

Do multi-agency safeguarding hubs improve child protection outcomes? Evidence from national administrative data

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Abstract

Multi-Agency Safeguarding Hubs (MASHs) have been implemented across England to improve information sharing, risk identification and decision-making at referral to children's social care. Despite their rapid expansion, there has been limited empirical assessment of whether MASHs improve child protection outcomes or reduce serious harm. This observational study addresses this by providing a national, outcome-focused analysis of MASH implementation. Freedom of Information requests to all English local authorities identified when MASHs were established in 130 of them. This was linked to national administrative data covering the period 2010–2024 on Section 47 child protection investigations, child protection plans and serious incident notifications. Rates of investigations and plans are examined in the year following MASH implementation and over the longer term, with comparisons made to local authorities without a MASH. The findings show that MASH implementation is associated with sharper increases in section 47 investigations, both immediately and cumulatively over time. However, these increases are not accompanied by proportional rises in child protection plans, nor by reductions in serious incident notifications. The study questions the assumption that centralised multi-agency 'front door'

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models improve safeguarding accuracy or effectiveness and considers the implications for social work practice, workforce capacity and policy directions.

Keywords: child protection investigations; child protection plans; multi-agency safeguarding hubs (MASHs); safeguarding policy; section 47.

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Introduction

Multi-agency safeguarding hubs (MASHs) were developed and established to ‘...improve the safeguarding response for children and vulnerable adults through better information sharing and high-quality and timely safeguarding responses’ (Home Office 2014a: 4). They are non-statutory, multi-agency ‘front door’ arrangements within English children’s social care. They typically bring together professionals from social work, police, health and education to share information and were founded on the three principles of information sharing, joint decision-making between agencies and coordinated multi-agency intervention (Home Office 2014a; McManus and Boulton 2020). MASHs’ core functions include acting as a single point of entry for safeguarding referrals and triaging these referrals. They also aim to support clear and coordinated risk identification and management (Ball *et al.*, 2024; Home Office 2014a).

There is no statutory definition of what they are or statutory guidance on how to set them up, and there have therefore unsurprisingly been a range of approaches adopted across the UK (McManus and Boulton 2020; Shorrock *et al.*, 2019).

There is a notable lack of research into the effectiveness of MASHs. Despite their prominence and wide roll-out across England, little evidence exists to show whether they improve safeguarding decision-making, enhance the identification and management of risks, or ultimately improve safety for children and families (McManus and Boulton 2020; Shorrock *et al.*, 2019). As Ball *et al.* (2024) observe:

There is an abundance of literature over the past three decades detailing the benefits and challenges of multi-agency safeguarding, yet far less evidence to understand how this is successfully translated into practice and how we are assured that the multi-agency safeguarding arrangements are effective. (p. 104)

Evaluations that are often cited as evidence of MASH effectiveness provide limited answers to these questions. The Home Office (2014a) report, frequently cited as evidence of effectiveness, did not examine outcomes. It reported only the views of safeguarding professionals, focusing on perceived improvements in inter-agency communication, risk identification and referral processes. More

recently, the national evaluation commissioned by Foundations ([Méndez Pineda et al., 2025](#)) examined MASH implementation and operation in England. This study again relies heavily on the voices of staff to assess perceived effectiveness and focuses on process improvements such as timeliness of responses and strengthened inter-agency communication. While it provides valuable detail on implementation, it does not engage with outcome trends such as the substantial increase in section 47 investigations in recent years, most of which do not lead to child protection plans.

Taken together, these evaluations highlight a recurring gap in the evidence base: MASHs are largely assessed through practitioner perspectives and process measures, rather than through systematic outcome data. The study reported here starts to address this gap by using national datasets to analyse patterns of section 47 investigations, child protection plans and serious incident notifications in local authorities with and without MASHs. Rather than conceptualising change in terms of ‘thresholds’, this study focuses on patterns of decision-making, examining how organisational arrangements shape decisions to initiate investigation and intervention.

This study is informed by theories of risk amplification in child protection systems ([Parton 2014](#)). This perspective suggests that increased information sharing and multi-agency decision-making may increase the likelihood of decisions to investigate rather than improve the targeting of interventions. It also draws on critiques of risk-oriented systems that highlight how organisational arrangements intensify surveillance while failing to address underlying social harms such as poverty and inequality ([Parton 2019](#)).

The following section sets out the broader empirical and policy context for these developments.

Background and context

From 2005 a year-on-year trend of increases in child protection enquiries under section 47 of the [Children Act 1989](#) (hereafter s47 investigations) commenced. There was a 30% increase in the five years between 2005 and 2010, accelerating to a further 54% increase between 2010 and 2015. This latter period saw the increasing establishment of Multi-Agency Safeguarding Hubs (MASH) set up, according to the government’s press release ([Home Office 2014b](#)), to “mitigate the risk of anyone slipping through the safeguarding net”. Whilst MASHs are now commonplace, national statistics ([Table 1](#)) show that there were 2.5 times as many investigations in 2024 as in 2010. Over the same period, the number of referrals to children’s services changed little. Thus, the large increase in investigations was not due to increasing numbers of referrals being made. Where they existed, MASHs were central to decision-making about whether to initiate an investigation during this period of rapid increase.

Table 1. Trends in social work activity.

Activity	2009–10	2023–24	Change 2010 to 2024
Referrals	603,700	621,900	3.0%
Episodes of need starting in year	377,600	394,660	4.5%
Child protection investigations	89,300	224,520	151.4%
Child protection plans	44,300	62,110	40.2%
Principal abuse for new child protection plans			
Neglect	19,300	30,950	60.4%
Physical	6,200	4,810	–22.4%
Sexual	2,500	2,160	–13.6%
Emotional	12,400	23,150	86.7%
Mixed/missing	3,900	1040	–73.3%

Source: DfE Child in Need statistics.

Figure 1 shows that the increasing trend in investigations has not been accompanied by a similar increase in children being found to require a child protection plan to safeguard them from harm. In fact, the number of new child protection plans peaked in 2018, and numbers have since fallen by 7.4% whilst investigations have increased by 13.3% (Fig. 1). Between 2010 and 2024, the proportion of children placed on a child protection plan following these investigations collapsed from 50% to 28%. Given the harms associated with child protection investigations (discussed below), this increase raises concerns about the targeting of investigations.

Since 2010, investigations not followed by a child protection plan (CPP) have increased by a factor of 3.6. In 2024 alone, 161,700 investigations did not result in a plan. This means that 1.1% of all children were investigated without a plan in that year. These statistics led the independent review of children’s social care to call for a focus on the quality and accuracy of child protection work (p. 68).

It is important to place these trends within the wider context of the children’s social care workforce. Rising numbers of investigations place heavy demands on social workers, many of whom already face high case-loads and are instrumental in the challenges of recruitment and retention (Murphy *et al.*, 2024). The continuing expansion of the investigative net without clear evidence of improved outcomes risks further straining a workforce already under pressure (BASW 2023), with consequences for the quality of practice and for the sector’s capacity to provide meaningful support to children and families.

Investigations do significant harm to families

There is considerable evidence of the severe harm caused to families and children by being investigated and accused of harming their child (Bekaert *et al.*, 2021). Parents have a range of responses to being investigated,

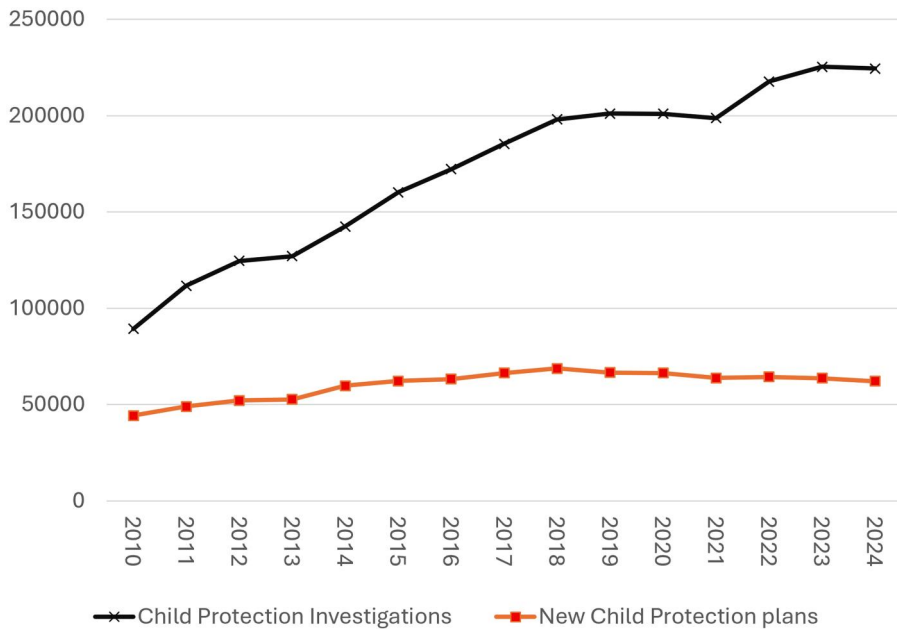


Figure 1. Section 47 child protection investigations and new child protection plans, England, 2010–2024. *Source:* Department for Education, Characteristics of Children in Need statistics. Available from <https://explore-education-statistics.service.gov.uk/data-tables/characteristics-of-children-in-need>.

including having no power, feeling judged and experiencing injustice; many feel threatened and fearful, punished and harmed. Clapton (2020) reviews this evidence, and his survey confirms these harms to parents. It found further harms, including the debilitating challenges of trying to maintain contact with a child or children in care; the frequency of social workers not understanding ADHD, autism and associated conditions; and the sheer depths of despair, helplessness, hopelessness and resignation felt by parents in child protection. It also found that being involved in child protection processes has a wider ripple effect that can negatively impact other family members, result in the loss of jobs, social isolation from friends and neighbours and breakdown of relationships with services such as schools.

Increased investigations have not reduced child deaths or serious harm

A large proportion of children are involved in child protection. Bilson and Munro's (2019) study found that in 2016–17 one in 16 of all children were investigated before their fifth birthday, a rate that will have increased because of a 22% increase in investigations since then. There are no figures

for the numbers of children investigated before they age out of the system at 18, though research (Jay *et al.*, 2025) estimates that 25% will have been a child in need receiving services because they were unlikely to achieve or maintain a reasonable level of health or development. Bilson and Jay (2025) used data on the focus of child in need services to estimate that during their childhoods one in five children will be in need because of concerns about abuse, neglect or inadequate parenting.

These trends demonstrate the increasingly risk-averse culture of decision-making during the period since MASHs have been introduced (Masson and Parton 2020). Figure 2 shows no decrease in notifications that a child has been seriously harmed or died due to abuse or neglect (serious incident notifications) since 2014, when this data started to be collected and similarly data on child deaths due to deliberately inflicted injury, abuse or neglect have not reduced. Thus, there is nothing to indicate that the increasing number of MASHs has reduced deaths or serious incidents.

Child protection plans increasingly focus on neglect and emotional abuse

Table 1 shows that where investigations found risk of significant harm leading to CPPs, these were less likely to be because of sexual or physical abuse, which both decreased, but increasingly because of neglect and emotional abuse. The increases in child protection plans citing neglect and emotional abuse require critical scrutiny. Both neglect and emotional abuse are strongly associated with poverty and material deprivation, with families in disadvantaged circumstances more likely to face inadequate housing, food insecurity, unstable employment, and limited access to services. However, responses are mostly risk-focussed and highly individualistic, with responsibility focussing on women who are frequently the subjects of domestic violence (Featherstone *et al.*, 2018). The expansion of these categories risks conflating structural inequalities and family adversity with parental culpability, reinforcing a culture of “parent blame” (Hansen and Ainsworth 2007) rather than addressing the root causes.

The government strategy

The government’s current strategy was strongly influenced by the Child Safeguarding Practice Review Panel’s (2022) review of the murders of Arthur Labinjo-Hughes and Star Hobson. This review called for multi-agency child protection units to be established in every local authority. These would extend the MASH model to deliver a multi-agency response across more of the child protection system. The current government policy paper *Stable Homes, Built on Love* (Department for Education 2023)

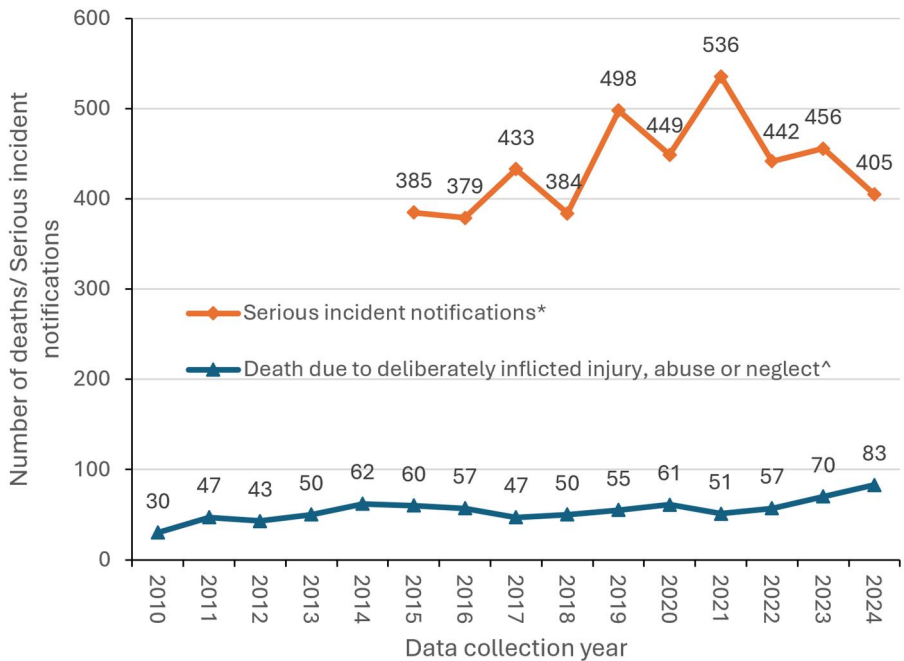


Figure 2. Serious incident notifications* and deaths due to deliberately inflicted injury, abuse or neglect^, England, 2010–2024. Sources: *Department for Education Serious Incident Notifications, Available from <https://explore-education-statistics.service.gov.uk/find-statistics/serious-incident-notifications>; ^National Child Mortality Database Child Death Review Data, Available from <https://www.data.gov.uk/dataset/cc03dfe-330a-437c-b951-71c9b79eab92/child-death-review-data-release-2023>.

emphasises prevention, stability and the importance of relationships. However, these proposals to extend the MASH model into multi-agency child protection units sit uneasily alongside this vision. Investing in centralised investigative structures risks reinforcing risk-averse practices rather than building the preventative, family-centred support that government strategy claims to prioritise.

In their argument for this approach the CSPRP state the following:

The Multi-Agency Safeguarding Hub (MASH) model has led to more accurate assessment of risk and need at the ‘front door’ of child protection, when it has been implemented well. (Child Safeguarding Practice Review Panel 2022: 10)

They base this statement on the Home Office (2014a) report, which took place when there were relatively few MASHs and clearly states that it does not provide research evidence. The CSPRP also cites Hampshire as an example of “successful authorities” (p. 106) that have extended their MASHs across more of the child protection system, providing

comprehensive information sharing. However, [Parents, Families and Allies Network \(2024: 8\)](#) showed that in Hampshire

between 2013 and 2021, the number of investigations starting in the year rose more rapidly than in any of its five closest statistical neighbours.

This trend has continued, and, by 2023, Hampshire's rate of children investigated had risen by 265% since 2013. It now has one of the highest rates of investigations in the country, only exceeded by local authorities with significantly higher levels of deprivation. In 2023 only 17% of its investigations led to a child protection plan, the lowest rate of any local authority in the country (excluding the City of London, which had only 11 investigations). Basing national policy recommendations on a Home Office report reliant solely on the views of practitioners about the success of the MASH model and examples with such questionable patterns of service as Hampshire demonstrates the need for a firmer evidence base for multi-agency practice.

This study

This study uses freedom of information requests to all local authorities in England to provide a national overview of when and where MASHs have been implemented. It then uses nationally available data to consider trends in section 47 child protection investigations and child protection plans and serious incident notifications to compare where a MASH was operating to local authorities that didn't have a MASH. Previous evaluations have concentrated on professional perspectives and process improvements but have not addressed whether MASHs improve child safety or reduce serious harm. By analysing national datasets, this study therefore begins to fill an important gap in the evidence base and offers a rare opportunity to examine outcomes at scale.

To examine the hypothesis that MASHs have an immediate impact on rates of s47 investigations and CPPs, the study compares changes in these rates in the year before and after a MASH was implemented. Since these implementations took place alongside wider changes in child protection activity, trends in local authorities introducing a MASH are compared with those in authorities without a MASH in the same years.

A second hypothesis is that MASHs continue to impact the rates of s47s and CPPs over the longer term. To examine longer-term effects, the study compares rates of s47 investigations and CPPs in local authorities where a MASH had been established for at least one year with those where no MASH was in place.

A third hypothesis, that MASHs help local authorities to prevent deaths and serious harm, is investigated using information on serious incident

notifications obtained through a freedom of information request. It compares numbers of serious incidents in local authorities with and without a MASH.

Method

This study adopts a national observational, quasi-experimental design using administrative data. It examines associations between the implementation of MASHs and trends in child protection activity and outcomes. A Freedom of Information request was sent to all English local authorities in 2023 to find whether and when a MASH or similar structure was implemented. 134 of the then 152 local authorities provided responses to the FoI. Four of these did not know when the MASH in their agency was established, and six local authorities had not set up a MASH at the time of the request. The study sample consists of the 130 local authorities providing data.

Data on section 47 investigations and child protection plans were sourced from the Department for Education's child in need statistics ([Department for Education 2025](#)). Similarly, data on serious incident notifications were sourced from a freedom of information request to the Department for Education to obtain unredacted data for the groups covering the period from 1 April 2018 to 31 March 2021. This range was chosen, as it covers the period from the start of this data being collected over a period that allows comparison of local authorities with and without a MASH. This data necessarily involves small numbers in individual local authorities, and the published version has values redacted. The FoI requested data on groups of local authorities with and without a MASH over this period and did not require redaction of data.

The analysis uses a comparative longitudinal approach, examining changes within local authorities before and after MASH implementation and comparing these with trends in authorities without a MASH over the same period. This allows assessment of whether observed changes differ from wider national trends.

Data on the population aged 0 to 17 used to calculate rates are from the [Office for National Statistics \(2025\)](#) population estimates for local authorities based on single years of age. Calculation of rates of children aged 0 to 15 living in low-income families was from the [Department for Work and Pensions \(2024\)](#). This data is only reliably available from 2015.

The study did not require ethical approval, as the freedom of information requests did not obtain any personal data, and all the other information is already anonymised and in the public domain.

The comparisons using the above data were carried out as follows:

1. Immediate impact: To assess the short-term effects of MASH implementation, rates of section 47 (s47) investigations and child protection plans (CPPs) per 10,000 children aged 0–17 were calculated for local authorities that introduced a MASH in a given year (ending

31 March). For these authorities, the rates in the year before implementation were compared with those in the year after. A comparator group was created from all local authorities that did not yet have a MASH in place during the same period (i.e. they had not established a MASH by the end of the year following the implementation year).

2. Cumulative impact: To examine the cumulative impact of MASHs a comparison was made for each year of rates of s47 investigations and CPPs between those local authorities that had a MASH in place for at least one full year and local authorities that had not established a MASH until at least one year after the comparison year.
3. Impact on serious incident notifications: serious incident notifications from 1 April 2018 to 31 March 2021 were compared between local authorities with a MASH before this period and those which did not have a MASH before 31 March 2021.

Findings

These findings should be interpreted as associations rather than causal effects. The study examines four areas: when MASHs were implemented; their short-term impact on s47 enquiries and child protection plans; their longer-term effects; and their relationship to serious incident notifications. Findings on each of these areas will be discussed in turn.

Implementation of MASHs

Figure 3 shows when the 124 local authorities implemented their MASH. The period from 2014 to 2018 had high rates of MASHs being established, and 100 local authorities, 77.5% of the sample and two-thirds of all local authorities in England, had established a MASH by 31 March 2019.

Impact of the establishment of a MASH in the year following implementation

The study considered how s47 investigations and child protection plans changed in the year following the implementation of a MASH in comparison with local authorities without a MASH.

Change in s47 investigations in the year following the establishment of a MASH

Figure 4 shows the percentage change in s47 investigations in the year before and after a MASH was established, compared with authorities without a MASH in the same period.

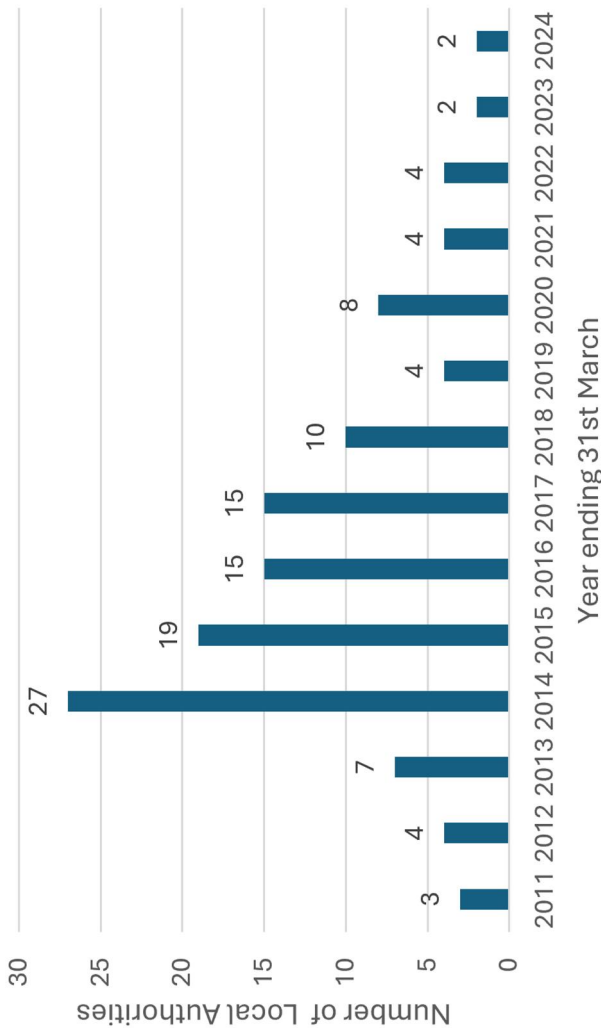


Figure 3. Number of local authorities establishing a multi-agency safeguarding hub, by year ending 31 March, 2011 – 2024. Source: Freedom of Information requests to English local authorities.

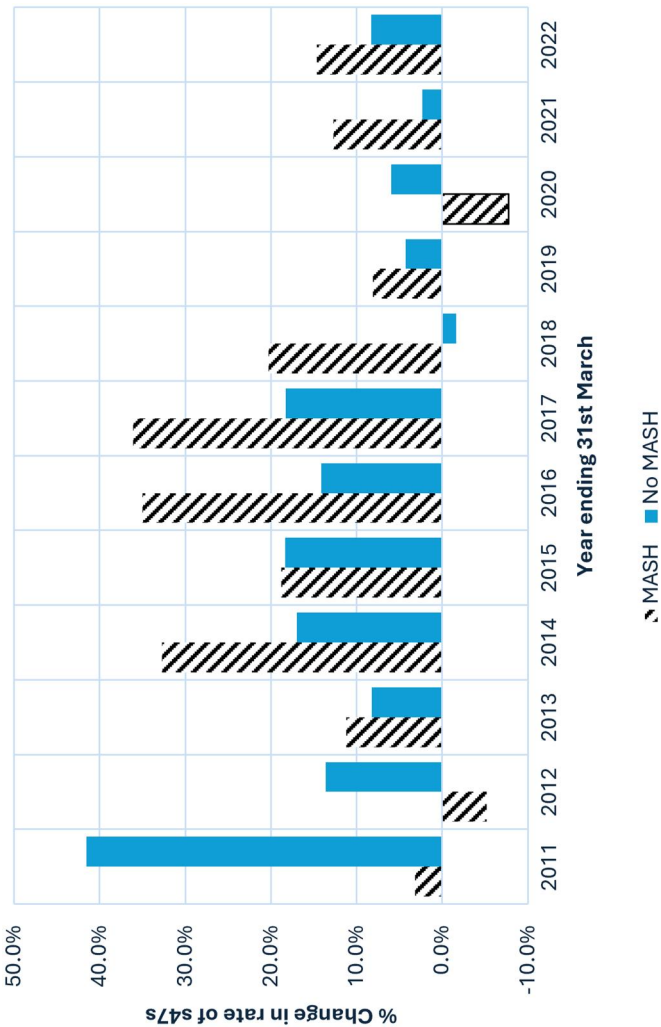


Figure 4. Percentage change in the rate of section 47 investigations per 10,000 children aged 0–17 in the year before and after MASH implementation, compared with local authorities without a MASH in the same period. *Sources:* Freedom of Information requests to English local authorities; Department for Education Children in Need statistics.

Across the 12 years studied, local authorities implementing a MASH experienced a greater increase in s47 investigations in 9 out of 12 years. The only exceptions were 2011, 2012 and 2020, when non-MASH authorities saw the larger rise. These three years involved relatively small numbers of local authorities (Table 2).

The overall pattern is therefore consistent with the establishment of a MASH being usually followed by sharper increases in s47 investigations compared to areas without a MASH.

Change in child protection plans in the year following establishment of a MASH

Figure 5 shows the change in the rate of child protection plans (CPPs) in the year before and after MASH implementation, compared with authorities without a MASH in the same period.

The pattern here is more mixed than for s47 investigations. In some years (notably 2014 and 2017) MASH authorities recorded significantly larger rises in CPPs than non-MASH authorities, but in other years the opposite was true. In several years (2011, 2019, 2021, 2022), non-MASH authorities saw larger increases, and in 2018 both groups saw small decreases.

Overall, the establishment of a MASH does not show a consistent or pronounced impact on CPP rates. This contrasts with the clearer pattern of increased s47 investigations following MASH implementation (Table 3).

Overall short-term impact of MASH implementation

The findings show that in the year following the establishment of a MASH, local authorities typically recorded sharper increases in section 47 investigations than those without a MASH. In 9 out of 12 years covering 94 of the 108 MASHs with data, the rise in investigations was greater in areas where a MASH was implemented. There were particularly marked differences in 2014, 2016 and 2017. Only a small number of years showed the reverse pattern, and these involved relatively few local authorities implementing a MASH. By contrast, the pattern for child protection plans (CPPs) was more mixed. In some years, such as 2014 and 2017, MASH authorities saw substantially larger increases in CPPs, but in others the growth was similar to or smaller than in non-MASH areas, and in several years CPP rates fell despite more investigations.

Taken together, these findings indicate that MASH implementation is associated with an increase in decisions to initiate investigations, but without a consistent or proportional rise in CPPs.

Table 2. Rate of S47 investigations per 10,000 aged 0–17 in the year before and the year after a MASH was established and similar years where there was no MASH.

Year	MASH ^a		No MASH ^b	
	No. of local authorities	Change in rate of S47	No. of local authorities	Change in rate of S47
2011	3	3.2%	102	41.5%
2012	3	–5.2%	107	13.6%
2013	7	11.2%	85	8.2%
2014	27	32.7%	69	17.0%
2015	19	18.8%	54	18.4%
2016	15	35.0%	39	14.1%
2017	15	36.1%	29	18.3%
2018	10	20.3%	25	–1.7%
2019	4	8.1%	17	4.3%
2020	8	–7.8%	12	6.0%
2021	4	12.7%	9	2.3%
2022	3	14.7%	7	8.3%

Source: Freedom of Information Request and [Department for Education \(2023\)](#).

^aAll Local Authorities that provided information showing they had a MASH established before the end of the year shown and had data on s47s, CPPs and CIN in the years before and after the year.

^bAll local authorities that provided information showing they did not have a MASH established before the end of the year following the year shown and had data on s47s, CPPs and CIN in the years before and after the year.

Effects over the longer term

[Figure 6](#) and [Table 4](#) present the rates of s47 investigations and CPPs in local authorities with a MASH in place for at least one year, compared with those that had not yet established a MASH until at least a year after the comparison year. The results show a clear and sustained divergence between investigation and planning activity. From 2014 onwards, local authorities with a MASH consistently recorded higher rates of s47 investigations than those without, and this gap widened over time. By 2023, the average rate of investigations in MASH authorities was 194.1 per 10,000 children compared to 108.5 in non-MASH areas, almost double the level.

In contrast, the rates of CPPs showed only modest differences between MASH and non-MASH authorities across the same period. Both groups followed broadly similar trajectories, with fluctuations year to year but no widening divergence. By 2023, MASH authorities recorded a CPP rate of 54.5 per 10,000 compared with 38.8 in non-MASH authorities, a smaller gap than for s47s.

Taken together, these findings indicate that the establishment of MASHs has been associated with a long-term increase in the likelihood of children being investigated under s47, but without a commensurate rise in the proportion placed on a child protection plan. This suggests that while MASHs intensify investigative activity, they do not appear to significantly alter decision-making about which children require formal child protection planning.

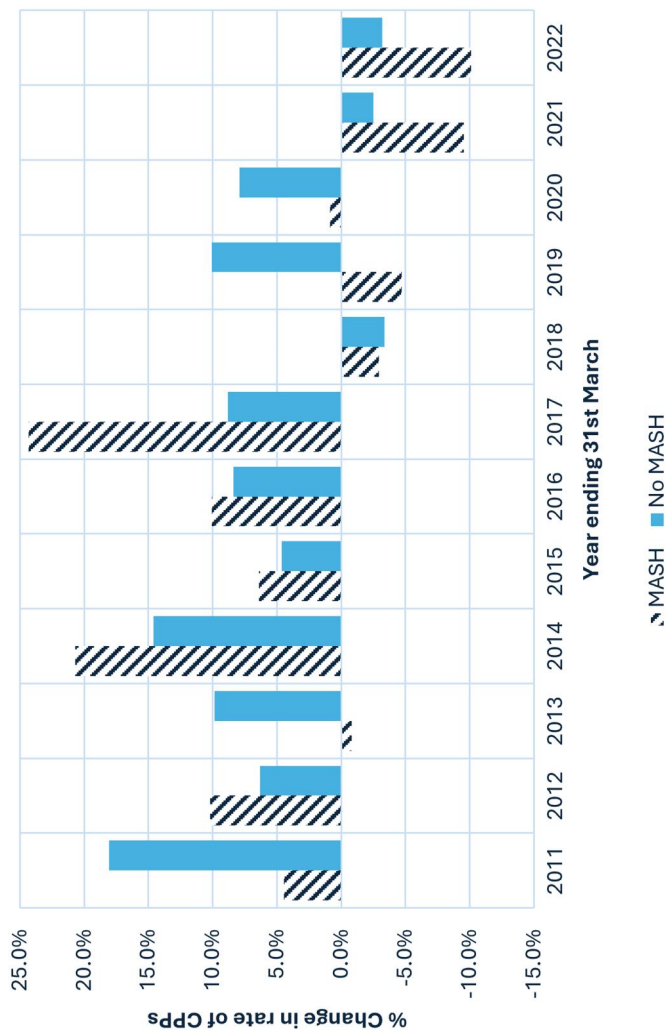


Figure 5. Percentage change in the rate of child protection plans per 10,000 children aged 0–17 in the year before and after MASH implementation, compared with local authorities without a MASH in the same period. Sources: Freedom of Information requests to English local authorities; Department for Education Children in Need statistics.

Table 3. Change in Child Protection Plans as rate per 10,000 aged 0–17 in the year before and after a MASH was established and changes in same years where there was no MASH.

Year	MASH ^a		No MASH ^b	
	No. of local authorities	Change in rate of child protection plans	No. of local authorities	Change in rate of child protection plans
2011	3	4.5%	102	18.1%
2012	3	10.2%	107	6.3%
2013	7	−0.8%	85	9.8%
2014	27	20.7%	69	14.6%
2015	19	6.4%	54	4.6%
2016	15	10.1%	39	8.4%
2017	15	24.3%	29	8.8%
2018	10	−3.0%	25	−3.4%
2019	4	−4.7%	17	10.1%
2020	8	0.9%	12	7.9%
2021	4	−9.5%	9	−2.5%
2022	3	−10.1%	7	−3.2%

^aAll Local Authorities that provided information showing they had a MASH established before the end of the year shown and had data on s47s, CPPs and CIN in the years before and after the year.

^bAll local authorities that provided information showing they did not have a MASH established before the end of the year following the year shown and had data on s47s, CPPs and CIN in the years before and after the year.

Figure 7 and Table 5 present the rates of section 47 (s47) investigations and child protection plans (CPPs) expressed relative to the number of children aged 0–15 living in families in relative poverty, available from 2015 onwards. Comparing these figures with the overall rates for all children aged 0–17 (Figure 5 and Table 4) reveals an important difference in the pattern of growth.

From 2015 onwards, MASH authorities consistently recorded higher rates of s47 investigations than non-MASH areas. In more recent years there was a growing divergence in the rates of investigations in local authorities with and without a MASH. The difference in rates was also found when rates were calculated as a proportion of children living in relatively low-income families, indicating that these differences were not due to MASH areas having higher rates of children in low-income families.

In contrast, CPP rates for areas with and without a MASH followed a similar pattern, though in the last two years, when rates of investigations were very much lower in areas without a MASH, there were also lower rates of CPPs in these areas.

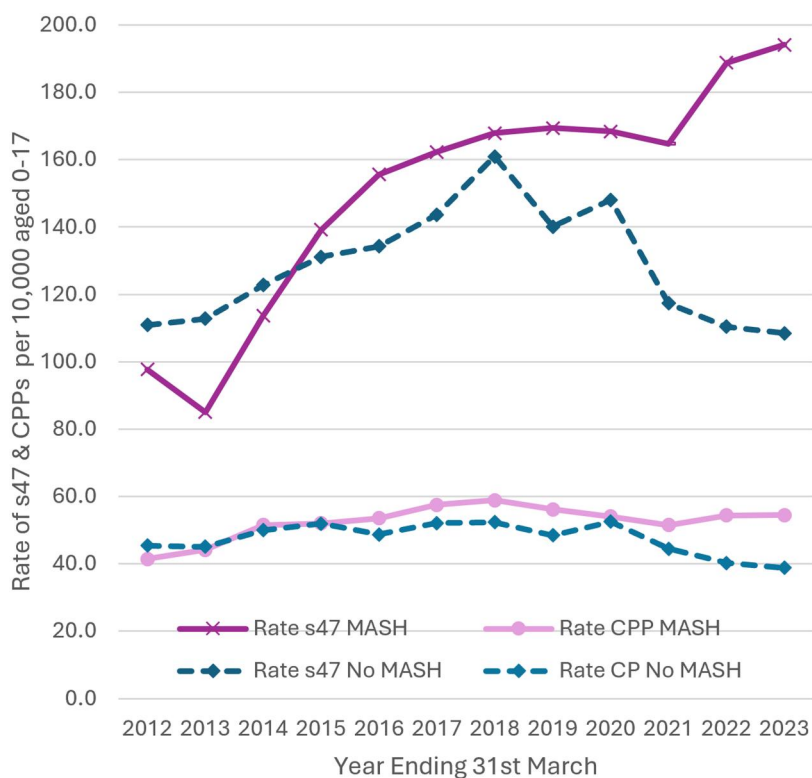


Figure 6. Rates of section 47 investigations and child protection plans per 10,000 children aged 0–17 in local authorities with a MASH established for at least one year and in local authorities without a MASH, 2012–2023. *Sources:* Freedom of Information requests to English local authorities; Department for Education Children in Need statistics.

Serious incident notifications and MASHs

This section considers findings regarding notifiable serious incidents, which are those that involve death or serious harm to a child where abuse or neglect is known or suspected and any death of a looked after child ([Children Act 2004](#), section 16C (1)). [Table 6](#) compares rates of notifiable serious incidents between 1 April 2018 and 31 March 2021 in local authorities with a MASH established before 2018 and those without a MASH in place before the end of the period. The findings show little evidence that MASH implementation reduced the likelihood of serious harm or death due to abuse or neglect.

Local authorities with a MASH established before 2018 reported 968 serious incident notifications during the period, equating to a rate of 12.0 per 100,000 children and 70.3 per 100,000 children living in families with relatively low incomes. In comparison, the 13 authorities without a MASH

Table 4. Section 47 investigations and child protection plans as a rate per 10,000 children aged 0–17 where a MASH had been established for at least a year and where no MASH was operating.

Year ending 31st March	MASH ^a			No MASH ^b		
	No. of Local Authorities	Rate s47 per 10,000 aged 0–17	Rate CPPs per 10,000 aged 0–17	No. of Local Authorities	Rate s47 per 10,000 aged 0–17	Rate CPPs per 10,000 aged 0–17
2012	3	97.7	41.5	117	110.9	45.4
2013	6	85.1	44.1	115	112.8	45.1
2014	13	113.6	51.5	88	122.8	50.0
2015	41	139.2	52.1	69	131.1	51.9
2016	60	155.6	53.5	54	134.3	48.7
2017	75	162.3	57.5	39	143.7	52.1
2018	90	167.9	58.9	29	161.0	52.4
2019	100	169.4	56.2	25	140.1	48.5
2020	104	168.4	54.0	17	148.1	52.6
2021	112	164.7	51.6	12	117.4	44.5
2022	116	188.8	54.4	9	110.4	40.2
2023	120	194.1	54.5	7	108.5	38.8

Source: Freedom of Information Request and [Department for Education \(2025\)](#).

^aNumber of local authorities with a MASH established for at least 12 months before the year shown and had data on s47s and CPPs.

^bNumber of local authorities without a MASH established for at least 12 months after the year shown and had data on s47s and CPPs.

before 2021 reported 122 notifications, with very similar rates: 11.2 per 100,000 children and 69.0 per 100,000 children in low-income families.

Overall, the data show that the presence of a MASH does not translate into lower rates of notifiable serious incidents.

Discussion

Despite the limitations (discussed below), the findings presented here mark a significant step in building an empirical evidence base on MASHs. These findings can be interpreted through the lens of risk amplification and the expansion of investigative approaches in child protection systems. The concentration of multi-agency expertise at the point of referral may increase the visibility and salience of risk, contributing to higher rates of investigation without necessarily improving the identification of cases requiring intervention. The findings indicate that MASH implementation is associated with rising s47 investigations. However, this increase is not matched by a proportional rise in CPPs, nor by any measurable reduction in serious incident notifications relating to serious harm or child deaths. Although necessarily crude, these findings challenge the assumption that centralising multi-agency expertise at the “front door” improves decision-making. They suggest that greater information sharing does not automatically lead to more accurate identification of risk. On the contrary, the

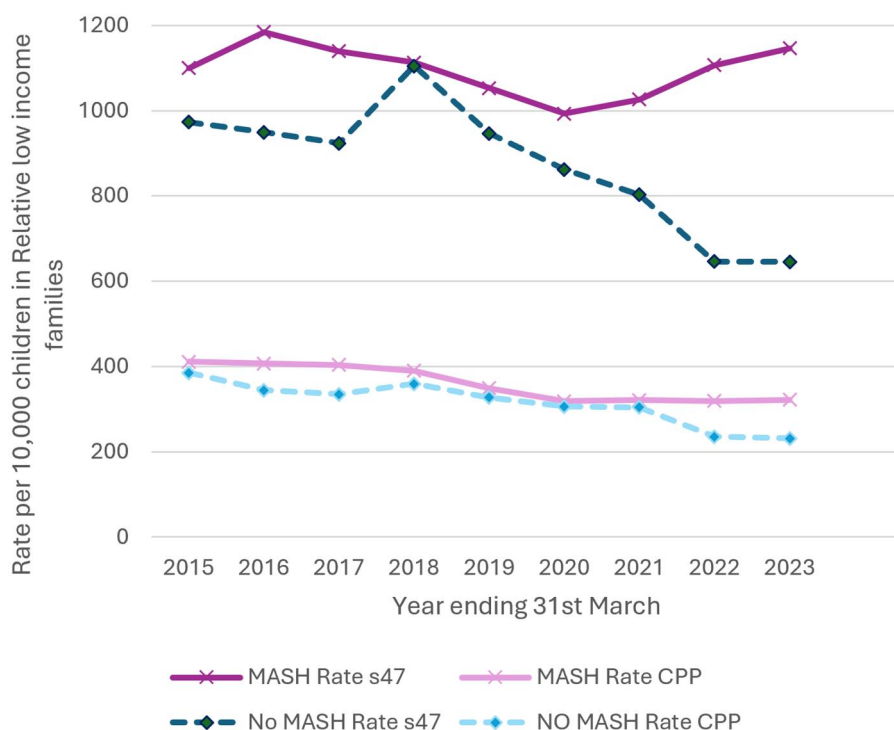


Figure 7. Rates of section 47 investigations and child protection plans per 10,000 children aged 0–15 living in families with relative low income, in local authorities with a MASH established for at least one year and in local authorities without a MASH, 2015–2023. *Sources:* Freedom of Information requests to English local authorities; Department for Education Children in Need statistics; and Department for Work and Pensions relative low-income data.

shared focus on risk within MASHs may amplify concerns. This increases the likelihood of decisions to investigate, while doing little to improve focus on cases where intervention is needed to address serious harm.

These results reinforce concerns previously articulated in sector commentary: that multi-agency child protection units lack a robust outcome evidence base (Bilson 2022), and that social care has expanded to touch the lives of a quarter of all children in England (Bilson and Jay 2025). Investigations themselves are not neutral acts. They carry harms for parents and children, leaving families devastated, feeling judged, powerless and mistrusted, and fracturing relationships with schools and health services. For children, being subject to an investigation can generate significant harm through its impact on their families alongside stigma, anxiety and mistrust.

The ever-expanding investigative orientation also risks undermining the capacity of social workers to protect children effectively. A wider net of

Table 5. S47 Investigations and Child Protection Plans as a rate per 10,000 children aged 0–15 children living in families with relatively low income where a MASH had been established for at least a year and where no MASH was operating.

Year ending 31st March	MASH ^a			No MASH ^b		
	No. of local authorities	Rate s47s	Rate CPPs	No. of local authorities	Rate s47s	Rate CPPs
2015	41	1100	411	69	973	385
2016	60	1184	407	54	949	344
2017	75	1140	404	39	923	335
2018	90	1113	390	29	1105	359
2019	100	1053	349	25	946	328
2020	104	993	319	17	863	306
2021	112	1026	321	12	803	304
2022	116	1107	319	9	646	235
2023	120	1146	322	7	646	231

Source: Freedom of Information Request and [Department for Work and Pensions \(2024\)](#)—information on families living in relative low income families is available only from 2015 to 2023.

^aNumber of local authorities with a MASH established for at least 12 months before the year shown had data on s47s, CPPs and CIN.

^bNumber of local authorities without a MASH established for at least 12 months after the year shown and had data on s47s and CPPs.

Table 6. Comparison of number of Serious Incident Notifications from 1 April 2018 to 31 March 2021 between agencies with a MASH and those without.

	Number of agencies	Number of serious incident notifications 1/4/2018 to 31/3/2021 [#]	Rate of serious incidents per 100,000 CIN	Rate of serious incidents per 100,000 children	Rate of serious incidents per 100,000 children in poverty
MASH pre 2018 ^a	100	968	359	12.0	70.3
No MASH pre 2021 ^b	13	122	417	11.2	69.0

Source: Freedom of Information Request and [Department for Education \(2025\)](#).

^aAgencies included if MASH was established before 31 March 2018.

^bAgencies included if no MASH established before 31 March 2021.

investigations does not guarantee that serious cases will be identified. Instead, it may contribute to missed opportunities by overwhelming practitioners with high volumes of low-yield enquiries. This leaves less time and attention for the most concerning cases. This contributes to the risk-averse culture and to recruitment and retention challenges, as high volumes of low-evidence investigations strain workforce morale.

Moreover, while neglect and emotional abuse are genuine harms, the investigative approach observed here does little to prevent or treat them ([Parton 2019](#)). Investigations consume scarce professional capacity but

rarely lead to sustained therapeutic intervention or practical support. The substantial resources devoted to staffing and administering MASHs therefore represent a considerable opportunity cost: funds that could instead strengthen early help, multi-agency community services and family support. These findings highlight the policy contradiction at the heart of current reforms. *Stable Homes, Built on Love* promotes a vision centred on prevention, stability and relationships, yet investment continues to flow into costly investigative structures. Unless this contradiction is addressed, the gulf between rhetoric and reality will continue to widen.

Limitations

This study provides some of the first outcome-focused evidence on the effects of MASH implementation, but several limitations must be acknowledged. The freedom of information requests used in this study were limited to identifying when local authorities had established a MASH and to combining data on serious incident notifications. In many cases, local authorities were only able to provide the year of implementation rather than the specific month. In addition, the national statistics used to analyse s47 investigations and CPPs are only available for reporting years ending 31 March. Together, these factors meant that the before-and-after analysis had to use whole reporting years, comparing the year before and the year after the year of implementation, which reduces the precision of the comparisons.

The analysis of s47 investigations and CPPs relied on nationally available datasets. While these sources provide comprehensive coverage, they do not allow for disaggregation by characteristics such as gender and ethnicity, and they cannot capture the complexity of local practice or contextual differences between authorities. Similarly, data on children living in poverty were only available for those aged under 16 and for a limited time range, which constrains the scope of the poverty-adjusted analysis.

As an observational study, the analysis cannot establish causal relationships. Findings should therefore be interpreted as associations between MASH implementation and outcomes, recognising that other factors—such as local policy changes, resource levels, inspection regimes, or demographic variation—may also influence how decisions about investigation and intervention are made. While comparisons with non-MASH authorities help contextualise trends, unmeasured confounding factors may contribute to differences observed between areas.

Future research should seek to build on these findings in several ways. More precise data on the timing of MASH implementation would strengthen before-and-after comparisons. Analyses disaggregated by child and family characteristics such as age, gender, ethnicity, and disability would provide important insights into equity and disproportionality. Finally, mixed-methods studies combining outcome data with qualitative accounts from families and

practitioners could shed light on how decision-making within MASHs influences investigative patterns and on the lived experience of those subjected to them.

The study does not distinguish between MASH models that process children's referrals exclusively and those that also include adult safeguarding functions. This variation may influence decision-making processes and represents an area for further research.

Despite these limitations, the study offers an important contribution: it provides one of the first systematic, national-level analyses of outcomes associated with MASHs, in contrast to the largely perception-based evaluations that have dominated the evidence base to date.

Conclusion

This study provides some of the first empirical outcome evidence on the impact of MASHs, and the results are sobering. Despite substantial investment, MASHs appear to intensify investigations without delivering better outcomes for children. There is no indication that they reduce serious harm or child deaths. Instead, this study suggests they contribute to widening intrusion into family life, consume scarce professional resources, and contribute to workforce pressures. These results corroborate concerns already voiced in sector commentary: that multi-agency safeguarding hubs are costly, unsupported by evidence, and harmful to families.

The findings underline that a system which prioritises surveillance over support does not better identify cases of serious harm and deaths and may, in fact, contribute to obscuring them. Investigations themselves can harm children and families, while the opportunity cost of maintaining MASH structures and the increasing investigative response diverts resources from preventative, family-strengthening services.

Future research should continue to develop outcome-focused approaches, using more precise and disaggregated data and integrating quantitative trends with qualitative accounts from families and practitioners. Only by building a stronger empirical base can the sector move beyond process-driven evaluations and assess the true impact of MASHs on children's safety and wellbeing.

A more credible path forward would be to shift towards family-strengthening, community-oriented responses to harm, where the emphasis is on building relationships, addressing poverty and inequality, and providing timely, therapeutic support. Such models would not only reduce the harms caused by unnecessary investigations but also allow practitioners to focus their attention on the children and families at greatest risk. Developing evidence-based, needs-led approaches of this kind offers a

more promising route to improving outcomes than continued reliance on expensive, process-driven structures like MASHs.

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