social Care, Healthcare, Mental Health, Drug and Alcohol Services, Specialist support for children, 3rd sector/Voluntary organisations, Domestic Abuse Practitioners, Support for parents with learning disabilities)

Of these core partners, who do you work with most frequently?

Of these core partners who do you consider to be essential to MASH?

Are there any core partners regularly missing (what is the impact of them not being present)?

First 15 minutes

I would like you to think about a child, young person, or family where you think MASH has worked well. Could you tell me about that case?

How can you tell when a MASH has 'worked'?

What made you think it worked well for that family?

Why did you pick this case?

Is this case reflective of the type of families a MASH might see?

Thinking about how MASH might work differently for different families.

What about for families who are ethnically minoritised?

What are challenges related to cultural/language barriers?

What about refugees/asylum seekers, trafficking, modern day slavery victims?

What about children of different ages (at the time of referral)?

How does MASH work with issues around domestic violence, substance use?

What about families in need of Early Help?

How are these barriers overcome?

What are some of the barriers/facilitators of working together?

What makes it easy to work together about your setup?

Are there any MASH specific training or resources available for staff?

How do you think working on MASH changed the way you work and relate to other safeguarding partners?

Bringing lots of different agencies together, with different ideas/cultures, etc., how well do you feel everyone 'comes together' in MASH?

What do you think are the biggest challenges of working in a MASH?

Are there constraints around MASH implementation and new ways of working?

How compatible is MASH with existing structures, policies, and views in your organisation? (i.e. what needed to change? Information sharing processes?)

What are the opportunities for service improvement?

What is the process of improving MASH (e.g. feedback loops, clinical audits)

Have there been changes since you have been in the MASH?

Have you noticed a change in staff views/acceptance of new ways of working?

'Blue sky thinking'

What do you think an ideal MASH would look like and why?

What would be the 'big picture' outcome for children and families receiving the 'right service at the right time'?

What would that mean for you as a professional?

Reflections/any further comments.

Appendix F. Topic guide for MASH Stakeholder Workshop (Objective 3 – for theory consolidation)

Introduction by researchers

Welcome to this Workshop. We are a part of a team of researchers from UCL and NCL whom the DfE and Home Office have funded through Foundations to identify and explain how and why MASH could contribute to better outcomes for children, young people, and their families to inform principles of best practices for adapting and innovating locally. As you know, the government's Working Together 2023–24 is being worked on. This research is intended to provide your insight into multi-agency arrangements.

We are here because we have undertaken focus groups across England and interviewed MASH practitioners in other MASH sites and would like to sense-check these results with you. Mainly, we'd like to reflect and sense-check what's been told to us and what we have understood.

So, this session is to present and consolidate our preliminary findings from this research. We want to make sure we have understood correctly how and why a MASH works. What we will present are some of the findings related to experiences, understanding, and reflections about working in a MASH, its components, how you would expect MASH to work (or not), in what contexts will MASH work (or not) and why, what is the perceived impact of MASH and for whom, and what is the place for feedback loops and quality improvements.

During this session, we might also ask you to reflect on a particular case and family, and we would appreciate it if you could please avoid mentioning their names. Nobody will be identified from this research, we will make sure everything we publish and present is anonymous so neither you, our local areas nor any children can be identified from any details.

So, some last details:

- Everybody's ideas are equally important.
- The group needs to hear everybody's views, so please pitch in.
- The moderator is here to present and consolidate the ideas from different MASH workers, not to influence you in any direction.
- All comments made today will be anonymised and will remain completely confidential. When we give feedback on our findings, no comments will be attributed directly to any one person.
- The session will be transcribed. Again, transcriptions will be anonymised, remain confidential, and be used to help analyse the results of the focus groups.

Switch on recording in each breakout room (approximately 4–5).

Please note: The workshop is dependent on the Findings from Focus Group 1, Focus Group 2, and 1-1 Interviews with Professionals in 3 MASH sites in England. The aim of these focus groups and interviews is to develop our logic theory. This workshop is to consolidate findings with a larger

group of MASH practitioners from across England – being the last step in the broad-deep-broad approach to our data collection. Throughout this workshop we will present our emerging findings to professionals (for example: within our data collection sites we found X, what is your view/perspective of this, or even a logic model with an explanation of how we think these models work and why) and discuss, probing participants about their understanding and experiences of working with families and children in their own sites.

The workshop will take place online via Microsoft Teams and we will then use breakout rooms (approximately 4–5 breakout rooms) to facilitate discussion in small manageable groups. Breakout room discussion will be recorded to capture the detailed discussion and to aid our understanding which in turn will support the development of our logic theory. This topic guide will aid us in probing our results/findings from data collected within that local authority and other sites included and analysed from the qualitative data collection (iterative and dependent on Focus Group 1 and 2 and 1-1 interviews with professionals). We anticipate that these results/findings may include but are not limited to the following topics for discussion:

Topics for discussion

1. Their perspective and understanding of the structure of MASH based on our emerging findings.
2. The purpose of MASH for professionals and the families they support (including types of families/cases).
3. Understand and consolidate the aims and objectives of MASH (including the difference it can make for families and children).
4. Present the facilitators and barriers of a MASH within local authorities and check if they agree/disagree and have anything to add.
5. Discuss what we understand are the core principles of MASH that lead to the success of the model for both professionals and families they work with in local authorities. Are there any common principles?
6. Their reflections on our results regarding feedback loops, and what may be needed to ensure that MASH works well.

Appendix G: MASH models by Site

The following figures (A1–A4) present a visual and slightly simplified representation of the MASH structure in each of the three case study sites.

The diagrams illustrate the following points:

- Referral processes are reasonably similar (left side of diagrams), with a slight exception in Site 3, which also receives referrals via phone calls.
- Relationships centre around children's social care (centre of diagram) with partners sharing information and analysis primarily with children's social care rather than each other.
- There are differences in the place of Early Help. In Site 1 Early Help appeared less well integrated into core MASH activities, while in Site 3, Early Help had a central place.
- Site 1 is the only site where members of the Locality's Assessment team are co-located and lead strategy meetings attended by MASH practitioners.

The coloured arrows at the bottom of each figure represent the timelines for different types of cases that come into the MASH, based on the initial triage.

Figure A1. Site 1 visual representation (go to accessibility text)

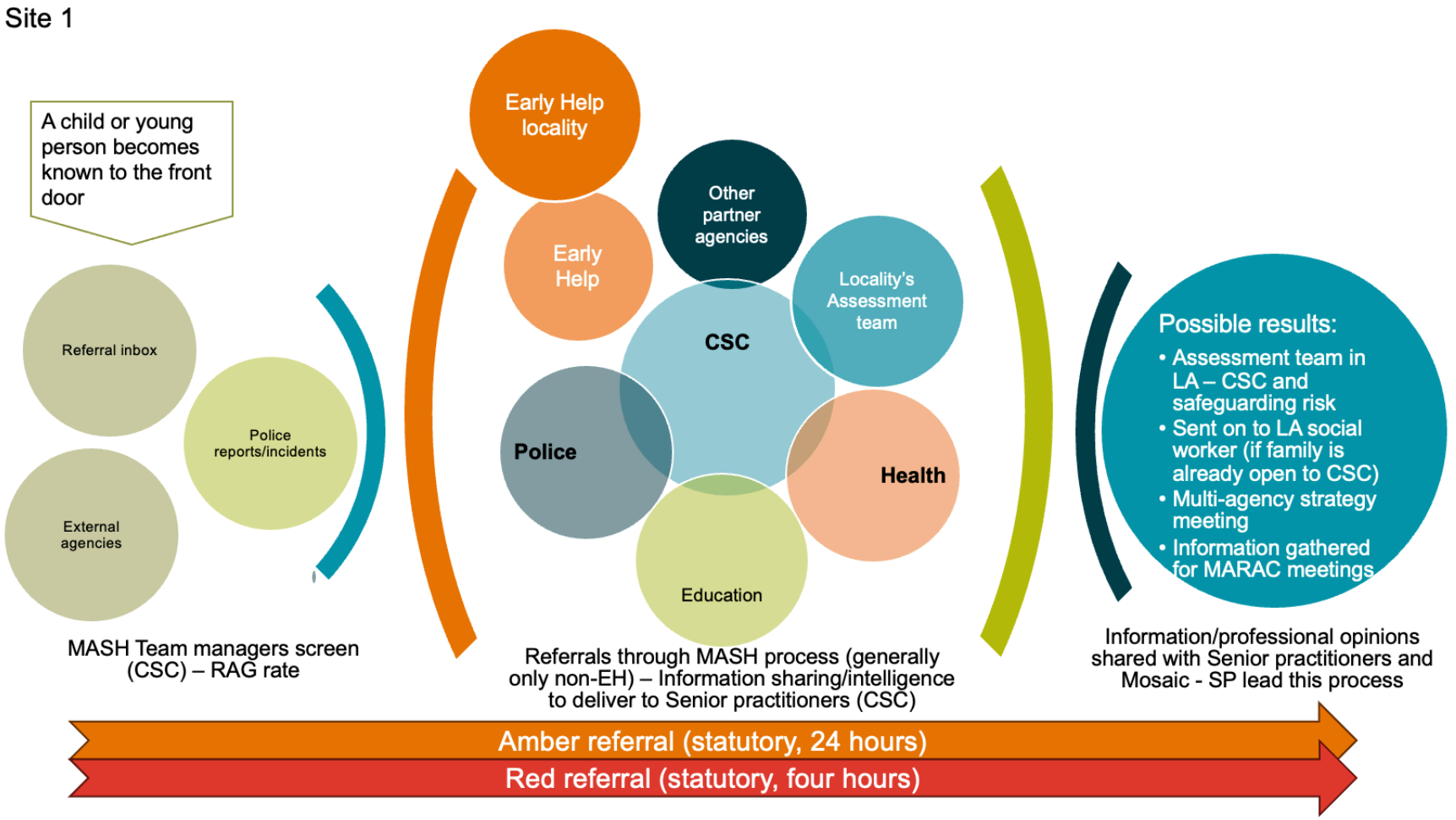


Figure A2. Site 2 visual representation (go to accessibility text)

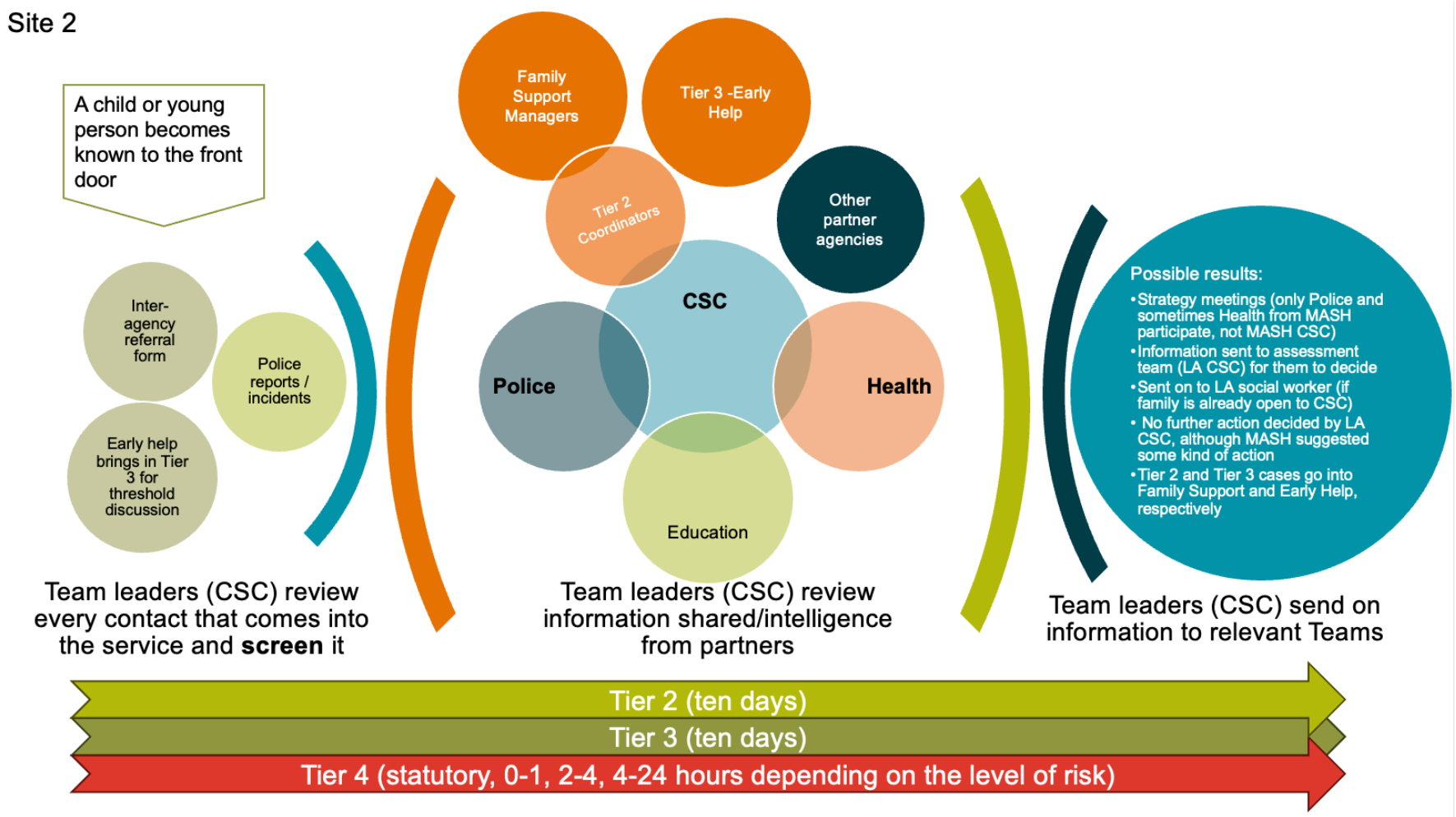


Figure A3. Service manager leading MASH and EH services in Site 3 – integration of risk and needs assessment and service planning functions through joined-up service leadership (go to accessibility text)

Site 3

Joined up services led by one same service delivery manager.

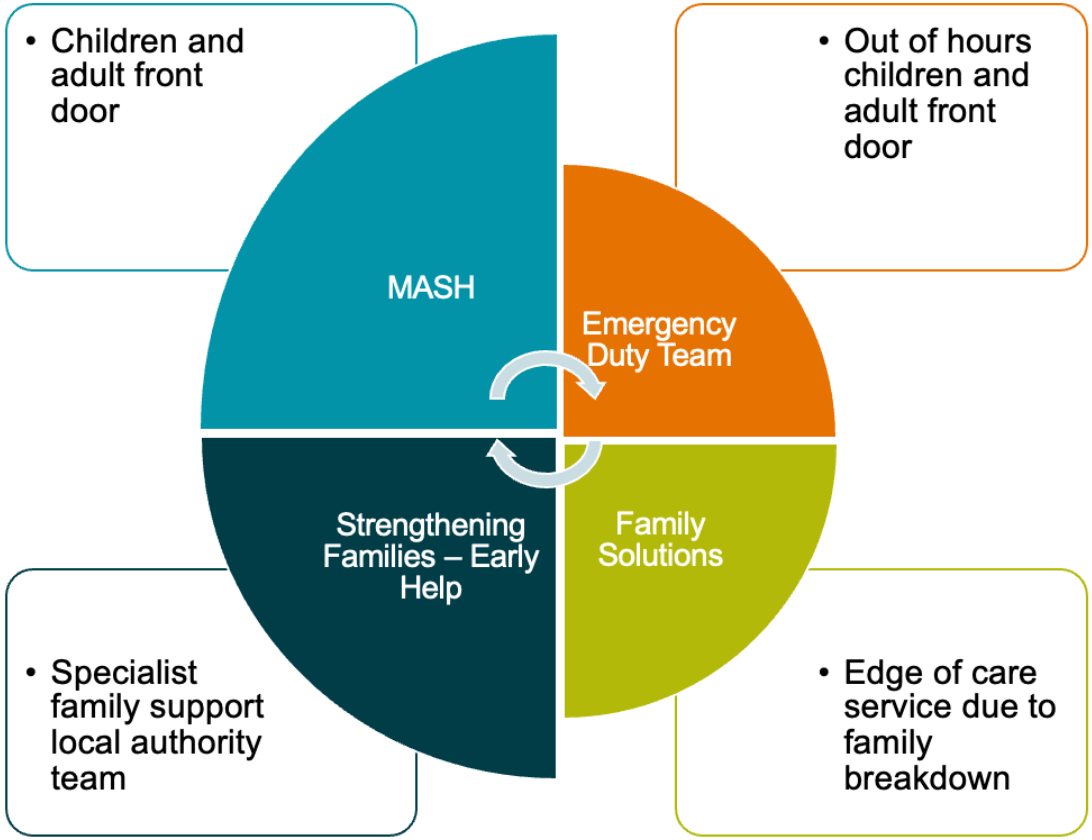


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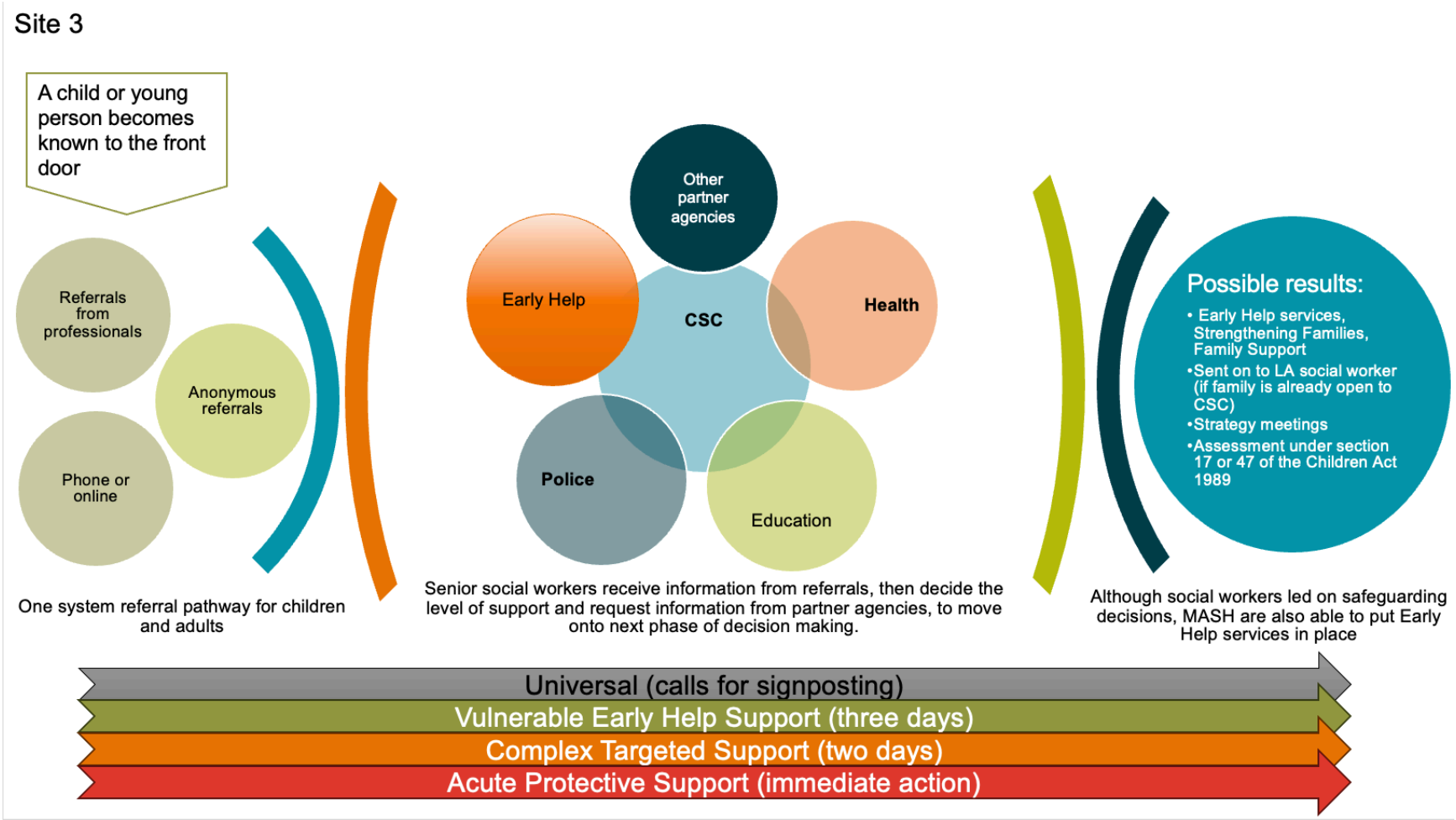
Figure A4. Site 3 visual representation (go to accessibility text)



Appendix H: Accessibility text

Figure 1 and Figure 2. The two strategic functions of a MASH

This image presents a visual representation of the spectrum of MASH (Multi-Agency Safeguarding Hub) functions. The diagram employs a horizontal arrow to illustrate the range of approaches, from left to right.

On the left side, the "Risk assessment function" model is characterised by:

- A narrower range of partner agencies involved
- Processing high volumes of cases
- Early Help is a core part of MASH operations
- Early Help representatives typically do not attend MASH meetings

On the right is the "Risk and needs assessment and service planning function" model, characterised by:

- A broader range of partner agencies
- Early Help actively participates in MASH activities
- Early Help tends to influence Early Help services

The diagram features colour coding with red, amber/yellow, and green blocks at the bottom of both sides, indicating risk levels. For the "Risk assessment model," the colour coding includes only red and yellow, demonstrating that only more urgent or serious cases go through the MASH process. On the right side, concerning the "Risk and needs assessment function," the colour coding incorporates green, amber, and red, indicating that cases across the entire spectrum of need go through the MASH process.

At the bottom of the diagram, there are two black text boxes. The left one, associated with the "Risk Assessment function" MASH, indicates that "Cases with serious child protection concerns are processed by all MASH models". The right text box, related to the "Risk and needs assessment function," states that "Cases where the whole spectrum of need is present are processed by all MASH models".

The horizontal arrow traversing the bottom of the main diagram is labelled "Spectrum of the function of MASH," indicating that these are not binary models but rather points along a continuum of approaches to multi-agency safeguarding.

Click here to return to main report (figure 1).
Click here to return to main report (figure 2).

Figure 3. Strategic intention (purpose) of a MASH reported in workshop (options not mutually exclusive)

This image shows a bar chart titled "Strategic intention (purpose) of MASH reported in workshop (options not mutually exclusive)." The graph displays participants' responses regarding the different purposes of Multi-Agency Safeguarding Hubs.

The y-axis represents "Number of participants" ranging from 0 to 15, and the chart illustrates nine different response groups with colour-coded bars – from left to right, you can find the following:

- First blue bar (15 participants): Selected all four strategic purposes (Professional assurance, Prevention of death/injury, Holistic assessment, and Planning quick services)
- Second blue bar (6 participants): Selected Preventing death/injury, Holistic assessment, and planning quick services.
- Third blue bar (4 participants): Selected Holistic assessment and planning quick services.
- One red bar (2 participants): Selected Professional assurance and Preventing death/injury.
- Fourth blue bar (2 participants): Selected Professional assurance, preventing death/injury, and planning quick services.
- Fifth blue bar (2 participants): Selected Professional assurance, Holistic assessment, and planning quick services.
- One orange bar (1 participant): Selected Professional assurance.
- Sixth blue bar (1 participant): Selected Professional assurance and Holistic assessment.
- Seventh blue bar (1 participant): Selected Preventing death/injury and planning quick services.

The legend explains that blue bars represent responses consistent with needs assessment and service planning MASH, red bars represent responses consistent with risk assessment MASH, and orange bars represent responses inconsistent with the research framework.

Below the bar chart is a dot matrix showing which of the four strategic purposes each response group selected:

- Professional assurance (chosen by 24 out of 34 workshop participants): Professional assurance and protection.
- Preventing death/injury (chosen by 25 out of 34 workshop participants): Preventing cases of death or serious injury (preventing safeguarding practice reviews).
- Holistic assessment (chosen by 27 out of 34 workshop participants): Holistic needs assessment of child and family members.
- Planning quick services (chosen by 28 out of 34 workshop participants in total): Planning services for a child so that they can be provided quickly.

A note indicates that although 35 practitioners attended the workshop, only 34 answered this question.

Click here to return to main report.

Figure 4. Practitioner workshop results: Which strategic intention (purpose) of their own MASH is stronger?

This image shows a bar chart titled "Which purpose is stronger in your MASH?" presenting results from a practitioner workshop that asked participants to identify the strongest strategic intention or purpose in their own Multi-Agency Safeguarding Hub.

The chart displays five teal vertical bars with the y-axis showing "Frequency" from 0 to 15, and the x-axis labelled "Strategic Intentions." Each bar represents one strategic purpose, with both the count and percentage of responses from the total sample of 35 practitioners:

- Planning quick services (defined as "Planning services for a child so they can be provided quickly "): 15 practitioners (42.9%)
- Preventing death/injury (defined as "Preventing cases of death or serious injury"): 9 practitioners (25.7%)
- Holistic assessment (defined as "Holistic needs assessment of child and family members "): 7 practitioners (20.0%)
- No Answer: 3 practitioners (8.6%)
- Professional assurance (defined as "Professional assurance and protection "): 1 practitioner (2.9%)

The results indicate that planning quick services for children was identified as the strongest purpose by the most significant proportion of practitioners. In contrast, only one respondent recognised professional assurance as the strongest purpose. Each of the 35 participants could select only one option as the strongest purpose in their MASH.

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Figure 5. Practitioner workshop results: Prioritised strategic intention (purpose) of a MASH by reported role of Early Help

This image shows a stacked bar chart titled "Distribution of Purposes by Early Help Involvement", which illustrates how different strategic purposes of MASH vary across different levels of Early Help involvement.

The chart displays four stacked bars along the x-axis representing different Early Help involvement categories:

1. "Part of MASH, steps up cases only" (21 respondents)
2. "Not integrated with MASH" (9 respondents)
3. "Part of MASH, attends all meetings" (3 respondents)
4. "Other" (1 respondent)

The y-axis shows "Number of Responses" from 0 to 20.

Each bar is divided into coloured segments representing different purposes:

- Teal: "Planning services for a child"
- Honey: "Preventing cases of death or serious injury"
- Lilac blue: "Holistic needs assessment"
- Orange: "Professional assurance and protection"

Key findings are shown in the chart:

- For "Part of MASH, steps up cases only" (21 respondents): Planning services is the dominant purpose (10 responses, 47.6%), followed by Holistic needs assessment (6 responses, 28.6%), Preventing death/injury (3 responses, 14.3%), and Professional assurance (1 response, 4.8%).
- For "Not integrated with MASH" (9 respondents): Planning services is most common (5 responses, 55.6%), followed by Preventing death/injury (3 responses, 33.3%), with no responses for other purposes.
- For "Part of MASH, attends all meetings" (3 respondents): All selected Preventing death/injury (3 responses, 100%).
- For "Other" (1 respondent): The single response selected Holistic needs assessment (100%).

This visualisation shows how the primary purpose of MASH varies depending on how Early Help services are integrated into the MASH structure.

Click here to return to main report.

Figure 6. Logic model for risk assessment MASH

This image is a four-column logic model showing the strategic approach of a MASH (Multi-Agency Safeguarding Hub) that prioritises **risk assessment and protection of 'missing' children**. The columns, titled *Context*, *Activities*, *Mechanisms*, and *Intended Impact*, outline how this approach is structured.

Column 1: Context (blue background)

- The MASH's strategic priority is assessing risk and avoiding harm to 'missing' children.
- There are higher-than-average volumes of referrals into children's social care and of complex cases.
- Needs assessments and planning for children below statutory thresholds occur outside of MASH.
- The team includes experienced social workers to screen and triage referrals, experienced practitioners from core agencies (CSC, health, police, education), and a stable, long-standing workforce.
- There is also dedicated senior time, a dedicated MASH office, and clear policies.

Column 2: Activities

- All MASH practitioners:

    - Gather and analyse family information.
    - Attend meetings to verbally present their analysis.
    - Document their findings and informally share information and expertise.
    - Debrief and support each other.
- A senior social worker makes decisions on child risk.
- Multi-agency staff participate in shared strategy, understanding roles and thresholds, and in audit and quality review processes.

Column 3: Mechanisms

- Driven by strong inter-professional relationships.
- Emphasis on conversations between experienced MASH staff.
- Stable and skilled workforce.
- Shared understanding of thresholds, documents, roles.
- Parents are appropriately consulted for information sharing.

Box titled "Unintended Harms" (in red)

- Increased mistrust of services among parents, including therapeutic services.
- Distress and confusion among parents.

Column 4: Intended Impact

For Services and Staff:

- Fast and proportionate sharing of information.
- High volumes of complex cases processed quickly.
- Multi-agency decision-making and accurate risk assessment.
- Child protection teams not overwhelmed.
- Timely referrals to the correct local team.
- Practitioners feel supported and confident.
- Practitioner wellbeing is promoted.

For Children and Families:

- Children are protected from harm.

Click here to return to main report.

Figure 7. Logic model for needs assessment and service planning MASH

This is a second version of the logic model, also in four columns (*Context*, *Activities*, *Mechanisms*, *Intended Impact*) but representing a different MASH approach. This approach prioritises **early intervention and prevention**, with a less emphasised focus on risk. The background colour for this version is green.

Column 1: Context (green background)

- MASH's strategic focus is on assessing needs rather than just risk.
- Referral volumes are average or below average.
- The MASH's role is understood to include early intervention and prevention.
- The remit includes multi-agency planning before statutory thresholds.
- Staff include experienced social workers, experienced practitioners from core agencies, and a wide range of other partners.
- There is a stable workforce, dedicated senior time, a shared office space, and clear procedures.

Column 2: Activities

- MASH practitioners working on specific cases:
    - Gather and analyse agency-specific information.
    - **Produce written analysis** shared through common IT systems (documented, not just verbal).
    - Collaborate on service plans for early help cases.
    - Share information and debrief.
- Senior social workers make risk decisions.
- Multi-agency staff also participate in shared strategy, understanding roles/thresholds, and service reviews.

Column 3: Mechanisms

- Strong inter-professional relationships.
- Dialogue among experienced practitioners from a *wider range of agencies*.
- Skilled and stable MASH workforce.
- **Practitioner accountability to MASH for delivering services** they offer.
- Shared understanding of policies, roles, responsibilities.
- Parents are appropriately consulted for information sharing.

Box titled "Unintended Harms" (in red)

- Increased mistrust of services among parents, including therapeutic services.
- Distress and confusion among parents.

Column 4: Intended Impact

For Services and Staff:

- Quick and proportionate information sharing.
- Multi-agency decision-making.
- Accurate risk assessment.
- Prevention of service overload.

- Demand for child protection services is reduced by early intervention.
- Repeat referrals are prevented.
- Practitioners feel supported.
- Approach supports *relational working* with families, aligning with values.
- Practitioner wellbeing is promoted.

For Children and Families:

- Families receive help early and avoid escalation.
- Improved experiences and trust in services.
- Children are protected from harm.

Click here to return to main report.

Figure A1. Site 1 visual representation

This diagram illustrates the process by which Site 1's Multi-Agency Safeguarding handlSH) processes referrals. The flow begins with "A child or young person becomes known to the front door", shown in a speech bubble at the top left.

Initial referrals come from three sources (shown as pale green circles on the left): referral inbox, Police reports/concerns, and external agencies. These are screened by MASH Team managers (CSC - RAG rate).

The central part shows the core MASH participants as interconnected circles of different colours. Children's Social Care (CSC, light blue) is at the centre, closely connected with Police (grey), Health (peach), and Education (light green). Early Help (orange) and Early Help locality (lighter orange) are positioned slightly outside the main cluster, indicating they function more peripherally to the core MASH operations. Other partner agencies (dark blue) are positioned farther from the centre, suggesting less direct integration.

The right side shows possible outcomes in a teal circle, including assessment team involvement, social worker allocation, and multi-agency strategy meetings.

The bottom shows a workflow arrow transitioning from amber referrals (statutory, 24 hours) to red referrals (statutory, four hours), indicating prioritisation of cases by urgency.

Figure A2. Site 2 visual representation

This diagram shows Site 2's MASH process, starting with "A child or young person becomes known to the front door" at the top left.

Initial contacts come through an inter-agency referral form, police contact/incidents, and Early Help brings in Tier 2 or Tier 3 referrals (shown in pale green circles). These are reviewed by team leaders (CSC) who screen all contacts.

The central arrangement shows CSC (light blue) at the core with Police (grey), Health (peach), and Education (light green) in close proximity, indicating stronger integration. Family Support Managers and Tier 3 Early Help (orange circles) and Tier 3 Coordinators (light orange) are positioned around the core but still within the workflow boundaries. Other partner agencies (dark blue) remain somewhat separate.

The process flow shows team leaders reviewing shared information/intelligence, then sending information to relevant teams. Possible results (teal circle) include joint working with Police and CSC, statutory assessment, no further action, or cases going to Family Support and Early Help.

The bottom arrow illustrates a tiered response system, consisting of Tier 2 (ten days), Tier 3 (ten days), and Tier 4 (statutory, with varying response times ranging from immediate to 24 hours, depending on the risk level).

Figure A3. Service manager leading MASH and EH services in Site 3 – integration of risk and needs assessment and service planning functions through joined-up service leadership

This image provides additional information about Site 3's integrated service model, represented as a four-part circular diagram with each section in a different colour.

The diagram is titled "Site 3" and shows four interconnected services that are "joined-up services led by the same service delivery manager", as noted on the left side.

The four quadrants of the circle represent:

- Top-left (teal): "MASH" - Labelled as "Children and adult front door" in an attached text box
- Top-right (orange): "Emergency Duty Team" - Labelled as "Out of hours children and adult front door"
- Bottom-right (lime green): "Family Solutions" - Labelled as "Edge of care service due to family breakdown"
- Bottom-left (dark blue): "Strengthening Families – Early Help" - Labelled as "Specialist family support local authority team"

White arrows connect the quadrants in the centre of the circle, indicating the interrelated nature of these services and how cases might flow between them.

This diagram illustrates Site 3's integrated approach, where multiple services (safeguarding, emergency response, family support, and early help) are coordinated under unified management, creating a more seamless service experience for families with different levels of need.

Figure A4. Site 3 visual representation

This diagram depicts Site 3's approach, beginning with "A child or young person becomes known to the front door" at the top left.

Initial referral sources include referrals from professionals, anonymous referrals, and phone or email (pale green circles), feeding into "One system referral pathway for children and adults."

The central arrangement shows CSC (light blue) at the core, closely connected to Health (peach), Education (light green), Police (grey), Early Help (orange), and other partner agencies (dark blue). The positioning suggests a more integrated approach with Early Help having greater prominence than in the other sites.

Senior social workers receive referral information and partner agency intelligence, then decide the level of support needed. While social workers lead safeguarding decisions, MASH can also put Early Help services in place (shown in the teal circle of possible results).

The bottom arrow shows a tiered response system ranging from Universal (calls for signposting), to Vulnerable Early Help Support (three days), Complex Targeted Support (two days), and Acute Protective Support (immediate action).

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