Assessing the Early Impact of Multi Agency Safeguarding Hubs (MASH) in London

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MASH Multi Agency Safeguarding Hubs

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EXECUTIVE SUMMARY

Background

The failure of agencies to work together effectively to safeguard children and young people has been highlighted in numerous serious case reviews of child protection cases. *The Munro Review of Child Protection* (2011) recognised the key role of the Local Safeguarding Children Boards (LSCBs) in fostering multi agency working and the same year the London Safeguarding Children Board (London SCB) began to roll out Multi Agency Safeguarding Hubs (MASH) in boroughs across the city. There are now 26 MASH operating in London. They follow a model developed by the LSCB in Devon and focus on the point at which child protection referrals are initially received.

Aims and methodology

A review of the implementation of this method of multi-agency working and its impact on safeguarding services to children was carried out in five London boroughs in order to assess how effectively it is being put into practice. One of the boroughs investigated had a relatively established MASH and the other four boroughs developed their MASH teams over the course of the review allowing the collection of data both pre- and 2 months post implementation.

A mixed methods approach was used including: pre implementation MASH site visits, a pre and post implementation snapshot audit of referrals to MASH, a pre and post implementation qualitative interview study of MASH professionals and a post implementation qualitative interview study of referrers to MASH.

A number of challenges were encountered in the collection of data from the five boroughs including delays to the implementation of MASH which reduced the time available for data collection and the difficulty of finding times when professionals were free to participate in interviews.

These difficulties meant that amendments had to be made to the data requested and collected and to some of the analyses conducted.

Findings

The findings from this review provide early evidence that the MASH approach has the potential to address some of the issues highlighted in serious case reviews in the past. MASH appears to facilitate

more effective multi-agency working and there are signs that the professionals working together in MASH teams were developing their own MASH culture as distinct from single agency cultures. This demonstrates the potential for improvement in partnership communication and information sharing.

The benefits of this improvement are already being felt in some of the boroughs under review. One of the most significant findings was the reduction in turnaround time of referrals to safeguarding services at all levels of risk (RAG (Red, Amber, Green) Ratings). The mean turnaround time for cases initially assessed as level 3 (high or complex needs) nearly halved from two and a half days to slightly over one and a quarter days and the turnaround time for referrals initially assessed as level 2 (low to vulnerable) halved from more than four and a half days to less than two and half days.

Professionals interviewed pre implementation had questions about how MASH would work, but in general people felt it would bring benefits to safeguarding. It was expected that this form of multi-agency working would lead to a better mutual understanding of the various roles involved in child protection and that faster information sharing would lead to more effective decision-making.

Professionals interviewed post implementation were generally positive about MASH working and the impact on services to children. There was evidence that more children were receiving services appropriate to their needs following referral. The main areas of concern arose from heavy workloads, poor staffing levels and frustrations with inadequate information technology resources.

The introduction of MASH has necessitated structural changes and a shift in cultural attitudes. It is therefore perhaps not surprising that at such an early stage in their development, some boroughs perceived themselves as being more operational than others and the site visits found a degree of variation in the ways they met the five core elements of the MASH model. These core elements of the London MASH were based on elements of the first MASH which was set up in Devon.

Both MASH professionals and those referring to MASH recognised that further work was needed to educate professionals (such as those responsible for making safeguarding children referrals) about the role and responsibilities of MASH. Many professionals outside of the MASH team appeared to be unfamiliar with the MASH process which could result in a reluctance to provide information when requested, particularly information that was regarded as confidential.

Furthermore, some non social care or police professionals within the MASH teams felt somewhat marginalised and complained of a failure to fully utilise their skills and experience, feeling that they were only used to provide information and did not take part in discussions or make decisions about children. Referrers to MASH complained about the failure to communicate feedback about the outcome of referrals.

Conclusion and recommendations

The MASH in the boroughs reviewed have made a lot of progress in a relatively short time. There were indications that a MASH culture is emerging which it is hoped will continue to develop as a support to multi agency working and the safeguarding of children. A key finding has been a reduction in turnaround times from referral to decision, regardless of initial RAG rating. However, while there are promising indications that improved access to information from a range of different agencies has helped decision makers get a fuller picture of the child in his or her situation; there are still a number of challenges which must be met if MASH is to become fully effective.

The report recommends that more is done to increase the sense of inclusion of all professionals in MASH, the provision of information about the outcomes of referrals and training for professionals with potential for making safeguarding children referrals about the role of MASH. The creation of a pan London MASH working group would also provide opportunities to consider various approaches to MASH and to share practice ideas.

This evaluation took place in the early stages of the implementation of MASH and therefore was only able to assess the short term impact of MASH implementation. Further evaluation will be required to assess the longer term impact of MASH on services to children and young people at risk.

Recommendations

1. The review found benefits of implementing MASH, particularly in a reduction in the turnaround times from referral to decision. It is not possible to identify from the evidence presented in this review which elements of MASH working contribute to this reduction. Further research should focus on identifying these elements so that they can be incorporated into current MASH and those implemented in the future.

2. A reduction in turnaround times was seen regardless of the initial RAG rating. This is particularly noteworthy for green and amber RAG-rated referrals. While it is too early to say whether rapid response to these cases prevents deterioration in the situation of these children and families, it would be valuable to identify whether this is the case in future research.

3. There was evidence that some non- social care and police professionals felt marginalised and that their expertise was not being fully used within MASH. A number of actions should be taken to improve this situation including:
    a. team building activities to increase the integration of all professionals in to the team;

b. include all professional groups in triage and decision making which would likely benefit not only the individual professionals but also the effective working of MASH

4. The evidence of a sense of marginalisation and inadequate utilisation of professional skills raises questions as to the job satisfaction of MASH professionals. Future research evaluating job satisfaction in MASH and the impact of job satisfaction on outcomes such as turnaround times and referrals might provide evidence as to the benefits in ensuring that all professionals are fully integrated into the MASH system of working.

5. Both MASH professionals and MASH referrers would value more information about the outcomes of referrals. This would have benefits giving MASH professionals a sense of how the information they provide contributes to the decisions made and increasing understanding of how MASH works among MASH referrers.

6. There is evidence of incomplete knowledge of MASH among professionals outside the MASH team. It is recommended that:
    a. further work is completed to raise awareness of the role of MASH and address concerns about the issue of consent among professionals outside the MASH.
    b. that strategic managers be included in some training events for MASH professionals to ensure they have a full picture of how MASH works and what MASH working is able to offer their discipline.

7. Boroughs varied considerably in how safeguarding services were organised prior to the implementation of MASH and how much preparation there was for professionals about MASH working. Such preparation is likely to be particularly important where, as in MASH professionals are coming together from different professional backgrounds with little prior history of working together. Although there was encouraging evidence of an inclusive MASH culture developing MASH team building activities, particularly those allowing professionals from the different professional backgrounds to share their expertise and knowledge with other team members, would facilitate this process.

8. A lack of resources, particularly in terms of staffing and IT services, were seen as impairing the ability of MASH professionals to work effectively. At a time of severe economic constraint, it would be valuable to assess any associations between good resourcing of MASH and reductions in longer term use of expensive specialist services.

9. The importance of evaluating MASH in London was noted by staff in the boroughs and considerable support was given to the research team by managers and staff. Future studies should engage MASH staff in the development of research ideas to ensure that they address questions of concern and are feasible in terms of the timescale and resources allocated. Staff members might then feel additional ownership over the research and an even greater preparedness to contribute to it.

10. A working group should be set up to explore the feasibility of developing a pan London MASH dataset to facilitate on-going evaluation of the impact of MASH.

CHAPTER 1

BACKGROUND

Child protection concerns

Children Act of 1989 requires every local authority "to safeguard and promote the welfare of children within their area who are in need." However, safeguarding children has long been a central concern for a range of agencies, including not only the local authority, but also the police, health services and education. Each of these agencies has a responsibility to identify children at risk and take appropriate action where necessary. The failure of such agencies to work together effectively has been highlighted in numerous reviews of child protection cases. As far back as 1945 the inquiry into the death of 13-year-old Dennis O'Neill at the hands of his foster father, identified poor communication between those responsible for his care (Baginsky, 2007). A review into several child deaths linked to violence and abuse in the late 1970s (DHSS, 1982) revealed a number of failures in inter-agency systems.

More recently, Lord Laming's inquiry into the death of Victoria Climbié identified continuing failings within social services, the police and the NHS (Laming 2003). The subsequent publication of *Every Child Matters* in 2003 followed by the Children Act 2004, demonstrated the Labour government's commitment to radical change. It set out 'being safe' as one of five important outcomes for children and young people. The agencies required to deliver these outcomes were to focus on four main areas including early intervention and protection. Moreover, each local authority was to promote co-operation with "each of the authority's relevant partners and such other persons or bodies as the authority consider appropriate, being persons or bodies of any nature who exercise functions or are engaged in activities in relation to children in the authority's area." Local Safeguarding Children Boards (LSCBs) became the key mechanism to facilitate this co-operation.

Following yet another high profile case - the death of Baby P - Lord Laming was asked to review the child protection arrangements introduced after his first report (DCSF, 2009). He identified key weaknesses in the way that agencies and individuals in contact with children at risk work together and share information. In June 2010, concerned that the child protection system had become overly bureaucratic, the new coalition government commissioned Professor Eileen Munro to conduct an independent review of child protection in England. The final report of her review once again found that "with so many providers involved, often working with members of the same family, coordination of help is important to reduce confusion, inefficiency and ineffectiveness in service provision." It recognised the key role of the Local Safeguarding Children Boards in fostering multi agency working and acknowledged the growing body of evidence on the effectiveness of early intervention with children and families (Munro, 2011).

Multi agency working

The co-location of professionals in teams is central to the new models of multi agency working, but the literature reports that a number of key elements are required in order for it to be successful. It is reported that the staff recruited into teams need the right experience, knowledge and commitment to drive change forward and that they have a 'joined-up attitude' which includes a willingness to be self-reflective and enthusiastic about collaborative working, and to take on new roles in liaison, bridging and coordination (Boddy et al., 2006, p 19). It is recognised that for professionals, the move to working in a co-located setting is a demanding process and that to succeed in this area they must first feel secure in their own roles (Abbott et al., 2005). It is recommended that in order to prepare staff for working in a co-located setting, bonding activities and common training are provided to promote the building of social relationships and common understandings as research on failed organisational change has identified neglect of 'people issues' and a lack of trust within the network as principal causes of failure (Horwath and Morrison, 2007).

Successful partnerships between agencies also require clarity about the particular contribution of each service and of professional boundaries (Statham et al., 2006). It is important that clear and realistic goals and targets are created that are accepted by all agencies and that there is a common understanding on data protection issues to promote the assessment and decisions made about children at risk (Hudson, 2005). Opportunities should therefore be provided to air and resolve contradictions between different agencies as the quality of inter-agency collaboration is highly influenced by the internal environment of each constituent agency - the more turbulent, poorly led and resourced the agency, the greater will be its difficulty in joint working (Horwath and Morrison, 2007).

Devon Multi Agency Safeguarding Hub (MASH).

The Multi Agency Safeguarding Hub (MASH) model of multi-agency working was pioneered in the UK by the LSCB in Devon. An audit commissioned by the Board found that information was not being shared between agencies and as a result outcomes for children and young people were being jeopardised. The findings coincided with work being carried out by the Devon police led by area commander, Nigel Boulton. In an article for *Community Care* (March 2011), he explained that police and social services work "in isolation a lot of the time and have to make decisions about risk without a true understanding of the information which would enable them to make the most appropriate and proportionate decisions and interventions." He was keen to develop a system that would enable information and intelligence to be shared more effectively between agencies so that professionals could make better risk assessments and reduce potential harm. Subsequent discussions facilitated by the Devon LSCB led to the

development of the MASH model which was rolled out in stages across Devon between April 2010 and April 2011.

The MASH replaced the Devon County Council Referral and Consultation Unit. It consists of a multi agency team of people who continue to be employed by their individual agencies (local authority children's social care, police, health services and education) but who are co-located in one office. Co-location was considered the most effective means of building trust and understanding between agencies. There are also virtual links to the early years team in children's centres; the youth offending team; probation; both children's and adults' mental health; housing; and the ambulance service. Information is shared securely within the hub and is gathered from teachers, GPs, health visitors, school nurses, police officers and others. Once this information has been collected, a social work manager makes a decision as to what further action is required.

Devon County Council commissioned the National Foundation for Educational Research (NFER) to carry out a case study of the Devon MASH (Golden et al., 2011). It found that those involved thought the main advantages of MASH were: more informed decision making; an improved service for children and young people; benefits to partner organisations; identification of gaps and areas for improvement; and a greater willingness to share and greater mutual understanding between partner organisations. The study identified several key components needed for the MASH model to be successfully implemented elsewhere: strategic buy-in; clear governance, aims and terms of reference; sufficient staffing; co-location; and an adequate IT infrastructure.

The Devon MASH generated interest from other local authorities, police authorities and safeguarding specialists nationally. The final report of the *Munro Review of Child Protection* (2011) highlights the Devon MASH as an example of good practice. Furthermore, the review into youth violence following the riots of August 2011, stated that in order to join up the way local areas respond to such violence, the government would "promote the roll-out of Multi Agency Safeguarding Hubs (MASH) which co-locate police and other public protection agencies to cut bureaucracy and make it easier to share information and agree actions" (Home Office,2011).

London Safeguarding Children Board MASH project

The London Safeguarding Children Board provides strategic advice and support to London's 32 LSCBs and their partner agencies, including the Metropolitan Police, the NHS and third sector organisations. The Munro Review (2011) highlighted multi agency initiatives already in operation in two London boroughs as examples of good practice: The Family Recovery Project in Westminster and the Integrated Pathways and Support Team in Tower Hamlets. However, in 2011, inspired by the Devon MASH, the Board initiated a pan London multi agency project which aimed to develop better co-operation between

the agencies working with children and young people in all London boroughs. The new MASH would focus particularly on the point at which child protection referrals are initially received. The work was overseen by a Project Board, comprising senior membership from the Association of London Directors of Children's Services, the Metropolitan Police Service, the Greater London Authority, the NHS in London and London Probation.

Because of the wide differences across London boroughs, it was agreed that there would be no single MASH type model, but instead a set of agreed core elements. As of November 2013, 26 Multi Agency Safeguarding Hubs are already operating in London, with the remaining boroughs in line to implement MASH by the end of 2013/14 financial year.

There are five core elements of the London MASH:

1. All notifications relating to safeguarding and promoting the welfare of children to go through the hub.

2. A co-located team of professionals from core agencies (Children's Social Care, Police, Health, Education, Probation, Housing and Youth Offending Service) delivering an integrated service with the aim to research, interpret and determine what is proportionate and relevant to share.

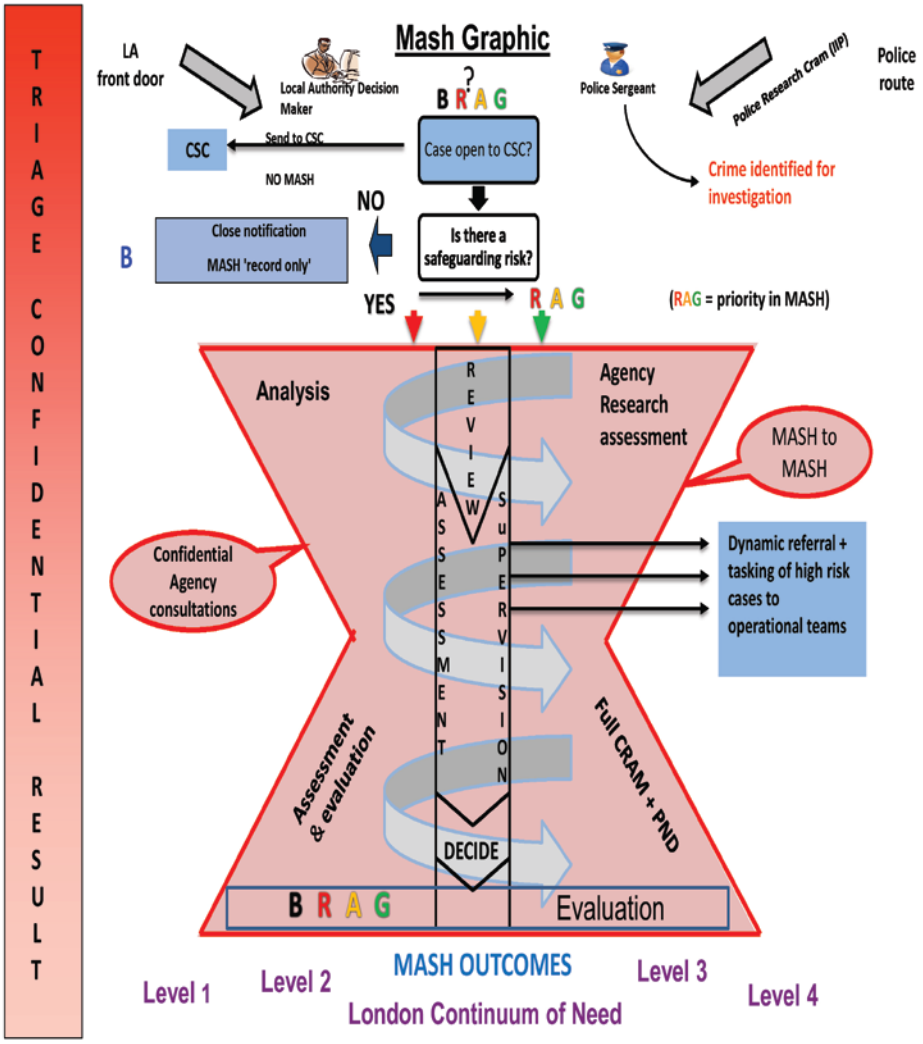
3. The hub is fire walled, keeping MASH activity confidential and separate from operational activity and providing a confidential record system of activity to support this.

4. An agreed process for analysing and assessing risk, based on the fullest information picture and dissemination of a suitable information product to the most appropriate agency for necessary action.

5. A process to identify potential and actual victims, and emerging harm through research and analysis.

There are many ways that notifications of concerns relating to the welfare of children can be referred into MASH. The police provide the largest number through their Merlin reports, but referrals can also come from members of the public, health, education and other sources (Figure 1.1).

Figure 1.1: MASH Process



(source: Metropolitan police)

Once the needs of the child and young person have been identified, if they meet the threshold for an assessment they will be referred to LA children's social care, otherwise, they will be referred to another appropriate resource. As a result of Every Child Matters (ECM), the Metropolitan Police Service developed the Merlin Pre-assessment Checklist (Merlin PAC) to be used in cases presenting children or young people in need. This assessment is based on the five ECM outcomes to check if the child is healthy, safe, enjoying and achieving, making a positive contribution and achieving economic well-being. The Multi Agency Safeguarding Hub (MASH) will manage Merlin referrals in which additional

needs are identified. A multi-agency triage team working within a "fire walled" confidential hub will be responsible for screening enquiries in order to identify and allocate targeted and specialist services to children, young people and families in need. This approach aims to provide a solution to the problem that agencies are often not aware of each other's involvement and are unable to see each other's information thus making it more difficult to make accurate informed decisions regarding these cases. Within LA children's social care many referrals are read and marked as no further action because they do not appear to meet the threshold for a statutory assessment or further investigation. MASH aims to support practitioners by providing the best possible information to enable them to make accurate decisions to deliver effective and focused interventions.

As a result, MASH aims to:

- gather all relevant information about the child in one place to inform decision making;
- facilitate early intervention to prevent the need for more intensive interventions;
- identify potential victims in order to provide appropriate intervention;
- improve co-ordination, communication and information sharing between practitioners;
- reduce referrals to LA children's social care for those who do not meet the criteria for services but require early intervention or support.

Who will MASH target?

The plan for MASH is that it will develop a triage system incorporating members of the key agencies listed in Core Element 2 which will screen the referrals and enquiries made to them. For example, the police will report concerns of a child or young person at risk of not being able to achieve the 5 outcomes detailed in *Every Child Matters*. When they believe that the child is at risk of significant harm, referrals would go directly to LA children's social care. When they believe the risk of harm is not immediate, but the child may meet the threshold for section 17 of the Children Act (1989) defined as being in need, or those needs are unclear, the Merlin report will be passed to the MASH to be screened. Figure 1.2 below illustrates the London Continuum of Need levels used to assess the risk posed to children and young people.

Figure 1.2: The four levels of need of the London Continuum.

The London Continuum builds from the four levels of need.

Level 1 No identified additional needs. Response services are universal services.	**Level 2 - Low risk to vulnerable** Child's needs are not clear, not known or not being met. This is the threshold for beginning a common assessment. Response services are universal support services and/or targeted services.
Level 3 - Complex Complex needs likely to require longer term intervention from statutory and/or specialist services. High level additional unmet needs - this will usually require a targeted integrated response, which will usually include a specialist or statutory service. This is also the threshold for a child in need which will require Children's Social Care intervention.	**Level 4 - Acute** Acute needs, requiring statutory intensive support. This in particular includes the threshold for child protection which will require Children's Social Care intervention.

As illustrated and discussed above, it is only level 4 referrals presenting significant risk, that are referred onto LA children's social care. The other referrals, particularly those between levels 2-3 (which prior to MASH were not followed up), will now be handled through MASH.

Figure1. 3 details the Red, Amber, Green ratings of incidents coming to MASH and how these link to the continuum of need outlined in Figure 1. 2.

Figure 1.3 RAG (Red, Amber, Green) Ratings for Incidents and Referrals Coming to MASH

	Red	Amber	Green
Risk Level	Child or young person appears to be at risk of immediate and/or serious harm.	Child or young person at risk of harm, but not imminent and possibly less serious.	Concerns about the wellbeing of child or young person, which if not addressed, may lead to poor outcomes.
Links to London Continuum of Need Level	Level 4 Complex or Acute	Level 3 High or Complex	Level 2 Low to Vulnerable
Linked to Borough Threshold Document	*To be completed by each local authority using the terms they have adopted.*		
Action/MASH Response Time	Relevant teams informed immediately; MASH product within 4 Hours	As soon as possible, but within One Working Day	As soon as possible, but within Three Working Days

In early 2012, London Councils commissioned Jeanne King to carry out a scoping exercise assessing the readiness of boroughs that were not part of the first wave, to implement the MASH model (King, 2012). Mary Mullix carried out a similar exercise with regard to the health services (Mullix, 2012). Both reports found differing levels of support for the MASH concept and concerns over the practicalities of roll-out.

CHAPTER 2

EVALUATING MASH

This report outlines the findings of a research project designed to evaluate the impact of the Multi Agency Safeguarding Hubs (MASH) in London by determining 'what works' in a MASH setting (Hobb et al., 2008) and the barriers and facilitators to its successful implementation.

Aims and objectives

The aim of this review was to examine the effect MASH has had on supporting practitioners in delivering effective and focused interventions, and furthermore changing approaches to safeguarding practice. Hence we were evaluating how MASH can help practitioners make better decisions regarding what services and interventions can be put in place to produce better outcomes for children.

The study sought to:

1. monitor implementation and impact of the intervention and assess programme fidelity
2. explore with MASH staff and other key stakeholders how programme outcomes might be achieved, including the identification of barriers, facilitators and mechanisms of change.

Methodology

The study focused on four of the 15 London boroughs that were scheduled to implement MASH between May to July 2013: Brent, Tower Hamlets, Tri-Borough (Kensington and Chelsea, Westminster, Hammersmith and Fulham), and Merton. A fifth borough, Newham, declined the offer to participate in the study due to the organisational changes taking part in the service, resulting in a lack of time to participate in the evaluation. In addition, Lewisham MASH, an established MASH that was considered an example of good practice, was recruited for comparison. This allowed us to benchmark the four new MASH against an established MASH and against recent series case review recommendations (e.g.

supervision, decision making, recording of information) and the five core elements of MASH. This impact and process study was designed to show how MASH operates, whether referrals have changed following the implementation of MASH, and whether MASH has succeeded in better communication and information sharing between services. The study also explored decision-making amongst professionals regarding need levels 2-3. An essential part of this study was to gain a thorough understanding of mechanisms of change: what was it about MASH that worked effectively for practitioners; and furthermore children and families? And what did not work as effectively? In order to understand how the programme might be delivering change in practice, we investigated the implementation and programme fidelity. The results were compared across all five MASH.

Data collection

This study used data from a variety of sources: visits to MASH, observational data to consider the physical set up of rooms, administrative data on referrals (including Merlin PACs and other records); and in-depth interviews with MASH staff and key stakeholders.

Data Analysis

The process and impact study drew together a range of evidence in order to understand and compare the implementation of each MASH and to identify barriers and facilitators to implementation. The processes through which outcomes are achieved (or otherwise) were determined. This study aims therefore to provide explanations for how and why MASH is succeeding or not and to compare the findings across boroughs. In order to analyse the data, we conducted a thematic analysis (Braun and Clarke, 2006), within a mixed methodology. The thematic analysis generated categories and emerging hypotheses which were tested and modified through constant comparison and the search for deviant cases (Silverman, 2001). A coding framework was devised relating to all sets of interviews and included the distinctive concerns of particular groups of informants about the processes of change. The qualitative data added depth and understanding to an assessment of what worked and why; and provided this understanding from different perspectives.

The quantitative data was generated from records of referrals held by boroughs and was analysed using IBM SPSS (a quantitative data analysis software package). This analytical process enabled the research report to summarise the key issues and patterns derived from the data, as well as discuss theoretical models, and analyse processes of change.

There were five phases to the project:

- Phase 1. Pre implementation MASH site visits
- Phase 2. Audit of administrative records of referrals (pre implementation and 2 months post implementation)
- Phase 3. Qualitative interviews with MASH staff (pre implementation and 2 months post implementation)
- Phase 4. Post implementation qualitative interviews with referrers to MASH
- Phase 5. Dissemination

This study served a number of purposes and explored a wide range of issues in order to:

- provide a detailed account of how MASH is put into practice;
- examine how MASH deals with any barriers both to initial participation (of different agencies), and to retaining their involvement;
- examine how the programme's different elements are used to promote success;
- examine how risk is assessed and the factors that inform threshold and decision making;
- examine how the programme interacts with other aspects of professional practice;
- examine systematic differences in practice and engagement with other services;
- examine practitioners' perspectives on the programme, and perceptions of outcomes;
- examine what is required of practitioners to deliver the programme effectively;
- examine how MASH trains practitioners to deliver the programme;
- examine how information is shared between practitioners and agencies;
- examine how decisions around safeguarding are made;
- examine the implementation of MASH in various boroughs to determine any local differences in interpretation and application of the model and to consider what impact this has;
- examine how MASH operates across Borough boundaries for mobile families;

- examine how data are recorded, stored and shared.

Table 2.1 indicates the selection of quantitative and qualitative methods used in the different phases of the evaluation.

Table 2.1: Methods of data collection used across different phases of the evaluation

Research Area	Study Phase	Method for Data Collection	Data Source	Number and Phase of Study of Data Collection Rounds
Target Population, Target Needs and Target Services	1	Observation (n=5)	MASH site visits	1- Pre implementation
Target Population, Target Needs and Target Services	2	Audit of administrative records of referrals (n=409).	Records held on IT systems used in the MASH	2 - Pre implementation and 2 months post implementation
Target Population, Target Needs, Target Services, Coordination, Communication, Program Delivery and Monitoring	3	Qualitative interviews with MASH teams (n=24 pre-implementation and 16 post-implementation)	Mixed Interviews: Multi agency practitioners from each MASH were purposively selected to represent the range of disciplines involved in each MASH	2 - Pre-implementation and 2 months post implementation
Target Population, Target Needs, Target Services, Coordination, Communication, Program Delivery, Outcomes and Monitoring	4	Post implementation qualitative interviews with referrers to the MASH (n=5)	Interviewees: Referrers to MASH from each MASH site (from Police, Children's Social Care, Health Services) were purposively selected to represent the main referrers to MASH	1 - 2 months post implementation

In practice, the quantitative and qualitative elements of the research were closely integrated and the results of each stage informed the next stage of research.

CHAPTER 3

CHALLENGES WITH DATA COLLECTION

A number of very specific challenges were encountered in the collection of data from the five boroughs. These difficulties meant that amendments had to be made to the data requested and collected and to some of the analyses conducted. In this chapter the difficulties will be outlined, likely reasons for these discussed and implications and recommendations for future research on the MASH presented.

Phase 2: Audit data

The provision of "snapshot" audit data pre and post MASH implementation proved problematic for both the researcher and for the boroughs asked to provide the information.

Problems for the researcher:

- difficulties contacting the right person to provide the information;
- information not provided in the numerical format requested so not possible to use,
- delays in receipt of the information leaving insufficient time to address problems in data received.

Problems for the boroughs:

- data requested held in multiple databases and thus difficult and time consuming to collate;
- data requested could only be extracted by the data analyst going through data bases and checking each individual case for the required information;
- pressure of time and resources for the data analyst - requested tasks could not be undertaken in the required timescales.

In order to resolve this, a narrower set of data was requested and a new proforma developed in collaboration with the MASH. Obtaining these data often required telephone or in-person conversations with the data analyst and other staff from the MASH. Furthermore, due to the implementation delays the post implementation snapshot period was set as 7-18th of October 2013 which was relatively late in the evaluation period. Boroughs then had to collate the information for that period and provide this within a short window in order for the data to be included in the report (see Chapter 5).

Phase 3: Interviews with MASH professionals

Pre implementation interviews

In total, 24 of the 25 (96%) of the planned staff interviews were completed. The final interview was started but had to be abandoned due to competing work demands. While a further time was arranged to complete the interview, the staff member was not available to do so at that rescheduled time and it was not possible to reschedule this interview despite attempts to do so.

Post implementation interviews

Tower Hamlets was not included in this phase as the MASH was not considered fully operational in time to have a viable follow up time for the post implementation phase within the time constraints of the project. Sixteen participants were interviewed post implementation (16/20, 80%), 15 of whom had previously been interviewed pre implementation. Due to staff turnover, one staff member who had not participated in a pre implementation interview was interviewed post implementation. A brief description follows of the issues arising during the follow up phase which did not allow for all participants to be re-interviewed within the project timescale – mainly due to the cancellation of interviews due to competing demands and staff turnover.

In Tri-Borough all the interviews were conducted, one case a replacement was interviewed for a participant who had left since the pre implementation interviews. In Lewisham four of the five staff interviewed pre implementation were re-interviewed post implementation. The staff member we were unable to interview in Lewisham was contacted five times by phone and once by email, and we were then informed they no longer worked in the MASH and their position had not been filled. In Merton, three interviews were completed post implementation. We were unable to contact two staff members despite leaving several telephone messages and email contacts. In Brent, three interviews were completed. Two of these interviews were only completed after numerous phone and email contacts and in both cases the interview had to be rescheduled three times before it was possible to conduct the interview. In one of the remaining cases several attempts at contacting the interviewee were made before a date was set. The interview was rescheduled but the participant was not available at the specified time and further contact attempts were unsuccessful. The final interviewee was not able to participate in the interview at the agreed time and attempts to re-arrange the interview were unsuccessful. Competing work demands were a recurring issue in the difficulties in scheduling and rescheduling of interviews. Participants indicated that staff shortages and the need to prioritise urgent and unexpected cases interfered with the ability to participate in interviews.

Phase 4: Interviews with referrers to MASH

Concerns were raised in some boroughs over the confidentiality of identifying and providing contacts of staff who had referred clients to MASH and one participant had to gain their manager's approval before participating. In addition, one MASH stated it was not possible to provide actual referrers' details due to the way their systems worked. In this case, names were provided of staff who have a role in supporting referrals to the MASH in that borough. One borough provided a comprehensive list of 171 referrers to the MASH representing a range of agencies including, housing, residential care and domestic violence as well individuals such as members of the public, parents and a solicitor. Twenty-seven attempts at contact were made with 11 possible participants representing health, education and social care. Two interviews were scheduled one of which generated an interview following rescheduling of the interview. Potential participants with whom contact was made indicated that any referral to MASH was a very small part of their work and that consequently they had little to say about the incident, or had difficulty remembering the details. Moreover, the supply of these details took on average around three weeks from first request. As a result, it was only possible to interview five referrers.

Possible reasons for data collection challenges:

- pressures on frontline staff- many interviews had to be rescheduled, in some cases multiple times because of uncertainty of work flow;
- lack of time and resources – this was a recurring theme in many of the interviews;
- while MASH staff recognised the importance of the evaluation and in most cases went out of their way to participate, referrers to MASH with less knowledge and experience of MASH, could not be expected to have the same commitment to participating in the research;
- the lack of a common and easily accessible pan-London dataset for MASH also made data collection more difficult.

CHAPTER 4

PHASE 1: PRE-IMPLEMENTATION MASH SITE VISITS

Background

The researchers visited five MASH sites between the 7th and 19th June 2013. The purpose of these site visits was to provide a context about how each of the five London boroughs was implementing MASH in their area and to develop an understanding of the mechanisms of change involved. In addition, the pre implementation site visits focused on any early operating difficulties and how practitioners were dealing with them, the purpose of MASH, which practitioners/professionals were working in the MASH, and the skills they were bringing to the MASH. Four of the sites: Merton, Tri-borough, Brent and Tower Hamlets were selected as they were scheduled to 'go live' between May and July 2013. Lewisham was selected to take part in this study as it is an established MASH and considered to be an example of good practice. It also provided a benchmark to measure the progress in the other four boroughs.

Results

Who took part in the site visits?

The majority of site visits were conducted by at least two members of the MASH team from the University of Greenwich. Jonathon Davies and Lisa Wales conducted the visits to Merton and Brent. Gail Gilchrist joined Jonathon Davies and Lisa Wales for the visits to Tri-borough (Kensington and Chelsea, Hammersmith and Fulham, and Westminster) and Tower Hamlets. The final site visit to Lewisham was conducted by Gail Gilchrist and Lisa Wales. The meetings during these visits were overwhelmingly with senior social work managers designated with the responsibility of implementing MASH in the Local Authorities where they were employed and who invited the professionals they felt should attend. Subsequently, the opinions of other professional groups were not represented during these meetings. Three of these meetings also included the MASH project managers who had been overseeing its implementation (Brent, Tri-borough and Lewisham).

When were the MASH 'going live'?

MASH were considered to be implemented, or "live" at the point at which services would be co-located and receiving MASH referrals. The four pre implementation boroughs that were selected to take part in this evaluation were chosen as they originally had implementation dates between May and July 2013. Only one (Brent) of the four pre implementation sites went live in July, with two (Tri-borough and

Merton) going live in August. The final pre implementation site (Tower Hamlets) intended to 'go live' in October following the co-location of the police. Lewisham had been 'live' since December 2012.

What are the main aims of MASH?

During site visits, members of staff from each borough were asked what they considered to be the main aims of the MASH. Across the four pre implementation boroughs the responses were similar reporting that the introduction of MASH would:

1. improve the sharing of information between professionals allowing for earlier preventative intervention, better assessment and decision making;
2. help develop awareness of different professionals roles and create a unified and consistent system;
3. reduce the number of unnecessary statutory assessments;
4. help to match families with services;
5. provide the central feature of a reconfiguration of safeguarding services which would be organised around the MASH.

The responses from Lewisham added to these as they felt that MASH also offered greater understanding of risk thresholds across the agencies, swifter information sharing and less duplication of work which enhanced efficiency.

Do all notifications relating to safeguarding and promoting the welfare of children go through the Hub (CORE ELEMENT 1)?

Out of the four pre implementation sites only two MASH (Brent and Merton) would be accepting all referrals made. Tower Hamlets MASH would be accepting the majority of referrals apart from those made by the hospital, about children with disabilities and those in private fostering arrangements. Referrals made in Tri-borough would first be RAGed (assessed on the red, amber, green risk continuum) by social workers in locality teams to determine whether there was an involvement for MASH. This was a similar approach to that followed in Lewisham.

In terms of receiving referrals, four boroughs responded as this was not confirmed with Tower Hamlets**.** Two of the boroughs (Merton and Lewisham) dealt with all methods of referrals and Merton was developing a system which would allow the most appropriate staff in the MASH to deal with walk-ins. Brent handled all forms of referral apart from walk-ins which were dealt with by staff at locality teams who determined whether there should be MASH involvement. Tri-borough MASH had a relatively complex system as locality teams in each of the three areas were responsible for updating the database

with the details about the referral. It was then the responsibility of MASH staff to check the three individual systems to manually extract this information and add to a white board in the centralised MASH team office so it could be actioned by the appropriate staff. No clear alerts are placed onto the systems to inform staff of new notifications. Also, Tri-borough MASH were able to accept all three boroughs' social care referrals but not police Merlins from Hammersmith and Fulham or Kensington and Chelsea until early October due to police staffing not then being in place.

What professionals are in the MASH (CORE ELEMENT 2)?

All MASH currently had, or intended to have, the following full time professionals in their teams:

- Social Workers (LA children's social care);
- Health: not onsite in Lewisham;
- Police;
- Education: Merton – in team F/T, Tri-borough – in team F/T but does not serve the three boroughs, Brent and Lewisham – F/T telephone access only and Tower Hamlets did not mention whether Education would be in their MASH;
- Youth Offending Team (YOT): Merton – 2/3 days a week and telephone for the remainder, Brent and Lewisham would have telephone access only and Tower Hamlets were in discussion about this. Tri-borough intended to have a number of teams such as sexual exploitation and gangs who will have a remit for working with the YOT;
- Probation: Merton -1 x day a week via telephone, Tri-borough and Lewisham co-located 1 day a week, Tower Hamlets were in discussion about this and not mentioned by Brent;
- Housing: no co-location in any of the five boroughs with telephone contact only. In Tri-borough only Westminster had signed up to work with the MASH.

No MASH included in this review had professionals from all core agencies co-located. Finally, a number of the boroughs (Merton, Tri-borough and Tower Hamlets) spoke of the possibility of adult services joining the MASH at some point in the future.

Do these professionals have access to the necessary resource (databases) so that they are able to research?

All professionals in the five MASH have access to their own agencies' databases.

Do information sharing protocols exist within MASH (awareness of policy and content)?

Four of the boroughs (Brent, Merton, Tri-borough and Lewisham) had created information sharing protocols for the implementation of MASH. Tower Hamlets felt that further evidence about MASH was required before making a decision on this.

Layout of MASH offices. Does this support confidential working?

Three of the MASH sites (Merton, Tri-borough and Lewisham) had designated areas where the teams would work that were accessed through a door requiring a security code. The two other boroughs (Brent and Tower Hamlets**)** had not yet finalised arrangements for locating their MASH teams.

All MASH teams were either working or intended to work in open plan offices with a separate secure room where the police national database is located. In Lewisham professionals from the same agencies sat together and confidentiality was not an issue as everyone was working towards the same aim.

Is the system firewalled keeping MASH activity confidential and separate from operational activity and providing a confidential record system of activity to support this?

The systems were firewalled in four of the five boroughs with only Tower Hamlets not having established whether this would happen until they were clear about the benefits from doing so. In Tower Hamlets, all professionals who used Framework I within the service could view and add to records on the system (including MASH records), although there was a facility to restrict access to particular files.

In four boroughs (Merton, Brent, Lewisham and Tri-borough) only allocated members of the team with specific login rights had access to the MASH area of the local authorities' database. However, only certain members of this group, social care managers, were able to access all of the information so that they could make decisions about individual children and families. To assist this process, other professionals were invited by the social care team manager to add comments and provide information about children and families but could not view the input from any other MASH professional. In Merton, professionals who provided this information were able to indicate to the social care manager what could and could not be shared. In Brent, it was intended that MASH records would be stored for a period of six months on Share Point and then key features of the case would be transferred to Framework I and other information will then be deleted. All non MASH staff working in the local authority would then be able to view this information.

In Lewisham, all social care staff could access MASH records and it was not possible to print off referral information. Other team members were informed of the MASH outcomes through case discussion or requests for information.

Finally, in Tower Hamlets, all staff in the MASH team wouldl be able to view and add to MASH records. Further decisions could be made on access to information following the appraisal of further evidence on the benefits of restricted vs. open access.

What risk assessment and threshold models are used when making decisions on referrals (CORE ELEMENT 4)?

Two of the boroughs (Brent and Merton) had adapted the Pan-London Continuum of Need as the model of risk used in their MASH. Merton had three levels of risk and the MASH would generally considered level 2 cases but would also complete background checks on level 3 cases (s.47 Children Act, 1989) before passing them onto the Risk and Assessment (R & A) team.

In Tri-borough, there was uncertainty about the risk assessment tools used as different agencies such as social care and the police used different ones. There were also anticipated differences in the threshold models across the three boroughs although it was unclear how these would be resolved leaving the potential for lots of "interesting discussion".

Tower Hamlets identified a number of risk models such as the Signs of Safety, DoH Framework and Risk Resilience Models to develop a common approach to assessing risk and decision making across all staff and agencies. Some concern was raised that the Signs of Safety approach was not being conducted fully due to the extra work it produced for practitioners.

Lewisham reported using the RAG rating system with all NSPCC, anonymous referrals, missing persons and repeat risks having to go through the MASH system. There was no threshold document and a conflict resolution process had been developed so that the duty manager could intervene in cases where there was disagreement about thresholds. It was acknowledged that 'borderline cases' generated greater discussion.

What mechanisms are in place to ensure the MASH shares proportionate and relevant information to the most appropriate agencies?

The dissemination of information in all boroughs was determined by the social care team manager. Two boroughs (Merton and Brent) spoke of getting the families' consent to share information (on top of E-CAF in Brent), unless the case was considered to be a section 47 investigation (Children Act, 1989).

How does the MASH identify victims and perpetrators who have been repeatedly notified and individuals who may suffer increasing levels of harm in the future (CORE ELEMENT 5)?

There was a wide range of approaches to this across the five boroughs. In Merton, a pro-forma had been developed to manually extract information from Care First, and other professional databases, to generate information about a particular child or family which would then be presented as a chronology.

Brent had no plans to change their current system of allowing the locality teams to identify repeated notifications and potential victims, although the MASH IT system had facility to view all notifications to the police and local authority. Tri-borough highlighted the data analyst role as being central to the identification of potential families and children at risk across a range of areas such as child sexual exploitation or gangs. This information would then be used to identify patterns of behaviour to build up MASH intelligence. However, it was not clear how this was going to happen across the three boroughs. Tower Hamlets reported that the police searched three of their own databases using an Integrated Intelligence Platform (IIP) to collate police intelligence about children and their families. This information was then shared with Children's Social Care to supplement information which may not be available on Framework I, such as intelligence about cases concerning child sexual exploitation. This process would consider repeat notifications and the nature of these to identify potential risks such as domestic violence. Lewisham had successfully used the sharing of information, particularly from the police to identify children at risk. On one occasion, intelligence was used to identify 26 members of a paedophile ring. It has also been used to inform Multi Agency Risk Assessment Conferences (MARAC) on potential domestic violence by identifying perpetrators and understanding more about the movement of individuals from family to family. Lewisham were looking at ways of developing this system by being able use MASH to MASH mapping. This was where information from a MASH in one locality may be shared with another, although this is limited at the moment as other MASH teams are not as well embedded as them.

Conclusion

At the time of the site visits the MASH varied in the extent and ways in which they met the five core elements. For example, although not all the services were co-located in all MASH, all the services were available remotely.

It was anticipated that the MASH would reduce cultural barriers and a lack of understanding of colleagues' and their organisations' roles. As a result, the relationship between local authority children's social care and the public protection desk was better than originally anticipated. Some of the MASH such as Merton perceived themselves as being more operational than others such as Tri-borough, given they had their referral and assessment embedded with the team. Tri-borough considered themselves as being more of a remote intelligence hub that had no contact with members of the public, unlike Merton and Lewisham, and instead only provided information remotely.

Some of the MASH included teams with responsibility for: sexual exploitation, gangs, and family recovery projects. There was also an intention in Triborough to create a wider intelligence sharing operation beyond the MASH. This generated high expectations of the data analyst role in terms of joining up intelligence between agencies and their databases, thus providing greater understanding of

the families that were being working with. At the time of visiting, it was accepted that this would be a high level task and it was not then clear how this role would be established.

CHAPTER 5

PHASE 2: PRE-POST IMPLEMENTATION AUDIT "SNAPSHOT"

Aim

The aim of this part of the review was to monitor the implementation of the intervention, to assess programme fidelity and to analyse mechanisms of change. This was achieved using a quantitative audit of enquiries to the MASH in two snapshot periods, one prior to the implementation of MASH and the other following the implementation of MASH.

Methods

Based on our experience with the evaluation of the safeguarding service development in Bromley[1], we had estimated there would be around 200 cases in any two week period at a MASH. Therefore we anticipated 1000 (200 cases per MASH) pre implementation records would be compared to 1000 post implementation records in this "snapshot". We adapted the proforma we developed and used for the evaluation of Bromley to extract data from case notes (see Appendix 1).

The research team had requested that detailed administrative records be kept and that these were made available for the evaluation. However, the collection of "snapshot" audit data pre and post MASH implementation proved problematic for a number of reasons as discussed in Chapter 3. In discussion with the boroughs the data requested was adjusted to fit with what could be provided relatively easily. Table 5.1 shows the data that were originally requested and that which each of the five boroughs was able to provide.

In determining the "snapshot" periods in which referrals would be audited, it was decided that the same periods should be used for each borough regardless of the length of time since implementation. This ensured consistency in relation to any external factors, such as a newsworthy safeguarding case, that might have an impact on referrals across boroughs. In addition, in setting the time for the pre and post audits it was necessary to avoid any periods such as school holidays that might have an impact on referrals. Thus the pre implementation "snapshot" period was set as Monday 13th to Friday 24th May 2013 and the post implementation period was set as 7th to 18th October 2013.

[1] This is an ongoing evaluation of the Bromley MASH being conducted by the University of Greenwich

Table 5.1 Data collected for the snapshot audit in each borough

	Who* referred?	Reasons* for referral?	*RAG rating	Initial RAG rating	Final RAG rating	*List professions involved	*Professional interactions with practitioners	*Professional interactions with family	*Outcome	*Turnaround time	*Previous referral and outcome
Brent	✓	✓							✓	✓	✓ - previous referral date only
Triborough	✓	✓		✓	✓	✓			✓	✓	
Merton±	✓	✓	✓						✓		✓
Lewisham‡									✓	Date of referral only	

* Information originally requested

± Summary data supplied for pre but not post implementation period.

Confidentiality of Records

All personal details on the records were anonymised by MASH staff to ensure confidentiality. MASH staff removed identifiers such as name, address, school and any other information that could easily be used by the public to identify the child. The only identifier within these records was the unique case number and the research team did not have access to information linking this number to the individual. The researcher signed a contract ensuring the data would be used for the sole purpose of the research project and would not be disclosed or made accessible to anyone outside the research team. All identifying information on records sent to the research team was removed by MASH staff.

Data analysis

The data received were entered into SPSS statistical analysis software package. Where necessary, descriptive variables were re-coded into numerical variables to allow statistical analysis. Descriptive statistics including frequency and means were calculated. To assess whether there were significant differences in who referred cases to MASH, reasons for referral and the outcomes of the MASH referral pre and post MASH implementation, chi square tests were calculated. Differences in the time taken to turn around cases pre and post MASH implementation were assessed using independent sample t-tests and One-Way Analysis of Variance.

Results

Some referral data were received from each borough. From Merton we received summary data only for the pre implementation period and for Lewisham we received only data about the numbers referred and some information about outcomes. In both cases there were insufficient data to include in the analyses. As Tower Hamlets MASH was not fully implemented by the end of the second snapshot data collection period, we only received data from this borough for the pre implementation period. Tri-borough were able to provide detailed information about all referrals to Westminster in both the pre and post implementation period and Brent was also able to provide this information. The following analyses are therefore based on the data from these three boroughs (Table 5.2). The following analyses consider any impact of the implementation of MASH in the combined data for Westminster and Brent on referral source, reason for referral, outcomes and turnaround time. In addition, for the data from Westminster we are able to look at the effects of MASH on the relationship between RAG rating and turnaround time pre and post implementation. Finally given that Tower Hamlets had been conducting safeguarding assessments through the Integrated Pathways and Support Team (IPST), which might be considered a

prototype MASH, we compared the impact of this team against the both the pre and post data for Brent and Westminster.[2]

Table 5.2 Summary of eligible referrals by boroughs included in the audit analyses

	Pre MASH referrals	Post MASH referrals
Brent	103	97
Tower Hamlets	104	N/A
Tri-borough	69	45
Total	267	142

Combined data analysis for Brent and Westminster

The source of all referrals pre and post MASH implementation is shown in Figure 5.3. At both time points the majority of referrals came via children's social care or the police with substantial percentages coming also from health and education. Referrals received via children's social care includes cases that were referred from other sources, such as locality teams. However, the data received did not allow us to identify where referrals via children's social care originated. In total these four agencies accounted for 81% and 83% of referral respectively pre and post implementation. In order to confirm that there were no significant differences in the source of referrals in the two snapshot periods the data on referrals were collapsed into one of five categories, social care, police, health education and other. There were no significant differences in who referred at the two time points ($p>0.05$).

[2] In analyses comparing pre implementation data to post implementation data from Brent and Westminster the achieved sample size gave 80% at the 0.05 significance level to detect a small (d= 0.3) effect of the implementation of MASH on outcomes.
In analyses comparing data from Tower Hamlets pre implementation, Brent and Westminster pre and post implementation the achieved sample gave 90% at the 0.05 significance level to detect a small to medium (f=0.2) effect of the implementation of MASH on outcomes.

Table 5. 3: Referrals prior to and post MASH implementation (percentage (number))

Number of Referrals	Pre- MASH (N=172)		Post MASH (N=142)	
	%	n	%	n
Children's social care	23	39	20	28
Police	35	60	34	48
Health	10	17	14	20
Education	13	22	16	22
NSPCC	1	1	1	2
Home Office/UKBA	0	0	1	1
Parent/relative/carer/friend	6	11	4	5
Member of public	1	2	1	1
Anonymous	1	1	0	0
Common assessment framework	2	4	0	0
Domestic violence	1	1	1	1
Connexions	1	1	0	0
Housing	0	0	2	3
Substance misuse	0	0	1	2
Self	1	2	1	2
Other	5	9	4	6
Total	100	170	100	141

Reasons for referral pre and post implementation of MASH are shown in Figure 5.4. Most children at both time points were referred for multiple reasons. Due to the large number of different but overlapping reasons given for referrals, reasons were re-coded into one of the summary reasons shown in the table. Post implementation, there was a close significant increase (although not significant) in the number of children referred for suspected neglect or abuse (X^2=3.74 p=0.053).

Table 5.4: Reasons for referral prior to and post MASH implementation (percentage/number)

Reasons for Referral*	Pre- MASH (N=172)		Post MASH (N=142)	
	%	n	%	n
Neglect or abuse of child	38	66	55	72
Behaviour of parent carer or other	9	16	8	11
Family situation	24	42	22	31
Child needs	18	31	20	29
Domestic violence	8	13	11	16
Other/unknown	11	18	9	12

**Some children were referred for multiple reasons so total percentages > 100*

Table 5.5 shows the outcomes of referrals to pre and post MASH implementation. The only outcome which shows a difference is referral for a strategy discussion. Examination of table 5.5 suggests a significant increase in the number of referrals resulting in a strategy discussion (X^2=3.08, p=0.08)

Table 5.5: Outcomes of enquiries to safeguarding pre and post MASH implementation (percentage/number).

Outcome of enquiry	Pre- MASH (N=172)		Post MASH (N=142)	
	%	n	%	n
Child and family chronology‡	31	53	33	47
Assessment	46	79	46	65
Strategy discussion	20	35	29	41
Refer to localities	13	22	11	15
Refer to universal/other services or blue team	4	7	4	6
Initiate care proceedings	3	5	0	0
No further action/case closed	16	28	13	18
Other	2	3	2	3

**Some children experienced multiple outcomes so percentages will not add up to100*
‡Child and family chronology gives a summary of past events experienced by the child and family as part of an assessment process.

There was an overall reduction in the turnaround time between referral to safeguarding and a decision being made from 1.7 to 0.9 although this was not a significant reduction. However, the change in turnaround time was different for the two boroughs. In Brent there was a marginally statistically significant increase in turnaround time from 0.8 (SD 1.5) to 1.6 (SD 4.2) days (t= -1.86, df=198 p=0.065). In contrast in Westminster there was a decrease in turnaround time from 3.6 (SD 2.9) to 1.8 (1.5) days (t=3.86, df =112, p<0.001). It should be noted that these changes resulted in a very similar post implementation turnaround time.[3]

RAG rating in Westminster

Table 5.6 and figure 5.7 shows the distribution of RAG ratings pre and post implementation. The distribution of the ratings across green, amber and red at the initial RAG rating are rather similar but there is some change in the final ratings with a reduction from pre to post MASH in the numbers of blue ratings and some increase in amber and red ratings.

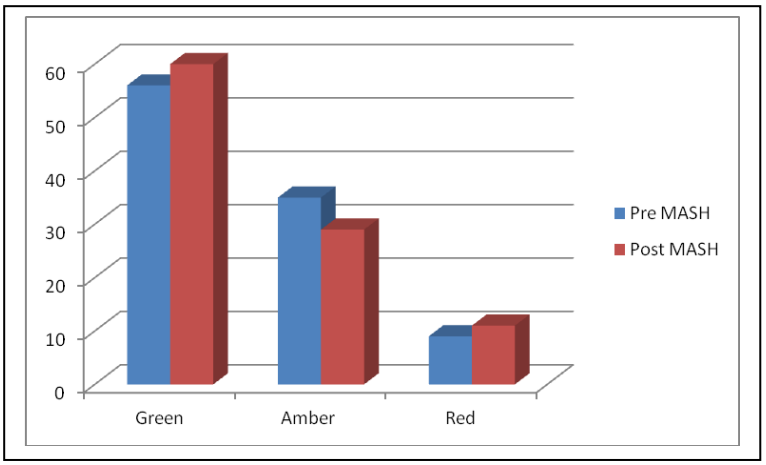
[3] Relatively large standard deviations compared to means suggest that data presented in this chapter are not normally distributed. However, t-tests and Oneway ANOVA used to analyze these data are considered to be robust tests against moderate violations of the normality assumption, especially in larger samples such as these.

Table 5.6: Rag rating in Westminster at referral (initial) and decision (final) pre and post implementation of MASH.

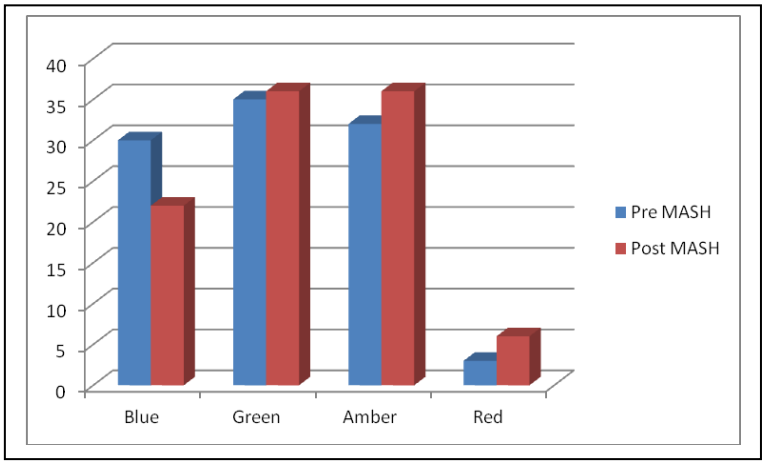
	Initial RAG rating				Final RAG rating			
	Pre MASH		Post MASH		Pre MASH		Post MASH	
	%	n	%	n	%	n	%	n
Blue	-	-	-	-	30	21	22	10
Green	56	39	60	27	35	24	36	16
Amber	35	24	29	13	32	22	36	16
Red	9	6	11	5	3	2	6	3
Totals	100	69	100	45	100	69	100	45

Figure 5.1: Rag rating in Westminster at a) referral and b) decision pre and post implementation of MASH.

a)



b)



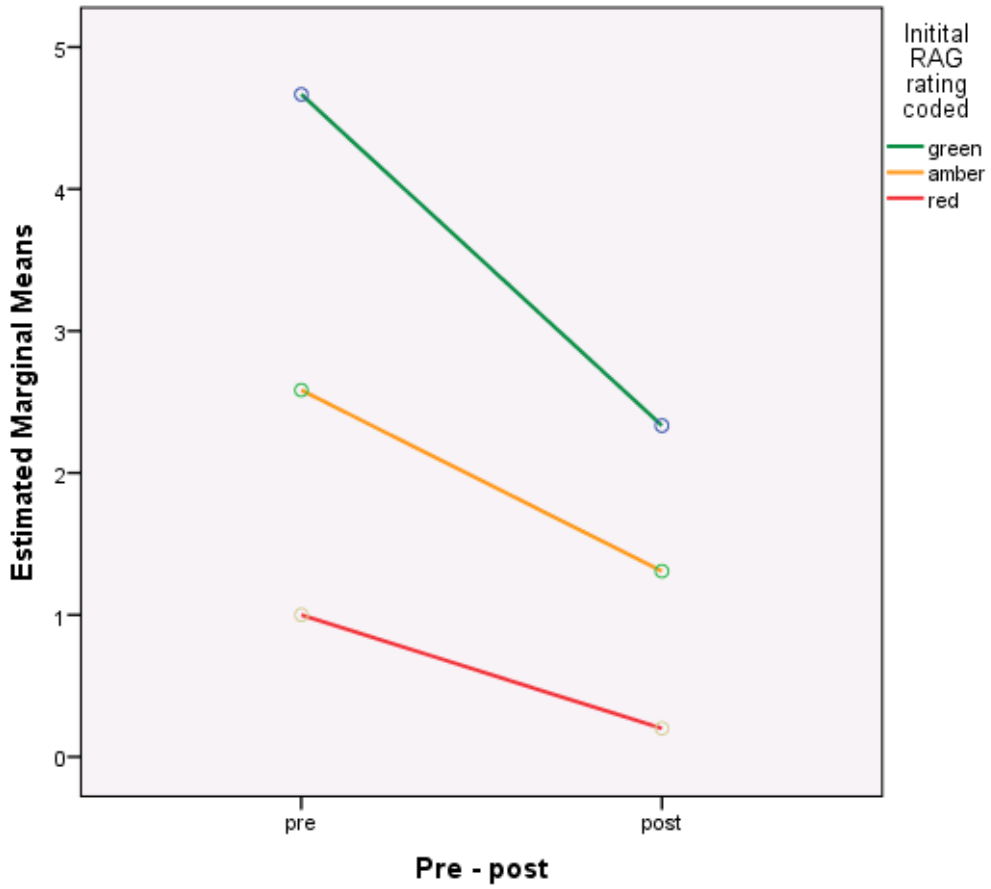
In line with these results Table 5.7 indicates a small increase in cases escalated to a higher RAG rating after the implementation of the MASH.

Table 5.7: Change in RAG rating in Westminster from referral to decision pre and post implementation

Change in RAG rating	Pre MASH		Post MASH	
	Percentage	Number	Percentage	Number
No change	52	36	53	24
Escalation	6	4	11	5
De-escalation	42	29	36	16
	100	69	100	45

It was also possible to explore the impact of the implementation of MASH on the turnaround time of referrals by initial RAG rating. Figure 5.1 shows that there was a decrease in time taken to complete a referral from pre MASH to post MASH regardless of the initial RAG rating.

Figure 5.2: Estimated marginal means of referral turnaround in working days by initial RAG rating pre or post referral in Westminster.



insufficient data to identify the decrease in turnaround time by initial RAG rating and snapshot period, Table 5.8 shows an interesting pattern in the decrease in turnaround time. The mean turnaround time for cases initially RAGed as red decreased from one day to a fraction (0.2) of a day. The mean

turnaround time for cases initially RAGed as amber nearly halved from two and a half days to slightly over one and a quarter days and the turnaround time for referrals initially RAGed as green halved from more than four and a half days to less than two and half days.

Table 5. 8: Turnaround time in working days by snapshot period and initial RAG rating of referrals in Westminster (mean (standard deviation)).

	Initial RAG rating					
	Green		Amber		Red	
Snapshot period	Pre(n=39)	Post (n=27)	Pre (n=24)	Post (n=13)	Pre (n=6)	Post (n=5)
Turnaround time in working days	4.67(3.14)	2.33 (1.36)	2.58 (1.95)	1.31 (1.03)	1.00(6.32)	0.20 (.45)

Comparison of Tower Hamlets data with Brent and Westminster

To provide some comparison of the functioning of the pre MASH Integrated Pathways and Support Team (IPST) in Tower Hamlets with implemented MASH, the turnaround time for referrals to the IPST was compared with the turnaround time for referrals before and after the implementation of MASH in Brent and Westminster. Table 5.9 shows the mean turnaround time in working days was lowest in Tower Hamlets and greatest in Brent and Westminster before the implementation of MASH. This difference was marginally significant ($F(2, 415)=2.54$, $p=0.08$). Bonferroni post hoc tests indicated that the turnaround time for referrals was marginally quicker ($p= 0.08$) in the IPST than pre MASH in Brent and Westminster. There was no significant difference in the turnaround time when the IPST was compared with the Brent and Westminster MASH.

Table 5.9: Turnaround time of referrals to the Tower Hamlets IPST and Brent and Westminster pre and post MASH implementation in working days (Mean (Standard deviation)) [3]

	Safeguarding approach		
	Tower Hamlets IPST (n=104)	Brent and Westminster pre MASH (n=172)	Brent and Westminster post MASH (n=142)
Turnaround time in working days	1.12 (2.38)	1.92 (2.58)	1.66 (3.54)

Key points

- The time taken to complete referrals did not change overall. Although there was an increase in turnaround time in Brent and a decrease in Westminster the final turnaround time in both boroughs was very similar post implementation.
- There was a significant increase in Brent and Westminster in children referred for possible neglect or abuse from pre to post MASH implementation.
- In Westminster, the only borough for which we have the relevant data, there were decreases in the time to complete a referral for children whatever the child's initial RAGing.
- The turnaround time for cases referred to the IPST in Tower Hamlets was significant lower than the turnaround time in Brent and Westminster before the implementation of MASH, but there was no significant difference to the post MASH implementation time in Brent and Westminster.

CHAPTER 6. PHASE 3:

PRE-POST IMPLEMENTATION QUALITATIVE INTERVIEWS WITH MASH STAFF

Aims

The aim of the pre implementation interviews was to gather a broad range of opinion on the aims, and expected outcomes of the programme, and also on how the programme is being implemented in its early stages. The post implementation interviews were conducted to explore the impact of the introduction of the MASH on the work of individual professionals and on safeguarding more generally. The post implementation interviews also aimed to capture some of the changes that the move to MASH had brought to safeguarding services.

Methods

Telephone interviews were conducted with a range of MASH professionals both prior to the implementation of the MASH and around two months later. Potential participants were identified by managers within each MASH and their contact details sent to the research team. A researcher then contacted them to invite them to participate and arrange interview times. The information sheet and consent forms developed and used for the evaluation of Bromley were adapted for use in this phase (see Appendix 2).

The aim was to interview five professionals from each of the five boroughs pre implementation and the same five professionals post implementation. While this target was achieved for the pre implementation period, as described in Chapter 3, 16 participants were interviewed in the post implementation period,

one replacing a pre implementation interviewee. As Tower Hamlets was not fully operational in the post implementation follow-up the five interviewees from this borough were not re-interviewed. Additionally, other participants were either not contactable at follow-up or were unable to participate. Table 6.1 show the range of professionals interviewed at each time point.

Table 6.1: The number and professional backgrounds of professionals interviewed pre and post MASH implementation.

	Pre MASH	Post MASH
Social work	7	4
Health	5	4
Police	5*	3
Education	2	2
Probation and YOT	5	3
Housing	1	0

** One interview not completed*

Data collection.

Interviews were conducted by phone using a semi-structured interview schedule developed in line with the study aims (Appendix 3). Although the post implementation schedule followed a similar format to the pre implementation schedule, it also focussed on changes to the professional's work and the service to children and families at risk brought about by the MASH (Appendix 4).

Because of the problems in scheduling interviews, in some cases the pre implementation interviews were conducted during the early stages of the MASH implementation. Although staff who were interviewed during the earlier stages were asked to recall their situation prior to the MASH being set up these participants also described how things were working at that point in the MASH. This is reflected in the presentation of themes from the pre implementation interviews.

Data analysis

The telephone interviews were digitally recorded and notes were made by the interviewer during the course of the interview. Subsequently, the content of the interviews was written up in note form. Framework analysis (Ritchie & Spencer, 1994) was used to identify themes and the process by which these themes emerged within each interview. Framework analysis was chosen because it provides a method in which the data can be used to address specific research questions rather than purely providing an exploration of themes that emerge from the data in the process of the analysis. This characteristic is a consequence of its development within the context of applied policy research which requires specific information to address research questions and suggest actions to put the research findings into practice (Ritchie & Spencer, 1994). As its name suggests Framework Analysis uses a matrix

to classify and organise the data under consideration according to key themes and concepts. The main themes are then subdivided into a succession of related subtopics (Ritchie & Spencer, 2004).

However, as well as organising the data, the framework can be used to interpret the data.

Framework Analysis involves five different stages (Ritchie & Spencer, 1994).

1. Familiarisation. This is the process of reading the interview transcripts to become familiar with the material and to gain an overview of them. All the interview transcripts may be read at this point or if this is not possible, either due to the number of interviews or to pressure of time, a selection may be read in detail. During the reading, the researcher records responses to the data, listing key ideas and themes that seem to recur.
2. Identifying a thematic framework. The researcher uses the notes made at the familiarisation stage to identify the key issues and concepts through which the data can be understood. These key issues may be drawn both from themes that have begun to emerge through reading the transcripts and from the original research aims. These key ideas form the basis of the framework leading to identification of the main themes and sub-themes. This framework is revised and refined throughout the process of analysing the data.
3. Indexing. If the thematic framework was developed in a sample of the data, it is now applied to all the interview transcripts. The different themes within the framework are given a code and the transcribed interviews are annotated with the codes.
4. Charting. Charts, or grids, are created with each participant being represented along one row and each theme being represented by a column. Data from the indexed transcripts are lifted and placed into the framework to show how each participant illustrated the theme. A blank space indicates that the participant did not make comments representing that theme.
5. Mapping and interpretation. Richie and Spencer indicate that this is the most difficult part of the process to describe. It may be achieved in various ways, but is driven by the original research questions. The charts are used to examine and interpret the data. The framework makes it possible to identify how different themes emerged within each interview, associations between the themes and the participants to develop explanations of the phenomena under investigation.

Presentation of results

The results of this phase of the research are presented in two sections. The first section provides an analysis of the pre implementation interviews to explore the environments in which the MASH were to be established and the second section does the same for the post MASH implementation environment.

In the presentation of the results, participants are represented by a participant number with the initials MP to indicate they are a MASH professional.

Results I: Themes identified in the pre implementation interviews

Theme 1: Communication and information sharing

The importance of sharing information between agencies was widely acknowledged:

> "*Every single serious case review talks about information not being shared*" (MP8)

Interviewees reported various problems with accessing information from other agencies before MASH:

- difficulty finding the appropriate person, e.g. which health visitor to contact;
- colleagues' absence leading to delays in the response to information requests;
- necessity for parental consent before information could be released in certain cases.

Although that is not to say that information sharing pre MASH was always problematic, MASH is seen as an extension of previously good information sharing relationships in some boroughs (for example ensuring that health visitors would always get Merlins that involved children).

Professionals used the Seven Golden Rules for information sharing, the pan-London Information Sharing Agreement and protocols specific to their own agencies across the MASH. Lewisham had put an information agreement in place between all partners in the MASH, before it went live. Tri-borough and Merton also had information sharing agreements in place between key partners. These agreements give reassuring clarity:

> "*We have information sharing protocols in place so we all know where we stand on what can be shared under what circumstance*." (MP9)

Respondents said that they would only share information that was relevant to the particular referral and where they were unsure, would seek advice from managers.

However, the sharing of information is still an area which causes great anxiety for some. The recent case in Haringey (where parents successfully sued the local authority for sharing information without consent) has raised tensions in this area. GPs, professionals external to MASH, were frequently reported as being reluctant to share data and respond to requests for information. This was felt to be due to a lack of awareness of MASH and its role, and concerns about patient confidentiality, for example:

"*I had one the other day… and she said I'm not going to talk to you, you could be anyone, you could be a journalist*." (MP2)

Finally, in terms of information sharing, participants discussed the variety of databases used by different services and in different areas. The lack of access to databases holding information used by other professionals and services was a source of frustration for some.

Theme 2: Roles and Inter-professional working

Different cultures

A number of participants contrasted the way in which their profession undertook safeguarding to the way other agencies operated. For example one police officer (MP24) described himself and colleagues as being trained to make rapid decisions and compared this to social workers who take a more "softly softly" approach that takes longer and another police officer acknowledged cultural differences between the two professional groups (MP14). However, in turn the police were described by other agencies as not fully on board with MASH and having their "own ways of doing things" (MP10). It was also felt that before MASH some agencies tended to keep information "close to their chest" (MP5) perhaps leaving some professionals from other disciplines on the periphery of decision-making processes (MP10). For some professionals this has continued after the implementation of MASH (MP5) although there were indications that this would change.

However, generally it was felt that MASH was having a positive impact in bringing professionals together despite the different professional cultures they came from. Interviewees across all the boroughs felt that working closely together as part of a MASH had facilitated, or would facilitate a better understanding of the roles, duties and responsibilities of other colleagues in the team (MP17; MP11; MP3; MP4; MP16; MP6). This is beneficial in achieving the aims of MASH, fostering a greater understanding of the purposes for which information is requested, identifying appropriate person to go to if they wished to make a request for information themselves, and also the limits and boundaries of each other's roles:

"*MASH has given us all a greater insight into what we do*" (MP9)

"*That blinkered view is now opened*". (MP14)

For Lewisham, which had been live for the longest period of time, one respondent reported that prior to MASH, health and social services would only meet to discuss cases where there was a disagreement, but now working together has made decisions more accurate and timely. (MP8)

Relationships take time to build and this was felt to be still in process in at least one borough (MP6 and MP5) with one respondent alluding to negative experiences of team working in the past which had affected levels of trust and citing this as an area which still needed to be addressed (MP5).

Working together

Co-location was seen as promoting relationship building, mutual professional understanding (MP15) and the development of trust:

"Having professionals in one room, you establish a level of trust, understanding which may not have been quite as strong when you're all in separate areas" (MP5)

Having a secure meeting space at MASH also saved time travelling to meetings in different areas (MP4). However, occasionally those whose agencies that were not co-located felt somewhat isolated and cut off from their colleagues in MASH (MP10 and MP3).

There are challenges involved in this closer working, for example agencies having different thresholds with regard to risk (MP9); different language/terminology (MP8); different working styles and cultures (MP8; MP15 & MP14, both police). For example one police officer (MP15), used to the hierarchical, disciplined nature of the police force had to become accustomed to working in an open plan office with a different management style at MASH, but has found this an interesting experience rather than a difficulty.

Theme 3: Assessing risk

Apart from the RAG rating, professionals within MASH are using various risk assessment tools, some of which are generic to their profession e.g. MP3 - health triangle; MP17 - health assessment triangle; MP15 and MP4 (both police officers) - the Child Risk Assessment Matrix (CRAM) which is part of the Merlin. Respondents from Merton also spoke of *The Merton Child and Young Person Well Being Model* (MWBM), which has been in use for some time and informed the development of the RAG rating system. Other tools mentioned in other boroughs were:

- the Signs of Safety template (developed in Australia)
- the Brearley Risk Assessment tool
- OASys (Probation).

However, they were unlikely to rely on these tools alone and also used the benefit of their own experience (MP17; MP4; MP6). Conversations with others, either their own managers or other

colleagues, were crucial, particularly in cases where they were unsure or there was disagreement about the level of risk;

> "*It's definitely about being open and listening to other people's opinions and having those discussions. Communication is the most important thing."* (MP6)

Co-location was seen as important in resolving disagreements (MP10; MP7 (who was not co-located but saw the advantage)).

> "*When you talk it through you get clarity*" (MP8)

MASH had helped team members understand how other agencies assess risk, and the different thresholds that were used (MP9; MP15). Over time, this led to fewer disagreements and less need for the long discussions previous cases had required (MP14). In addition, MASH made decisions about risks every day; it is their core business so professionals became accustomed to this (MP8).Trust in other professionals' judgements also developed over time thus facilitating the assessment process (MP10).

Although some respondents reported that there had not been any disagreements within the MASH team so far (MP8; MP13; MP4; MP11), where there had been differences in other MASH, these had been recorded in the following ways:

- In emails and case notes (MP12, MP7).
- On databases and risk assessment forms (MP9)
- On Merlins (MP15)

One of the benefits of MASH that participants identified related to families at the low risk end of the RAG continuum. Such families were sign posted towards appropriate services at an earlier stage than previously, facilitating rapid intervention before a situation escalated and risks became more serious. At the other end of the continuum, MASH allowed more rapid identification of high risk cases and more informed decision-making than pre implementation (MP14).

<u>Summary comments</u>

Overall, while there were questions pre implementation about how MASH would work, in general people felt it would bring benefits to safeguarding. Some of these have a direct impact on improving decision-making, such as faster information sharing, but others may have a more indirect, although no less real impact, for example a better understanding of other professional roles and approaches to decision-making.

Results II: Themes identified in the post implementation interviews.

The Framework analysis of the post implementation interviews resulted in the identification of 19 minor themes clustered into six major themes (Table 6).

Theme 1: Information

1.i Communication

Professionals talked about the reasons for MASH being set up in the context of the need for improved information sharing. This had been highlighted in a number of recent serious case reviews, such as Baby P in Haringey, in which a failure of information sharing between professionals was identified as a major problem. Establishing MASH was seen as a commonsense way to get all the partner agencies to work together (MP4) and as a way of facilitating better communication between professionals within the MASH (MP18). High quality communication ensured that appropriate information was "gathered in line with risk to children" (MP5). Knowing other professionals in MASH facilitated such information gathering by making communication easier as

> "*You know people you are talking to and can have informal conversations which can get a lot more done*" (MP5).

In addition professionals had a clearer understanding of the 'jargon' used by different professional groups (MP11).

Table 6.2: Thematic structure of interviews with professionals post MASH implementation

	MAJOR THEMES					
SUB THEMES	1. Information	2. Risk and decision making	3. The professional in MASH	4. MASH internal relationships	5. MASH external relationships	6. Challenges
i.	Communication	Managing risk	Benefits of Multi agency working	Building the team	Impact of MASH on services to children	
ii.	Information-sharing	Decision making	Challenges of Multi agency working	Collegiality and working together	Role of MASH in wider safeguarding services	Getting the work done
iii.	Putting the picture together		The individual professional in MASH	Culture of MASH	Spreading the word about MASH	IT and technical issues
iv.	Information vacuum		Hard facts vs. intuition			

1.ii: Information sharing

High quality communication facilitated appropriate information sharing in MASH. As with any new team it had taken time for processes within the group to develop and this had been the case with information sharing. An education welfare officer noted that to begin with there was a problem because the perception was that social services had all the information and they did not tell navigators[4] anything because they were not aware they could share the information. This interviewee then went on to note that subsequently it was agreed that information could be shared with anyone in the MASH but indicated that she was a little offended that there had been any question about whether she could be trusted with information, given her professional experience. The central role of information sharing in child protection, and therefore in MASH, was noted by a police officer who indicated that he would want information to be shared in this way in order to protect his own children (MP4).

1.iii: Putting the picture together

Sharing information allowed professionals to put together the picture about the potential risk to a child. Referring to the case of Baby P, a policeman described how many agencies involved in the case were "doing little bits" but because the information was not shared between the agencies, "no one had the whole picture". The process of information sharing pulls together a picture of the child and their family as well as establishing patterns, for example in terms of numerous contacts with the police or multiple issues in relation to health or education (MP1).

1.iv: An information vacuum.

Participants gave various descriptions of the way in which they collected information that was then collated to enable decisions about risk to be made. However, professionals working in MASH often felt frustrated that they fed information into the assessment process, but did not then know what happened to referrals as they progressed through the MASH. One professional felt this was unhelpful "because working in a vacuum is very difficult" (MP5). Even where professionals were aware of the decision made, they were not aware of what happened to the case after it left MASH unless that case was later referred back to them (MP1).

<u>Theme 2: Risk and decision making</u>

2.i: Managing risk

The sharing of information was seen as fundamental in MASH as it allowed the risks to a child to be assessed and facilitated informed decision making. The MASH was described as a team who evaluated risk, collated information and made recommendations to boroughs about actions needed (MP1).

[4] MASH professionals who identify and communicate information relevant to the referral to decision-makers

Thereafter, it is the decision of the borough as to whether they take up the recommendation. Risk management was described as involving a process of balancing risks against resourcing constraints

> " *Risk management is what it says…it is managing the risk, you have to be aware …..we might send it off to them, they have to risk manage it because they've only got a certain amount of staff to review things and if something doesn't reach a threshold then it doesn't reach the threshold*". (MP4)

The difficulty of managing risk is heightened by the adverse impact of making the wrong decisions. As this participant further noted, services are never going to get everything right,

> "*At some stage a child will die and somebody will lay blame at social services or police…you are never going to eradicate child abuse…death of child."*

2.ii Decision making

Once the risks to a child had been assessed a decision could be made about what further actions were necessary. However, the inherent uncertainty in managing risk made decision-making difficult. Professionals had to gather information and say:

> "*Look, we think there is something here and perhaps arrange early intervention but somebody has to make the decision somewhere along the line*" (MP4).

Once a decision was made it was difficult to judge whether or not it is the right decision,

> "*Touch wood so far I think we have made mostly the right decisions, but then again hindsight…if years down the line someone says oh yes three years ago police should have done this*" (MP4).

<u>Theme 3: The professional in MASH</u>

The implementation of MASH brought professionals together in one multi agency team. This way of working brought both benefits and challenges. For the professionals within the team, MASH had implications for their own role and how they perceived themselves as professionals both individually and in relation to others.

3.i: Benefits of Multi agency team working

Working in a multi agency team led to greater understanding between professionals from different agencies. MASH professionals,

"*Know people, understand the way they work and get to understand what they are looking for as well and what they need to know*" (MP4).

In the MASH,

> "*Barriers have been broken down and there can be open discussion about safeguarding without egos being involved. This team has very nice culture of working, everyone gets along does their job and it's a very nice place to work."(*MP1).

This openness had benefits for safeguarding. There was a range of expertise and experience in MASH which could be shared and being able to discuss cases with the other agencies was invaluable in assessing risk and enabled professionals to make joint decisions (MP11, MP15, MP23).

3.ii: Challenges of multi agency working

Perhaps unsurprisingly there had been challenges for MASH professionals in terms of understanding the different working methods within each agency. A police officer described how he felt he had to tread carefully initially while he adjusted to these,

> "*In the police if you are told to do something, you pretty much do it whereas the social services they tend to question a lot more so there were little things …. that took a little while to become familiar with*" (M15).

One participant also described how different professional attitudes can be a problem although he did not seem unduly concerned about these stating "but that is just human nature" (PO: MP4).

3.iii: The individual professional in MASH

Adjusting to multi agency working also had implications for the individual as a professional in MASH. Some participants felt that they were being asked to take on roles which were not appropriate to their professional background. For example, a health professional who was asked to contact a referring school or to ring a social care client felt "maybe that crossed the boundary a little bit" (MP17). Other professionals felt that insufficient use of their professional skills was being made and that it was "de-skilling" to be used as an "information conduit" without the opportunity to use her professional perspective on how a case might be progressed (MP5). While it might be anticipated that an appropriate use of the particular skills of different professionals could support professional identify, one police officer highlighted the possibility of losing his. He emphasized the importance of remembering that he is a police officer and not, as he has seen happen to some police officers "becoming more like a social worker than a police officer" (MP4).

3.iv: Hard facts vs. intuition

Some experienced professionals also found a tension between their professional intuition and the requirement for hard facts in conducting a MASH enquiry. While the use of risk assessment tools to assist the collection of objective data is advocated in MASH, one professional stated "but to be quite honest these matrixes are run by people, you know…who don't have a bloody clue. Often it is about experience and gut feeling" (MP4). These thoughts were confirmed by a colleague who believed that hard facts were not enough, "sometimes you just know something is not right" (MP5).

<u>Theme 4: The MASH Team</u>

The MASH have become more than a group of different professionals, but teams with a developing culture and ethos of their own.

4.i Building the team

The MASH teams came together as a collection of diverse individuals and together had to build a new team and new way of working. At the beginning there was a

> "*Sounding out process of the different cultures within the different organisations, but that is long gone now."* (MP15).

Working together builds trust between professionals,

> "*It's like me and you … I haven't met you but if we sat down together and worked together there would be more trust*"(MP4).

Trust can provide an environment in which there is a

> "Willingness to take on good advice and adapt and to change" (MP1).

However, there was also recognition that building the team needs support and at least in some teams this support is being provided with training and morning coffee breaks when each profession can talk through what they do and what they can offer to MASH (MP4).

4.ii: Collegiality and working together

Building a strong team provided an environment in which people could build relationships and work together effectively. MASH had facilitated inter professional working. A fundamental aspect is co-location and being able to just walk across the office to discuss a case rather than picking up the phone to someone you don't know- "personal relationships get built"(MP15). The familiarity with one another made it easier to "chip in, exchange ideas, give the Education perspective" (MP5). The strength of the teams that have developed was reflected in comments such as,

"*I've been really impressed with everyone in terms of working together*" (MP1)

and in the support that individuals report that they receive from their colleagues (MP17).

4.iii: Culture of MASH

Given the diverse range of professionals involved in MASH and the strength of the teams it is unsurprising that some participants reported MASH as developing its own culture.

> "*This team has a very nice culture of working, everyone gets along, does their job and it's a very nice place to work…professionals working in MASH have been able to meld it together into something good*" (MP1).

Similarly a police officer had talked about this with a senior social worker and she thought social workers had become a bit more like the police and the police a bit more like the social workers. He agreed they have "found a middle ground".

<u>Theme 5: MASH and external relationships.</u>

Not only do the individual professionals working in MASH have relationships with one another, but the MASH teams also have relationships with external services.

5.i: Impact of MASH on services to children

One of the particularly beneficial impacts of the MASH on services to children was in the identification of children who would not have come to notice previously, but were now receiving a service (MP5). Indeed, identification and intervention at an early stage could be highly beneficial. Identifying the family who requires support and signposting them on to early help was useful in terms of prevention so that the situation does not escalate in the future (MP1). Moreover, appropriate targeting of resources was beneficial for higher risk children and families as greater resource could be focussed on clients with greater needs, while clients with lower needs could be referred to mainstream universal services (MP18).

5.ii: Spreading the word about MASH

A key issue for the MASH has been raising awareness amongst external agencies about the role of MASH and the referral process. A lot of work (MP1) and proactive outreach had been carried out with police officers on the street, GPs in practices etc to explain risk thresholds. Local authority training packages had been developed (MP15) and the benefits of this were being seen as awareness of MASH grew and was reflected in the receipt of more appropriate referrals to MASH (MP15).

Theme 6: Challenges

As with any new initiative the MASH were meeting challenges. Some of these were intrinsic to the setting up of a new team, but others might be more deeply rooted and require active attention and resources to resolve.

6.i : A new start

The MASH was a new way of working and thus it was hardly surprising that there have been challenges since the MASH went live in terms, of getting things right, ensuring appropriate training for staff and communication with the boroughs (MP1). New ways of working bring change and this too can be challenging (MP5).

6.ii: Getting the work done

Getting the work done was challenging both in terms of the workload and in terms of staff shortages. Several participants noted that there had been an increase in referrals and services, including MASH, had to meet this increase with limited staff. One participant observed that the senior social workers were so busy that they would be working on cases late at night and stress levels had increased (MP17). This was having an impact on the MASH service as decisions were being made without all the information "which isn't helpful." (MP1). In contrast, one participant observed that good resourcing in their borough meant that they could turn around most of the reports well within the time scales, so risks and dangers were highlighted at the earliest opportunity (MP15).

6.iii: IT and technical issues

The multitude of IT systems used was a major challenge highlighted by many participants, particularly where a professional did not have access to a database that they needed or had to travel to a different site to access information from a database that was unavailable in the MASH.

Summary

Overall participants were positive about MASH working and the impact on services to children. The main areas of concern arose from heavy workloads and poor resourcing. However, it was noticeable that some professionals, notably those who were not from a social care or police background felt that their skills were not being appropriately or fully used by the MASH with participants being asked to take on activities that were not part of their professional role or that their professional expertise was not being fully used. Overall, while police and social care professionals were generally positive about their role in

MASH, some health and education professionals, were more negative about their role in MASH and there was a sense that these professionals felt on the periphery of the MASH rather than at its heart.

CHAPTER 7

PHASE 3: MASH CASE STUDIES

Aim

In the post implementation interviews participants were asked to describe a case where they felt the MASH system had worked particularly well. In this chapter, two representative case studies are presented with the aim of identifying how MASH working could improve services to children and young people at higher and lower levels of risk who were referred to MASH.

The stories

A high risk case

A very young child came to the notice of the police. The incident was reasonably serious and the team soon realised after that they did not have the full picture. They liaised with social services who carried out a full MASH investigation. When all the agencies had reported back, it was clear that no one agency had enough information to justify intervention. However, by collating all the different pieces of information, a fuller picture emerged. It then became obvious that the child was at the centre of quite a "nasty paedophile ring where over a period of years 16 children had been taken into care, permanently removed." Without the MASH enquiry it would not have been possible to make the links between the families. "This is an example of where a child was removed from a potentially very, very dangerous situation" (MP15).

A lower risk case

A neighbour reported concerns that a child was possibly being neglected or abused. There was little other information and the case went to MASH as amber. Checks did not provide any substantiation for the allegations. Based on their research, the police were of the opinion that it was a malicious allegation on the part of the neighbour. In this case, the referral to MASH reduced the work for the borough and the risk was downgraded. Anonymous referrals were considered an area where MASH really excelled as the MASH could gather information quickly to substantiate concerns or to confirm the concern is low risk and could be dealt with via universal or non statutory agencies.

Discussion

These two examples illustrate that MASH has been able to improve the response to cases at both the higher and lower levels of risk in a way that would not have been possible prior to MASH. In the higher risk case multi agency working allows the full picture of the child's situation to be identified and rapid action taken to remove a child from a very dangerous situation. In the lower risk case the absence of serious risk of harm to the child is also quickly identified. The de-escalation of the case had benefits in terms of reducing unnecessary use of scarce resources, but may also have reduced the possibility of involving the family in an unnecessary investigation.

Summary

The case studies indicate that MASH allows risks to be rapidly and appropriately assessed facilitating effective decision making and appropriate use of resources.

CHAPTER 8

PHASE 4: QUALITATIVE INTERVIEWS WITH REFERRERS TO MASH

Aim

In order to explore the change process in-depth qualitative interviews were conducted with key referrers to operational MASH. These interviews were used to discuss findings from the professional interviews, to understand fully how the programme is operating and how MASH is supporting the work of the referrers.

Methods

Data collection

Originally it was planned to carry out 20 interviews with four referrers from each of the five boroughs. With the delays in implementation of the Tower Hamlets MASH, the target fell to 16 interviews. However recruitment for this part of the evaluation proved to be particularly challenging as outlined in Chapter 3. Within the timescale available, we were able to recruit and interview five potential referrers to MASH services in Brent, Lewisham and Tri-borough. The professional roles represented were a general practitioner, a voluntary sector broker, a social worker and two early intervention workers.

Telephone interviews were conducted with the referrers using a semi-structured interview schedule. The schedule was informed by that used in Phase 3, but was developed to address the aims of this phase (Appendix 5).

Data analysis

The telephone interviews were digitally recorded and notes were made by the interviewer during the course of the interview. Subsequently, the content of the interviews was written up in note form. From these notes emergent themes were identified through a process of immersion in the text of the interviews.

Theme 1: Knowledge and understanding of MASH

MASH was likened to the triage system within hospital Accident and Emergency departments: a case is assessed for priority and then assigned appropriate services. MASH was also seen as a virtual multi

agency team, whereby various databases are interrogated in order to ascertain the level of risk in a case. MASH operated to add information and provide a more complete view, in situations where various concerns were raised but there was no clear picture of the circumstances. Understanding of roles had improved in both directions, that is, MASH staff and MASH referrers had a clearer understanding of what was required from each other. Both parties had found a middle ground where they could work together.

Theme 2: Information sharing

All the MASH referrers interviewed wanted more information on the outcomes of cases for which they supplied information. Lewisham used to supply information on outcomes but no longer does so. There were some frustrations around information sharing. One referrer, who was used to dealing with confidential information, was concerned that she could not access the MASH systems:

> "*If a family is being MASHed then why couldn't I see that information and see what's relevant. It kind of feels like a bit of a frustration to me. Instead you have to wait for people to kind of let you know what the relevant information is*."

One referrer reported that consent for reporting health related information was an issue. Westminster was still in the process of putting together an information-sharing agreement and firewall for protecting confidential information. However, one benefit reported was the ability to talk directly to a member of the MASH team and there was now more information available from social services as to the nature of their concerns. Information sharing in Westminster was seen as 'massively better'.

MASH was also reported to have improved information sharing in Lewisham. Previously, concerns would have been reported to the duty manager, which still happened, but now the duty manager had access to information from the other agencies. The co-location of services was said to have facilitated information sharing in the borough. The referrers of Lewisham MASH did not work with confidential information and operated with parental consent. However, if parents refused to engage, their team now had access to information via MASH. The referrers' team had to prioritise MASH requests over other aspects of their work. There was mention of a particular case of communication breakdown, where the referrer had requested information to feed into a 'Team Around the Child' (TAC), but this was turned down, possibly because of concerns about a breach of confidentiality.

Theme 3: Impact of MASH on services for children

Information was now gathered at an earlier stage, leading to better decisions about the level of risk. For GPs, MASH had given them a better understanding of the system, they now had a clearer understanding of what would happen after a referral was made. MASH had made the system more holistic.

"*Well it's got to be a better service. It means that families that are being MASHed …will get picked up where they normally may not have got picked up previously because if this information wasn't there before, it would probably have just been NFA'd*" (no further action)

The greater understanding of roles and the enhanced transparency of MASH was thought to be beneficial in Lewisham, as professionals now had more confidence and faith in each other.

Theme 4: Managing risk and referrals

All referrers had to assess risk to some degree as part of their work, adopting various approaches to this, for example unpicking factors in a face-to-face consultation or via a telephone conversation. The referrer who worked as a GP did not use a particular tool, but assessed factors such as domestic violence, substance abuse, mental health issues when measuring risk. However, this GP was not aware of the protocols used by the MASH team to assess risk. Amongst other referrers, there was awareness of the RAG rating system, although their teams did not use it, using instead the CAF or TAC where appropriate.

It was seen as beneficial that MASH now provided a single point of access for referrals. Referrals could also now be emailed, which was efficient and worked well. Even in cases where MASH did not take on the referral, it was seen as positive that the case was now '*on the radar'.* In Lewisham, it was reported that the referrers received daily reports on CAF forms that had gone through referral and assessment and had been evaluated as 'no further action'. The referrer for these cases would then be contacted to inform them that the case had not met the threshold and support could be provided through the 'Team Around the Child'. One referrer gave the example of a family who had moved borough and the referrer was then able to refer to the MASH in the new borough and a handover took place.

Theme 5: Challenges

Referrers reported a variety of challenges and difficulties relating to MASH, as follows:

- IT systems still problematic and need more funding;
- possibility of litigation by parents;
- non communication of outcomes;
- time consuming process of completing forms to request police checks;
- consistency from duty managers towards MASH referrals;

Summary

Although there were concerns about working with the MASH, particularly around information sharing, referrers were also aware of improvements in safeguarding services. Services to children were seen to have improved with a better picture of children and their needs being provided. Additionally, referrers believed that inter-professional working had improved with better understanding of one another's respective professional roles and the chance to communicate directly with a member of the MASH team.

CHAPTER 9

DISCUSSION AND SUMMARY OF PROCESSES OF CHANGE IDENTIFIED.

This analysis has provided a comprehensive overview of safeguarding services before and after the implementation of the London MASH. In this chapter, the key findings of the report will be summarised and changes resulting from the implementation of MASH are described and discussed.

As described in Chapter 4, each of the MASH has been implemented in slightly different ways reflecting local needs and realities. Despite these differences, it is clear that the MASH are sharing many similar experiences in terms of improvements in services to children and improved inter-professional working. In terms of improved services to children, Chapter 5 suggests a number of interesting findings. First, the turnaround time for assessing cases had decreased in the combined data from Brent and Westminster. Although this hides a slight increase in the turnaround time in the data from Brent, in both boroughs turnaround time was similarly low post implementation. Where children are at risk of harm, low turnaround times has to be a key achievement as the quicker decisions can be made and appropriate actions taken, the less likely it is that a child will come to harm.

The data from Westminster also allowed us to identify that turnaround time had decreased regardless of the initial RAG rating of a child. The assessment of children who have been identified as being at high risk was conducted quickly prior to the implementation of MASH and while there has been a decrease in turnaround time for these referrals, more striking has been the reduction in turnaround time for green RAGed cases. In these cases the mean turnaround time halved from around two and a half days to around two and a quarter days. Quicker assessment of these cases will allow faster but appropriate intervention at an early stage. In addition professionals highlighted that more borderline cases were getting appropriate input following a MASH referral. These findings suggest that MASH may help prevent the escalation of cases which, over a period of time, may serve to reduce some of the burden on

LA children's social care. In considering turnaround times, it is also noteworthy that the Integrated Pathways and Support Team in Tower Hamlets, which provided an approach to safeguarding similar to MASH, had similar turnaround times for referrals to the implemented MASH, suggesting the benefits of multi agency working go beyond a pure MASH model.

Although the audit data showed little difference in who referred to MASH and the outcomes of MASH referrals from the pre to post implementation phases, there was a difference in what children were being referred for, with more children being referred for suspected abuse or neglect post MASH implementation. We are not able to determine whether this was as a result of a better understanding of the role of MASH by referrers or whether it is a consequence of high profile child abuse cases in the media over the summer. However, several MASH professionals interviewed commented that more appropriate referrals were being made to the MASH as time progressed.

The overall similarity between the pre and post implementation periods in who made referrals to MASH and the outcomes of referrals fits with the suggestions from the Phase 3 interviews with MASH professionals that there has been little change in the mechanics of the way that risk is assessed. What has changed is the context in which these assessments are made. The Phase 3 analysis of the professional interviews suggests that multi agency teams are generally working well in MASH, and a supportive and facilitative MASH culture is developing. However, there is also some suggestion that professionals outside of social care and the police, are having a less positive experience. Some feel that they are on the periphery of MASH and that their professional skills are not being adequately used. This is an area that will probably need some proactive work in terms of team building, but the full use of all the skills and experience available in a MASH can only be beneficial to safeguarding services.

A key aim of the MASH was to bring about improvements in information and intelligence gathering. Certainly participants described a wide range of sources for intelligence. Central to these are the various databases that different members of the MASH have available providing a huge range of potential sources of information. However, while these databases are a key tool they are also a hindrance and a source of frustration as not all professionals have access to all the databases and, therefore, the information they need.

Concerns about information sharing and consent have been raised in a number of stages of the review. Over the period of the evaluation, the MASH have been agreeing and adopting information sharing protocols. Merton and Lewisham use the Pan London Information Sharing Protocol and Tower Hamlets and Tri-borough use the London Information Sharing Agreement. Concerns about information sharing and obtaining consent were heightened over the summer of 2013 by a judicial review of the handling of a referral to the Haringey MASH (Judicial Review: R (AB and CD) v Haringey London Borough Council

(2013)). However, despite this background, participants suggest that information is being shared effectively in MASH to the benefit of children.

The interviews with the MASH professionals and MASH referrers suggest some interesting areas of overlap in the experience of these groups. Positively, both MASH professionals and referrers felt that information sharing had improved since MASH was implemented and also that there was better understanding between professionals from different agencies. Just as positive relationships between MASH professionals were seen as improving the service to children, so positive relationships between MASH professionals and MASH referrers may also be expected to improve safeguarding for children at risk. However, there were also similarities in the negative experiences of MASH. Referrers wanted more information about the outcomes of their referrals and also expressed concern about issues around consent and information technology. Resolving these issues for MASH professionals needs to take account also of the needs of MASH referrers.

Summary

There has been a significant process of change in the work of MASH professionals and indeed referrers. As professionals note, change can be challenging, but even so, considerable progress has been made in implementing the MASH effectively. However, the MASH are still in the early stages of implementation, particularly in Brent, Merton, Tri-borough and Tower Hamlets. If the challenges identified within the current process of change are not addressed then this could have an impact on the continuing development and future effectiveness of the MASH.

CHAPTER 10

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

In conclusion it is clear that the MASH in the boroughs reviewed have come a very long way in a relatively short time. The introduction of a new working model has involved a period of substantial change both in the process of referrals to LA children's social care, but perhaps more importantly, in the way professionals from different agencies relate to each other and share information. There were indications that a MASH culture is emerging which may facilitate working together and information sharing.

There are also promising signs within the review that MASH working can lead to improvements in safeguarding outcomes. Speedy access to information from a range of different agencies means that social care professionals are now beginning to get a fuller picture of the child in his or her situation. This makes it possible to make more informed decisions that are appropriate to the level of risk. The audit data also revealed an improvement in the turnaround time for referrals.

However, there are still a number of challenges which must be met if MASH is to reach its full potential and improve safeguarding services for children and young people.

The difficulties encountered during the review in the collection of data from the five boroughs arose partly from the fact that information is held in many different databases. Research participants also thought the multitude of IT systems used by the MASH was a major problem, particularly where a professional did not have access to a relevant database or had to travel to a different site to access information from a database that was unavailable in their own MASH.

Another key issue for the MASH has been raising awareness amongst external agencies, for example, police officers on the street, GPs and school staff, about the role of MASH and the referral process. A lot of outreach work has been done to address this and slowly the benefits are being seen in more appropriate enquiries to MASH. However, it would seem from the qualitative interviews that more work still needs to be done in this area.

The reduction in referral time may come at a price. Some professionals from agencies feeding in information to MASH referred to the very limited time they are given to search their databases and report back. Heavy workloads and staff shortages add to this pressure.

Professionals who refer into the MASH complained about the paucity of information they received back from MASH about the outcome of cases.

Finally, it was noticeable that some professionals, notably those who were not from a social care or police background, felt that their skills were not being appropriately or fully used by the MASH and there was a sense that they felt on the periphery of the MASH rather than at its heart.

Recommendations

11. The review found benefits of implementing MASH, particularly in a reduction in the turnaround times from referral to decision. It is not possible to identify from the evidence presented in this review which elements of MASH working contribute to this reduction. Further research should focus on identifying these elements so that they can be incorporated into MASH implemented in the future.
12. A reduction in turnaround times was seen regardless of the initial RAG rating. This is particularly noteworthy for green and amber RAG-rated referrals. While it is too early to say whether rapid response to these cases prevents deterioration in the situation of these children and families, it would be valuable to identify whether this is the case in future research.
13. There was evidence that some non- social care and police professionals felt marginalised and that their expertise was not being fully used within MASH. A number of actions should be taken to improve this situation including:
    a. team building activities to increase the integration of all professionals in to the team;
    b. include all professional groups in triage and decision making which would likely benefit not only the individual professionals but also the effective working of MASH
14. The evidence of a sense of marginalisation and inadequate utilisation of professional skills raises questions as to the job satisfaction of MASH professionals. Future research evaluating job satisfaction in MASH and the impact of job satisfaction on outcomes such as turnaround times and referrals might provide evidence as to the benefits in ensuring that all professionals are fully integrated into the MASH system of working.
15. Both MASH professionals and MASH would value more information about the outcomes referrals. This would have benefits giving MASH professionals a sense of how the information they provide contributes to the decisions made and increasing understanding of how MASH works among MASH referrers.
16. There evidence of incomplete knowledge of MASH among professionals outside the MASH team. It is recommended that:
    a. further work to raise awareness of the role of MASH and address concerns about the issue of consent among professionals outside the MASH.

b. that strategic managers be included in some training events for MASH professionals to ensure they have a full picture of how MASH works and what MASH working is able to offer their discipline.

17. Boroughs varied considerably in how safeguarding services were organised prior to the implementation of MASH and how much preparation there was for professionals about MASH working. Such preparation is likely to be particularly important where, as in MASH professionals are coming together from different professional backgrounds with little prior history of working together. Although there was encouraging evidence of an inclusive MASH culture developing MASH team building activities, particularly those allowing professionals from the different professional backgrounds to share their expertise and knowledge with other team members, would facilitate this process
18. A lack of resources, particularly in terms of staffing and IT services, were seen as impairing the ability of MASH professionals to work effectively. At a time of severe economic constraint, it would be valuable to assess any associations between good resourcing of MASH and reductions in longer term use of expensive specialist services.
19. The importance of evaluating MASH in London was noted by staff in the boroughs and considerable support was given to the research team by managers and staff. Future studies should engage MASH staff in the development of research ideas to ensure that they address questions of concern and are feasible in terms of the timescale and resources allocated. Staff members might then feel additional ownership over the research and an even greater preparedness to contribute to it.
20. A working group should be set up to explore the feasibility of developing a pan London MASH dataset to facilitate on-going evaluation of the impact of MASH.

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APPENDICES

Appendix 1. Draft data extraction proforma.

P number	Who referred?	Reasons for referral?	RAG rating	List MASH professions involved	MASH interactions with		MASH outcome	Turnaround time	Previous MASH referral and outcome
					Practitioners	Family members			

Appendix 2. information leaflet and consent form for practitioners

Dear Staff Member,

Re: Impact analysis of the Multiagency Safeguarding Hubs (MASH) in London

We are currently conducting an evaluation of 5 Multiagency Support Hub (MASH) in London and we would like to invite you to participate in this evaluation.

We will be conducting interviews with a range of professionals such as yourself, on their involvement and experience of using MASH, and how it has impacted on their practice. These interviews will last between 30 minutes to an hour and will be audio recorded with your consent.

Any information you share with us will be anonymised and any identifying information will be removed. However, we would like to highlight that after these precautionary measures, your feedback may still be identifiable to others. As a result, you will be given the chance to comment and make amendments to any information you have given us that we have included in the final report. Your involvement is voluntary and you are free to withdraw from the study at any time without any repercussions.

If you have any reservations or queries, please do not hesitate to ask the researcher.

We look forward to your participation.

Consent Form for Participation in the MASH Evaluation

To be completed by the participant		
1.	I have read the information sheet about this study	YES
2.	I have had an opportunity to ask questions and discuss this study	YES
3.	I have received satisfactory answers to all my questions	YES
4.	I have received enough information about this study	YES
5.	I understand that I am free to withdraw from this study: • At any time • Without giving a reason for withdrawing • Without affecting my job or employment status	YES
6.	I agree to take part in this study	YES
7.	I agree for this interview/focus group to be audio recorded	YES
Signed (participant)		Date
Name in block letters		
Signature of investigator		Date

Appendix 3: MASH professional pre implementation interview schedule

Interview schedule for Pan London MASH evaluation (Pre-Implementation)

LOCATION AND EMPLOYMENT DETAILS

Location .....

Directorate/Borough .....

Organisation .....

Section/Department.....

Which of the following applies to you?

a) Strategic/Senior Manager

b) Operational Mgr (Social work/police/Health services etc)

c) Operational Staff (Social work/police/Health services etc)

Which of the following applies to you?

a) Police Officer b) Social Worker c) Health Visitor

d) Probation Officer e) YOT worker f) Adult Health Worker

g) EWO h) Other (please specify) .....

What is your job title? .....

What is your grade (where applicable) .....

Are you: a) Full-time b) Part-time c) Job-share

(i) What is a MASH?

- What do you think are the main aims of MASH?
- Can you describe what a MASH is/does?
- Why do you think it is being set up in your Borough?
- Do you think the MASH will affect services to children and families at risk? If so, how?
- What do you consider to be the current challenges and strengths in safeguarding children and young people in the Borough where you work?
    - Interprofessional working/communication?
    - Information sharing?
- How you think the introduction of the MASH will impact on this?

(ii) Assessing risk and decision making - current practice (Pre MASH)

- In your practice, how do you assess risk to children and young people?
    - How do you determine the level of risk?
    - Agency protocols/risk assessment tools?
- What do you think are the key factors when making decisions about risk?
    - Such as the different levels of risk (threshold)
- How do you know that the right decision has been made when assessing risk?
- What happens when there is not agreement with other professional/agencies about a decision?
    - Are these differences of opinions recorded?

(iii) Roles and interprofessional working

- What is your role when assessing risk to children and young people?
- What do you consider to be the current challenges and strengths when working with other professionals in assessing risk to children and young people?
    - What are the strengths and difficulties with this?
- How do you think MASH will help professionals work together to safeguard children and young people?
- What do you think are the barriers and facilitators to professionals working together in a MASH?
    - Chance to discuss problematic referrals?
    - Culture?

(iv) Information sharing

- How do you currently share information with other professionals/agencies who are involved in safeguarding children and young people?
    - What are the strengths and difficulties with this?
- How do make decisions about what information to share/not to share with other professionals/agencies?
    - For example, is there an agency information sharing protocol?
- How do you think the information sharing with other professionals will change following MASH?
    - Identify potential strengths and difficulties with this.
- How is information shared with other professionals/agencies to identify families where children and young people could be at risk?
    - Intelligence gathering about families.

Thank for your taking the time to participate in this interview.

Appendix 4: MASH Professional Post Implementation Interview Schedule

Interview schedule for Pan London MASH evaluation (Post-Implementation)

LOCATION AND EMPLOYMENT DETAILS

Location .....

Directorate/Borough .....

Organisation .....

Section/Department.....

Which of the following applies to you?

a) Strategic/Senior Manager

b) Operational Mgr (Social work/police/Health services etc)

c) Operational Staff (Social work/police/Health services etc)

Which of the following applies to you?

b) Police Officer b) Social Worker c) Health Visitor

d) Probation Officer e) YOT worker f) Adult Health Worker

g) EWO h) Other (please specify) .....

What is your job title? .....

What is your grade (where applicable) .....

Are you: a) Full-time b) Part-time c) Job-share

(i) What is a MASH?

- What do you consider are the main aims of MASH?
- Can you describe what the MASH is/does?
- What were the reasons for it being set up?
- Has MASH had an effect on services to children and families at risk?
    - If so, how?
- What do you consider to be the current challenges / strengths in safeguarding children and young people in the Borough where you work?
    - Inter-professional working/communication?
    - Information sharing?
- How has the introduction of the MASH affected these?

(ii) Assessing risk and decision making in MASH

- In your practice in MASH, how do you assess risk to children and young people?
    - How do you determine the level of risk?
    - Agency protocols/risk assessment tools?
- What do you think are the key factors when making decisions about risk?
    - Such as the different levels of risk (threshold)
- How do you know that the right decision has been made when assessing risk?
- What happens when there is not agreement with other professional/agencies about a decision?
    - Are these differences of opinions recorded?
- Can you describe a MASH enquiry where you felt the system worked really well?
    - Did MASH work better in this case than the previous system would have done?
    - Why (*this answer*)?
- How do you gather intelligence about children who may be at risk?
    - Where does the information come from.
    - How do you use the information to assess whether the child is at risk

(iii) Roles and inter-professional working

- What is your role when assessing risk to children and young people?
- What do you consider to be the current challenges and strengths when working with other professionals in assessing risk to children and young people?

    - What are the strengths and difficulties with this?
- How has MASH helped professionals work together to safeguard children and young people?
- What do you think are the barriers to professionals working together in a MASH?
- What are the facilitators to professionals working together in MASH?
    - Chance to discuss problematic referrals?
    - Culture?

(iv) Information sharing

- In MASH, how do you share information with other professionals/agencies who are involved in safeguarding children and young people?
    - What are the strengths and difficulties with this?
- How do you make decisions about what information to share/not to share with other professionals/agencies?
    - Is there an information sharing protocol?
- How has information sharing with other professionals changed since the implementation of MASH?
    - Identify potential strengths and difficulties with this.
- How is information shared with other professionals/agencies to identify families where children and young people could be at risk?
- How does MASH help make children visible?
    - How does MASH put the pieces of the picture together about a child or family?

Thank for your taking the time to participate in this interview.

Appendix 5: MASH Referrer Interview Schedule

Interview schedule for Pan London MASH evaluation (MASH Referrers)

LOCATION AND EMPLOYMENT DETAILS

Location .....

Directorate/Borough .....

Organisation .....

Section/Department.....

Which of the following applies to you?

a) Strategic/Senior Manager

b) Operational Mgr (Social work/police/Health services etc)

c) Operational Staff (Social work/police/Health services etc)

Which agency are you employed by?:

What is your job title? .....

What is your grade (where applicable) .....

Are you: a) Full-time b) Part-time c) Job-share

(i) What is a MASH?

- Can you describe what a MASH is/does? How do you know this?
    - What do you think are the main aims of MASH?
- Why do you think MASH was set up in your Borough? How does this relate to you?
- How does your role bring you into contact with the MASH in this Borough?
- How many times have you used the MASH? How often do you use it?
- What changes (if any) have there been to your work following the introduction of MASH? Please could you describe these changes?

(ii) Assessing risk and decision making – (recipients)

- In your practice, how do you assess risk to children and young people?
    a. How do you determine the level of risk?
    b. Agency protocols/risk assessment tools?
- What do you think are the key factors when making decisions about risk?
    a. Such as the different levels of risk (threshold)
- How do you think your agencies assessment of risk compares/differs with MASH?
- What changes (if any) do you think the introduction of MASH has had on how you assess risk? Please could you describe these changes?
- Who in the MASH makes the decision about the level of risk?

(iii) Making a referral

- How did you make safeguarding referrals prior to the introduction of MASH? What were the benefits/difficulties when doing this?
- Please describe if this is different following the introduction of MASH? What are the benefits/difficulties when doing this?
- Has there been any change in how you make a referral following the introduction of MASH?
- How do you know that the right decision has been made by MASH about a referral?
- What happens if there is not agreement with other professional/agencies about the outcome of a referral?
    a. Are these differences of opinions recorded?

(iv) Interprofessional working

- What challenges and benefits have you experienced when working with other professionals to safeguard children and young people?
- Has the introduction of MASH made any changes in the way you work with other professionals when safeguarding children. Please could you describe these changes?
- Has the introduction of MASH changed the way you work with families and young people?

(v) Information sharing

- Prior to MASH how did you share information with other professionals/agencies who were involved in safeguarding children and young people?
    a. What were the strengths and difficulties with this?
- Has the way you share information with other professionals/agencies changed following the introduction of MASH? Please describe any benefits/difficulties with this.
- How do you make decisions about what information to share/not to share with other professionals/agencies such as MASH?
- How do you feel about the way MASH records and responds to the information you have shared. Please describe any benefits/difficulties with this.

Finally,

- What are the challenges (if any) following the introduction of the MASH? Do these impact on children, young people and their families and why?
- What are strengths (if any) following the introduction of the MASH? Do these impact on children, young people and their families and why?

Thank for your taking the time to participate in this interview.