REPORT

Prioritising Protection

The role of children's services and wider safeguarding partnerships in protecting young people impacted by extra-familial harm

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Executive Summary

The role of children's services in responding to extra-familial harm (EFH), and the wider safeguarding partnerships in which they work, has undergone significant transformation over the last decade across England and Wales (Gorin and Jobe, 2013; Hanson and Holmes, 2013; Pearce, 2013; Hallet, 2016; Firmin et al., 2016; Maxwell and Wallace, 2021; Tackling Child Exploitation Support Programme, 2023; Firmin et al., 2024; Wroe et al., 2025). EFH refers to interpersonal violence and abuse that occurs beyond the family environment—and can include child sexual exploitation, child criminal exploitation, harmful sexual behaviour, serious youth violence and relationship violence.

Since the early 2000s, key stakeholders have worked with researchers to better understand different forms of EFH and the capacity of services to respond. This work has facilitated a shift in how children and young people impacted by EFH are perceived by professionals: previously viewed as 'a risk' of harm to others and increasingly viewed as 'at-risk' of harm and in need of protection (Cockbain and Brayley, 2012; Firmin, 2017; Lefevre, Langhoff and Luckock, 2018; Lloyd and Firmin, 2019; Maxwell, 2022). This shift has led to greater emphasis on the role of children's services in coordinating multi-agency safeguarding responses to EFH. Such shifts have occurred in a challenging context, characterised by complex multi-agency landscapes, varying levels of national guidance and resourcing, and ongoing questions about how best to respond (MacAlister, 2022; Action for Children, 2023; Tackling Child Exploitation Support Programme, 2023).

Prioritising Protection was commissioned by the Youth Endowment Fund to examine two ways in which children's services convene multi-agency safeguarding responses to EFH: operational responses via multi-agency child exploitation (MACE) panels (and alternatives to them), and strategic safeguarding partnerships via Local Safeguarding Children Partnerships in England and Regional Safeguarding Boards in Wales. It provides a significant contribution to the evidence base on strategic and operational responses to safeguarding children and young people from EFH by capturing both local and national perspectives, highlighting promising practice, strengthening understanding of racial equity and lived experience in safeguarding responses and offering a sector-wide view of the challenges and opportunities facing services supporting young people affected by EFH.

The project explored three questions and 11 sub-questions regarding operational panels, and seven questions about strategic partnerships. The datasets developed, summary answers to the questions set by YEF and their combined implications for safeguarding systems are reported in this executive summary. For a detailed methodology please see chapter 3 of the full project report.

Dataset

This project adopted a mixed methods approach and ethical approval was secured through the Ethics Committee of Durham University's Sociology Department.

National practices were mapped via:

- A rapid evidence assessment (REA) of published research on multi-agency strategic and operational responses to extra-familial harm in England and Wales (undertaken 16/10/25-18/12/25)
- A review of 43 Serious Case Reviews and Local Child Safeguarding Practice Reviews, and 20 Rapid Reviews (published and unpublished) where extra-familial harm was a factor
- A national survey of Business Managers from Local Safeguarding ChildrenPartnerships in England and Local Safeguarding Children Boards in Wales (n=69)
- A national survey of chairs of operational safeguarding panels, including MACE (or equivalent) panels and alternatives to them (n=65) collectively representing 90 local authorities (LAs).
- A review of 8 MACE protocols and 10 local safeguarding partnership (LSP) strategies submitted as part of the surveys and a sampled review of 11 submitted separately to the survey to provide geographical variation
- Interviews and focus groups with service leaders, practitioners, chairs, scrutineers and policymakers

Six local case studies of multi-agency arrangements were built to add depth to how the national picture was understood. Case studies were developed using a combination of practice observation, analysis of children's assessments and plans, documentary analysis of local procedures and strategies, professional focus groups, and workshops to map local systems and pathways.

Context of the study

It is important to note that multi-agency operational panels and multi-agency strategic partnerships are operating in national contexts of confusion and inconsistency in respect of EFH and the children and young people impacted. There is no unified policy framework for EFH in either England nor Wales; neither place has specific safeguarding guidance for serious youth violence or teenage relationship abuse, for example, and in England there is also no safeguarding guidance for harmful sexual behaviours. There is, in this context, a persistent tension between welfare and criminal justice leadership for different forms of EFH, starting with the relationship between the Department for Education and the Home Office, and to a lesser extent the Department for Health and Social Care, in terms of central government leadership. This division is evident in the disparate legislative basis upon which areas have built their safeguarding responses to children and young people affected by EFH, with key approaches spread across child protection and crime and disorder legal frameworks that do not speak to each other; and enacted through regional policing protocols to respond to exploitation, that are distinct from responses to serious

violence, and both of which are distinct from local children's social care and child protection pathways. Professional responses are under significant scrutiny, and the impact on the workforce was visible in our dataset; practitioners are operating in a context of reduced resources and heightened anxiety. Finally, the lack of protection afforded to Black and other racially minoritised children and young people impacted by EFH has already been well-evidenced, particularly in recent years (Firmin et al., 2021; Davis, 2022; Dodzro and Goode, 2023; Davis, 2025). All the above impacts the efficacy of whole-system responses to EFH and the practices within those systems; this is visible in our project findings.

Findings: Nature and scale of MACE panels and alternatives to them

Most areas that participated in this study were using a MACE (or equivalent) panel as part of their response to EFH; between 15-20% had an alternative arrangement in place.

MACE (or equivalent) panels fulfil two broad functions: oversight of plans for individual children and young people and oversight of responses to trends/locations. These panels vary in terms of their frequency, who chairs them, the harms they consider and their approach to categorising risk and applying thresholds.

MACE (or equivalent) panels are used to share information about children, young people, groups and locations impacted by EFH. They are described as coordinating responses to EFH through their information-sharing function, however the available evidence from this study suggests much coordination happens outside of panel meetings. MACE (or equivalent) panels provide a space for professionals to share concerns and seek/provide reassurance. Evidence was less clear on the contribution that MACE (or equivalent) panels made to providing safety and stability for young people.

To develop safety plans, MACE (or equivalent) panels draw upon youth service support, referrals into wider services for education, diversionary or needs-orientated intervention, disruption activities led by policing and community safety, and actions to escalate concerns about young people's access to services. Most rely on policing and community safety interventions to respond to locations and trends, however some use youth and social work to do so.

Alternatives to MACE (or equivalent) panels tend to replace their case-oversight function rather than their trend-oversight function. Alternatives differ from MACE (or equivalent) panels in that they are: used to review/develop plans for an individual child or young person, rather than a list; chaired solely by children's social care; attended largely by professionals who know the child or young person (rather than having a standing membership of sector representatives); use children's social care categories of harm and thresholds for support; and involve children, young people and families in meetings.

Findings: Coordination of panels within local systems

Data from case study sites enabled us to map how MACE (or equivalent) panels were used and positioned in local systems or were no longer a feature of them. In summary:

- Three sites used MACE (or equivalent) panels to fulfil a case-oversight function
- Three sites used alternative approaches holding oversight of 'cases' and two used additional approaches to MACE panels in situations of significant harm
- Four sites used MACE (or equivalent) panels to fulfil a thematic-oversight function, three of which relied on community safety and policing processes to respond to those themes
- Three sites utilised youth work and social work teams, and wider specialist co-located teams to assess and respond to contexts and trends associated with EFH
- In all sites the police and community safety partnership had processes for responding to serious youth violence and anti-social behaviour outside of safeguarding processes
- Three sites reserved child protection processes for situations in which EFH is attributable to parents/carers; three sites had a child protection pathway in place for responding to EFH even when it was not attributable to parents/carers
- Four sites used risk categories outside of standard child protection processes to classify EFH – such as red, amber, green or high, medium, low; one of these also used 'significant harm' to denote a link into child protection processes, as did an additional two sites who used a significant harm threshold for both familial harm and EFH

It was difficult for *MACE (or equivalent) panels* to coordinate well with other safeguarding structures or partnership responses to EFH, given that these various structures or partnerships were rarely coordinated into a single streamlined response to EFH. Such challenges were reinforced by distinct policing processes for serious violence/knife crime, and/or when local responses to EFH were largely positioned outside of child protection processes.

Findings: Are MACE panels identifying and protecting children?

There is no existing baseline against which to measure the success of MACE (or equivalent) panels, or alternatives to them. They are also being developed in local and national contexts that are not conducive to effective practice. As such efficacy in local practices is being achieved despite, not due to, system conditions. In this study we identified seven ways areas created conditions conducive with the effective use of MACE (or equivalent) panels and alternatives to them:

1. The use of welfare-orientated assessments, in which risk could be considered
2. Planning support in ways that were not reliant on investigatory options
3. Using youth work responses to individuals and contexts
4. Ensuring panels were integrated with child protection pathways and thresholds
5. Using clear parameters to ensure proportional information sharing
6. Building escalatory routes to school inclusion processes into the panel design
7. Consistently seeking and considering the views of children and young people

Challenges with coordination impact the ability of MACE (or equivalent) panels to effectively identify and protect all children and young people impacted by EFH. Various forms of EFH are responded to under different assessments/panels/pathways (of which MACE panels are one), some of which are overseen by policing and community safety, and others by children's services. Each local area currently operates differently in this respect.

At present and as designed, panels are best placed to identify and protect children and young people impacted by sexual and criminal exploitation; those impacted by serious violence, violence in intimate relationships and peer-sexual abuse are often excluded from MACE (or equivalent) pathways and in some instances are left without children's services oversight altogether.

In terms of protection, our findings varied. Some survey respondents displayed confidence in their ability to protect children and young people discussed at MACE (or equivalent) panels, however some focus group participants and site observations highlighted risks related to the criminalisation of children and young people discussed at panels, and tensions in meetings between policing and children's services regarding whether to use secure placements and other restrictive interventions for children and young people's protection.

Alternative approaches to MACE panels appeared better able to involve children, young people and families in decision-making; consider the welfare and needs of children and young people impacted by EFH; and challenge partners on decisions that were not in the best interest of children and young people.

Professionals struggled to explain how their use of MACE (or equivalent) panels was adapted to meet the needs of Black and other racially minoritised children and young people. A general silence on ways to identify/address racism within safeguarding systems left it confined to discussions about: monitoring disproportionality data, commissioning training on adultification, or individual practitioners advocating for Black children and young people outside of MACE (or equivalent) panels. Panels themselves, and particularly their use in generating/sharing large volumes of information about children and young people, did not appear to be designed with (in)equality impacts in mind.

Findings: Expectations of local safeguarding partnerships responses to EFH

In England, local safeguarding children partnerships (LSCP) are expected to:

- **Coordinate** the work of all partner agencies involved in safeguarding children
- Develop and agree upon multi-agency **policies and procedures** to guide local safeguarding practices, such as developing a shared threshold document

- **Monitor and evaluate** the effectiveness of safeguarding practices, for example by completing joint audits of case files to identify areas for improvement.
- **Commission reviews** of serious cases (Child Safeguarding Practice Reviews) and child deaths, share learning and implement recommendations
- Ensure the availability of single-agency and multi-agency **safeguarding training**
- Participate in the **planning and commissioning** of services that are required to safeguard children.
- **Ascertain the views of children and their families** regarding local safeguarding activities, and consider these views when changing/developing local approaches

Each partner on the LSP also has a set of specific responsibilities which include a duty to cooperate in the LSP, ensuring strategic representation on the LSP to facilitate accountability and policy development, sharing information to support learning, and challenging each other to ensure children's welfare remains held as paramount.

In Wales, Regional Safeguarding Boards (RSBs) are expected to fulfil a similar set of expectations. Set out in the Social Services and Wellbeing (Wales) Act2014, these expectations also include responsibilities to **coordinate** agencies, undertake **practice reviews and case audits** and action any recommendations, and meet **training** needs. Commitments to understanding and responding to children and young people's views include responsibilities to **co-produce** solutions with children, young people and families. RSBs also have an additional responsibility in Wales to provide bilingual information and support. The work of RSBs in Wales is guided by five underlying principles: Paramountcy principle (as in England), Parental Responsibility, Prevention, Partnership and Protection. Board membership includes regional representation from Local Authorities, Police, Health Boards and Public Health Wales, Education representatives, Probation and Youth Justice services and the Welsh Ambulance Service.

The details of how LSPs fulfil these responsibilities in respect of EFH are left largely to local discretion and are therefore subject to local variation. This is rarely guided by national frameworks.

LSPs are expected to coordinate multi-agency safeguarding responses and ensure that children's welfare remains central, including working with Community Safety Partnerships to address serious violence. However, national guidance provides limited direction on how partners – particularly policing and children's social care – should manage differing organisational priorities, leaving key tensions unresolved in practice. While policies emphasise the importance of sharing information and monitoring trends, they offer little guidance on how shared information should be interpreted or acted upon, particularly in relation to peers or children and young people who are not open to children's social care. Similarly, although LSPs may track disproportionality by monitoring operational data (for example from MACE (or equivalent) panels), there are few explicit requirements for them to address discrimination or embed anti-racist

responses to EFH. As a result, partnerships may meet formal expectations, such as providing training or developing policies, without necessarily delivering the strategic oversight needed to support effective responses to EFH.

Findings: LSP ability to meet expectations

LSPs are meeting some expectations in relation to EFH more than others. In many respects their response to EFH requires greater depth to create the conditions for effective operational practice.

Children's services and the police are providing leadership in strategic responses to EFH; however, such leadership between the two agencies is at times in conflict. Policing often set local protocols, thresholds and risk categorisation for EFH which sometimes take precedence over social care thresholds/categorisation. Consistency and effective leadership from health, education, housing, youth work and voluntary and community sector services is challenging to establish, given resource constraints and fractured levels of influence.

The above challenges in leadership are reflected in work around strategic coordination. Most evidence gathered on strategic coordination featured activities such as participation in meetings, sign-up to procedures and engagement in information sharing, rather than surfacing and resolving the practical challenges of multi-agency responses to EFH found in the delivery of MACE (or equivalent) panels.

LSPs are inconsistent in their approach to developing EFH strategies and policies. Many do not include all forms of EFH in current strategies, and some do not have any form of EFH as a strategic priority. LSPs use audits, case reviews and inquiries to review their approach to EFH; and the rate at which they are doing so is increasing. To build upon this, work is required to develop shared outcome frameworks or markers of efficacy against which they can monitor multi-agency strategic and operational performance.

LSPs have invested in training to develop local responses to EFH. To date, most training has focused on the nature of different forms of EFH; supporting professionals to identify the harm, particularly amongst children and young people who professionals are less likely to perceive as vulnerable. However, training now appears most needed in how to respond to EFH (and not solely see it); with attention given to local variations in approaches, strengths and challenges of particular local contexts.

The views of children and young people impacted by EFH do not appear to have consistently shaped the strategic direction of local responses to EFH. Strategic priorities are more likely to reflect the views of practitioners – such as improving information sharing practices – which do not always reflect the views of children and young people – such as reducing churn in the relationships they trust.

As such, while activity is underway in most areas of LSP responsibilities, there is space to either add depth, build consistency or work with complexity, to facilitate effective operational responses to EFH.

Findings: Facilitators and barriers to LSPs meeting expectations

To facilitate improvements in LSP responses to EFH and address barriers, this study identified five key issues.

1. **Leadership**: Relational, restorative and trusted leadership can support LSPs to fulfil expectations regarding EFH. However, our dataset suggests that such leadership needs to resolve tensions in the relationship between social care and policing and assert cultural leadership in which children and young people's welfare is paramount, to address the operational challenges of interagency practice.
2. **Duplication or gaps in strategic arrangements**: LSPs need to be intentional in addressing the relationship between safeguarding and community safety legislation, and processes, to create the conditions for consistent operational approaches. Current duplication, particularly on serious violence, between Community Safety Partnerships and LSPs creates strategic conditions in which parallel rather than integrated operational approaches have developed.
3. **Nuanced position on information-sharing**: LSPs require space, and support, to reflect on the results of this study and offer more nuanced leadership on information sharing. Such leadership needs to better outline the purpose, parameters and partnerships in which information is shared, with a primary purpose of safeguarding children and young people's welfare impacted by EFH.
4. **Proactive mapping**: LSPs require support to move beyond reactive strategic responses to EFH and reflect on what an integrated approach would entail, including mapping their local arrangements across various harm types that fall under the banner of EFH and understanding the tensions within these arrangements.
5. **Resourcing**: LSPs require resource to achieve the above, particularly in ways that ensure children and young people's needs can be met and where youth services are available to respond to EFH in context. Presently, budgets across LSPs and Community Safety Partnerships for EFH responses have not been drawn together, creating conditions in which policing are better resourced to respond to EFH even when social care would be better placed to do so.

Findings: Addressing racial disparities in support

To effectively safeguard racially minoritised children and young people, and address disparities in the support they receive, LSPs have largely focused on monitoring data on disproportionality and commissioning training on adultification to change attitudes. LSPs need to build upon this by reviewing the design of their local processes to identify,

and address, sources of discrimination *within* responses to EFH. A lack of attention to system design risks exacerbating the issue of racial inequality and fails to give professionals a language through which to understand why disproportionality exists.

Findings: Combined results

The findings of the Prioritising Protection project reflect practice conditions in which: a) MACE (or equivalent) panels have grown over the last 15 years in specific response to EFH; and b) policy frameworks have gradually increased the extent to which EFH is an area of responsibility for LSPs. By combining our findings on MACE (or equivalent) panels and LSPs, we identified five overarching themes that characterise these practice conditions; themes that warrant attention if we are to improve safeguarding responses to EFH in the future.

1. **Going beyond and getting underneath 'information-sharing'**: At the time of finalising this report new information duties and national guidance are further emphasising the position that safeguarding concerns provide a legal basis for information sharing. These policy narratives are focused on dispelling misconceptions that are barriers to information sharing. Yet, our findings evidence that operational structures, such as MACE (or equivalent) panels, are already key sites for exchanging large volumes of information. In these processes sharing information is often treated as a safeguarding action, with limited attention paid to how the information is interpreted or acted upon. Rather than further reinforce messages about the need to share information, national governments and local strategic partnerships should support practitioners to engage critically with how shared information informs safeguarding decisions and outcomes; with further facilitated reflection and potentially associated guidance on various facets of information-sharing including information-gathering, information-recording, acting on information that is shared and informing young people of information-sharing practices.

2. **Coordinated action and accountability**: MACE (or equivalent) panels often function primarily as spaces for sharing information rather than translating that information into coordinated safeguarding action. While these panels provide a focal point for responses to EFH, many effective interventions occur within multi-agency practice teams, often co-located and led by youth work and social care, where welfare-oriented responses are developed. Limited capacity in local systems to convert multi-agency discussion into action points to the need for clearer accountability structures and a clear, nationally consistent child protection pathway for EFH. Such arrangements could strengthen oversight, enable escalation when services fail to meet children and young people's needs and allow operational panels to focus on addressing systemic barriers to safeguard children and young people from EFH.

3. **From identifying disproportionality to delivering anti-racist systems**: The language of 'disproportionality' in both strategic and operational responses to EFH creates contexts of silence and discomfort around the topic of racism. It appeared easier for professionals to talk about disproportionality in their systems (the

perceived product of racism outside of the system), rather than discuss and address racism within their systems as contributing to the disproportionality. It is critical that practitioners and system leaders are supported to recognise that treating everyone the same, or assuming that this happens, in systems that reproduce inequality, is not sufficient. To be anti-racist, organisations also need to know how to mitigate the impacts of racism on children and young people's welfare. This requires more than training on 'adultification'; it demands structural change in how services assess needs, gather information, involve agencies such as policing and education in panels, and design support for racially minoritised children, young people and their families. Strategic leaders and policymakers must therefore examine how legal frameworks, assessment processes, service access, and historical relationships between communities and statutory agencies shape safeguarding responses and potentially reproduce inequality.

4. **Workforce pressures and impact:** Professionals involved in responding to EFH are under significant pressure. The children and young people they are supporting are at risk of significant, and sometimes fatal, harm. They express tangible worry for these children and young people and are acutely aware that they are working in contexts of stretched resources which compromise their ability to adequately meet needs. It is somewhat unsurprising therefore that despite the challenges raised in this report many practitioners raised concerns about the idea of losing a MACE (or equivalent) panel. These panels may not be a consistent site of multi-agency coordination, but they are often a multi-agency site in which worry can be contained, and reassurance can be sought/provided. Those who deliver MACE (or equivalent) panels, or deliver LSP strategic oversight of such panels, must alleviate the pressure on the EFH workforce and the impact of that pressure. The findings highlight the need to strengthen workforce support by prioritising relational safeguarding approaches, ensuring that information gathering exercises do not undermine trusted relationships with children and young people, and creating reflective supervision spaces to mitigate the potentially trauma-inducing nature of safeguarding discussions. LSPs also have a role to monitor workforce wellbeing and foster environments where practitioners can reflect on challenges they face, build confidence in local responses and avoid defensive practices driven by stress or uncertainty.

5. **Resolving the crime and welfare binary:** Responses to EFH are shaped by a persistent tension between criminal justice and child welfare frameworks. Information sharing, decision-making and intervention strategies often serve both welfare and policing objectives, which can result in the continued criminalisation of children and young people who require protection. In practice, EFH does not fit neatly within systems structured around this crime–welfare binary, with some children and young people being diverted away from child protection pathways or managed through community safety responses to EFH rather than accessing consistent welfare-oriented support. Stronger children's services leadership and a shared safeguarding outcomes framework are needed to prioritise welfare and mitigate criminalisation. However, achieving this remains challenging given

structural divisions in legislation, policy leadership and funding across government departments, which continue to shape local safeguarding responses.

Insights for Change: Improvements to multi-agency operational panels

Findings from the Prioritising Protection project raise significant questions about the usefulness, and potential risks, of using MACE (or equivalent) panels to oversee plans for individual young people impacted by EFH. These panels appear to hold most potential in providing thematic oversight of responses to EFH; addressing system/service barriers and developing responses to local trends or locations impacted by EFH. We recommend eight local actions to realise this potential.

1. Use MACE (or equivalent) panels for thematic-oversight, and integrate case-oversight into child protection pathways
2. Map the local operational pathway for responding to EFH to identify and remove points of duplication or dissonance
3. Clarify the purpose, and effectiveness measures, for MACE (or equivalent) panels to ensure welfare is held as paramount
4. Recognise, respond to, and take steps to not reinforce, discrimination within MACE (or equivalent) processes
5. Review the usefulness and rationale of co-chairing between social care and policing on MACE (or equivalent) panels
6. Inform children and young people about MACE (or equivalent) panels
7. Involve youth workers in MACE (or equivalent) panel meetings and in the delivery of associated actions
8. Ensure MACE (or equivalent) panels are action-orientated

The efficacy of MACE (or equivalent) panels is also informed, and undermined, by a lack of clarity on the position of EFH in national systems. We recommend six changes to national systems to address this shortfall.

1. Introduce a consistent statutory social work pathway for coordinating and monitoring support for children and young people impacted by EFH
2. Clarify the relationship between the serious violence duty and paramountcy principle for children and young people impacted by EFH
3. Provide detailed guidance on ‘information-gathering, information-sharing, information-recording and acting on information shared’ in the context of EFH
4. Clarify the primary purpose of multi-agency EFH panels within statutory safeguarding guidance
5. Recognise the clinical supervision needs of the EFH workforce and monitor the ways in which this is addressed via inspection processes
6. Produce a cross-government strategy on either EFH or safeguarding adolescents, led by the Department for Education and with child protection legislation as its basis

Insights for change: LSP responses to EFH

As was the case with findings related to MACE (or equivalent) panels, the system and practice challenges identified for LSPs are being shaped by national system shortcomings. As such, while we have identified changes to law, guidance, funding and inspection that have the potential to improve the work of LSPs, such changes are less about those partnerships and more about the conditions in which such partnerships operate.

In terms of national policy, guidance and funding we recommend:

1. The Government to provide a framework that integrates all legal tools relevant to the issue of EFH and resolves areas of contradiction
2. The Department for Education to lead the development of a cross-government strategy on EFH
3. The Department for Education to work with LSPs and Community Safety Partnerships to develop a Shared Outcomes Framework for monitoring efficacy in response to EFH
4. National bodies to resource responses to EFH that go beyond discrete interventions – and consider children and young people's needs holistically

Based on the findings of this study, we also recommend that Directors of Children's Services / Directors of Social Services specifically:

1. Explore the extent to which national narratives about system challenges in response to EFH reflect the operational difficulties at play in their local areas
2. Ensure the views of children and young people are sourced and considered when identifying local system priorities in response to EFH
3. Lead the LSP in holding the welfare of children and young people impacted by EFH as paramount, recognising that other partners may be operating to different goals

Finally, this study identified four opportunities for the Children's Wellbeing and Schools Act to support improved strategic responses to EFH:

1. Integrate responses to EFH into the work of Multi-Agency Child Protection Teams (MACPTs)
2. Use MACPTs to explore and resolve tensions in safeguarding approaches across children's services and policing
3. Ensure MACPTs have routes to escalate concerns about system/service barriers to effectively protecting children and young people impacted by EFH
4. Explicitly apply a commitment to Family Group Decision-Making to networks around peer groups and locations impacted by EFH

Conclusions and implications

This study has provided a rare opportunity to focus on systems and services used to coordinate responses to children and young people impacted by EFH, as opposed to studying those children and young people or the harms they face. By examining both key operational and strategic structures we have been able to evidence that the approaches of both, and the challenges they face, reflect significant shortfalls and points of confusion in national responses to EFH across England and Wales. We have also identified that while Welsh LAs operate to a distinct safeguarding model and slightly more integrated policy framework, many of the operational challenges are shared.

Local areas have undertaken a vast amount of work to respond to EFH; largely in the absence of comprehensive national guidance and direction on this. Gaps in national guidance, and complexity caused by siloed (and misaligned) policy and legislative frameworks, have created the conditions for the inconsistency we identify. Most local areas are working to their own arrangements, sometimes coordinated regionally or by police force area. Even when certain structures like MACE (or equivalent) panels are present across local areas, they often vary in terms of harms they include, the way they assess need or categorise risk, and whether they function to oversee plans for individual children and young people or for responses to trends, themes and locations. Despite these variations, there is much that local areas share in common. It is these points of commonality that we draw most attention to in this report. We believe that these points of commonality provide a clear indication of what systems and services need to do to improve responses to EFH in the future.

In conclusion, to build on 15 years of gradual reform, local responses to EFH now need to:

1. Strengthen the relationship between information-sharing and taking action on information that is shared. This should be achieved through clearer national guidance, and robust local protocols, that consider the purpose, storage, and use of information, safeguarding responses to EFH must ensure that information-sharing supports clear safeguarding decisions, actions and accountability
2. Use MACE (or equivalent) panels to coordinate those actions that address locations and trends impacting multiple children and young people, while creating distinct ways to recognise and respond to the anxiety and worry of individual practitioners who are supporting the children and young people who are impacted
3. Ensure processes to oversee plans for children and young people impacted by EFH are integrated into local child protection pathways
4. Intentionally resolve the harms caused to children and young people impacted by EFH when both racism and persistent welfare/crime binaries in local and national responses are left unaddressed

We have identified ways that local areas can, and do, attempt to do this – both in local safeguarding partnerships and in their local operating models. However, these changes must be visible amongst government and national sector leaders if such changes are to lead to consistent improvements in local responses to EFH in the future.

1. Introduction

The role of children's services, and the wider safeguarding partnerships in which they work, in responding to extra-familial harm, has undergone significant transformation over the last decade across England and Wales (Gorin and Jobe, 2013; Hanson and Holmes, 2013; Pearce, 2013; Hallet, 2016; Firmin et al., 2016; Maxwell and Wallace, 2021; Action for Children, 2023; Tackling Child Exploitation Support Programme, 2023; Firmin et al., 2024; Wroe et al., 2025).

Extra-familial harm (EFH) is defined as interpersonal violence and abuse that children and young people experience beyond their families. It can include physical, sexual, emotional and psychological violence and abuse and is an umbrella term for a range of harms that can occur in extra-familial context or relationships including child sexual exploitation (CSE), child criminal exploitation (CCE), harmful sexual behaviour (HSB), serious violence from peers or adults in public/school contexts, and abuse in intimate relationships. Responses to EFH vary within and across local authorities who, in the absence of a national steer, have often used different processes to address some forms of harm collectively (such as CSE and CCE together) and others via separate systems and pathways (such as serious violence or harmful sexual behaviours). Throughout this report, we use the term EFH to refer to various harms that occur beyond families, as well as referencing specific types of EFH such as CCE or CSE where it is necessary to do so.

Back in 2013, with the focus predominantly on child sexual exploitation (Pearce, 2013), research noted the need for a significant 'shift' in child protection and wider safeguarding systems to sufficiently meet the needs of children and young people harmed in contexts and relationships beyond their families (Hanson and Holmes, 2013). Over the following decade, practitioners, services leaders, researchers, children and young people, families and wider communities have worked together to better understand different forms of EFH including and beyond CSE, and the capacity of services to respond. This work has:

- increased recognition of children and young people impacted by EFH as being 'at-risk' of harm, rather than viewed primarily as 'a risk' to others (Cockbain and Brayley, 2012; Firmin, 2017; Lefevre, Langhoff & Luckock, 2018; Lloyd and Firmin, 2019; Maxwell, 2022)
- evidenced that for those experiencing EFH, such harm often persists beyond someone's 18th birthday, despite children's services support often ceasing (or significantly reducing) at this point; thus requiring a transitional safeguarding approach to bridge gaps between children's and adult safeguarding systems (Holmes and Smith, 2022, T2A Alliance, 2025)
- led to a policy landscape with increasing requirements on children's services to coordinate corresponding multi-agency safeguarding support for children and young people affected (All Wales Government, 2021a; 2021b; HM Government, 2023).

These developments have taken place in a challenging context, characterised by complex multi-agency landscapes, varying levels of national guidance and resourcing, and ongoing questions about how best to provide tailored responses to the extra-familial contexts in which EFH occurs (MacAlister, 2022; Action for Children, 2023; Marshall, 2023; Tackling Child Exploitation Support Programme, 2023). Questions remain as to what has been achieved in respect of safeguarding children and young people from EFH (Hood et al., 2023; Firmin et al., 2024; Wroe et al., 2025) and where markers of consistency or divergence across local responses signal a need for further system or practice reform.

1.1 The research

'Prioritising Protection' is a research project commissioned by the Youth Endowment Fund (YEF) to explore two key structures in this complex landscape – multi-agency operational panels that coordinate responses to EFH, and the multi-agency strategic safeguarding partnerships that oversee their activity. Prioritising Protection is led by the Global Centre for Contextual Safeguarding (Durham University) in partnership with Research in Practice, The Association of Safeguarding Partners, and the National Policing Vulnerability Knowledge and Practice Programme (hosted within the College of Policing).

The project involves two studies which explore the role of children's services, within wider multi-agency safeguarding responses, to child criminal exploitation[1] and other forms of EFH.

- One study is focused on the role of Multi-Agency Child Exploitation (MACE) panels (and alternatives to them) as a key structure for coordinating operational safeguarding responses to EFH. Specific attention is paid to the scale, nature and remit of such multi-agency panels, the practices they involve, their efficacy and connectivity within local systems, and national and local factors which could improve their use in the future[2].
- The second study is focused on strategic arrangements that govern operational processes, with a particular focus on Local Safeguarding Children Partnerships (LSCPs) in England and Regional Safeguarding Boards (RSBs) in Wales (collectively referred to as local safeguarding partnerships (LSPs) for the purpose of the project). It explores the role of children's services within these partnerships, working alongside police, health and other safeguarding partners, and considers how roles, expectations and arrangements set out in law and guidance are being met in practice.

[1] As a form of harm that is predominantly extra-familial, but may also occur in a manner associated to families

[2] In this report, "equivalent" panels refers to locally named forums that operate in a similar way to MACE panels, while "alternatives" refers to different local arrangements used in place of a MACE panel (these distinctions are explained in more detail in Chapter 4).

We have delivered the two studies as one combined project, to reduce the burden on participating local areas and to develop a joined-up picture on strategic and operational responses to safeguard children and young people impacted by EFH.

1.2 Research questions

The research questions for this project were set by the Youth Endowment Fund as follows:

MACE Panel Research Questions

RQ1. How prevalent are MACE and equivalent panels, how do they typically operate, and what other approaches are local authorities using in their stead?

a. Which local authorities are using MACE panels (or equivalent panels of a different name)?
b. Are there areas not using MACE panels, and if so, why? Are these areas using alternative approaches?
c. How do MACE panels typically operate and how does this vary across areas? (This should include a description of the threshold for referral, and which children MACE panels are serving)
d. What are the options available to MACE panels to protect children?

RQ2. How effective are MACE panels?

a. Are MACE panels successfully coordinating with other safeguarding structures (e.g. MASH)?
b. Are MACE panels successfully identifying and protecting children who are being exploited?
c. Are the alternative approaches used in place of MACE panels in some areas performing better?
d. Is the operation and delivery of MACE conducive to protecting all children (including children from Black, Asian and Minority Ethnic communities)? For instance, are racially and ethnically diverse perspectives represented and are they influencing decision-making?
e. Are there examples of best practice delivery of MACE panels?

RQ3. How can MACE panels be improved?

a. What changes can be made at a local, practice level to support and improve the delivery of individual MACE panels?
b. What system changes (e.g. to regulation, funding, inspection, guidance and training) can be made at a national level to improve the delivery of MACE panels across England and Wales?

LSP Research Questions

Part 1: The current context

RQ1. What are local safeguarding partnerships currently expected to do to protect children at risk of involvement in EFH across England and Wales? (As set out in law and guidance). This should include a description of the expectations on:

- The Local Authority (including Children's Services)
- Integrated Care Boards
- The Police
- The collective LSP (including any other non-statutory partners)

RQ2. To what extent are local safeguarding partnerships meeting these expectations in practice? (This should assess the performance of each of the three main statutory partners, in addition to the collective partnership).

RQ3. What are the facilitators and barriers to meeting these expectations? (This could include resource, confusion around policy and guidance, competing priorities or other challenges or facilitators).

RQ4. Does current law, guidance and practice exacerbate or reduce racial disparities in support?

Part 2: System and practice changes that would improve safeguarding of children at risk of CCE and EFH

RQ1. What changes should be made in law, guidance, funding and inspection to improve the safeguarding of children from CCE and EFH by local safeguarding partnerships?

RQ2. What should Directors of Children's Services do to improve the work of local safeguarding partnerships in safeguarding children from CCE and EFH?

RQ3. How should the government implement the measures in the Children's Wellbeing and Schools Bill to ensure LSPs are protecting children from CCE and EFH?

1.3 Research methods

A mixed methods approach was adopted to examine (a) national trends and patterns across England and Wales and (b) provide detailed accounts of local practice (see Methodology chapter for full details).

National level data collection consisted of:

- A rapid evidence assessment of multi-agency strategic and operational practices in England and Wales, with specific questions about the role of children's services and the role of safeguarding partners in collaborating with them
- A review of Serious Case Reviews and Rapid Reviews (published and unpublished) where extra-familial harm was a factor, identifying the roles played by multi-agency partnerships and recommendations made to them
- A national survey of Business Managers[3] from Local Safeguarding Children Partnerships in England and Local Safeguarding Children Boards in Wales, exploring strategic activity and arrangements, and facilitators/barriers of that activity
- A national survey of chairs of MACE (or equivalent) panels, or alternatives to them (including Police and Social Care perspectives)
- A review of MACE (or equivalent) protocols and LSP strategies submitted as part of the surveys
- Interviews and focus groups with service leaders, practitioners, chairs, scrutineers and policymakers
- A review of local multi-agency panel protocols and strategic documentation (sourced separately to the survey)

Local level data collection consisted of:

- Six case studies of multi-agency arrangements in local authority (LA) areas. Case studies were developed using a combination of practice observation, analysis of children's assessments and plans, documentary analysis of local procedures and strategies, professional focus groups, and workshops to map local systems and pathways.

1.4 Contribution

This project has provided a rare opportunity to build a substantial evidence base on strategic and operational safeguarding responses to children and young people impacted by EFH; capturing local and national experiences and highlighting promising practice.

[3] Business Managers lead the administrative, operational and strategic support for local safeguarding arrangements.

Crucially it also contributes to building a stronger evidence base on racial equity in, and lived experience of, safeguarding responses. Whilst the primary focus of this research has been on the role of children's services in convening local safeguarding responses to the needs of children and young people in the context of EFH, to do so it has also been essential to consider the insight and experiences of partner agencies with whom they work. The research provides a deeper, sector-wide understanding of the challenges and opportunities around safeguarding children and young people impacted by EFH – supporting both strategic and operational improvement in safeguarding systems and clarifying the roles of children's services within these.

The YEF seeks to prevent children and young people becoming involved in violence, through generating and acting upon evidence of what works. Understanding the context in which children and young people live and in which services support them is imperative to this, including the children's services sector. The project findings are being used to inform the YEF's work to develop Practice Guidance and Systems Guidance on the role of children's services in preventing and responding to children and young people's involvement in violence. The findings are also being considered alongside YEF's other interdependent workstreams on sectors including policing, health, youth work and education.

1.5 Report structure

The report is organised according to the following structure.

Chapter 2 offers a background to the study, presenting the results of a rapid evidence assessment on research into the role of MACE (or equivalent) panels and LSPs in responding to EFH, in the context of wider literature on safeguarding responses to EFH. In doing so, Chapter 2 illustrates the evidence gaps that this study and report begins to fill.

Chapter 3 details the methodological approach we have taken, setting out the data collection strategy for each dataset used in this study, and our approach to combining them all via a narrative analysis to answer the questions posed by the YEF.

Chapter 4 details our findings in relation to MACE (or equivalent) panels, and local alternatives to them, as a key feature of local operational responses to EFH. Chapter 5 details our findings in relation to LSPs, and their role in offering strategic oversight of local multi-agency safeguarding arrangements.

Across both Chapters 4 and 5 we answer the specific RQs posed for each study, before surfacing themes shared across both in Chapter 6. Chapter 7 concludes this report, summarising key learning points and required actions.

2. Background and Rapid Evidence Assessment

This chapter provides background context to our findings on the role of MACE (or equivalent) panels and LSPs in responding to EFH, before presenting the results of the Rapid Evidence Assessment (REA) into what has already been written on these specific operational and strategic structures. The methodological approach to the REA is outlined with full details available in Appendix A and results that were found in line with the agreed search strategy are presented in Appendix B.

2.1 National policy context

Safeguarding responses to children and young people impacted by EFH are influenced by various discrete policies, policy focused documents and practice guidelines, largely organised around specific forms of EFH.

2.1.1 England

England's statutory safeguarding guidance, Working Together to Safeguard Children, provides the statutory basis upon which local safeguarding responses to EFH are delivered. The document states that:

> *"Where children may be experiencing extra-familial harm, children's social care assessments should determine whether a child is in need under section 17 of the Children Act 1989 or whether to make enquires under section 47 of the same Act, following concerns that the child is suffering or likely to suffer significant harm."* (HM Government 2023: 68)

However, the document does not include specific detail on how children's social care pathways, such as child protection procedures, specifically apply in situations of EFH. For example, it states there may be a need to work with Community Safety Partnerships but does not explain how. The most detailed policy directive on this matter can be found in *The Families First Partnership (FFP) Programme Guide Delivery expectations for safeguarding partners in England* published in March 2025. This is not a guidance document. Instead, it details what is expected of all local authorities (LAs) in England regarding the children's social care reforms that are underway at the time of writing this report. Within a section detailing the introduction of multi-agency child protection teams, a sub-section is included on how those arrangements may apply to EFH. This is the first time in English national policy that the government has indicated what a child protection process must entail in situations of EFH; it is yet to be included in statutory guidance.

Supplementary to statutory guidance, are the English guide on CSE published by the Department for Education:

- *Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation* (Department for Education, 2017)

and guidance on CCE published by the Home Office:

- *Criminal exploitation of children and vulnerable adults: county lines* (Home Office, 2023)

It is important to note therefore that sexual exploitation policy is led by the Department for Education, situating it in a safeguarding brief; whereas criminal exploitation is led by the Home Office, situating it in a policing and criminal justice brief.

Beyond these two documents, in regard to peer-to-peer abuse the government now organises its responses largely through the statutory safeguarding advice to schools:

- *Keeping children safe in education: 2026 Statutory guidance for schools and colleges* (Department for Education, 2026)

Previously the government published specific advice on *Addressing sexual violence and sexual harassment between children in schools and colleges* (Department for Education, 2021), however this was withdrawn in 2022 and integrated to an extent into *Keeping Children Safe in Education*.

The Home Office also released policy documents on teenage relationship abuse between 2011-2015, however, these have since been withdrawn. A briefing published in 2024 by the House of Commons Library states that:

> *"The policy position is that teenage relationship abuse involving under 16s should be categorised as child abuse rather than domestic abuse, with a response that focuses on child protection. This is reflected in the statutory guidance on domestic abuse, which says that 'Whilst young people under the age of 16 can experience abuse in a relationship, it would be considered child abuse as a matter of law', and that 'ultimately, in responding to cases of abuse involving those under 18, child safeguarding procedures should be followed'."* (Lipscombe, 2024: np)

This position would revert local areas back to the core position in *Working Together to Safeguard Children* which as we note does not presently detail how multi-agency safeguarding or child protection procedures specifically apply in situations of EFH.

There are no supplementary *safeguarding* guidance documents available for children and young people who display harmful sexual behaviours or who are impacted by 'serious youth violence'.

2.1.2 Wales

In Wales, the *Wales Safeguarding Procedures* provide the overarching framework for coordinating multi-agency safeguarding activity. The document details the grounds for supporting children and young people with care and support needs, and in situations where child protection procedures are required. The procedures are linked to a range of *All Wales Practice Guides* which offer greater detail on a range of harms children and young people face. For EFH, separate practice guidance are available for:

- Safeguarding children from Child Criminal Exploitation
- Safeguarding children who may be trafficked
- Safeguarding children affected by domestic abuse
- Safeguarding children from online abuse
- Safeguarding children where there are concerns about harmful sexual behaviour
- Safeguarding children who go missing from home or care
- Safeguarding children from child sexual exploitation
- Safeguarding children from radicalisation

In regards, to domestic abuse, the policy position in Wales is the same as England, in that the definition of domestic abuse applies to interpersonal harm between people aged 16-and-over, and in these situations domestic abuse practice pathways for adults would apply. When children and young people experience this form of EFH under the age of 16 it is considered a form of child abuse – and in Welsh documents is referred to as peer-abuse – and so child protection processes apply as they do for all other harm types impacting children and young people.

As has been the case in England, the Welsh inspectorate, Estyn, has undertaken a review regarding sexual violence and harassment in schools; and the Welsh government has released an action plan in response, which embeds this issue in its policy agendas on health and wellbeing, and violence against women and girls.

There are no supplementary *safeguarding* documents for children and young people impacted by serious violence.

2.1.3 Across England and Wales

Beyond the above, additional Home Office policy influences multi-agency responses to EFH across both England and Wales.

As we noted above, neither England nor Wales have supplementary *safeguarding* guidance for responding to serious violence impacting young people. Instead, the Home

Office have released the following guidance, underpinned by the serious violence duty as opposed to child protection or safeguarding legislation for England and Wales:

- *Serious Violence Duty: Preventing and reducing serious violence, Statutory Guidance for responsible authorities England and Wales* (Home Office, 2022)

While the document includes a section on children and young people it reverts back to core safeguarding documents like *Working Together to Safeguard Children* stating that 'there is extensive existing statutory guidance found in "Working together to safeguard children" to support local partners to develop their serious violence strategy and consider the importance of safeguarding children' (Home Office, 2022:46). Yet as has been outlined above, there is minimal detail in these documents as to how safeguarding duties apply in situations of serious violence.

In addition, the Home Office has released a *Disrupting Exploitation* toolkit in 2019, that was further updated in 2022. The document states that:

> *"The use of disruption tactics, including legislative tools such as civil orders and injunctions, are an essential part of the safeguarding process and can also support future prosecutions."* (Home Office, 2022: 2)

However, it does not detail how disruptive actions interface with child protection procedures in England or Wales, nor does it recommend ways to resolve scenarios when children and young people who are subject to safeguarding processes might also be targeted via disruption activities.

2.1.4 Cumulative policy framework for responding to EFH

As detailed above, the policy framework guiding local responses to EFH is fragmented, often limited, and features key gaps. In summary:

- Welsh policy better organises most forms of EFH under a unifying safeguarding framework than that available in England
- English policy is limited in terms of guidance on different forms of EFH, particularly from a *safeguarding* perspective. CCE policy is led by the Home Office and there is no safeguarding guidance for Harmful Sexual Behaviour at all.
- Serious youth violence is excluded from safeguarding policies in both England and Wales
- Intimate partner abuse impacting under-16-year-olds also falls through policy gaps. 16–17-year-olds are included in pathways determine by domestic abuse impacting adults. Those under-16 are referred into child protection pathways in both England and Wales, without specificity of how those pathways apply for children and young people facing this form of EFH
- More generally, there is limited detail on how child protection and/or wider safeguarding pathways apply in situations of EFH, with the exception of new

expectations for risk outside of the home child protection pathways set out in guidance for implementing children's social care reform in England.

Across this myriad of policies very little is detailed about the role of MACE (or equivalent) panels specifically, or how they relate to child protection or wider safeguarding processes. There is important context for this.

The policy frameworks outlined above have emerged gradually, over a 15 year-period of increasing concern about EFH. It was not until 2018 that England's statutory safeguarding guidance named all forms of EFH as 'child protection issues'. Before this, safeguarding responses to EFH was largely detailed in supplementary rather than core safeguarding guidance documents. Even after this policy clarification, debates have persisted as to whether EFH is a child protection issue or not; with studies evidencing that children and young people impacted by EFH have often been screened out of child protection processes when social workers conclude they are relatively safe with their families (despite being at risk of significant harm beyond them) (Lloyd and Firmin, 2019; Hood et al, 2023). Local responses to EFH have therefore mirrored the national policy pattern. Initially in respect of CSE, and gradually broadened to other forms of harm, responses to EFH were developed outside of core safeguarding processes. MACE (or equivalent) panels, as a structure through which to oversee/monitor operational responses to EFH were introduced in the absence of core safeguarding guidance; and have largely been convened under policing protocols rather than national statutory guidance. Just one national policy document explicitly offers guidance on the role MACE (or equivalent) panels in response to EFH:

- Research in Practice (2023) *Multi-agency Practice Principles for responding to child exploitation and extra-familial harm*. Available at: https://tce.researchinpractice.org.uk/

As statutory safeguarding guidance has increasingly recommended child protection responses to EFH, and children's services leadership in this area, support for children and young people impacted by different forms of EFH has increasingly been coordinated through social work pathways and plans (Firmin et al, 2021; Action for Children, 2023). Like MACE (or equivalent) panels, such pathways/plans offer oversight of safeguarding responses for children and young people impacted by EFH. Despite this changing climate, and the lack of direction about how they should be delivered, MACE (or equivalent) panels remain a core feature of responses to EFH in many local safeguarding systems.

Unlike MACE (or equivalent) panels, LSPs are a statutory structure required in all local safeguarding systems. As such, there is far more national guidance on their nature and role in both England and Wales including in:

- Part 7 of the Social Services and Well-being (Wales) Act 2014. Available at: working-together-to-safeguard-people-volume-i-introduction-and-overview.pdf
- Department for Education (2023) *Working Together to Safeguard Children*. Available at: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- The Regional Safeguarding Boards Framework. Available at: The Regional Safeguarding Boards | Social Care Wales
- The Child Safeguarding Review Panel (2021) *Annual Report*. Available at: https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2021
- Department for Education (2021) *Multi-agency reform: Key behavioural drivers and barriers*. Available at: http://www.gov.uk/government/publications/multi-agency-reform-key-behavioural-drivers-and-barriers
- Department for Education (2016) *Wood review of local safeguarding children boards*. Available at: https://www.gov.uk/government/publications/wood-review-of-local-safeguarding-children-boards
- Department for Education (2016) *Information sharing to protect vulnerable children and families*. Available at: https://www.gov.uk/government/publications/protecting-vulnerable-children-and-families-information-sharing

In relation to EFH specifically, there is much less direction on the role of LSPs. Some inspectorate reports comment on the importance of strategic arrangements for responding to EFH, including the *Joint Targeted Area Inspection of multi-agency responses to serious youth violence* (2024). Relevant guidance is also provided in the *Multi-agency Practice Principles for responding to child exploitation and extra-familial harm*, noted above. However, for the most part, national guidance on LSPs' role in responding to EFH reflects the fragmented and under-specified policy context outlined above: while LSPs are clearly expected to provide strategic safeguarding leadership, there is limited direction on what this should mean for EFH specifically. As EFH has gradually become recognised as a safeguarding and child protection issue, LSPs have increasingly been expected to help coordinate the response. Yet their remit is much broader than EFH, leaving their contribution in this area open to interpretation.

2.2 The role of LSPs in safeguarding responses - an overview of the evidence

Local Safeguarding Partnerships (Local Safeguarding Children Partnerships (LSCPs) in England and Regional Safeguarding Boards (RSBs) in Wales) are multi-agency governance arrangements used to strategically coordinate and oversee child safeguarding systems. Research into the activities and effectiveness of LSPs provide an evidence base about the facilitators and barriers to effective strategic multi-agency safeguarding generally, but much less about what LSPs specifically do, or should do, in relation to EFH, as we summarise in this section.

In England, LSCPs were introduced following reforms to safeguarding structures in the Children and Social Work Act 2017 and implemented through the statutory guidance Working Together to Safeguard Children (Department for Education, 2018; updated 2023). These arrangements replaced Local Safeguarding Children Boards and aim to strengthen accountability and collaboration between key agencies responsible for protecting children. In Wales, RSBs were introduced under Part 7 of the Social Services and Well-being (Wales) Act 2014 to fulfil a similar function to LSCPs in England. Under this these legislative frameworks, LSPs (both LSCPs in England and RSBs in Wales) have strategic responsibility for leadership, governance and oversight of all local arrangements for safeguarding children and young people, including EFH.

Through our REA we identified a range of factors believed to facilitate LSPs in meeting these expectations; many of which feature elements of collaboration and cultural features of practice. The Child Safeguarding Practice Review Panel (CSPR) annual report (2022) identified good attendance at meetings, good communication and effective joint working as important. The Wood Review (2021) noted that the gathering and sharing of data, improved communication between adult and children's services, and closer operational working across partnerships were enablers of effective multi-agency working. The culture of partnerships is consistently found to play an important role in their efficacy across the literature reviewed. For example, Dudau et al. (2016) outline key catalysts for collaboration, including middle management representation at LSP, joint inspection and evaluation, inter-professional/inter-disciplinary training, encouragement of debate and personal investment in partnership. This was echoed more recently in Ball et al.'s (2024) study which found present, passionate, proactive leadership, well-established and well-functioning partnerships and congruence between strategic leadership and operational activity are key to underpinning effectiveness. The Department for Education (2021) also noted the importance of active participation and leadership across strategic and operational multi-agency working, along with understanding of agency roles and shared processes and thresholds. Racher and Brodie (2020) found that safeguarding partnerships became more embedded during the

pandemic, with increased willingness to collaborate and improved information sharing, engagement and efficiency, partly because of improved virtual communication.

In terms of barriers, the evidence base discusses the challenges of working across sector, cultural, practical and policy boundaries. The Wood Review (2021) and Dudau et al. (2016) amongst others identified challenges around developing skills and setting expectations; differing capacity, responsibility, power and approaches amongst safeguarding partners; ambiguity around referral and intervention thresholds; and the difficulties of working across complex geographical footprints with differing agency boundaries. Kantar's (2021) report on multi-agency reform reflects many of these challenges and provides important nuance. Despite a good understanding across agencies and levels (strategic and managerial) of why partnership working could be effective in safeguarding children and young people, there were lower levels of understanding of how to effectively achieve this goal, particularly at the frontline level. Additional barriers included: cross-agency misunderstanding of operational roles, legislative changes which could exacerbate geographical and cross-partnership processes and challenges, and reduced input from wider, non-statutory organisations (such as education and the voluntary sector), particularly where LSP structures have been reduced in size.

More recently, Driscoll et al.'s (2024: vii) evaluation of Multi-Agency Child Safeguarding Arrangements, which was not returned during the REA search process, also evidenced challenges that LSPs face. Findings from 322 responses from 102 LSCPs showed that less than half of survey participants considered that their LSCP has access to adequate data to inform service design/respond to safeguarding issues across agencies; and less than half reported having adequate financial resources, staffing, and administrative/data systems. Furthermore, although mechanisms to include children's voices are often well embedded in individual services, this is not yet consistently captured across the diversity of local populations nor is it used to inform policy and practice changes. The evaluation also found that effective strategic collaboration does not easily translate to improvement at the frontline.

Similarly, Frost (2017) identified structural and organisational issues and differences in ideological and explanatory frameworks by different agencies and workers as challenges for co-located social workers in multi-agency settings. In their ethnographic study of LSPs, Dudau and McAllister (2018) examined the roles that occupational segregation (the over-population of a profession by one gender) and gender bias in the welfare professions play in persistent failures in inter-agency and inter-professional collaborations. They argued that occupational gender segregation in the welfare professions could be a barrier to collaborative working, jeopardising effective communication by reinforcing traditional boundaries between the core agencies involved in service delivery. A cultural dissonance

was found to exist between more traditionally 'feminine' welfare agencies (e.g. social work) and 'masculine' agencies (e.g. police), which can act as a barrier to collaborative working.

Only six documents identified in the REA related to RSBs in Wales. McManus et al.'s (2023) recent thematic analysis of child practice reviews in Wales is the most useful source for this study, providing recommendations for Authorities and Boards. This includes the need for clearer multi-agency threshold guidance, a national Safeguarding Health Working Group, clearer demonstration of the effectiveness of strategic multi-agency safeguarding arrangements and adoption of the Collective Safeguarding Responsibility Model: 12Cs as a toolkit to help with this. The findings of Machura's (2016) study of inter and intra agency cooperation in North Wales continue to resonate. For example, co-operation at the agency level was associated with the use of shared terminology and effective mechanisms for resolving conflict between those agencies.

While all of the above is likely relevant to understanding facilitators and barriers to LSPs fulfilling their expectations specifically in relation to EFH, current policy frameworks do not sufficiently specify LSP responsibilities in respect of EFH, and current research does not account for the extent to which those specific responsibilities are met. Moreover, while efficacy and challenges to strategic multi-agency working are documented in the established evidence base, it is less clear which of these are most pertinent for the contributions LSPs make to coordinating local responses to EFH.

2.3 The role of multi-agency panels in responding to EFH - An overview of the evidence

Multi-agency panels have been a feature of local area responses to exploitation for over a decade (Ibbetson et al., 2022; Wilson and Mueller-Johnson, 2024). Yet there is no official account of their scale, nor of their core functions/activities. This is largely because, as outlined above, they have developed in the absence of, rather than in accordance with, national guidance on safeguarding responses to EFH. Over a 15-year period, children and young people impacted by different forms of EFH have been drawn into safeguarding processes, but without clarity as to whether these processes should be within or additional to established children's social work pathways (Lloyd and Firmin, 2019; Ofsted, 2019; Hood et al., 2023). During this time MACE panels, originally intended for CSE and then latterly CCE, have become a central local multi-agency structure for coordinating responses to different forms of EFH. In addition, the contextual nature of EFH, means the children and young people impacted together may not be in the same family, but will be friends, share school or community contexts; creating drivers for process through which to oversee responses peer groups and public spaces impacted by

EFH (Berelowitz et al., 2013; Firmin, 2017; The Tackling Child Exploitation Programme, 2023; Wroe et al., 2025).

In theory, MACE panels offer a route to addressing both issues – they provide a pathway for, and oversight of, plans to support children and young people impacted by EFH (whether their support plan is coordinated via a traditional child protection plan or not), and to coordinate responses to contexts in which such harm occurs. However, specific research on their ability realises this potential is limited. Our REA elicited two documents that provide specific evidence on the scale, nature and efficacy of MACE panels (Wilson and Mueller-Johnson, 2024 and Ibbetson et al., 2022). The remaining documents found through the REA were tangentially useful in understanding the context for MACE panels but were less relevant to the research questions explored in this study.

Wilson and Mueller-Johnson (2024) undertook descriptive statistical analysis of a Northern English county's MACE referrals, in order to determine whether the most harmed exploited children and young people are referred to MACE panels. They found that 90.7% of exploited repeat victims were not referred to MACE. Methodologically the research explored several quantitative methods to predict harm in criminal exploitation. However, by using conditional probability and harm association, 90.7% of missed repeat victims became visible to professionals, thus providing the opportunity to minimise the risk of further victimisation and increased harm.

Ibbetson et al. (2022) present the findings of a peer review of MACE arrangements in London. The evaluation included two elements: 1) a self-assessment of local MACE arrangements returned on behalf of 24 of 32 London boroughs and 2) six peer review meetings in which local partnerships participated, building on the information provided in the self-assessment. The review sought to understand the implementation of MACE protocols and the Victim Offender Location Theme (VOLT[4]) approach, and assess the effectiveness of MACE processes, their operational oversight and impact. The review concluded that substantial differences in approaches operate across the city, with no clear criteria or data for measuring effectiveness or impact and that it is therefore not possible to measure their effectiveness. A hierarchy of meetings usually take place: a pre-MACE meeting (screening cases for discussion), Operational MACE meeting (arrangements to support operations and evaluate the effectiveness of activity) followed by a Strategic MACE meeting (structures to support strategic oversight and planning of activity) (table 2, Ibbetson et al., 2022). It identifies the need for statutory guidance of EFH and evidences the consequences of the absence of such a framework. This includes different interpretations of activity and harm, no shared processes of assessment or

[4] The VOLT approach is a strategic, intelligence-led framework used by safeguarding partners to identify and address wider contextual risks related to child exploitation, serious violence and organised crime.

thresholds, unreliable, inconsistent and incomparable data, leading to a lack of clearly defined objectives or identifiable impact. The authors identify the benefits of a successful MACE approach as related to the development of operational MACE (though success is not clearly defined or measurable), and the resulting culture of trust and collaboration between partners.

The remaining documents identified through our REA do not specifically discuss MACE panels but provide learning about multi-agency operational working and panel responses to EFH more widely, which are relevant to consideration of MACE panels. For example, Radcliffe et al. (2020) in their study of CSE partnerships in coastal towns discuss the concept of vulnerability, describing it as a 'slippery, loaded, moral, ethical and exclusionary' term, which may be helpful in reflecting on how vulnerability is considered within MACE panels and alternatives to them. Whilst MACE panels are not discussed in the study, other multi-agency partnership meetings and the related challenges that arise within them are discussed, such as limitations with the assessment tools that partnerships use to identify and agree approaches to address exploitation. Creaney and Burns' (2025) article on high-risk panels within the Youth Justice arena similarly engages with conceptual complexities that play out in practice, including how responses must balance responsibility for public protection and safeguarding. The authors also reflect on children and young people's participation within panels – even when they are framed as victims, multi-agency panels rarely include children and young people within the panel processes.

Two further documents, again neither of which are MACE specific, seek to tackle some of these challenges by outlining principles and responses for multi-agency working in responding to EFH in general and CCE specifically. Multi-agency practice principles for responding to child exploitation and other forms of EFH were developed for HM Government (2023) by the Tackling Child Exploitation Support Programme. The programme identified eight practice principles to support a more holistic response to children and young people impacted by EFH as follows:

1. Putting children and young people first.
2. Recognising and challenging inequalities, exclusion and discrimination.
3. Respecting the voice, experience and expertise of children and young people.
4. Being strengths-based and relationship-based.
5. Recognising and responding to trauma.
6. Being curious, evidence-informed and knowledgeable.
7. Approaching parents and carers as partners, wherever possible.
8. Creating safer spaces and places for children and young people

Examples of how agencies enact Practice Principle six are presented, including one reference to a MACE panel, in which a learning culture was created in the panel that

emphasised harm reduction rather than risk management to engage with the complexity of EFH and recognise the uncertainty that often features in how professionals understand what children and young people are facing. Harm reduction approaches were enabled through co-chairing (social care and police), coordination and collation of partner data to identify trends and highlight outcomes to inform multi-agency service delivery and review processes (Gov, 2023: 71). A study by Lloyd et al.'s (2023) drew on data from two children's social care departments applying a Contextual Safeguarding framework to EFH. The researchers explored factors that facilitated welfare approaches for children and young people who were criminally exploited, and those conditions that undermined welfare approaches to the same issues. The welfare framework they have established is useful for considering in the activity of MACE panels. They outline five conditions which facilitate or inhibit welfare responses including:

- whether legal rights promote the best interests of the child or young person,
- if harm reduction prioritises a child or young person's needs,
- if language is underpinned by caring intention,
- the extent that system's harm is recognised and addressed,
- relationships between children and young people and practitioners are resourced over time and provide the basis therefore for relational forms of knowledge

No documents on MACE panels specifically related to Wales were surfaced through the REA.

Overall, the current evidence base on MACE panels is limited but illustrates the challenges they face, and some opportunities to address these, through welfare-orientated and harm-reduction approaches to delivery. However, this evidence base does not offer a national account of the scale, nature, efficacy and impact of MACE panels in response to all forms of EFH. Whilst previous research on EFH has drawn upon data from MACE panels to understand the nature of EFH and the children and young people impacted, far less has been written about MACE panels themselves.

2.4 Evidence on racial disparities in responses to EFH

Both the MACE Panel and LSP studies undertaken for this report answer specific questions on the extent to which operational and strategic responses to EFH protect racially minoritised children and young people and address racial disparities in support. Very little literature was identified through the REA in which race and anti-racism were discussed in the context of MACE panels and/or LSPs, despite wide acknowledgement of these issues within EFH literature more broadly.

The language of 'disproportionality' is used in accounts of both strategic and operational responses to EFH and in a few documents was raised as an issue that required greater

understanding. Some reports recommended improvements to multi-agency responses to the racism itself. In particular, the Child Safeguarding Practice Review Panel Annual Reports which analyse rapid reviews, included a particular focus on EFH in their 2023-24 report. The report concluded that the adoption of a 'child first'[5] approach to youth justice had been inconsistent, which could lead to labelling of, and adultification bias towards, Black children and young people given that practitioners disproportionately identify these children and young people as impacted by serious violence and 'gang' associated harm. Of the 330 Rapid Reviews featured in the report, 78 featured EFH. When comparing reviews of children and young people aged 11-17 years old who experienced EFH with children and young people of the same age who did not, the proportion of Black children and young people was three times higher in the EFH sample than in the comparison sample and the proportion of white children and young people was notably lower.

Wroe's (2021) study of safeguarding responses to exploitation via 'county lines' drugs distribution found that dominant norms about gender, race and age intersected to produce subjective assessments of vulnerability and risk of the children and young people affected. It noted the need to consider how routine policies and practices in multi-agency partnerships and the national context they operate within might be driving over-representation (racial disproportionality). The LGA's (2021) resource pack on EFH cites reports on racial disparities in criminalisation, CCE and CSE, suggesting that LAs need to be aware of the under and over-representation of some groups in service responses to EFH, but does not provide tangible guidance about how any identified disparities should be addressed. In the same year a study into safeguarding arrangements for Black young men in Lambeth (Firmin and Wroe, 2021) identified that while these children and young people often needed better/safe access to education, timely assessments in terms of ADHD, Autism and Wider Learning Needs, and improved access to housing and employment, responses to support them often focused on mentoring, behaviour change and gang-exit provision. The study also identified that professionals found it difficult to name racism as an issue within their services, and instead talked about disproportionality and difference; rendering Black young men both invisible in safeguarding systems and hyper-visible in policing and justice interventions.

While the evidence base on race, racism and EFH establishes issues related to both the over-and-under-representation of children and young people in different support services, it does not specifically account for how MACE panels and LSPs mitigate, or contribute to, these patterns.

[5] Child First is the guiding principle of the youth justice system in England and Wales. It means seeing children as children, focusing on their rights, needs and potential and diverting them from the justice system (YJB, 2025: 4).

2.5 Background summary and conclusion

There is not a large or robust evidence base on the role of MACE panels and LSPs in responding to EFH. However, reviewing the literature and policy outlined in this chapter reveals both what is present/visible in the current evidence base and what is absent. It also tells a broader story about how EFH's position within the safeguarding system has shaped the evidence base, and how gaps in that evidence may in turn reflect and reinforce that positioning. Three themes emerge from the current evidence base: each reflects strategic or operational challenges and/or demonstrates the need for the research presented in this report.

Firstly, the evidence base on EFH is predominantly focused on responses to particular 'types' of harm: for example, distinct studies into service responses to CSE, CCE, exploitation via 'county lines', on and offline grooming, and so-on. Whilst it is helpful to explore particular manifestations of harms that children and young people experience and navigate, and how they are responded to, such studies do not capture the complexity involved in developing integrated safeguarding responses to EFH (that address the shared features of the harms, the ways they overlap with each other, and the need to offer children and young people who are impacted equal levels of oversight and support regardless of the form of EFH experienced). In this respect the evidence base on responses to EFH seems splintered and siloed in a manner reflective of local operational and strategic structures.

Secondly, several evaluations of responses to EFH are focused on discrete 'interventions' delivered to individuals or groups systematically identified as similar, e.g. excluded from school (rather than related by friendships, peer groups or everyday community contexts) (e.g. Radcliffe et al., 2020, Firmin and Wroe, 2021). As will be discussed in Chapter 4, use of such interventions are evident on MACE (or equivalent) panels, and tend to be imbued with educational undertones and assumptions of choice and agency. Referring children and young people impacted by EFH into services that are intended to change their behaviour/thoughts without changing the situations young people are in is a limited feature of current practice models.

Thirdly, much of the literature on EFH relates to the identification, assessment and experience of harm experienced by children and young people. This is important. However, there is far less evidence on the multi-agency systems and partnerships that shape responses to EFH. As a result, research tends to focus more on children and young people positioned as outside the system - 'them' - than on the professionals, structures and institutions within it - 'us'. The REA shows that there is very little evidence about the systems and structures used to respond to EFH, the actions that such structures facilitate, and what impact these have. On reflection, this imbalance may unintentionally

obscure the relationships between structures and systems, and the harms that children and young people experience in their everyday lives.

Given these gaps there is much to learn from the findings presented in this report. In particular, we address limited evidence on:

- System responses to EFH holistically, as opposed to distinct harm types
- The nature, scale, efficacy and impact of MACE panels
- The specific contribution of LSPs to the issue of EFH
- The way all of the above engage with racial disparities and discrimination in the provision of support to children and young people impacted by EFH

3. Methodology

The Prioritising Protection project incorporates two simultaneous work-packages – one focused on MACE panels and one focused on LSCP/RSBs (collectively referred to as LSPs). The methodological approach to the project straddles both work-packages. The scope and methodology were agreed with YEF following inception meetings, including agreement on stakeholder engagement/mapping, securing case study sites, delivery plan, research instruments, ethics, data analysis, triangulation and ongoing risk assessment and mitigation strategies for each element.

Reflecting the relationship between the two elements of this project, the two work-packages are also connected methodologically. Separate data was collected to address the aims of both. However, this involved some shared methods, thus collecting data from the same participants about the two distinct sets of questions. Desk-based methods (REA, learning review analysis of Serious Case Reviews and Rapid Reviews, national policy mapping) were undertaken with a focus on both work-packages. Separate surveys were conducted for each work-package, as was analysis of the strategies of each. National focus groups and case studies focused on both work-packages. These methods are mapped against the research questions below.

A mixed-methods approach was adopted, using primary and secondary data sources, to address project aims by mapping national contexts and examining their local implications. Local area case studies added depth to the breadth provided by desk research, survey and case review analysis. This multi-method approach allowed us to:

b) identify: if/how MACE panels are integrated with other multi-agency operational and strategic arrangements; the impact of such arrangements on the ability of professionals to effectively support young people impacted by EFH; and how this support is experienced
b) build examples of how LSPs influence safeguarding practices from individual case, team, organisation, interagency partnership and wider system levels.

Shared points of data collection and analysis have enabled the research team to build a picture of strategic multi-agency practice at LA level and to understand operational multi-agency practices, such as MACE panels (or alternatives to them), within that strategic picture and vice versa. This has enabled a deeper understanding of both LSPs and MACEs. Here we outline the research questions for each work-packages accompanied by tables that map our data collection methods across the research questions.

3.1 MACE research questions and methods mapping

RQ1. How prevalent are MACE and equivalent panels, how do they typically operate, and what other approaches are local authorities using in their stead?

a. Which local authorities are using MACE panels (or equivalent panels of a different name)?
b. Are there areas not using MACE panels, and if so, why? Are these areas using alternative approaches?
c. How do MACE panels typically operate and how does this vary across areas? (This should include a description of the threshold for referral, and which children MACE panels are serving)
d. What are the options available to MACE panels to protect children?

RQ2. How effective are MACE panels?

a. Are MACE panels successfully coordinating with other safeguarding structures (e.g. MASH)?
b. Are MACE panels successfully identifying and protecting children who are being exploited?
c. Are the alternative approaches used in place of MACE panels in some areas performing better?
d. Is the operation and delivery of MACE conducive to protecting all children (including children from Black, Asian and Minority Ethnic communities)? For instance, are racially and ethnically diverse perspectives represented and are they influencing decision-making?
e. Are there examples of best practice delivery of MACE panels?

RQ3. How can MACE panels be improved?

a. What changes can be made at a local, practice level to support and improve the delivery of individual MACE panels?
b. What system changes (e.g. to regulation, funding, inspection, guidance and training) can be made at a national level to improve the delivery of MACE panels across England and Wales?

Table 1 MACE methods mapped onto MACE research questions

Research question						
	REA	Learning Review analysis	MACE protocols sample	Survey MACE chairs	National focus groups	Site case studies
RQ1a				✓		
RQ1b				✓		
RQ1c	✓		✓	✓	✓	✓
RQ1d						✓

RQ2a		✓			✓	✓
RQ2b	✓	✓				✓
RQ2c	✓					✓
RQ2d	✓	✓		✓		✓
RQ2e				✓	✓	✓
RQ3a	✓	✓	✓		✓	✓
RQ3b	✓	✓	✓			✓

3.2 LSP research questions and methods mapping

Part 1: The current context

RQ1. What are local safeguarding partnerships currently expected to do to protect children at risk of involvement in CCE and EFH across England and Wales? (As set out in law and guidance). This should include a description of the expectations on:

- The Local Authority (including Children's Services)
- Integrated Care Boards
- The Police
- The collective LSP (including any other non-statutory partners)

RQ2. To what extent are local safeguarding partnerships meeting these expectations in practice? (This should assess the performance of each of the three main statutory partners, in addition to the collective partnership).

RQ3. What are the facilitators and barriers to meeting these expectations? (this could include resource, confusion around policy and guidance, competing priorities or other challenges or facilitators)

RQ4. Does current law, guidance and practice exacerbate or reduce racial disparities in support?

Part 2: System and practice changes that would improve safeguarding of children at risk of CCE and EFH

RQ1. What changes should be made in law, guidance, funding and inspection to improve the safeguarding of children from EFH by local safeguarding partnerships?

RQ2. What should Directors of Children's Services do to improve the work of local safeguarding partnerships in safeguarding children from EFH?

RQ3. How should the government implement the measures in the Children's Wellbeing and Schools Bill to ensure LSPs are protecting children from EFH?

Table 2 LSP methods mapped onto LSP research questions

Research question							
	REA	National policy mapping	LSP strategic sample	LSP survey (business managers)	National focus groups	Site case studies	Learning Review analysis
RQ1.1		✓		✓	✓		✓
RQ1.2	✓		✓	✓		✓	✓
RQ1.3	✓			✓	✓	✓	✓
RQ1.4	✓	✓			✓	✓	✓
RQ2.1	✓	✓	✓	✓	✓	✓	✓
RQ2.2	✓	✓	✓		✓	✓	✓
RQ2.3	✓	✓	✓		✓	✓	✓

3.3 Research team and approach

The research has been undertaken by a team of partners and led by Prof Carlene Firmin (PI), Director of the Global Centre for Contextual Safeguarding (GCCS; Durham University). The team includes researchers from the GCCS and Research in Practice, The Association of Safeguarding Partners and the National Policing Vulnerability Knowledge and Practice Programme (hosted within the College of Policing). The design of the research tools and our conduct as researchers involved being alert to the adversity, trauma and marginalisation of children and young people with experience of safeguarding and to the systemic challenges within existing safeguarding law, guidance, structures and practice. This has included remaining alert during analysis to the complexities and nuances that arise when trauma is recognised. Adopting a trauma-informed approach ensured that factors relating to race equity were explored by applying an intersectional lens to all documentary analysis, as well as explicitly integrating questions around race and ethnicity in site case study data collection tools, national surveys and focus groups. A member of the GCCS team is first language Welsh, which increased accessibility for engagement in Wales. The project team (project leads from each partner) met fortnightly throughout, with bi-weekly meetings with YEF. The full team were involved in designing the research tools, supporting data collection and analysis and sense-checking, with GCCS researchers leading on data collection, analysis and writing.

3.4 Research methods

This section provides an outline of the individual methods used in the project, with a breakdown of their application to each work-package where relevant. Desk-based research involved a rapid evidence assessment (REA) of academic and grey literature (as presented in Chapter 2), a review of existing case/practice reviews and analysis of MACE protocols and LSP strategies. Quantitative data collection involved surveying MACE

Chairs and LSP Business Managers. Qualitative data collection involved case studies (observations, focus groups, system mapping workshops, case file analysis) and national focus groups and interviews.

3.4.1 National data collection

Rapid Evidence Assessment (REA)

The REA was designed to address the research questions of both the MACE and LSP studies and to identify key cross-cutting themes. It included academic and grey literature to establish:

b) what is already known about MACE and wider multi-agency panel meetings in England and Wales
b) the policy landscape in England and Wales, identifying appropriate insights into research questions relating to LSPs

The review followed an explicit protocol and a 'PICOS' framework was developed and agreed. The PICOS approach focuses the review's inclusion and exclusion criteria across a range of relevant domains: population, intervention/activity, context, outcomes, setting, study design. The full protocol can be found in Appendix A.

A structured search to identify relevant literature and studies was conducted, with the process and sources recorded. Screening was undertaken to remove duplicate sources then title and abstract screened against inclusion and exclusion criteria. Screening was undertaken by one reviewer (PDRA) for each work-package (MACE and LSP), a second reviewer (Co-I King) screened any 'maybe'/unclear sources, and a sample of sources were screened to ensure consistent application of criteria. Data extraction was recorded in Excel with summary information where data was available. Synthesis of findings addressed the key research questions for both work-packages and was presented in tabular format with a narrative commentary. Where applicable, comparisons and connections were identified between the two work-packages and commented upon.

The tables included in Appendix A outline the results of the initial searches for both MACE and LSP and screening using the inclusion and exclusion criteria. Following a review of the original search results, the research team and commissioner (YEF) provided further potentially relevant documents for screening.

For the MACE work-package, initial searches of the agreed databases identified a total of 547 documents, with 29 selected following initial screening. Manual identification through websites agreed for screening returned 164 documents. Following further screening of the combined 193 documents (full criteria/titles/abstracts/summaries), five

documents were included and a sixth added via research team recommendation (Ibbetson et al., 2022).

For the LSP work-package, initial searches of the agreed databases identified a total of 752 documents, with 65 selected following initial screening. Manual identification through websites agreed for screening returned 60 documents. Following further screening of the combined 125 documents (full criteria/titles/abstracts/summaries), 23 documents were included.

Learning review analysis (Serious Case Reviews and Rapid Reviews)

A total of 43 Serious Case Reviews (SCRs) and Local Safeguarding Child Practice Reviews (LSCPRs) published from 2020-2024 held by the Global Centre for Contextual Safeguarding (GCCS), along with 20 unpublished Rapid Reviews completed between 2021-2025, sourced from LSPs through The Association of Safeguarding Partners (TASP), were analysed. The reviews selected included those with EFH as a feature; these cases were analysed to identify:

- the contextual dynamics of harm, including references to family, peer, community and school contexts,
- the role of MACE panels, or other meetings, in coordinating responses
- recommendations made for the delivery of MACE panels in the future
- recommendations made to LSPs

Findings from the reviews were organised according to questions posed for each work-package. For each question we recorded whether the review held 'good evidence', 'some evidence' or 'no evidence' along with quotes and notes that evidenced this position. By documenting our findings in this way we were able to capture both quantitative and qualitative data results, with care taken to ensure that data extracted from rapid reviews was kept confidential. Reviewers used reflective notes at the end of each case analysis to reflect on the dominant themes emerging from the case and how these themes related to the project questions.

For MACE, the following themes/questions were explored in each case review report:

- Discussion of MACE or similar meeting
- Multi-agency coordination
- Description of risk to a child or young person
- MACE actions
- Race and ethnicity

For LSPs, the following themes/questions were explored in each case review report:

- Identification of EFH
- EFH referrals
- Planning to protect against/prevent the escalation of EFH
- Support and intervention
- Statutory partnership working
- Involvement of non-statutory partners
- Barriers to safeguarding

National MACE survey

The purpose of the MACE survey was to build a clearer national picture of how Multi-Agency Child Exploitation (MACE) panels (including equivalent panels that performed a similar function but were called a different name), and alternatives to them, were being used across England and Wales in response to EFH. We aimed to understand:

1. where MACE panels or alternative arrangements were in place
2. how these panels operated
3. how effectively and equitably such panels protected all children and young people, including those from Black, Asian and Minority Ethnic communities; and
4. examples of good practice and innovation that others can learn from.

An online cross-sectional survey was designed in Qualtrics, targeted at chairs of MACE panels, their equivalents (under a different name), or alternative arrangements that had been introduced in place of MACE panels. The questionnaire was developed collaboratively by the research team and project partners, drawing on existing literature and sector feedback, and was structured around: panel structure (its focus, agenda and how it operates) and coverage (what is covered within the panel's remit), membership and leadership, capacity and system conditions (attendance, timely access to information, resource access and service availability), roles and activities, equity and inclusion, perceived outcomes, and examples of effective practice. The survey was available in both English and Welsh.

As there is no comprehensive national contact list of MACE (or equivalent/alternative) panels in England and Wales, a short scoping exercise was first conducted to build a distribution list. A brief scoping survey was circulated through the research team networks to identify named local contacts and obtain email addresses for panel chairs from both social care and policing. Where a MACE panel (or equivalent) did not exist, respondents were asked to provide contact details for the chair of their alternative arrangements. In parallel, partners compiled an additional informal list of MACE chairs through their existing contacts across local authorities. The final distribution list was created by merging these two sources and removing duplicates. Where both sources provided different contact details for the same LA, preference was given to information

gathered through the scoping exercise. Where available, two contacts were retained per LA area – typically a social care chair and a police chair – to maximise coverage. This means the total number of eligible panels invited is not known with sufficient precision to calculate a formal response rate.

The survey link was distributed via official emails by the study partners (including safeguarding networks and policing partners) and remained open from 29 October 2025 to 7 December 2025 in England, with two reminder emails sent during this period. Due to low response rates from Wales, the closing date was extended to 16 December 2025 for Welsh respondents.

In total, 90 responses were received. After removing test entries, duplicate responses and records with substantial missing data, 66 responses were retained for analysis, representing panels (both MACE/equivalent and alternative arrangements) operating across 65 LAs – 62 in England and 3 in Wales. Responses came from LA areas across both countries, of different sizes and structures. Data were cleaned and analysed in Stata using descriptive statistics (frequencies, percentages and cross-tabulations), with some simple comparisons between responses for MACE chairs and those involved in alternative arrangements. Analysis was done at the panel level, with some respondents covering multiple local authorities. Open-text responses were summarised thematically to findings relevant to the research questions. Participation was voluntary and informed consent was obtained at the start of the survey; responses were analysed and reported in aggregate. While 60 LAs (58 in England and 2 in Wales) said Yes to having a formal Terms of Reference document for their MACE/equivalent or alternative arrangements, only 17 LAs in England uploaded an example of that document in their survey return.

National LSP survey

The purpose of the LSP survey was to build a clearer national picture of how LSCPs in England and RSBs in Wales understand and meet their expectations in relation to children and young people impacted by EFH. An online cross-sectional survey was designed in Qualtrics, targeted at LSCP/RSB Business Managers. The questionnaire was developed collaboratively by the research team and project partners, drawing on existing literature and sector feedback and was structured around: partnership structure (its focus, agenda and how it operates) and coverage (what harms are covered within the partnership's remit); clarity of roles and expectations in relation to EFH; coordination and accountability across partners; and perceived facilitators and barriers to effective safeguarding. The survey was available in both English and Welsh.

A list of all LSCP Business Managers was compiled through project partner TASP and LSP Business Managers through the GCCS. We sought to reach Business Managers across all LSPs and the survey was disseminated via these channels.

The survey link was distributed via official emails by the study partners (including safeguarding networks and policing partners) and remained open from 6 November 2025 to 27 November in England, with two reminder emails sent during this period. Due to low response rates from Wales, the closing date was extended to 16 December 2025 for Welsh respondents.

In total, 90 responses were received. After removing test entries, duplicate responses and records with substantial missing data, 69 responses were retained for analysis, representing 55 English LAs and 16 Welsh LAs. Although 69 LSP Business Managers engaged with the survey, only 39 (57%) completed all sections, while 30 (43%) exited before the end. Our analysis is therefore based on 39 completed responses, representing 36 distinct LAs in England and 14 in Wales (with some partnerships/boards covering more than one LA). Responses came from LAs across both countries, of different sizes and structures.

Seventy-one per cent of respondents said they had a written strategy or plan covering CCE, either as a standalone document or as part of a wider exploitation, violence, EFH or safeguarding strategy. Of those, 10 Business Managers submitted a plan.

Data were cleaned and analysed in Stata using descriptive statistics (frequencies, percentages and cross-tabulations). Analysis was conducted at the partnership level, noting that some respondents covered more than one LA. Open-text responses were summarised thematically to capture findings relevant to the research questions. Participation was voluntary and informed consent was obtained at the start of the survey; results are reported in aggregate.

Analysis of MACE protocols

A total of eight protocols for MACE panels (or equivalents or alternatives) were submitted as part of survey responses. These were analysed against the research questions and were drawn upon to further explore emergent cross-cutting themes in other parts of the dataset related to the purpose of panels, whether and if so, how, risk was categorised or threshold applied; and guidance on information sharing.

Analysis of LSP strategies

A total of 10 LSP strategies relevant to EFH were submitted within LSP survey returns. A further 11 strategies were identified through an online search to build a sample with geographical spread, bringing the total to 21 strategies. These strategies were analysed against the research questions and explored further cross-cutting themes being identified within the wider study dataset including the extent to which strategies included or considered the issue of serious youth violence or children and young people's views.

National policy mapping

The policy landscape was engaged with through several routes. National policy in relation to multi-agency responses to EFH, MACE panels and LSPs were searched for and analysed as part of the REA. Discussions were also held with research partners to identify key policy documentation, reflect on policy frameworks and ensure no documents had been missed during the REA search. Research partners then triangulated through further sense-checking with colleagues in England and Wales. Discussion of policy documentation and frameworks during national focus groups and case study methods enabled further cross-referencing and analysis. Policy analysis is incorporated as appropriate within the background and findings chapters.

National focus groups and interviews

Data gathered through national qualitative interviews and focus groups helped us to triangulate and test quantitative results emerging from national surveys and documentary analysis, as well as identify any resonance with themes identified in local case study sites (see below section).

Interview and focus group participants recruitment took place through a public events page on Research in Practice's website (www.researchinpractice.org.uk) and through the networks and contacts of the research team. The invitation was also shared with sites that had expressed interest in participating in the research but were not selected as case study sites and was signposted to participants in the MACE and LSP surveys.

Eleven focus groups were held with 48 participants – seven of these explore questions for the LSP work-package, three were dedicated to questions on the MACE work-package, and one covered both as follows:

- LSP 1 and 2: Independent scrutineers
- LSP 3: Local authority (including social care and youth justice)
- LSP 4: Education
- LSP 5: Health

- LSP 6: Police
- LSP 7: Youth work, voluntary and community sector
- MACE 8: Youth work, voluntary and community sector
- MACE 9: Police
- MACE 10: Local authority
- LSP and MACE 11: Policy and strategic group.

The focus groups took place remotely, using MS Teams video conferencing. All sessions were recorded with participants' consent; anonymised transcripts were produced from the recordings and used in the data analysis. The data were analysed thematically by research question and by stakeholder group. Key themes, issues, recommendations for policy development or service improvement, and views of effective practice were captured, including where dissenting opinions and differences of experience or perception emerged.

3.4.2 Local case studies

A longlist of 20 local authorities across England and Wales were contacted by the GCCS based on the research team's knowledge of their variability in service design, geographical variation and service readiness/capacity to participate in the study. Sixteen areas volunteered to participate in the study, of which six were selected in consultation with YEF to reflect a range of approaches, structures and areas. The six case studies came from five areas in England and one in Wales, representing urban and rural geographies, metropolitan boroughs and large cities. For each site a case study was built via system mapping workshops, observations, focus groups and case file. Table 3 outlines the details of these for each site.

Table 3 Case study site data

	System mapping workshop	Focus groups	Observations	Case files
Site one	1	4	3	None submitted
Site two	1	3	4	None submitted
Site three	1	4	3	3
Site four	1	3	4	None submitted
Site five	1	4	4	3
Site six	1	4	4	3

System mapping workshops

One system mapping workshop was facilitated in each site and ran for 2.5-4 hours to map pathways that made up their local system response to EFH. Workshop participants consisted of professionals who were involved in local multi-agency operational or strategic processes used to coordinate responses to EFH. Invitees were convened by the LA but reflecting a range of multi-agency partners. The workshop involved presenting to the group a vignette of a young person impacted by violence (the young person had been stabbed and had disclosed this to a youth worker). The group were then asked to consider and map out pathway(s) this young person may take through this system from referral, through to processes of assessment, planning activities including via multi-agency panels, the type of support likely to feature in those plans, and the strategic oversight in place for the processes that were mapped. Data from the workshops were used to produce a visual map of local operational pathways in each LA and provided a reference point against which to understand the remaining data collected for the area as their case study was built. This visualisation was also used to respond to research questions across both studies, and to contextualise findings for case study narratives that are drawn upon for each study.

Observations

Observations of multi-agency meetings were completed in each case study site. These included observations of MACE (or equivalent) panels or meetings/panels introduced as alternatives to MACE, other operational meetings that were utilised in addition to MACE (or alternatives to MACE) to respond to different forms of EFH such as meetings specifically focused on serious violence, community safety activities, child protection

conferences and panels to discuss children missing from home. A strategic meeting was also observed either of the LSP or sub-group of it, that provided the oversight mechanisms for the operational meetings observed. An observation template was used by observing researchers to record key activities in the meeting, actions related to safeguarding, need and/or risk, roles and responsibilities of meeting participants, facilitators and barriers of effective practice, and any reference to racial disparities in who was identified during meetings or the types of support provided.

Site focus groups

Four focus groups were undertaken in each site with local representatives of the following groups:

- LSP
- Young people's exploitation or extra-familial harm teams
- Children's service managers
- Members of MACE (or equivalent) panels or site's alternative meeting process

All focus groups were facilitated online via Microsoft teams with the exception of one in person focus group which was held during a development day that was being run by an area's LSP. Following introductions including job roles, participants were guided through a semi-structured interview schedule designed to explore:

a. The contribution of MACE or alternative panels/processes in responding to EFH in their local arrangements
b. The role and effectiveness of LSPs in providing strategic leadership in response to EFH in their local arrangements

Site case file analysis

Finally, each site was asked to provide case files to the research team which included redacted social care assessments and plans for up to three children and young people. The case files needed to be from children and young people who had been discussed at a MACE or alternative meeting, and which illustrated the ways the site was recording their response to EFH, and the nature of that recorded response.

Case study development

Observation templates and focus group transcripts were analysed against the research questions for each study and for cross-cutting themes. One set of case files was collected from three site and coded to analyse results against questions for both the MACE and LSP work-packages. A narrative meeting was held for each LA amongst the research team to combine all the results of the four datasets for each case study site and produce an account of:

- The operational and strategic model for responding to EFH
- Identified themes related to the effectiveness of, or challenges in, that response

- Learning from that case study site that was of relevance to each research question

3.5 Analysis

The approach to analysing each dataset has been outlined in the above respective sessions. Additionally, all research team members held a two-day analysis session in London to develop a shared narrative across the study datasets that would form the basis of this report. Facilitated by the project PI, Prof Carlene Firmin, the analysis days were organised into four parts:

- Part 1: Each team member presented the results of the datasets for which they were responsible, sharing key themes identified at that point in the analysis
- Part 2: The team drew their findings together for each research question, working question by question to discuss what the analysis of their respective dataset offered to answering the questions posed. During this process points of synergy and divergence were identified between national and local datasets, and between different forms of data (for example national survey results compared to interviews)
- Part 3: The team discussed combined thematic findings from across the MACE and LSP questions: what shared points of learning, if any, could be reported across both studies, that went beyond the initial research questions
- Part 4: Points of disagreement or where conclusions could not be reached, that signalled where further targeted analysis was required of specific datasets

The results of this exercise informed the initial structure of this report, after which research team members conducted supplementary analysis on datasets as they related to themes/questions that had been identified. The results of this analysis were reported back to the project PI as the report was developed, with further additional checks run on datasets as the report was finalising.

3.6 Ethics

Ethical approval was secured through Durham University's Ethics Committee. Information about the research was provided to and written and/or recorded consent was obtained from all participants at each point of data collection. For meeting observations conducted as part of the local case study data collection, an opt out consent form was provided for all professional participants and where an individual opted out, no information relating to them was recorded. If parents or children and young people were in observed meetings, opt-in consent was required prior to the observation commencing.

All observation templates and focus groups group transcripts were stored securely on Durham University's server, alongside all other collected data and only accessible by the research team, in accordance with GDPR.

Limits of confidentiality were explained to participants throughout and all measures have been taken to ensure anonymity. A full research risk assessment was undertaken for all activities and a data management plan put in place. Strict confidentiality and data sharing protocols were followed: no identifying information was recorded during meeting observations and identifying details were redacted from case files.

4. Findings: Multi-agency operational panels

As summarised in Chapter 2, the precise origins of MACE (or equivalent) panels as a method for addressing EFH are unclear. Nonetheless they appear to have developed at a time of a) heightened scrutiny of local responses to child sexual exploitation (Berelowitz et al., 2013; Jay, 2014); b) where there was no consistent children's services pathway for overseeing safeguarding responses to EFH (Berelowitz et al., 2013; Gorin and Jobe, 2013; Hanson and Holmes, 2013); and c) many children and young people impacted by EFH were closed to children's services unless the harm they faced was attributable to the care provided to them by their parents (Lloyd and Firmin, 2019).

While initially used to coordinate responses to children and young people who were missing from home and/or being sexually exploited (and therefore referred to as MASE panels), they have since broadened in scope to address a wider range of harms, particularly CCE (Ofsted, 2019). As awareness of different forms of EFH has grown, alongside policy expectations to address these risks, there has been a significant expansion of panels focused on EFH (Bostock, 2023). However, despite being widely referenced in discourse and local safeguarding policies (for example, London Safeguarding Children Board 2021, Wakefield Safeguarding Children Board 2021, Staffordshire Safeguarding Board 2024), knowledge of MACE (or equivalent) panels is limited.

Research that uses data gathered from MACE (or equivalent) panels is often used to understand the nature of EFH and the children and young people impacted (for example, Lloyd, 2025), however, far less has been written about MACE (or equivalent) panels themselves. As detailed in Chapter 2, a study of northern English counties found that children and/or young people who were victims of repeat exploitation were not referred to MACE (or equivalent) panels, raising questions about how thresholds for access to MACE (or equivalent) panels were understood (Wilson and Mueller-Johnson, 2024). A second study of MACE (or equivalent) panel arrangements in London discovered substantial differences in: approaches taken by each local authority area; how the role of MACE (or equivalent) panels were understood between areas; and, how areas measured effectiveness of their MACE (or equivalent) panels or were unable to do so due to a lack of criteria for what would count as effectiveness (Ibbetson et al., 2022). A further two studies have explored the challenges of conceptual complexities of practice on MACE (or equivalent) panels, including how to balance public protection and safeguarding priorities for children and young people who straddle both of these agendas (Creaney and Burns, 2025, Radcliffe et al., 2020). Within this limited body of work therefore, there is no official account of the scale or core functions/activities of MACE (or equivalent) panels; and there is relatively little academic research on their effectiveness.

To begin to address this gap in knowledge, this chapter shares findings on:

4.1 The scale and nature of MACE or equivalent panels, and alternatives to them
4.2 The efficacy of MACE or equivalent panels and alternatives to them
4.3 Local and national opportunities to improve safeguarding responses to EFH, and the potential role of MACE or equivalent panels, and alternatives to them, within this

Before detailing these findings, it is important to detail how MACE and equivalent panels have been defined for this study (and in practice). This is particularly important as throughout this study we were informed of various equivalent multi-agency operational panels that performed in the same way as a 'MACE' panel but had different names including, an extra-familial risk and harm panel; a vulnerable, exploited, missing, trafficked panel; or a harm outside of the home (HOTH) panel. We grouped all of these panels under a 'MACE panel' heading, for the purpose of this study, if they were:

- chaired by children's services, or co-chaired between the police and children's services
- multi-agency (with standing representatives from different agencies)
- had an operational focus

AND WERE USED TO

- discuss and oversee decisions/plans for multiple children and young people who were identified as impacted by some form of EFH (either newly referred into services or those considered most at risk of harm), addressed one at a time in a single meeting (case-oversight function)

AND/OR TO

- discuss and oversee decisions/plans to address trends/locations associated with multiple children and young people who were impacted by EFH (theme-oversight function).

These panels were distinguished from alternatives that had been put in place in some sites. These alternatives also varied in nature, but the most consistent manner in which they differed from MACE or equivalent panels but were similar with each other was that they:

- were convened to discuss/oversee a plan for a single child or young person, or group of connected children and young people (rather than a list of unconnected children and young people)
- involved professionals with some form of relationship with that child or young person – so attendance varied at each meeting rather than having standing membership

While a number of areas may have meetings like this as well as MACE (or equivalent) panels, they are described as alternatives to MACE panels in this study when participants

described them as such, i.e. this was the way the site coordinated plans for children and young people impacted by EFH instead of having a MACE (or equivalent) panel.

Finally, this study was concerned specifically with panels that fulfilled specific operational functions in response to EFH, regardless of what they were called. We recognise that some LAs also operate what they call a 'strategic MACE' or a 'pre-MACE'. We captured data on these meetings in case study sites if they actually fulfilled one of the functions listed above – which some did – but excluded them if they did not. For example, some LA's had a 'strategic MACE' which in other sites was called something different and acted as a sub-group of the LSP focused on EFH Policy and Strategy.

In short, this study is more concerned with understanding the scale, nature, impact and use of panels with a similar function, and alternatives that have been introduced in their place, than it is with understanding meetings/structures with similar names.

4.1 Scale and nature of multi-agency operational panels

The first research question for this study was: How prevalent are MACE and equivalent panels, how do they typically operate, and what other approaches are local authorities using in their stead? (RQ1).

We answer this question by reporting on:

- 4.1.1: The scale of MACE and equivalent panels and alternatives to them
- 4.1.2: The structural features of MACE and equivalent panels and the activities they undertake
- 4.1.3: Options available to MACE and equivalent panels
- 4.1.4: The key features of alternatives to MACE (or equivalent) panels that make them distinct

4.1.1 The scale of MACE (and equivalent) panels and alternatives to them

72% of respondents (representing 49 LAs) from our initial scoping survey stated they had a MACE panel, 4% (representing 3 LAs) stated theirs was under review, and 24% (representing 17 LAs) stated they had an alternative.

Through the full survey of chairs of MACE panels (or their alternatives), completed following the scoping survey, 83% of respondents (representing 53 LAs) stated they had a MACE panel in place including those under review, and 17% (representing 12 LAs) stated they had put an alternative to such a panel in place. These alternative processes were referred to in various ways including 'ROTH child protection pathways', 'a Contextual Safeguarding Meeting', a 'Multi-Agency Strategy Meeting', and an 'Extra-Familial Harm Meeting.'

In answer to the specific question asked by this study about which LAs had MACE panels, this study found that MACE panels, in some form, are a common feature of local

responses to EFH. All nine regions in England had LAs which reported having MACE panels in operation via survey responses, and this was the same for one region in Wales. MACE arrangements were in place in four out of our six case study sites. Two regions in Wales and five regions in England had LAs who reported having an alternative to MACE panels in place, as did two of our six case study sites.

4.1.2 The structural features of MACE (or equivalent) panels and the activities they undertake

To understand the nature of MACE (or equivalent) panels, a sub-question of RQ1 was *'How do MACE panels typically operate and how does this vary across areas?'*. To answer this question, we first detail the common and variable features of MACE and equivalent panels and the activities they undertake; before explaining this with reference to their fit in local systems. We present the following features:

- The function the panel fulfils
- Meeting frequency
- Chairing arrangements
- Harm types included in the panel
- Approaches to categorising risk and applying thresholds prior to and during panels
- Core panel activities: information sharing, coordination, containment and planning

Panel function

Across our dataset, MACE (or equivalent) panels fulfilled one of two oversight functions: either a case oversight function – to monitor/agree plans for multiple children and young people impacted by EFH, or a 'thematic-oversight' function – to monitor plans/response to themes, trends and locations impacted by EFH; or in some cases they fulfilled both.

As the structure of MACE (or equivalent) processes are designed locally, without any agreed points of national consistency, areas may believe they are describing a similar panel, with a similar function when, in practice, they are describing very different ways of working. Some areas use a single MACE (or equivalent) panel to fulfil both functions in one panel structure. Others divide these functions into two-or-more 'levels' of MACE (or equivalent) panel. When these functions are split across different 'levels' of MACE (or equivalent) panel, participating sites referred to them under distinct headings; for example, MACE (or equivalent) panels used to perform a case oversight function are often referred to as triage and/or 'operational meetings'; MACE (or equivalent) panels used to perform a thematic oversight function may be referred to as 'strategic meetings'. However, in some sites a third level of meeting sat above both case-oversight and theme-oversight meetings which were also described as 'strategic meetings'; these meetings provided an accountability and governance structure over operational MACE (or

equivalent) processes. For this study we are principally concerned with the use of MACE (or equivalent) panels as part of an area's operational response to EFH; be this fulfilling a 'case-oversight' function or a 'thematic-oversight' function.

In terms of MACE (or equivalent) panels that fulfilled a case-oversight function, 44% of panel chairs who responded to our survey reported that their MACE (or equivalent) panel had considered more than 50 children and young people in the last three months. 13% of panel chairs representing 41 LAs in the West Midlands, the North-West, South-East and South-West of England reported reviewing over 100 children and young people during that period. These figures include both children and young people being considered for the first time and those being reviewed more than once.

Table 4 MACE survey results – number and frequency of children considered at panels

Children considered in last three months	**Frequency**	**Percent**
Less than 10	9	14.52
10-25	11	17.74
26-50	15	24.19
51-75	13	20.97
76-100	6	9.68
More than 100	8	12.90
Total	**62**	**100**

In three case study sites we observed panel meetings that fulfilled a case-oversight function, including those considering large volumes of children and young people in a single meeting:

> *The Chair of meeting describes the 'marathon' that they had ahead of them (a 4-hour meeting) with nine new cases and nine reviews. …. They commence with the first young person - a 15-year-old girl, looked after child, seeking asylum. …. The Chair asks "any intel from the Strat meeting and how was S47 going?" (MACE observation)*

Eighty-eight per cent of survey respondents reported that their MACE (or equivalent) panel fulfilled a theme-oversight function. In three case study sites we observed meetings of this kind. In the example below, senior leaders reiterated that their MACE was not to be used to review the situations of individual children, but to identify, and develop plans to address, themes impacting multiple children at once:

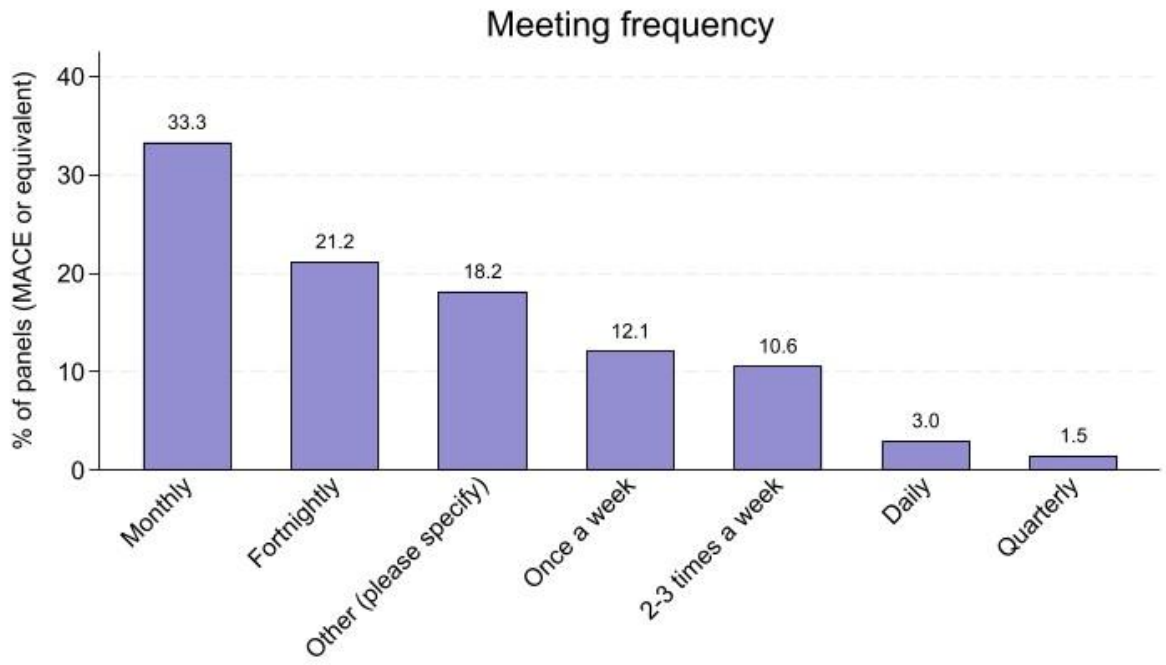
> *"What are our themes, what's our data, what are our problem areas? We can read these prior so let's make it worthwhile. … we are still using the VOLT [Victim, Offender,*

Location, Theme] model to contextualise what we are talking about but not in detail, no sharing individual names – locations can be brought but I don't want to turn this meeting into discussing individual children. We can then spend our time looking at our problem areas and think what can we do." (Meeting chair, MACE observation)

Panel meeting frequency

The frequency with which MACE (or equivalent) panels meet varies (Figure 1). According to survey respondents, about a third (33%) meet monthly, and around one in five (21%) meet fortnightly. Roughly a quarter (23%) meet weekly or more often (1-3 times per week). Daily (3%) and quarterly (2%) meetings are rare, and about 18% reported some other pattern (for example, meeting in line with children and young people's needs, such as with increased or decreased frequency as the demands for responses vary, or operating sub-meetings on a rotation if MACE (or equivalent) panel covers a large geographical area that is divided into districts).

Figure 1 MACE survey results – frequency of panel meetings



Data collected from case study sites suggests that this variation is largely informed by the purpose for which MACE (or equivalent) panels are used: those used primarily/solely to fulfil a theme-oversight function met monthly; whereas those used to primarily fulfil a case-oversight function met more frequently.

Panel chairing arrangements

MACE (or equivalent) panels are either co-chaired across children's social care and policing or chaired solely by children's social care (Table 5). In terms of the 66 panel chairs who responded to the survey question regarding chairing, around three-quarters

(74%) were from children's social care, 15% were from the police, and the remaining 11% described themselves as being based in specialist services and teams (e.g. exploitation hubs).

Table 5 MACE survey results – panel chair distribution by organisation

Organisation	Frequency	Percent
Police	10	15.15
Social care	49	74.24
Young people's services	1	1.52
Specialist services	1	1.52
Other	5	7.58
Total	**66**	**100.00**

This is not necessarily representative of chairing arrangements for all MACE (or equivalent) panels across England and Wales. However, it does illustrate that there is inconsistency across respondent LAs; and a similar inconsistency was identified in case study sites. In the four sites that had a MACE (or equivalent) panel, two had panels that were co-chaired between children's social care and police, and two had panels that were solely chaired by children's social care. We did not identify an area where the MACE (or equivalent) panel was solely chaired by policing. Our sample of MACE (or equivalent) panel protocols reflected similar variations in chairing arrangements.

When co-chairing was identified or described, this largely involved alternating a children's social care or policing representative as the single chair of any given meeting, rather than two people chairing a meeting at the same time. For the most part, the chairing role was described procedurally, in terms of who led the meeting, rather than as a wider leadership role in shaping the culture and way of working adopted by the panel. We return to this point later in the report.

Harm-types that panels include

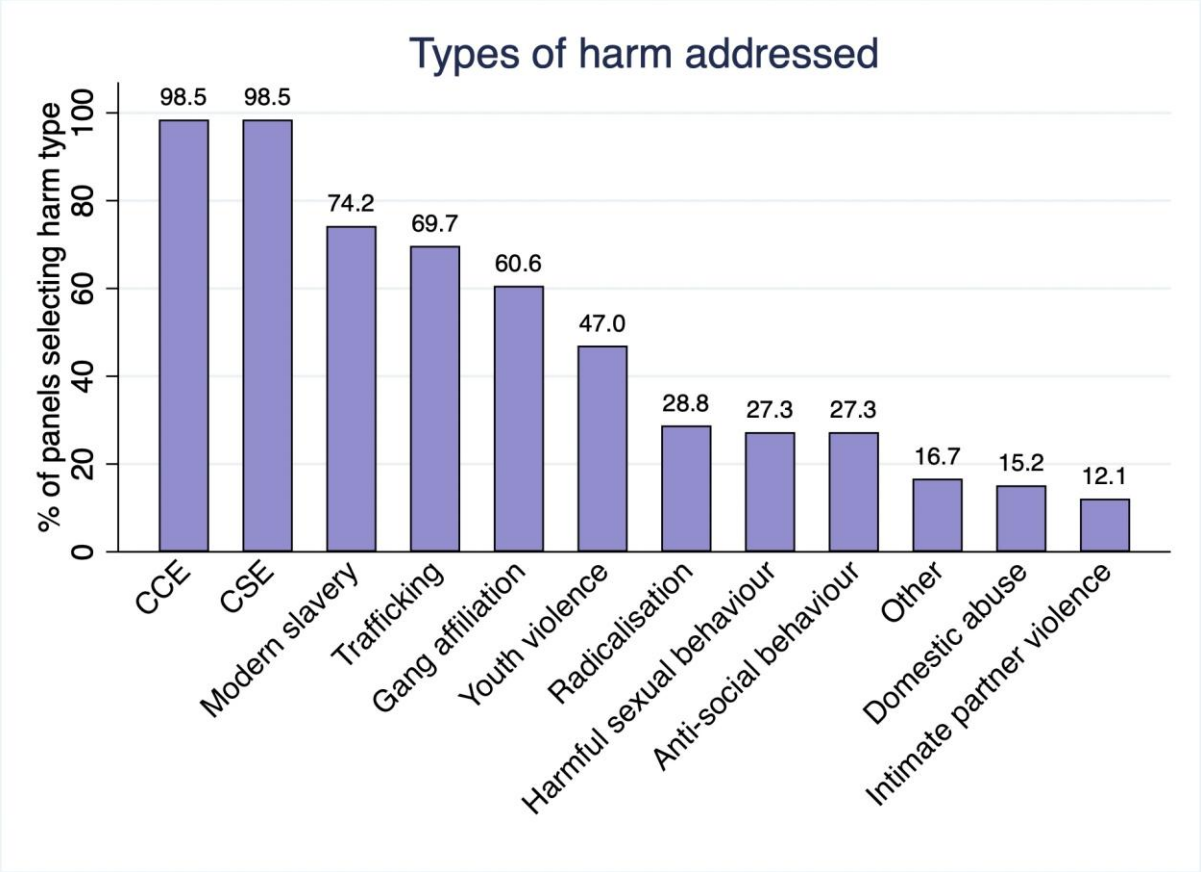
MACE (or equivalent) panels are being used to respond to different forms of EFH. However, while policy agendas have broadened to consider different forms of EFH (to some degree), it is not clear, from our data, that MACE (or equivalent) panels have done the same. All consider 'exploitation' – both criminal and sexual. However, the extent to which other forms of EFH are considered varies.

In our case study sites, various forms of EFH were not included in MACE processes. When mapping their local system (see section 4.2.1), professionals in the four sites that used MACE (or equivalent) panels stated that these panels were used to respond to serious

violence. However, during observations and focus groups this appeared more inconsistent. When children and young people were impacted by serious violence, but exploitation was not (yet) established, there was often debate amongst professionals about whether they could be considered at MACE (or equivalent) panels. Furthermore, in all case study sites, plans to respond to serious violence were also agreed at community safety or policing led panels that were additional to MACE (see later section regarding coordination with other parts of local systems). Harmful sexual behaviours displayed by children and young people towards peers, and abuse in children and young people's own romantic relationships, were also not consistently considered at MACE (or equivalent) panels in case study sites. During system mapping workshops participants had to be prompted to describe arrangements for both these forms of EFH. Most sites identified a different panel that was convened for responses to harmful sexual behaviour, often chaired by health professionals (psychologists) rather than by police or children's social care. As such, this form of EFH was often structurally excluded from MACE (or equivalent) panels, despite individual incidents of peer-sexual abuse appearing in MACE discussions (especially if they were thought to occur in wider contexts of serious violence and/or exploitation). Likewise, multi-agency risk assessment conferences for domestic abuse were cited as the local pathway for abuse in children and young people's intimate relationships rather than MACE (or equivalent) panels – with an acknowledgement that, at least in all six of our case study sites, children and young people under-16 would not be accepted into this pathway either.

Survey responses demonstrate that this variation is a national issue not isolated to our case study sites.

Figure 2 MACE survey results – types of harm addressed at panels



As illustrated in Figure 2, MACE (or equivalent) panels consistently included children and young people impacted by exploitation, and related harms, such as modern slavery and trafficking, and to a lesser extent 'gang' affiliation. Whereas less than half of survey respondents reported including serious violence within the remit of MACE (or equivalent) panels that they chaired, just over a quarter included harmful sexual behaviour and radicalisation and 15% included domestic abuse. Our analysis of serious case reviews also identified scenarios in which MACE processes screened out children and young people for whom there was evidence of violence but not (yet) exploitation.

As noted previously, when MACE (previously MASE) panels were first introduced it was often to consider children and young people who were being sexually exploited and/or were missing from home. National interview participants expressed concern that the widening remit of MACE panels risked children and young people missing from home for reasons other than exploitation getting lost and being left without clear oversight. Some had added 'missing' as an additional category of discussion in MACE (or equivalent) panels to avoid this:

> *"How it is set up is we have 'high', which are children and young people who are being exploited… And we talk about the high CCE or CSE, and any of the others by exception. But then there's a separate slot for missing."* (National focus group participant)

When we combine learning from our national and local datasets, it is apparent that in some areas, MACE (and their equivalents) has become the main or only operational forum through which EFH concerns receive children's services-led multi-agency oversight. In this context, when shifts in how different forms of EFH are recognised and prioritised is reflected in what is screened in/out of MACE (or equivalent) panels, conditions are created for some children and young people who are at risk of significant harm being left without social care oversight. Across our dataset this seemed to be particularly true for children and young people impacted by serious violence, harmful sexual behaviour, intimate partner abuse (particularly if under-16), and those missing from home (for reasons other than exploitation).

Categorisation of risk and application of threshold

The inconsistency in the forms of EFH considered by MACE (or equivalent) panels (outlined above) is shaped by variations in how children and young people are categorised during panel meetings, and in the thresholds used to determine whether they are considered by MACE (and their equivalents) in the first place.

Of the 65 panel chairs (one panel chair skipped this question) who answered this question in our MACE survey, 66% answered that they had a written referral policy or threshold criteria specifying which children and young people can be referred to their MACE (or equivalent) panel; 26% did not and 8% were unsure. Ten respondents provided their protocols – across which there was no consistency in approach to scoring or assessing risk to determine thresholds for discussion at MACE (or equivalent) panels, nor in the actions that would follow scoring or assessment in terms of alternative onward referrals.

As noted above, whether a child or young person meets the threshold for discussion at a MACE (or equivalent) panel can depend on the form of EFH identified. Findings from our case study sites and from national interviews, as well as the survey responses on harm-types considered outlined previously, evidenced that if a child or young person has not disclosed exploitation, then the risk of serious violence, or wider risks of significant harm, are not always considered sufficient to meet the threshold for discussion at a MACE (or equivalent) panel. In some instances, this threshold is applied as the police require investigatory opportunities related to exploitation to justify their attendance at these meetings; an issue identified in case study sites, discussed in national interviews, and critiqued in case review reports. In these situations, MACE (or equivalent) panels conflate thresholds for coordinating safeguarding response with thresholds for undertaking police investigations / allocating police resources:

Professional 1: "The young person doesn't see X as exploitative – there is no coercion or manipulation – so won't be taken on by police."
Professional 2: "I hear you, but my worry is serious concern about risk of harm and no children's services involvement." (Meeting observation)

As a result, decisions about whether a child or young person requires multi-agency safeguarding oversight can become conflated with whether there is a police investigation to pursue. In other instances, data from case study sites, and protocols submitted as part of survey responses, evidence that MACE (or equivalent) panels use assessment tools specific to EFH to inform threshold decisions. These tools often require evidence of exploitation, such as grooming or coercion before a child or young person could meet the threshold for discussion at a MACE (or equivalent) panel.

Approaches to determining and categorising thresholds for MACE (and their equivalents) also varied across case study sites. The following threshold categories were described:

- "Red, amber, green"
- "Significant harm, emergent harm"
- "Complex, established, suspected"
- Scoring system – 0-4 average

The implications for these categories varied. In one case study site, children and young people categorised as experiencing 'significant harm' and 'emergent harm' would be considered at a MACE (or equivalent) panel. However, being categorised as 'significant harm' in one site would also trigger a statutory child-protection equivalent planning process outside of the MACE (or equivalent) panel structure to develop a more detailed support plan. Whereas in another site, only those scoring 'red' via a pre-MACE assessment would be considered at a MACE (or equivalent) panel, and there was no child protection equivalent process to maintain oversight of their plan outside of that MACE process. Of the eight MACE (or equivalent) panel protocols submitted by survey respondents, 37% (n=3) detailed how such categorisation informed decision-making prior to meetings or support agreed afterwards.

The rationale, and associated underpinning evidence base, for these categorisations was unclear, and their application was also inconsistent. Interview participants were aware of this:

"We've changed our thresholds to experiencing, significant, complex and emerging and no evidence but what best practice tells us that we shouldn't have three tiers." (Focus group, case study site)

"So, what is the difference between emerging and experiencing or what's the difference between experiencing and significant? Because if I'm a victim of CSE then experiencing would tell me that I've already been a victim of crime so how many times do I have to be a victim of that crime to be significant?" (Focus group, case study site)

It was not always clear to researchers why some children and young people were categorised as having reached a 'threshold' for either consideration at a MACE (or equivalent) panel or for continued oversight from that panel, when others were not considered as having done so. During observations we noted debates between children's social care and policing as to whether thresholds were reached, which were more about what actions the police could or would take, as opposed to the levels of harm a child or young person was facing:

> *The meeting then discusses scoring different subsections [of the assessment] of key headings …The Police representative says "the young person is not at immediate risk so not a 4 but she is vulnerable, her vulnerability remains." Chair says there's "no way police will let her go – so qualifies for ongoing support." Decision made - scored 3 in the professional judgement [section of the assessment] but her overall score is raised to 4.* (Meeting observation)

> *[Professionals discuss the risk level for this young person]: Is (young person) moderate or significant? It's escalating, he's not been arrested but he has been seen in large groups, concern about peers. His family is not always reporting [the missing] straight away. He could be in-between moderate and we'll keep an eye on him. A professional raises concern that he's only 13 years old and that it feels concerning if [is scored as] moderate as "he's very, very young, I'm concerned as he's so young"…this isn't really taken up by anyone. The Police then say "the fact he's stating it's only £100, he's only 13, could he be high moderate or low significant? The question is what are we raising him (to MACE) for? He is managed. Would it be just to raise for discussion, we could, but would it change either way?'' Nobody gives a view on child being a high moderate or low significant.* (Meeting observation)

In case study sites, we also witnessed disagreement as to the usefulness of scoring systems. Some partner agencies, particularly those in policing roles, were supportive of scoring approaches to assessing risk; whereas social care professionals appeared more sceptical, expressing concern about the children and young people who might be screened out of safeguarding processes by such tools.

Core panel activities

To fulfil their two broad objectives of case-oversight and theme-oversight, MACE (or equivalent) panels were described, and/or observed, as undertaking the following activities:

- information sharing and discussion about children and young people being harmed, those causing harm and the locations/themes/groups associated with that harm
- coordination of partners
- providing a forum for professionals to share and manage anxiety, stress and uncertainty, and to have this contained/held by senior leaders
- risk assessing and planning responses to the identified issues

We consider each of these in turn, and collectively, to fully consider what each entailed in practice.

Information-sharing: By far the most common practice observed in MACE (or equivalent) panels was 'information-sharing'. By this, we mean professionals talking about children and young people at risk of, or experiencing EFH, and in the process telling each other what they know about those children and young people, their families, their friends and sometimes the locations where those children and young people were spending their time. Almost all survey respondents stated that MACE (or equivalent) panels were used to regularly share information (98%) and discuss risks from perpetrators (92%), risks in specific locations (91%) and discuss individual children and young person's needs (91%)). Most also consider risks to groups of children as well as discuss what they commonly reference as 'persons of concern' (i.e. adults or children and young people considered to be causing harm to others).

In case study sites, the quantity of information shared in MACE (or equivalent) panels, and the topics discussed, were vast. Information shared did not always relate specifically to EFH. For example, we observed discussions about children and young people's weight, their skin conditions and so on, without accompanying explanation as to why professionals felt these matters were related to the EFH a child or young person was experiencing, or any associated trauma. Information shared was also not always about the children and young people referred into the panel; we observed conversations about friends, including practitioners sharing personal information about these friends including addresses, who were not themselves open to statutory services. In short, in most MACE (or equivalent) panels that fulfilled a case-oversight function, professionals were encouraged to share everything they knew or believed about a child or young person, and their relationships; a matter upon which some participants raised concerns:

> *"Like there was just a couple of voices in it and lots of people sitting there listening and hearing information that they arguably shouldn't hear, do you know what I mean? It just felt a bit like it was an oversharing space. I was really keen, not for it to be that."* (Focus group, case study site)

Further information-gathering was also an action that often came out of panel meetings, with professionals tasked with finding out additional or 'missing' information from the panel's discussion.

> *ACTION (from meeting): case worker needs to understand impact of mum's substance misuse, understand mum's partner situation, and find out who his associates are, curious whether he's going out in the community or whether he's still fearful and staying at home.*
>
> *ACTION (from meeting): for (professional) to do additional triage to find out more information* (MACE observation)

In MACE (or equivalent) panels that fulfilled a theme-oversight function, information was shared about trends/themes and locations. In some instances this information came from social work assessments of the children and young people who were being supported due to EFH, and/or from youth workers who delivered that support. In other instances, discussions about trends were largely based on crime, anti-social behaviour and police datasets and intelligence modelling. As such, some information on themes came from systems, and some from direct relationships with children and young people.

In respect of locations, information-gathering and information-sharing largely happened in two ways. Sites that utilised youth work, particularly detached youth work offers, were guided by what youth workers understood about locations and local area trends, and/or would task youth workers to undertake welfare-based assessments of these contexts in collaboration with social workers to gather more information (Firmin and Lloyd, 2022; Owens and Bradbury-Leather, 2025; Global Centre for Contextual Safeguarding, 2026). Such assessments considered what children and young people needed in the location under-assessment, what their access was like to 'community guardians' (i.e. adults that they trusted and who understood and could enact a safeguarding role), and wider environmental or community factors that were undermining or contributing to safety:

> *Discussion about our visibility over winter months – we still have detached youth work where we feel we need to have included after school and school lunch times. Discussion about other information – two hospital admissions, things happened outside the home have been due to concerns in their home (self-harm) and married up with carnivals in local area – both young people open to CAMHS had professional input, both open, so discussions and safety plan already in place. Also, cannabis is the main concern – we're offering a different way in if young person not looking for/taking one to one support around harm minimisation.* (MACE observation)

The other way that information was gathered and shared on locations was via the involvement of Community Safety colleagues. This often took the form of environmental audits of locations, which are focused on levels of crime and anti-social behaviour in an area, opportunities to design-out criminality (in terms of lighting), and where increased policing presence for example may disrupt or disperse crime. On these occasions community safety professional would report back the findings of an environmental audit back to the MACE (or equivalent) panel, identifying on design or sanction/disruption-based opportunities for intervention.

> *Police tasked with sharing location of concern – incident of ASB in park with large group, share info with local inspector…Community safety rep asks if any intel on how this came about? Discussion: lots of young people in space, dispersal by police, weapons being seen, trying to understand what precursor had drawn them there. Convos had - there was nothing to suggest hypotheses this was pre-arranged. No evidence of this. Professional recalls from conversation a fight between two females - drawing upon "anecdotal intelligence."* (MACE observation)

It was notable, however, that in some instances, the presence of a youth worker – or other trusted adult – at MACE (or equivalent) panels were drawn upon for information-gathering purposes rather than as a support mechanism in-and-of itself, as reflected here by these focus group participants:

> *"So sometimes the targeted youth workers, or me, or whoever would sit in a MACE …there's discussion around like peer groups linked and often there's been sort of asks around, kind of, do some peer group mapping or do this. And we're obviously trying to steer away from doing that without young people's consent, and sometimes I think there's almost an ask to go and seek Intel, to go and find information and, almost like, put surveillance on young people. Which I think is sometimes an easy ask, but because people don't recognise actually.... that's not what we do. … we know that we need to understand the context and the young people's peers and, you know, what they're doing. But it's not about us going and doing that and then just reporting it back to the MACE process*." (Focus group, case study site).

> *"I think it has been, the more that we've learned over the past couple of years, I think we are able to challenge that better. But previously, I think there was a definite kind of… you need to go and find out who's who and where they're spending time and who they're with and put it in as Intel and tell us what we're going to do. And then we've like, I've had previous examples of young people then being told well, right, you know, [worker] said that she saw you with X, Y and Z and then that completely ruins your relationship with that young person. So sometimes you kind of end up arguing with your own colleagues to kind of say 'no I'm not going to do that'* (Focus group, case study site)

Given the volume of information-sharing at MACE (or equivalent) panels it is interesting that protocols rarely appeared to guide this activity. 63% (5/8) of protocols submitted by survey respondents provided no substantive detail on information sharing arrangements. 37% (3/8) referenced information sharing agreements, only one protocol offered detailed consideration of information sharing processes.

Coordination: 51% of survey respondents strongly agreed and 41% somewhat agreed that MACE (or equivalent) panels improved coordination of multi-agency responses; however, data from case study sites and national interviews suggests a need to interrogate what this means. Different agencies attending a meeting together is not, in and of itself, a signal of coordination. Nor does information sharing necessarily demonstrate coordination in the absence of agreed coordinated actions across partners that may occur consequently. The evidence collected in this study raised questions about the extent to which these panels enabled, directed, followed up, escalated or held partners accountable for coordinated activity that occurred outside of those meetings. There appeared to be the limits to the coordination and associated accountability function of MACE (or equivalent) panels as there are currently used.

Focus group participants described how different members of MACE (or equivalent) panels worked to different goals and understandings of risk, making it challenging to coordinate around responses:

> *"…sometimes their [MACE panel members] processes and things are not, you know, don't run in the same way or aren't set up…our thresholds don't match theirs, yeah…it's what we deal with all the time, isn't it? Where we have to, as social services, manage risk, whereas they want to alleviate it. And we can't always do that with our young people."* (Focus group, case study site)

As illustrated in the site system maps and explored in more detail in section 4.2.1, many local processes for responding to EFH were uncoordinated. This was particularly evident where actions agreed at serious violence panels to coordinate responses to children and young people were decided upon independently of MACE (or equivalent) processes, or any other case oversight structures led by children's services. Our dataset suggests that strategic and operational work is required to *coordinate* how the police and children's services respond to children and young people impacted by EFH; the lack of shared thresholds, language, outcome measures, practices and so on do not appear to be alleviated by a MACE (or equivalent) panel.

Moreover, 20% of survey respondents strongly agreed and 62% somewhat agreed that activities at MACE (or equivalent) panels increased safety and stability for children discussed. Focus group participants also raised concerns about this:

> *"… [we're] feeding the beast, the beast gets bigger and fatter. But then what's the outcome of all that information? And that's the frustrating part for me, at some point we're in 2025 now heading into 2026 with the same problems that we've been experiencing from 15 years ago."* (Focus group, case study site)

Many of the examples of coordinated partnership working shared with the research team, in both case study sites and in national data collection activities, were about practices that took place outside of MACE (or equivalent) panel meetings.

> *"What we've been able to do … is build on what we already have within our establishment, and we also have within children's services …. a family adolescent support team which does a lot of work with children that go missing, or at risk of exploitation or EFH."* (National interviews)

> *"Young person and family who had a threat to life notice served due to risks of CCE, the strategy meeting brought together professionals who were able to take prompt action, housing fast tracked a house move to safe location for the family, community safety initiated 'target hardening' increasing home safety and arranged patrols, local area policing teams initiated 'cuckoo watch' visiting property regularly, Social Care co-ordinated a safety plan and health were able to alert A and E and health visitors."* (MACE survey response)

There was rarely evidence across our datasets to suggest that such safeguarding actions had taken place because of a MACE (or equivalent) panel or would not have taken place

in the absence of such a panel. Such actions were facilitated by relationships between individuals from different agencies, and/or within interdisciplinary teams that operated outside of MACE and their equivalents. There is the potential that in some situations the existence of MACE (or equivalent) panels offered an accountability mechanism through which professionals could escalate barriers to multi-agency responses being developed, either for individual children and young people, or in response to identified themes and trends. However, evidence of such escalation was not commonplace in our dataset. In the three case study sites that provided children and young people's case files for review, there were records of tasks assigned to professionals from various panel meetings, however, most of these related to information gathering and the completion of administrative tasks such as completing additional forms or assessments and booking review meetings. The coordination of multi-agency actions, including support and intervention, occurred within co-located practice facing teams, as opposed to in panel meetings, particularly those with a case-oversight function. In meetings where up to, and in excess of, 20 children were being discussed at any one time, there was little time or space for the level of conversation of reflection required to coordinate actions (and resolved points of discord) for such plans.

Sharing and containing worry and anxiety: Beyond information-sharing and coordination, MACE (or equivalent) panels appeared to offer a space for professionals to share, contain or reduce anxiety or worry about children and young people impacted by EFH. 77% of respondents strongly agreed (26%) or somewhat agreed (61%) that MACE (or equivalent) panels contributed to a 'reduction in professional anxiety about managing exploitation risk'. This practice of providing containment was observed in case study sites where chairs and panel members acknowledged how hard some meetings were, how professionals sometimes moved to restricting children and young people because they were so worried, and what professionals were having to hold in the process:

> *Chair reflects emotions including "it's painful to hear isn't it, she's been through enough bless her, a dagger through her heart, what are we going to do as a partnership?"* (MACE observation)

> *Professional (in the meeting) highlights that people keep talking about restriction of liberty (for the young person) and says "we talk around this but we need to protect her not restrict her liberty."* (MACE observation)

The importance of having a space to share your worries and have them held by others was also described by focus group participants in respect of all panels which were used to review the situations facing large volumes of children and young people. They described the ways in which they, and others, used MACE (or equivalent) panels to both seek reassurance from individuals and partnerships to provide reassurance to others that things were in hand:

"The first person that everybody comes to in that meeting is us. [They'll ask] can you tell me anything about this child? Ten children. I've got 45 minutes, 45 minutes to check this right. And everybody is stunned in silence, waiting for you. And you're like, can you just give me a little bit of breathing space? Because I don't know... it is so anxiety driven and just the tenacity and the resilience that you need just to go - I'm going to breathe, I can only do as much as I can, but I'm going to give every child as much as I can... you know, it's that in itself is a skill for the day, because as soon as I come out of that meeting, I've got to do all of the follow-ups for that." (Focus group, case study site)

"I think some of these panels, though, for me anyway, it kind of confirms what you've already been thinking or some of the worries that you've had. It's like once you're speaking to all the different other professionals that have more expertise. It's that they're pre confirming again that actually you're correct to have this worry and then actually it helps more with case direction in terms of if you're a bit stuck in terms of where to go next because, you know, there's a risk but you're not sure which direction." (Focus group, case study site)

However, use of MACE (or equivalent) panels to share worries, or to seek reassurance, also appeared to create additional pressures or concerns. The level of risk discussed, and for the volumes of children and young people for whom there was significant concerns, was often difficult to hear, at times distressing, and in situations where people sometimes appeared lost as to what to do:

Chair: Does anyone have any questions or I can go through it [information]? I wasn't at NRM so this is what police shared - frequency episode of missing is increasing, anti-social, arrests, making £100 so concerns around exploitation, open modern slavery investigation, assaulted three teachers and smashed tv so four crime reports, [service] had closed at that point but didn't know about the £100. (Meeting observation)

Social worker says "there are no consequences for [name of young person] – he feels untouchable." Chair says "you need to think differently, what's driving him this way? Is he untouchable or does he just feel better when he is away then when he is with someone else, what else is happening to this child, what's happening for him, we need to understand as to why this is happening." Chair highlights "it's cold in November" [when prolonged missing episodes happening]. (Meeting observation)

Moreover, social work and youth work participants in particular described pressure from policing partners to use MACE (or equivalent) processes to provide certainty about assessed risks/situations that they considered to be far more fluid, as described here:

"...other agencies who come to the [panel meeting] get very caught up on the scoring and start disagreeing over the scoring. And I think, please, please ... the scoring system ... to us, it doesn't really matter whether they've scored low, medium or high. In terms of the score, it's the plan - it's the plan and the risks and actually, are we effectively addressing those risks? What can we mitigate, what can't we, what are we holding and then....but the police, the police very much want it at certain score." (Focus group, case study site)

> *"I think that when you're working in partnership with agencies … they're like 'let's send them to secure, let's wrap them up in cotton wool'. And it's like 'yeah, there's a whole huge court process in-between here and there and we're not going to get there'… I think there's a lot of discomfort within those meetings with professionals. With some of our very risky young people - it's a struggle to hold it and it's what we have to learn to do."* (Focus group, case study site)

Our dataset therefore suggests that a key function of MACE (or equivalent) panels, particularly those used for case-oversight purposes, was to provide a level of partnership reassurance. Indeed, in our observations these panels appeared to offer *containment* of interagency concern, whereas much of the *coordination* of interagency practice appeared to happen outside of the panel meetings, particularly in exploitation/EFH hubs or teams who were responsible for providing day-to-day support plans for children and young people. In this sense MACE (or equivalent) panel activities often offered a monitoring function more than a planning/action-orientated function. As such, in areas where MACE (or equivalent) panels no-longer provided a case oversight function, interagency plans were still being *coordinated* (detailed in later sections), via child protection pathways and/or in multi-disciplinary exploitation/adolescent teams. However, in one of these sites, system mapping participants expressed concern that the removal of the case oversight panel had reduced visibility of wider themes and trends, creating anxiety within the local system in a different way.

Planning: In terms of planning, the actions MACE (or equivalent) panels agreed upon fell largely into three main groups: educative or diversionary interventions; onward referrals to other services; or disruption activities. The nature of these will be explored in more detail in section 4.1.5 which outlines all options available to MACE (or equivalent) panels and alternatives to them. Additionally, survey respondents were also asked whether their area was placing children and young people at a distance from their home authorities as a response to EFH. Of the 69 professionals who answered this question, 39% were chairing panels that had discussed or recommended moving a child or young person at distance in the last three months, while just over half (52%) had not, and a small minority were unsure. Eighty-four per cent of those who had used a distance placement stated that this was primarily for 'safety from exploitation or perpetrators', 60% described it as 'an emergency move to prevent immediate harm', and 48% reported moving a 'child because suitable specialist placements were not available locally'.

Summary: Variations and points of consistency in the features of MACE (or equivalent) panels

Nearly all features of MACE (or equivalent) panels that we have summarised above are subject to local variation. MACE (or equivalent) panels vary in terms of:

- Their purpose
- Their frequency and length

- Who chairs them
- The forms of EFH considered
- How they categorise/assess needs and risks
- Thresholds they apply to decide which issues/children are discussed
- The extent to which they relied upon Community Safety Partnerships for coordinating responses to locations and groups
- The extent to which they relied on intelligence and reported crime or knowledge gathered through practitioners' relationships with children and young people, families and communities, to reach conclusions about needs and risks

Given the level of variance in the practices of MACE (or equivalent) panels, it was not surprising that some participants expressed confusion about their purpose:

> *"One of the biggest barriers is what is the role of meeting A, what is the role of panel B (MACE), what is the role of panel C and what is your role within that as an attendee?"* (Focus group, case study site)

> *"I'm still..... I'm not hand on heart...I can't say that the strategic MACE is fulfilling its function as best as I would like it to. I think operationally we deal with individual cases very well and we have engagement across the piece, but whenever I'm involved in discussions in strategic MACE I'm still left feeling a little cold in terms of the change we're actually able to drive."* (Focus group, case study site)

Despite this confusion, MACE (or equivalent) panels appear consistent in their:

- Presence providing a central accountability point (even if only in name in some areas) in the absence of a consistent safeguarding pathway for children and young people impacted by EFH
- Position as *one* of multiple meetings/panels used to convene responses to EFH
- Use as a forum for information-sharing
- Use for sharing and containing professional anxiety/ worry or offering reassurance

Before we consider the local system contexts in which this variation/consistency occurs, and the alternatives some areas have put in place, we provide further detail on the options available to MACE (or equivalent) panels in terms of their response to EFH and the children and young people affected.

4.1.3 What are the options available to MACE (or equivalent) panels to protect children?

In this section we detail the options available to MACE (or equivalent) panels, and where relevant alternatives to those panels, to protect children and young people impacted by EFH. To do so we report options that were observed in case study sites or referred to in national interviews and surveys. To do so we share findings on what was possible in some, but not consistent across all, participating LAs, and the conditions in which those

possibilities were more of less feasible. In summary, MACE (or equivalent) panels could draw upon the following in response to EFH:

- Access to, or referral into, youth services
- Access to, or referral into, wider systems and services, including health, education and crime prevention services
- Disruption of those who posed a risk of harm to children and young people, or the contexts in which EFH occurred
- Escalation activities to address barriers in providing services that children and young people needed

Access to, or referral into, wider youth services

Case study sites that had access to youth workers, both those that offered targeted 1:1 support and those who were detached, were able to respond to some of the issues identified at MACE (or equivalent) panel meetings, as well as in processes introduced as an alternative to such panels. Youth work offers were identified in one site with a MACE (or equivalent) panel, and in two sites that had put an alternative in place. Options offered by youth work in these sites included ongoing relational support to a child or young person (three sites), opportunities to explore children and young people's interests and support friendship building beyond the issue of EFH (two sites) or to assess and respond to locations/groups associated to the harm being discussed (two sites).

Youth work offers were identified in the two case study sites without a MACE (or equivalent) panel and one site with a MACE (or equivalent) panel. When answering the question 'who are core membership' only 50% of MACE survey respondents included youth work. Across the open text options, youth work was only mentioned twice and on both occasions in relation to the questions about challenges the panel faced: *'limited youth work offer'* and '*community based provisions once beloved by children have disappeared in the last 15 years - e.g. professional statutory youth work which provide unique safe spaces for children in communities'*. The limited involvement of youth workers in MACE (or equivalent) panels may go some way to explaining why survey respondents were least likely to report that their MACE (or equivalent) panel had developed plans to build community guardianship in contexts impacted by EFH

Access to, or referral into, wider systems and services, including health, education and crime prevention services

In case study sites, MACE (or equivalent) panels that fulfilled a case-oversight function sought to protect children and young people mainly by referring them to other services. At panel meetings decisions were made to refer children and young people into a range of other health, education or crime-prevention services, with the intention of either helping the child or young person think and then act differently, such as via consequential-thinking, knife crime awareness, or healthy-relationships education

programmes; or to meet particular needs, such as referrals into sexual or mental health services:

> *Referral to insight for substance misuse, referral to family practitioner to do some work, referral to mentor, referral to [service], … peer mapping to see who he is associating with if any and also check any missing episodes and if he is going missing and reporting, clarification needed if he is open to CAMHS or only when presents in A&E then closed, and presented to HSB service.* (MACE observation)

> *16 years old, recent change in behaviour … spoken to school a lot about him, mum worried about him on the streets, mum grounding him but he's stopped sharing location and being secretive with mum… ACTION: run session with young people around exploitation and grooming.* (MACE Observation)

Disruption of those who posed a risk of harm to children and young people, or the contexts in which EFH occurred

Interview participants and survey respondents also described various disruption-based options that MACE (or equivalent) panels could draw upon to protect children and young people impacted by EFH. Options were largely described in respect of targeting adults who posed a risk of harm to children and young people. Examples included pursuing licensing or driving offences to disrupt individuals lives or to indicate to them that that they were being watched by statutory services. Child Abduction Warning Notices (CAWNs) or Criminal Behaviour Orders (CBOs) were also referenced as options to prevent contact between adults and young people:

> *"You know, looking at issuing a CAWN order, which is a Child Abduction Warning Notice… we love acronyms…. So, you know, looking at the range of tactics that are available to us in terms of what we can actually do from a policing perspective rather than just a traditional sort of like safeguarding".* (Focus group, case study site)

> *"Identifying x2 perpetrators, holding police accountable for MDS investigation and disruption (CAWNs) being served, pull together with multi agency and stronger oversight of concerns. Allocation of [EFH] worker (prior to MACE); Escalations raised from MACE re missed opportunities of bail conditions upon arrest with two perpetrators but released with them and no bail conditions to not associate or communicate made it hard for disruption."* (Survey response)

> *"If there's been drift [with a child on MACE staying at high risk], how can we support that? How can we get some movement going and then the other bits we'll look at offenders. That's then bringing adults into that about what disruption tactics we're doing. So as adults, we're doing that and then look at locations and trends, we're looking at that contextual element about where there's [common] locations. What we're doing in those locations to again increase safety of children in those spaces or to disrupt harm coming in and then that's where you've got housing, community safety, environmental health, licencing, all those different agencies having an input into that location."* (National interview)

Observations offered real-time insights into accounts such as those provided above. Many of the disruption activities that were described in interviews, focus groups and surveys, were practically designed and coordinated outside of MACE (or equivalent) panel meetings; it was not always clear that the meetings themselves had been required to trigger such activities. Therefore, while disruption may have been an 'option' for MACE (or equivalent) panels, the level of detail required to discuss, agree, and action these disruption activities were not observed taking place within a MACE (or equivalent) panel setting. In some respects, this is unsurprising given the volume of children and young people being discussed in most panels with a case-oversight function.

In one of the sites that had disbanded their MACE panel and put in place an alternative process for children's services led multi-agency oversight case-oversight (see section 4.1.4), meetings were convened for one child at a time to specifically discuss and plan disruption activities. Professionals only called one of these meetings when a disruption opportunity had been identified for a specific child. These meetings offered space to discuss disruptions options in far greater detail in ways that were not observed to be feasible in MACE (or equivalent) panels that reviewed plans for large numbers of children and young people at once (section 4.2.1). In some respects, the ambition for MACE (or equivalent) panels to plan disruption activities appeared conceptually aligned to what happens at multi-agency risk assessment conferences (MARACs) for domestic abuse. In these meetings, chaired by the police, multiple adults impacted by domestic abuse are discussed. Each adult experiencing domestic abuse is subjected to a risk assessment which produces a score noted at the meeting, after which various disruption options are routinely discussed to reduce identified risks (such as house alarms and orders prohibiting the person who is being abusive from contacting the person they are abusing). However, such an approach is not easily transferred in response to EFH impacting children and young people for the following reasons:

1. Often professionals do not know who the adults are who pose a risk of harm to children and young people, whereas in most cases of domestic abuse the adult who is causing harm is named.
2. Children and young people who are being harmed in situations of EFH are often also harming others, and/or often committing 'offences' in the context of their own abuse. There is less clear water between a 'victim' and a 'perpetrator' in the context of EFH than in many situations of domestic abuse, meaning that in situations of EFH there may be an ongoing risk that some children and young people who are being harmed through EFH will be criminalised by responses due to the risks they also posed to others or offences they committed in the context of their own abuse (see section 6.5).

The nature of EFH therefore means that disruption activity often requires detailed and gradual planning to identify the appropriate target of the response and to mitigate the risk

that the action taken may inadvertently harm children and young people. Indeed, some study participants raised ongoing concerns about the ways that disruption activities had targeted children and young people impacted by EFH rather than the people who are harming them:

> *"But actually they're all our children that you are targeting, following and disrupting that you make up your crime statistics with because you're not prepared to go after the big (fish) .....my kids are just little fish that are easy to arrest and get the charge and will inundate youth justice and say 'well why you're not adhering to your conditions'....well because actually I'm being exploited and I can't."* (Focus group, case study site)

And we observed this in practice, when professionals focused on disrupting a child or young person who was spending time in places where he was at risk of harm, rather than the people who were harming him:

> *ACTION – keep monitoring address, disrupt him going to that address/spending time there.* (Meeting observation)

Therefore, while disruption activities may be an option for protecting some children and young people impacted by EFH, evidenced collected for this study raise questions about whether it was an option for MACE (or equivalent) panels with a case-oversight function. For MACE (or equivalent) panels to draw upon this way of responding to EFH, far more space is needed during the meetings to understand the situation of an individual child or young person, or a context where harm is occurring, and recommend approaches to disruption that will not criminalise children and young people in the process; this appears particularly hard to realise when large volumes of children and young people, who professionals in the meeting do not know personally, are being discussed. Where case-oversight MACE (or equivalent) panels discussed multiple children in one meeting, there was often limited space to plan disruption activity in detail. By contrast, meetings convened around an individual child, or panels focused solely on a theme, trend or location, appeared better suited to coordinating disruption activity effectively.

Escalation activities to address barriers to children and young people accessing services they need

MACE (or equivalent) panels can draw upon their status in local systems to escalate concerns about children and young people impacted by EFH. Various system or service barriers can exacerbate/escalate the issue of EFH, including reduced access to education (Temple, 2020; Lloyd, 2025), increased risks of criminalisation (Cockbain and Brayley, 2012; Lloyd and Firmin, 2019), delays in both assessments for neurodivergence or learning needs (Firmin et al., 2021; Franklin et al., 2024; Newham 2024; Allnock and Soares, 2025), and inability to access safe housing.

Two case study sites had explicitly designed ways for their MACE (or equivalent) panel to escalate concerns related to education: one with an escalatory route into a school

inclusion panel, and one who drew upon a schools' focused worker in their EFH team who attended panel meetings. In the latter situation, the panel drew upon this role to discuss escalation options for children and young people's access to education. However, because this worker was based in the local EFH team much of this escalatory work happened irrespective of whether it was specifically initiated by MACE (or equivalent) processes.

The ability to escalate actions regarding education are important. In the case files reviewed across three case study sites we noted significant challenges with supporting children and young people's access to education, as well as expediating assessments that may support planning around their learning needs – such as ADHD assessments. In these scenarios it was evident that some accountability mechanism was required to unlock barriers within services, and that it would help for these steps to be taken strategically/thematically across a partnership rather than on a case-by-case basis alone.

It was less clear that MACE (or equivalent) panels offered a context for accountability or escalation in respect of services other than education. Amidst ongoing tensions between children's social care and policing in local responses to EFH, discussed throughout this report, MACE (or equivalent) panels were not consistently used as spaces for children's services to challenge the criminalisation of children and young people affected by EFH. While we observed a challenge to the language used by police to describe a young person in one MACE panel meeting, broader challenges to policing decisions or actions were not observed in MACE (or equivalent) panels featured in our dataset. Where such challenge did occur, it was observed in alternative meeting structures.

We also heard through national surveys and interviews, as well as in case study sites, that structural issues, such as capacity and the ways that services were organised, prevented consistent engagement from health or housing on MACE (or equivalent) panels. A third of survey respondents stated housing was a 'core' member of their panel; this was the least common agency noted as a core member. When asked, 'are there any agencies you feel should be core members of your panel but are not currently represented?', housing was the most chosen option. Moreover, only about 28% of respondents stated that information from housing was "always" or "usually" available to their panels. When this was explored in case study sites participants stated that housing would be more likely to attend a meeting about an individual child or young person, than about a long list of children and young people; as different providers would be relevant to different families and would not be organised under a single point of contact. In terms of health, 98% of survey respondents recognised them as a core partner, however 20% of respondents reported not getting access to reliable, timely information from health partners at panel meetings. Health is a sector spread across different, and changing, structural arrangements to the point that it is again difficult to know who could represent them

effectively on a case-oversight panel that was discussing a vast array of issues and a long list of children and young people. Such challenges limited the extent to which MACE (or equivalent) panels were used to unlock access to health and housing support as a protection option.

4.1.4 Are there areas not using MACE (or equivalent) panels, and if so, why? Are these areas using alternative approaches?

Eighteen per cent of chairs who responded to the MACE survey stated that their LAs did not have a MACE (or equivalent) panel and had put alternative arrangements in place. Two of our six case study sites were in the same position. The rationale given for not having a such a panel varied and, in some survey responses, was not always clear.

Some English LAs had paused their MACE (or equivalent) panel while reviewing their local response to EFH, as part of wider children's social care reforms underway. Some of these LAs explicitly stated that they were introducing Risk Outside of the Home (ROTH) (sometimes referred to as Harm Outside of the Home (HOTH)[6]) child protection pathways as part of this wider reform agenda. ROTH/HOTH child protection pathways featured an initial child protection conference meeting, and review meetings, to develop and implement a plan to support an individual child or young person affected by EFH (rather than a panel to discuss multiple, unconnected, young people). The pathway utilised the same legal and policy basis and the same abuse categorisations, as wider child protection processes and therefore integrated local EFH responses into child protection processes. As such, it integrated local EFH responses into child protection arrangements, rather than running them in parallel to those arrangements. This pathway also provided an accountability function through which practitioners could escalate concerns about inaction from partners or increasing need/risk.

For some LAs, when a ROTH/HOTH child protection pathway was introduced as part of their reforms it would fulfill the case-oversight function of MACE (or equivalent) panels for children and young people at risk of significant EFH. For other respondents, ROTH/HOTH child protection pathways were already established in their LA and were cited as fulfilling MACE (or equivalent) panels for coordinating plans for, and having oversight of, children and young people at risk of significant EFH; in these scenarios had been gradually phased out, either formally or informally. In some sites MACE (or equivalent) panels have been retained while ROTH/HOTH child protection pathways are introduced; often the ROTH/HOTH pathway is owned by the LA, whereas the

[6] The acronym HOTH was also used at times for MACE equivalent panels. The distinction, as outlined earlier in this report, was the features of the panel/pathway, rather than the name. In alternative arrangements HOTH child protection pathways featured individual case planning meetings for children and young people at risk of significant extra-familial harm, and were using those meetings in place of a MACE panel with a case oversight function for multiple children and young people.

maintenance of MACE (or equivalent) panel is regional coordinated under a policing protocol.

Some Welsh survey respondents reported enhancing using specific exploitation assessment tools, teams, and meetings, to develop plans for individual child or young person impacted by some forms of EFH, which ran in parallel to child protection processes unless the EFH was in some way attributable to the care provided to the child or young person by their parent or carer. This process was used on a case-by-case basis, and was described by a Welsh case study site and Welsh survey respondents as providing oversight of responses to children and young people impacted by EFH instead of a MACE (or equivalent) panel; however, they still used a MACE-equivalent panel to fulfil a thematic oversight function.

Of the six case study sites:

- Two did not have a MACE (or equivalent) in place at all – for either case-oversight of theme oversight approaches – and each had different alternative arrangements in place.
- Two had a ROTH child protection pathway in place – one had disbanded its MACE panel and used the ROTH pathway as an alternative case-oversight process; the other had retained its MACE under regional protocols and was running its ROTH child protection process at an LA level as an additional case-oversight process.
- One had introduced what it referred to as a ROTH-equivalent arrangement for children and young people at risk of significant EFH. It had many of the structural features of a ROTH pathway summarised above (conference, social care assessment, core group to review plans etc.) but it was not formally used as a child protection pathway as most children and young people at risk of significant harm due to EFH in that area were children and young people in care. Therefore, while they used the threshold of 'significant harm' to allocate children and young people to their ROTH pathway they did not formally record any of the children and young people on this pathway as being on ROTH child protection plans. This process provided an additional case-oversight functions to their MACE equivalent panel.
- One used an EFH specific social care assessment/screening tool and individual meetings for children and young people impacted by EFH for case-oversight purposes as an alternative to MACE (or equivalent) panels, but retained their MACE (or equivalent) panel for theme oversight

In short, only one site used a MACE (or equivalent) panel alone as the central structure for both case and thematic oversight of EFH. Of the remainder, two did not use a MACE (or equivalent) process at all; one used it for thematic oversight only, and two used additional processes – a ROTH child protection or 'ROTH-equivalent' pathway – for case-

oversight purposes, while using their MACE (or equivalent) to also fulfil a theme-oversight function.

Alternative and additional approaches to fulfil case oversight functions

As summarised above, two case study sites had completely disbanded their MACE processes. One of these sites replaced their MACE panel with a ROTH child protection pathway. They used this pathway alongside a police-led trends meeting and interdisciplinary teams. This site had gradually stopped using a MACE panel and then, having established a ROTH child protection pathway, felt that they no longer had a need for such a panel. They also held another meeting, led by the police, which social work and youth justice attended to keep abreast of trends and key incidents related to EFH. However, this did not fulfil any accountability or monitoring functions in terms safeguarding responses. An interdisciplinary young person's service coordinated support for children and young people, and support for those at risk of significant harm was convened through ROTH child protection plans. A second interdisciplinary team was responsible for coordinating welfare-orientated assessments of contexts (locations and groups) impacted by EFH.

A second case study site had replaced its MACE (or equivalent) panel with two different meetings. One was a daily briefing to keep track of emergent issues, identify children and young people who had been missing, or where concerns were escalating, and then a second planning meeting that was convened for an individual child or young person for whom there were disruption/investigatory opportunities. Wider support plans for those children and young people were organised by an interdisciplinary EFH team, rather than through a MACE (or equivalent) panel. This site made these changes as the scale of need in their area resulted in MACE (or equivalent) meetings being too long, too big and as such feeling unsustainable. However, unlike the other site without a MACE (or equivalent) panel (summarised above), they had not retained any meeting to consider trends and themes and reflected that they felt they lacked senior leadership awareness of thematic operational challenges they were facing, as a result.

Other case study sites used a combination of MACE (or equivalent) panels and additional arrangements.

As summarised above, one case study site that had established a ROTH pathway also retained their MACE (or equivalent) panel for both case-oversight and thematic oversight functions. Their MACE (or equivalent) panel processes used distinct assessment and risk categorisations, which were set regionally rather than at LA level. Their decision to initiate a ROTH child protection pathway sat with the LA rather than the wider region. As such they ran both of these processes simultaneously and ran in parallel with each other.

In keeping with Welsh survey respondents, the Welsh case study site used their MACE panel for theme-oversight functions only. Case-oversight was provided through meetings

coordinated by their exploitation team, which were called to agree plans for an individual child or young person at risk of EFH one at a time. This meeting/process ran in parallel to a children's social care pathway (and used its own categories/risk ratings), rather than being integrated with it.

In summary, most alternative arrangements were introduced to fulfil a case-oversight function. While each arrangement differs in some ways, they are also distinct from case-oversight MACE (or equivalent) panels in terms of:

- Being organised around an individual child or group, rather than a list of children and young people impacted by EFH
- Being chaired solely by children's social care
- Involving children, young people and their families
- And with the exception of the work in Wales, was integrated with children's social care pathways, thresholds and categorisations rather than running in parallel to it

We consider each of these features in turn before exploring the efficacy of both MACE (or equivalent) panels and these alternative arrangements.

Meetings to plan for an individual child or group

Meetings convened around one child or young person at a time, featured time to discuss and reflect upon what children and young people needed, including the relationships they had access to, and the resources that would be needed to keep them safe. These meetings were usually attended by people with a direct relationship with that child or young person, and/or their family. We observed that the attendance of practitioners who knew the child or young person directly created opportunities for advocacy and challenge from both youth work and social work participants to the wider professional network:

> *Chair: Do you have any future goals or aspirations? I'm thinking about education plan and what we can support with.*
> *Social worker: He loves bikes [young person nods]. There's a space for you at a bike club at 4pm on Tuesdays for you. But hasn't been accessed yet but it's there*
> *Chair: Is there something you might want to do with a friend? Social worker mentioned a recording studio [observer notes - seems like social worker really knows him and likes him]*
> *Young person: Never liked my school, want to go to another school. Want to try another mainstream school, other school had bad vibes.* (Meeting observation)

> *...we need to know this because she may be socialising with her friend who might be dealing or criminal and there is a cross over, but we have to balance her rights to have relationships and friendships with who she wants. She highlights that people keep talking about restriction of liberty – we talk around this but we need to protect her not restrict her liberty... Chair reflects emotions including it's painful to hear isn't it, she's been through enough bless her, a dagger through her heart – what are we going to do partnership...what*

does young people want, blocked now but maybe Christmas she might want this – where will she go when she is older. (Meeting observation)

The reduced volume of children and young people being discussed in these meetings appeared to influence the tone of the meeting: listening to concerns for one child or young person at a time, rather than trying to plan for multiple children and young people all in one sitting, appeared to create space and pace for a different tone in thinking about need and holding risk.

Single chairing – solely with children's social care

All alternative case-oversight arrangements were chaired by a single agency – children's social care.

For meetings held on a ROTH child protection pathway social care leadership was not only demonstrated by who physically chaired the discussion; it extended to the design/tone of the meeting. Meetings were orientated around children's social care culture, terminology and processes. They were focused on needs and welfare, and harm was discussed in respect of 'significant harm' thresholds, as opposed to alternative categorisations/scores adopted by MACE (or equivalent) panels. Police were invited to attend ROTH child protection conferences alongside other practice partners but did not hold any chairing or leadership responsibilities in this meeting structure.

This same leadership approach was observed in all three areas that had introduced a ROTH (Sites 3 and 5) or ROTH-equivalent (Site 4) meeting; despite the latter also retaining its MACE (or equivalent) panel and the latter primarily using their ROTH meeting model for children and young people in care and so did not assign those children and young people child protection status.

Involvement of children, young people and/or parents

All ROTH meetings, both in sites with or without a MACE (or equivalent) panel, involved children, young people and their families in the meeting. We were not informed of any MACE (or equivalent) panels that did this, and in the three case study sites that did not have ROTH pathway, children and young people were not present in any meetings used by the site to coordinate responses to EFH.

Participants in sites that involved children, young people and families in planning meetings commented that they felt parents/carers were partners in safety planning, and that the information they used to agree next steps often came from parents/carers and young people as opposed to from professionals or organisational datasets.

Chair: How are things at home?
Mum: We don't have much sit-down family time, he's either in room or out. Always on his phone. Goes out every day, can't get him to stay at home. Been getting money from buying and selling shoes but think he's got money coming from somewhere else. Feels like he's ready to try and get out of it but he can't. He's said to me he wants to get out but he can't talk about it. (Meeting observation)

Mum and young person arrive. Chair (to young person): You can leave or stay as much as you want. Social Worker offers to take him out if he wants: If it gets too overwhelming or anything let us know. Chair introduces what the [meeting] is: "Get everyone's views and make sure the plan is right, help you do things you want to be doing, keep you safe when out and about. You might not always agree that you're not safe, but we can talk more about that." Social worker says "I'm really pleased you're here, I know sometimes you struggle to understand what we're worried about or why we're worried." Chair goes around and introduces everyone. (Meeting observation)

Integrated into children's social care pathway, rather than parallel to it

ROTH pathways were integrated into the children's social care pathway in all sites in which they were observed, rather than running parallel to it. This was different to the alternative meeting that was in place for Site 6, and the alternative-case oversight function used in the Welsh case study site, which both ran parallel to, rather than as an integrated part of, the children's services pathway.

By integration we mean that the pathway applied the same language – significant harm – and associated threshold to denote the level of social work oversight given to a child or young person. Whereas when case-oversight processes were not integrated, for example via a MACE (or equivalent) panel, a child or young person may be denoted the category of 'high risk' or 'red' by MACE (or equivalent), but then also be allocated on a 'Child in Need' or child protection plan in children's services, or no social work plan at all, depending on the extent to which the harm they were experiencing was attributable to their caregivers. In theory two children could both be flagged as 'high risk' by a MACE (or equivalent) panel, but one would also be on a child protection plan due to domestic abuse they were facing at home, whereas the other might not be on a social work plan at all, or could be supported via a child in need plan, if parents/carers were doing all they could to keep a child and young person safe.

4.1.5 Nature and scale of MACE (or equivalent) panels and alternatives to them: a conclusion

In summary therefore, most areas that participated in this study are using a MACE (or equivalent) panel as part of their response to EFH, however between 15-20%[7] have an alternative in place.

Where MACE (or equivalent) panels are in place, they are used to fulfil two broad functions: oversight of plans for individual children and young people (reviewed via a list or sheet) and oversight of responses to trends/locations. Despite their widespread use, these panels vary in terms of their frequency, who chairs them, the harms they consider and their approach to categorising risk and applying thresholds. They predominantly run in parallel with children's safeguarding and child protection pathways – for example, using distinct approaches to assessing risks and defining thresholds.

Of all the activity that takes place at MACE (or equivalent) panels, data collected across this study showed that the most common was professionals sharing information about children, young people, groups and locations impacted by EFH. While survey and interview participants described these panels as also as coordinating responses as a result of the information-shared, the available evidence from this study suggests that much coordination happens outside of MACE (or equivalent) panel meetings. While it is possible that the panels contribute to the coordinated activities that take place beyond panel meetings, what was more evident in the data was the role that MACE (or equivalent) panels played in containing professional anxiety and reassuring senior leaders of actions being taken. Evidence was less clear on the contribution that MACE (or equivalent) panels made to providing safety and stability for children and young people.

To develop safety plans for children, young people and locations impacted by EFH, MACE (or equivalent) panels draw upon: youth service support; referrals into wider services for education, diversionary or needs-orientated intervention; disruption activities led by policing and community safety; and actions to escalate concerns about children and young people's access to services, most commonly education. Most MACE (or equivalent) panels relied on policing and community safety interventions to respond to locations and trends, however some used youth and social work to do so. Youth and social work responses to locations sough to develop a more welfare-based responses to locations, orientated to consider children and young people's needs and access to adults they trusted, rather than responding to locations with a focus on crime prevention and anti-social behaviour.

LAs using an alternative to MACE (or equivalent) panels largely did so to replace its case-oversight function rather than their trend-oversight function. Some areas retained a MACE (or equivalent) panel for trend-oversight activities; a smaller number put an

[7] An initial scoping survey returned a higher percentage than the full survey.

alternative in place for trend-oversight meetings as well; and other raised concerns that the alternatives they had in place left them without a trend-oversight capability. Alternatives to case-oversight arrangements were different to MACE (or equivalent) panels by: being focused on an individual child or young person (rather than talking about a list of multiple children and young people in one meeting); being chaired solely by children's social care; being attended largely by professionals who know the child or young person (rather than having a standing membership of sector representatives); applying children's social care categories of harm and thresholds for support; and involving children, young people and families in meetings. In two case study areas these arrangements had been introduced as 'additional' rather than 'alternative' processes to MACE (or equivalent) panels; meaning some areas operated dual case-oversight pathways. On occasion, this was due to the police maintaining a MACE (or equivalent) panel at a regional level, while an individual LA had decided to introduce a children's social care-led case-oversight pathway for EFH.

4.2 Efficacy of multi-agency operational panels

The second RQ for this study asked: *How effective are MACE panels?* Given the above variations in how MACE (or equivalent) panels are run, and confusion as to their purpose, exploring their efficacy is both complex and important. Therefore, we organise our answer to this question, and the associated study sub-questions (see section 3.1), by sharing findings on:

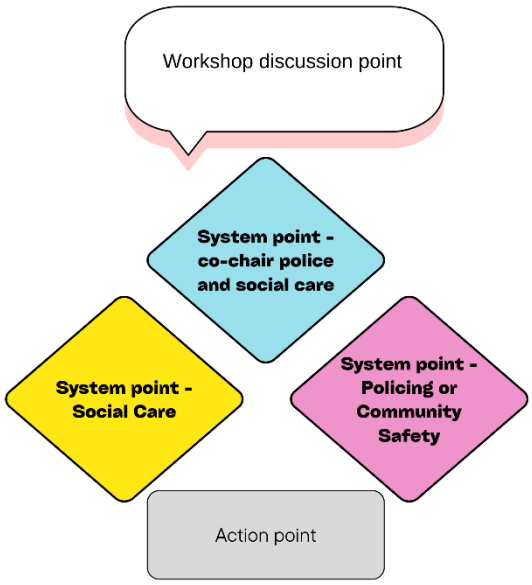
- 4.2.1 The extent to which MACE (or equivalent) panels and alternatives to them are coordinated with other safeguarding structures
- 4.2.2 The extent to which MACE (or equivalent) panels are successfully identifying and protecting children and young people impacted by EFH
- 4.2.3 Whether alternatives to MACE (or equivalent) panels appear to be more effective
- 4.2.4 Whether MACE (or equivalent) panels provide protection for all children and young people, including specifically Black children and young people
- 4.2.5 Best practice in respect of MACE (or equivalent) panels and alternatives to them

However, before sharing findings on efficacy, it is important to note that MACE (or equivalent) panels, and alternatives to them, are operating in national contexts of confusion and inconsistency in respect of EFH and the children and young people impacted. There is a persistent tension between welfare-led and criminal justice-led responses to EFH, reflected in a national policy landscape split across the Department for Education, the Home Office and, to a lesser extent, the Department for Health and Social Care. This division is evident in the disparate legislative basis upon which areas have built their safeguarding responses to children and young people affected by EFH. These responses feature distinct elements of child protection and crime and disorder legal frameworks that do not speak to each other; enacted through regional policing protocols to respond to exploitation, that are distinct from responses to serious violence, and both of which are distinct from local children's social care and child protection pathways. Professional responses to EFH are under significant scrutiny, and the impact on the workforce was visible in our dataset; practitioners are operating in a context of reduced resources and heightened anxiety. Finally, the lack of protection afforded to Black and other racially minoritised children and young people impacted by EFH has already been well-evidenced, particularly in recent years (Firmin et al., 2021; Davis, 2022; Dodzro and Goode, 2023; Davis, 2025). All the above factors impact the efficacy of whole-system responses to EFH, and the practices within those systems: and this is visible in the ways MACE (or equivalent) panels operate. As such, what we identified in respect of the efficacy of MACE (or equivalent) panels, is largely reflective of wider systems.

4.2.1 Are MACE (or equivalent) panels successfully coordinating with other safeguarding structures?

Figures 4-9 map the operational pathways used to respond to EFH in our six case study sites. Each map is different because each local area has designed its own safeguarding response to EFH. Neither national policies, nor the legislative basis upon which these local responses have been built, are coordinated. The lack of national coordination raises important questions about how MACE (or equivalent) panels can successfully co-ordinate within wider uncoordinated safeguarding structures. To answer this question therefore, we look across the six case study sites, within the context of our national data, to examine how MACE (or equivalent) panels connect with, overlap with, duplicate, or sit separately from other parts of the safeguarding system. In the process we also identify shared features of local pathways, and key points of divergence, to understand whether any features of efficacy or challenge are a national or local matter.

Figure 3 Key for case study system maps



Data from case study sites enabled us to map the different ways in which MACE panels were used and positioned in local systems, as well as explore systems in which MACE panels were no longer a feature. Each map was produced at a 2.5-4 hour workshop with representatives from the respective case study site, who were themselves selected by the site lead as people who were knowledgeable about local systems and processes.

Each system map (see below) illustrates a child or young person's potential journey through a local safeguarding system, from the point at which they disclose to a youth worker that they were stabbed in the shoulder three-days earlier. Each map visualises how the site representatives described their safeguarding processes in response to EFH, and the relevant position of MACE (or equivalent) panels, and alternatives to them, within this. The key for the maps is provided above in Figure 3. Participants described:

- The place(s) where a youth worker would 'refer' a child or young person into the local safeguarding system following disclosure
- The approach to assessing that child or young person's needs, including any initial screening activities or visits

- The meetings in which plans to support a child or young person would be agreed or monitored
- The types of responses such meetings would generate in the local safeguarding system

Participants also clarified who chaired/led the meetings that they mapped and described whether these meetings sat within a children's/social care services or community safety/policing pathway or were co-chaired between children's social care and policing. To accompany the visual maps, the table below describes what each one illustrates.

Table 6 Case study summary of use of MACE panels

Site	Summary	Use of MACE panel
1	This site uses its MACE (or equivalent) panel as a central feature of its response to EFH. Child protection processes are not used to coordinate plans in response to EFH unless the harm identified is attributable to parenting. A 'specialist young people's team' within children's services delivers support plans to children and young people impacted by EFH and discussed at the MACE (or equivalent) panel. Local responses to locations impacted by EFH are coordinated via community safety and policing structures which then feed into the MACE (or equivalent). Parallel meetings are held in the area for responses to children and young people impacted by serious violence and anti-social behaviour, and these are led by community safety.	MACE (or equivalent) panel: - Fulfils both a case-oversight and a theme-oversight function in the one meeting - Meets monthly - Is co-chaired by children's services and police - uses a specific process is to categorise risk faced by children and young people discussed in the process of 'red, amber and green' as distinct from child protection categorisation of significant harm - Uses a policing Victim-Offender-Location-Theme (VOLT) model to organise discussions around locations A pre-MACE meeting is also used to triage decisions about children and young people to be discussed at the monthly MACE panel meeting. A 'strategic' MACE meeting provides governance arrangements for the above.
2	The site uses a multi-agency exploitation team to co-ordinate responses to children and young people impacted by EFH. This team provides oversight of	MACE (or equivalent) panel: - Used for theme-oversight only - Meets monthly

	individual plans for children and young people as an alternative to a MACE (or equivalent) panel. The team use an exploitation risk assessment tool to organise plans for the children and young people they support. This tool uses categories that are distinct from child protection categories. Child protection planning is not used in situations of EFH unless harm is attributable to parenting. A MACE (or equivalent) panel is used for trend-oversight only. It was not a central feature of operational responses to EFH in the site and at the point of data collection this undergoing review.	- Is co-chaired across policing and children's social care - Uses the policing Victim-Offender-Location-Theme (VOLT) model to discuss locations
3	Site has a children's services pathway for EFH, and children and young people impacted by EFH are often supported via a children's social care plan (although rarely through a child protection plan unless risks are attributable to parenting.) The site also uses a MACE (or equivalent) panel to review and provide oversight of individual plans for children and young people (as an additional case oversight function), and to coordinate responses to locations. Children's services and youth work coordinate responses to individual young people and locations discussed at the MACE (or equivalent) panel. The local area also has a pathway for serious violence that are led by policing. This pathway runs in parallel to the children's services pathway for EFH.	MACE (or equivalent) panel: - Fulfils a case-oversight and a theme-oversight function in one meeting - Meets weekly - Is co-chaired between children's services and policing - Uses categories of 'emergent' and 'significant' when assessing risks faced by children and young people (in part therefore integrated with child protection and in part distinct) - Uses a Contextual Safeguarding framework to organise discussions around locations Children and young people reaching a 'significant' threshold at the MACE (or equivalent) panel are referred into an EFH children's services process bespoke to that area; this is not a child protection

		process as it is largely used for children in care. An individual 'MACE' meeting is also used in the site to triage each child or young person assessed prior to referral into their MACE (or equivalent) panel discussion.
4	A MACE (or equivalent) panel is a central feature of how the site coordinates its response to EFH, supported by an EFH team who deliver support plans for children and young people. MACE is connected into child protection pathway specific for EFH for children and young people at risk of significant harm not attributable to parenting, as well as a traditional child protection pathway where EFH is associated to care provided by parents. Local responses to locations impacted by EFH are coordinated via community safety and policing approaches which feeds into the MACE (or equivalent). Parallel meetings for young people impacted by serious violence and anti-social behaviour are led by community safety.	The MACE (or equivalent) panel: - Fulfils a case-oversight and a theme-oversight function in two separate meetings - Case oversight function occurs weekly - Theme oversight function occurs monthly - Both meetings are co-chaired by children's services and policing - A specific EFH assessment is used to guide decision-making at MACE (or equivalent) panels in respect of children and young people which use categories distinct from those used in child protection assessments and categorisations
5	Site does not have a MACE (or equivalent) panel in place. Their response to EFH features a children's social care pathway, including a ROTH child protection pathway, for case-oversight of individual children and young people impacted by EFH. All meetings on this pathway are sole-chaired by children's social care. Support for those children and young people is then coordinated by a 'young people's service', who work within the above pathway. A separate team in	No MACE (or equivalent) panel in place. The alternative for case oversight functions: - Is delivered by a ROTH child protection pathway - Is chaired by children's social care only - Meets as required in responses to individual children and young people being referred for discussion

	children's services coordinate responses to locations and groups impacted by EFH. The policing response to EFH in the site, particularly serious violence and associated drug distribution, largely runs in parallel to, rather than integrated with, the above children's services pathway. This includes parallel meetings for children and young people impacted by serious violence and ASB that are led by community safety.	- Uses the same thresholds and categorisations as on a wider children's services pathway An alternative theme-oversight response is delivered by: - A 'Contextual Safeguarding team' who coordinate welfare-based assessments of locations and groups impacted by EFH - The team also deliver responses to trends and themes that emerge on the ROTH child protection pathway Additional weekly meetings between policing, youth justice and children's services are attended to identify any emergent concerns about individual children and young people or themes and agree interim plans. This meeting is chaired by policing.
6	Site does not have a MACE (or equivalent) panel in place. Their response to EFH is coordinated by an interdisciplinary EFH team based within children's services. This team oversees coordination of plans/cases of children and young people impacted by EFH. The team holds an additional meeting with partners to discuss the situation facing an individual child or young person impacted by EFH when there are identified opportunities to disrupt that harm. The team refers children and young people they are supporting into a child	No MACE (or equivalent) panel in place. An alternative case oversight function is: - Fulfilled by a multi-agency EFH team (based in children's services), rather than through a specific pathway/panel. This team assessing risks faced by children and young people delivers all support plans - Uses the categories of complex, experiencing, emergent or not at risk, to organise their EFH assessments

	protection pathway only in situations where EFH is attributable to parenting. A police-led response to serious violence runs in parallel to, rather than integrated with, all of the processes outlined above.	- Supported via an additional planning meeting convened when there are 'disruption opportunities' identified for individual children and young people. This meeting is co-chaired by children's services and policing - Supported via daily EFH briefings at which referrals into the team are discussed, and workers are allocated to complete assessments. Co-chaired by children's services and policing

In summary, as detailed above and illustrated below:

- Three sites used MACE (or equivalent) panels to fulfil a case-oversight function (1,3 and 4).
- Three sites used *alternative* approaches to providing a case oversight function instead of a MACE (or equivalent) panel (2,5 and 6). Two further sites used an *additional* case-oversight process to their MACE (or equivalent) panel in situations of significant harm (3 and 4).
- Four sites used MACE (or equivalent) panels to fulfil a thematic-oversight function (1, 2, 3 and 4). Three of these sites relied on community safety and policing processes to respond to those themes (1, 2 and 4).
- Three sites utilised youth work and social work teams, and wider specialist co-located teams to assess and respond to contexts and trends associated with EFH beyond a MACE (or equivalent) process (3, 5 and 6).
- In all sites the police and community safety partnership maintained parallel processes for responding to serious youth violence and anti-social behaviour that sat outside of children's social care pathways and wider safeguarding processes.
- Three sites (1, 2 and 6) reserved child protection processes for situations in which EFH is attributable to parents/carers; three sites (3, 4 and 5) had a child protection pathway in place for responding to EFH even when it was not attributable to parents/carers.
- Four sites used risk categories that sat outside of standard child protection processes in situations of EFH (1, 2, 4 and 6), one of these also used 'significant' as part of these risk categories (4). Two other sites (3 and 5) used a significant harm threshold across both familial harm and EFH.

Figure 4 System map for case study site 1

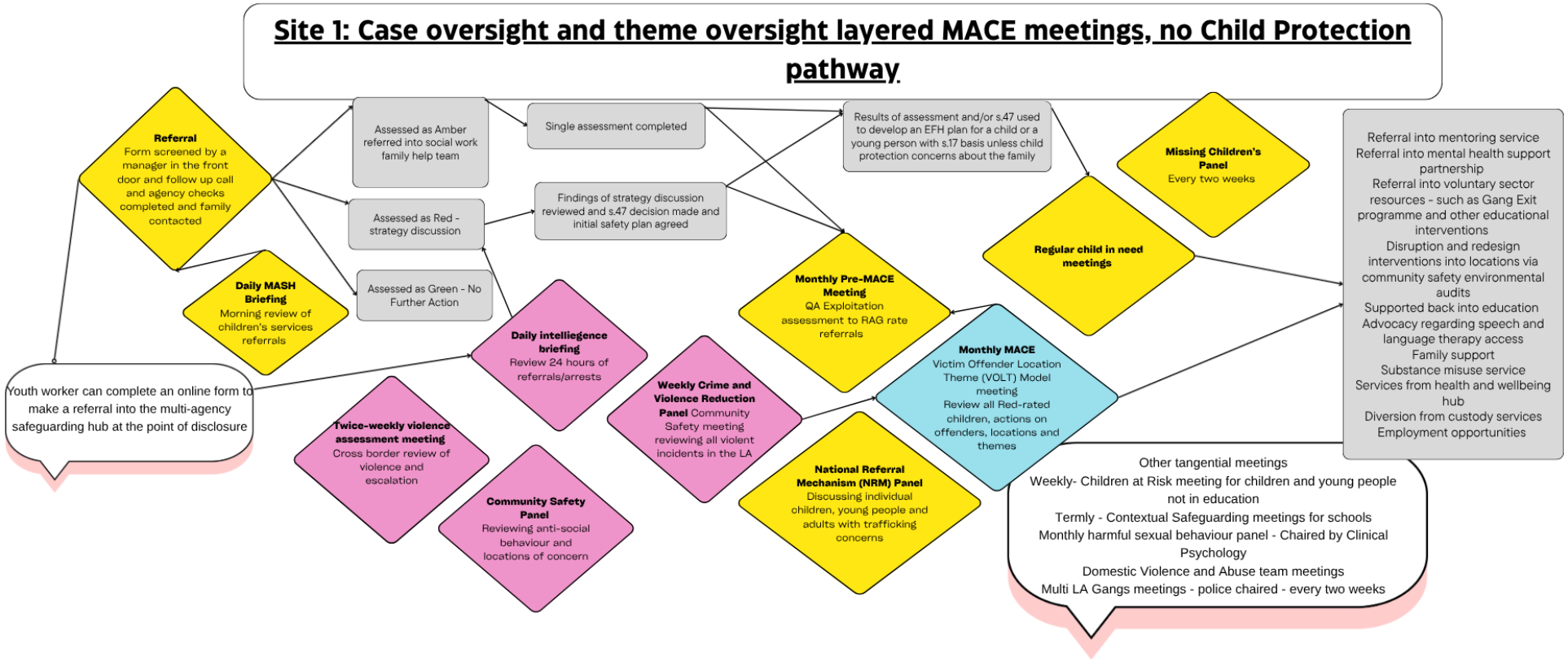


Figure 5 System map for case study site 2

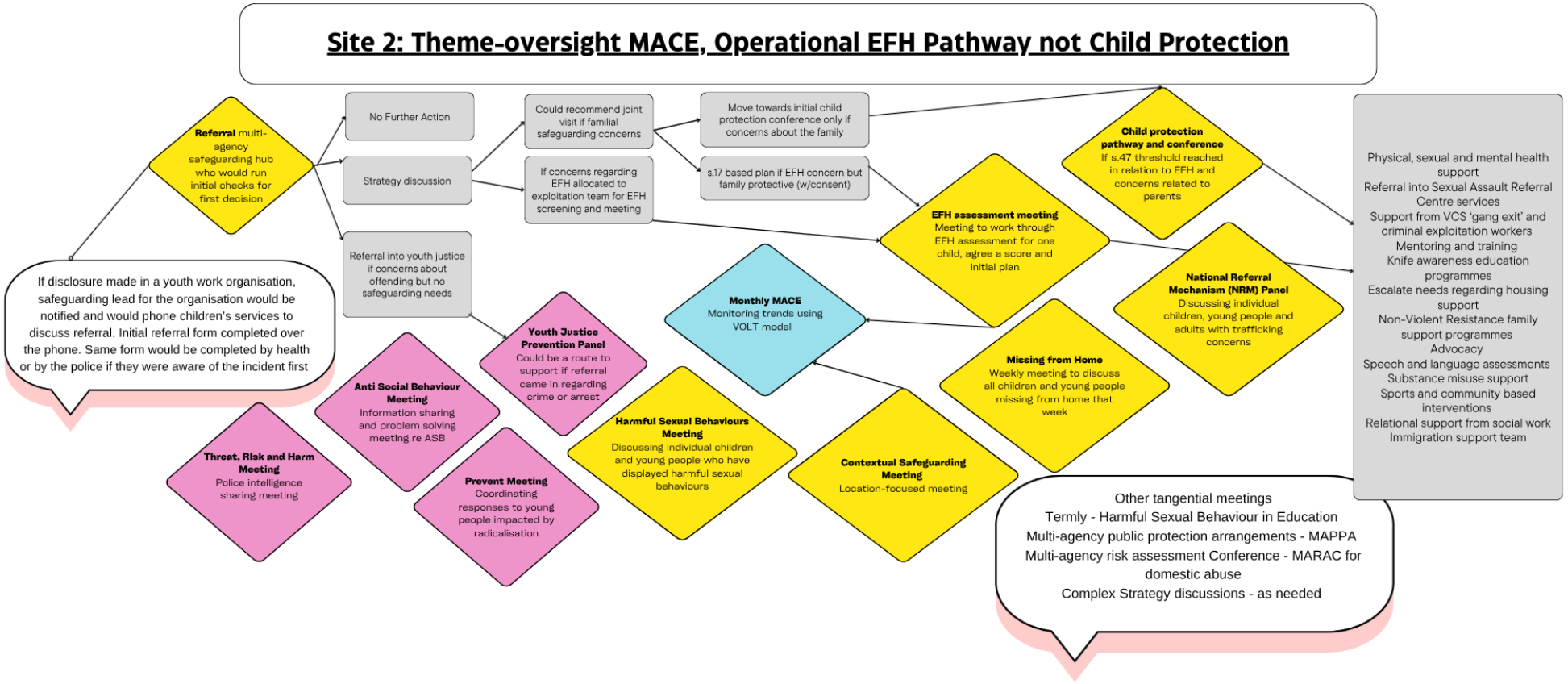


Figure 6 System map for case study site 3

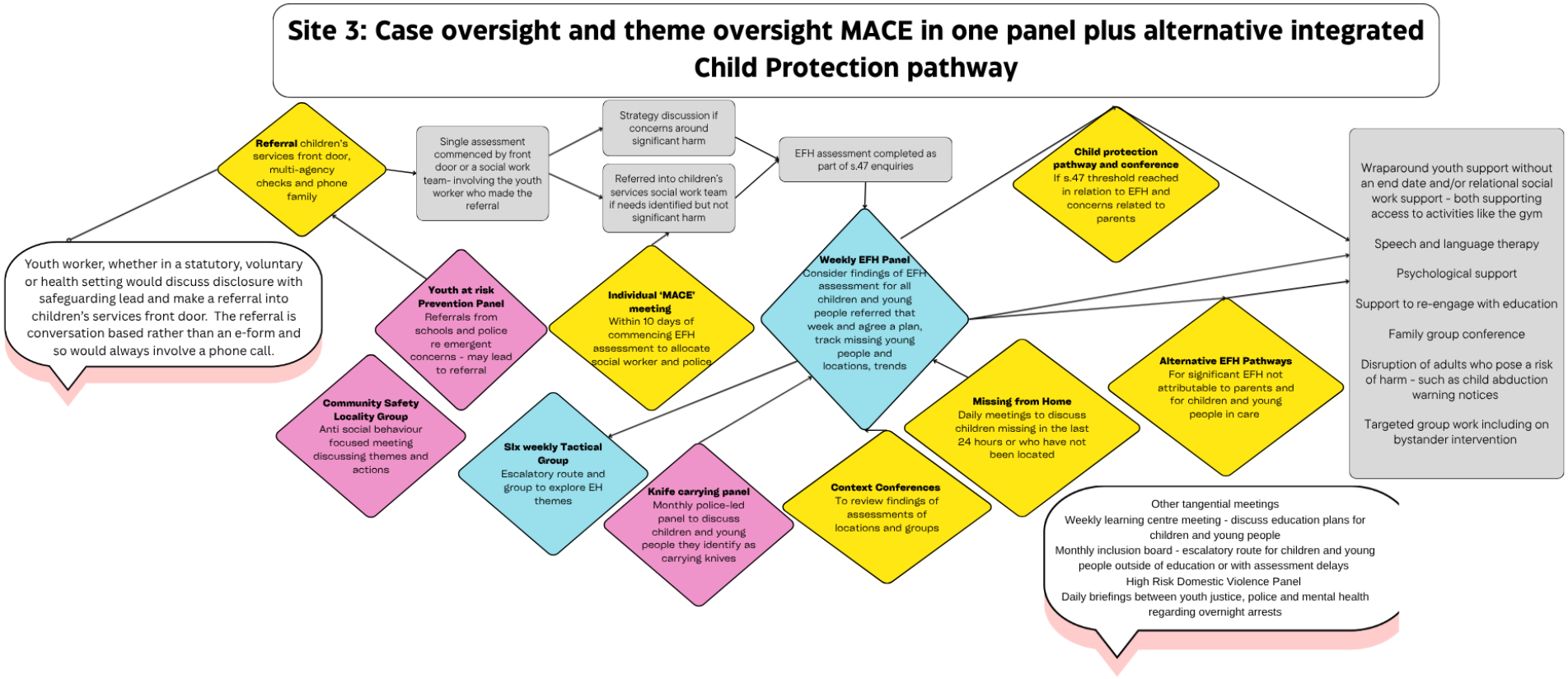


Figure 7 System map for case study site 4

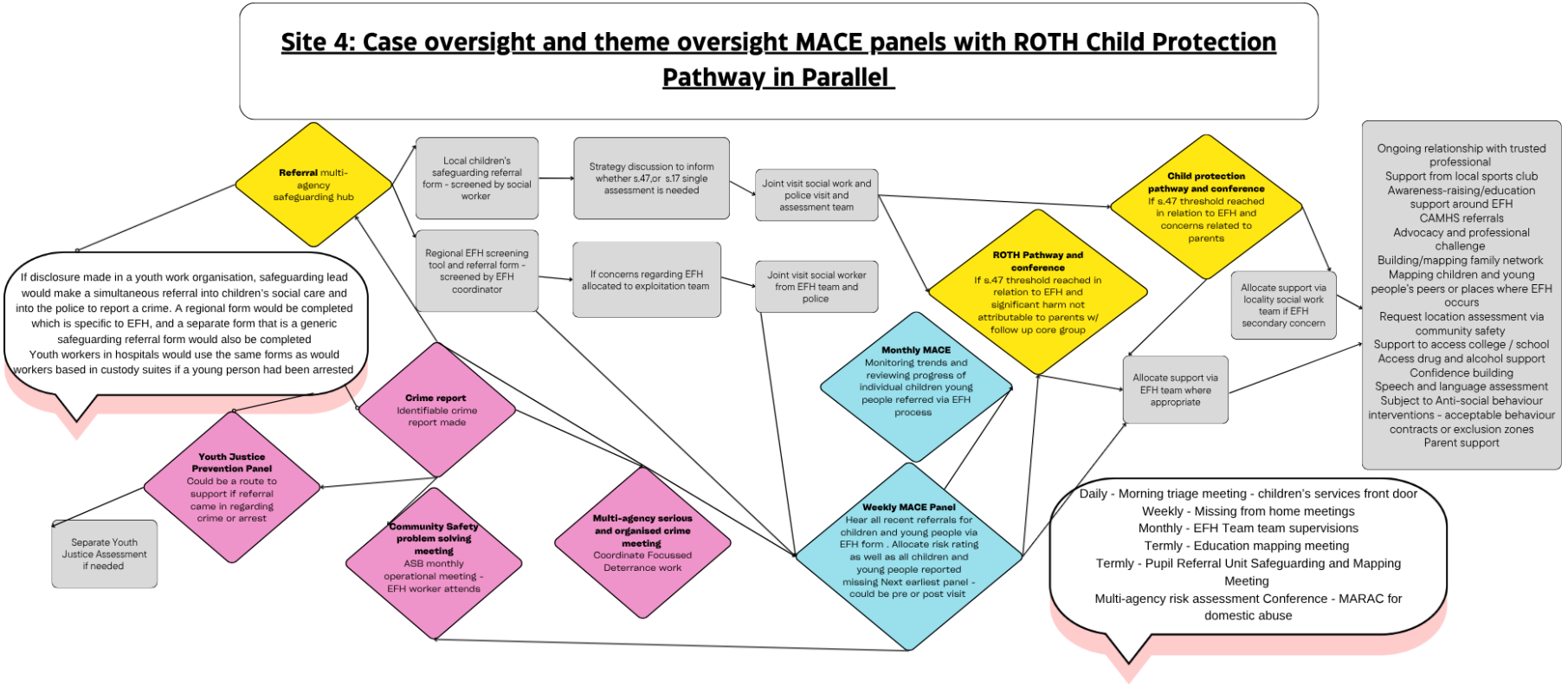


Figure 8 System map for case study site 5

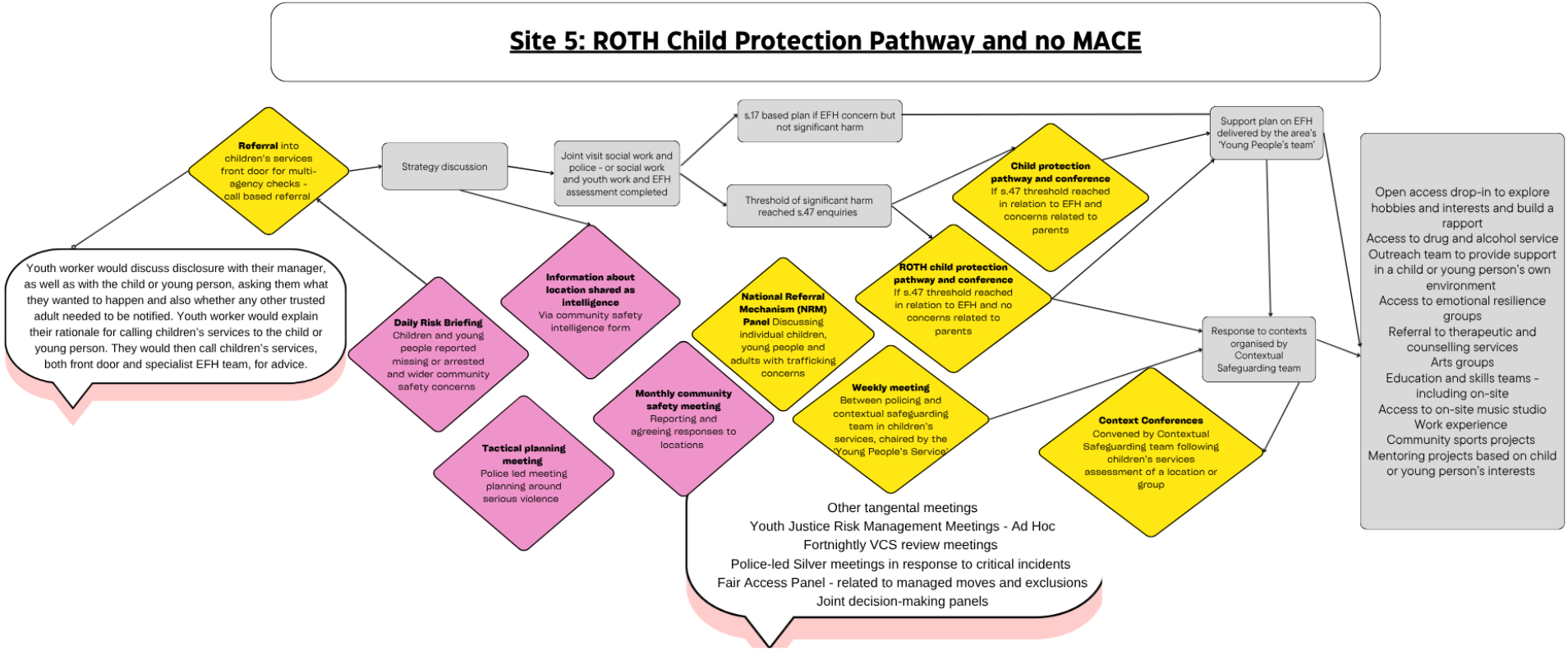
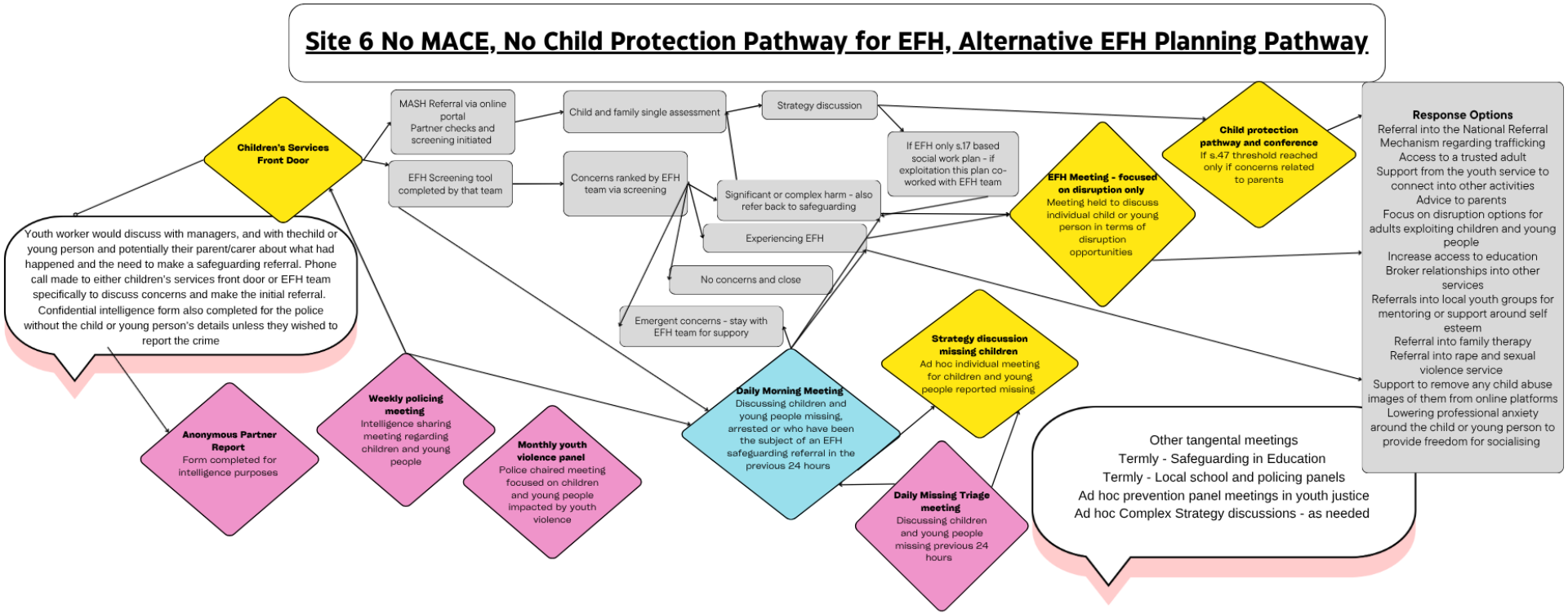


Figure 9 System map for case study site 6



As visualised, all local sites featured safeguarding pathways that had key junctures: referral into the pathway, assessments of risk and/or need, meetings held to plan/review responses, and individuals/teams that deliver those responses. These different junctures created opportunities for integrated/coordinated, or distinct/divergent pathways to emerge. In three of the four sites with a MACE (or equivalent) panel, and one site without a MACE (or equivalent) panel, a safeguarding pathway for EFH ran in parallel to the wider children's services pathway for other safeguarding issues. An initial single referral point (in all sites) quickly branched into two pathways:

- for assessment: a specific assessment (and associated categorisation of risk/need) was completed for children and young people affected by EFH, separately from (and in addition to) a core child and family or safeguarding assessment
- for meetings: MACE (or equivalent) panel meetings (and other EFH-related meetings) were held in addition, or instead of, meetings to coordinate child protection responses
- for response: an EFH, exploitation, or young person's team, coordinated and delivered the response, as distinct from social work teams more broadly

In short, for the most part EFH pathways that used MACE (or equivalent) panels to fulfil a case oversight function, ran in parallel and in addition to children's social care pathways rather than as an integrated feature of children's social care and child protection pathways. This was expressed through two forms of 'parallel' process.

First, in three case study sites, child protection meetings (and associated categories and pathways) were reserved for children and young people who were at risk of significant harm which was assessed as attributable to the behaviour of their parents/carers. In terms of EFH, therefore, this pathway was used for children and young people who were, for example, living in households where there was domestic abuse or whose caregivers sold/used drugs, and where these behaviours were assessed as in some way pushing children and young people into unsafe extra-familial contexts or relationships, or impacting a parent/carers capacity to safeguard their child. Children and young people experiencing EFH that was not assessed as attributable to their parents/carers were screened out of child protection planning processes.

Second, all case study sites featured a 'knife crime' or 'serious violence' panel in addition to MACE (or equivalent) panels (and alternatives to them). These panels were convened by either the police or the community safety partnership to fulfil the serious violence duty. Less than 50% of survey respondents stated that serious violence was routinely addressed in their MACE (or equivalent) panel, and in case study sites we observed this same pattern via the additional use of a serious violence or knife crime panel. These panels used a separate scoring mechanism to both MACE (or equivalent) panels and child protection processes, largely based on offending and risk of offending; and

operated independently of children's services and wider safeguarding processes. In Site 5 all forms of EFH were referred into their ROTH child protection pathway, including serious violence despite responses to this this issue also being overseen via community safety processes.

Beyond the two parallel pathways summarised above, MACE (and equivalent) panels, as well as alternatives to them, are operating within a meeting-saturated practice landscape more generally. Across the six case study sites, professionals described a minimum of seven and a maximum of 11 core panels or meetings at which children and young people, or contexts, impacted by EFH are discussed. This rose to a minimum of 11 and maximum of 15 when slightly more tangential panels were included (Figures 2-7). When mapping local systems, we often had to prompt discussion to identify additional panels used to coordinate plans for children and young people who displayed harmful sexual behaviours (HSB), which were often separate to MACE (or equivalent) panels and chaired by health practitioners rather than children's services or the police. MACE (or equivalent) panels did not appear to be coordinated with MARAC processes in terms of young people impacted by intimate partner abuse (as a form of EFH). As noted elsewhere, MACE (or equivalent) panels also had to coordinate with education inclusion processes for children and young people who were both impacted by EFH and struggling to access safe and secure education provision.

Through policy mapping we evidenced that a national policy framework for EFH does not exist; our case study data collection illustrated this same lack of connectivity in the design of local systems and pathways. It is not uncommon for local domestic abuse, exploitation and serious violence strategies to sit separately from one another, rather than being integrated. Legislatively, criminal justice duties – such as the serious violence duty – are not routinely considered in accordance with safeguarding duties, such as the duty to hold a child's welfare as paramount; and no national guidance has been provided to local areas on how to do this for contexts of EFH. National education inclusion and school exclusion policies are also considered independently of EFH. Some local partnerships may develop systems and practices to mitigate this. As detailed earlier (Figures 6 and 7) case study Sites 3 and 4 had developed specific approaches to coordinate across EFH and school inclusion processes for example, by having a dedicated schools' worker in the EFH team (Site 4), or an escalatory route into the school inclusion panel from the MACE (or equivalent) panel (Site 3).

The challenges observed in coordinating various local assessment and planning pathways relevant to EFH reflect the national policy landscape. Nationally domestic abuse policy is held separately to exploitation policy, which itself is considered separately to serious violence policy, and harmful sexual behaviour policy. The fact that most local areas we engaged with via surveys and case study activities organised

meetings in these same siloes simply meant their locally developed structures reflected the distinct national policy frameworks to which each pathway accords.

It is often the practitioners in EFH, exploitation, or young people's teams who are working through and within this complexity. The design of these teams is locally determined and is informed by and informs local structural pathways. For example, our findings show that some EFH teams are led by youth workers and social workers. In our case study sites these teams had a clear presence in MACE (or equivalent) panels or alternative meetings. It was these specialist teams that delivered the detailed support plans for children and young people impacted by EFH, and in two cases coordinated responses to the contexts where EFH was occurring. In some cases, these teams were integrated into a site's core children's services pathway for EFH, particularly in sites that used child protection procedures for EFH, whereas in others they (like a MACE (or equivalent) panel) sat outside of that pathway.

In conclusion, therefore, it was difficult for *MACE (or equivalent) panels* to coordinate well with other local safeguarding structures or wider partnership responses to EFH, given that these various structures or partnerships were not themselves always coordinated into a single streamlined response to EFH. Such challenges were reinforced by parallel processes for serious violence/knife crime, and when local responses to EFH was largely positioned outside of child protection processes.

4.2.2 Are MACE (or equivalent) panels successfully identifying and protecting children who are being exploited?

There is no existing baseline against which to measure the success of MACE (or equivalent) panels for children and young people impacted by EFH. Therefore, to answer a question about their success we identified key findings in relation to how MACE (or equivalent) panels did, or did not, identify or protect children and young people impacted by EFH – with the caveat that this information largely came from statutory services, rather than from children, young people, their families or wider communities. We organise these results in respect of firstly what/who panels identified, and then the extent which they could offer a protective response to what was identified.

Identification

As summarised earlier in this report, our dataset raised questions about which forms of EFH (and associated young people) MACE (or equivalent) panels identified or missed. Both data from our national survey and case study sites evidenced that MACE (or equivalent) panels were used to identify children and young people impacted by exploitation (both criminal and sexual) more frequently than for children and young people impacted by other forms of EFH. Serious violence, without evidence of exploitation, and the children and young people impacted were sometimes screened out of MACE (or equivalent) panels. This particularly applied to MACE (or equivalent) panels

that relied on risk assessment tools to identify children and young people that met a 'threshold' for consideration at MACE (or equivalent) panels, as many of these tools required evidence of coercion or grooming for example to achieve a high score; this issue was also found in our analysis of case review reports. Intimate Partner Abuse was even less likely to be considered in MACE processes (15% of survey respondents included it in their MACE processes). Given that children and young people under-16 are also largely screened out of MARAC processes (when experiencing abuse in their own relationships), there appeared to be a clear gap for oversight of children and young people impacted by this form of EFH.

In national interviews, participants also raised concern that children and young people who were missing from home, but were yet to disclose or indicate wider issues of exploitation, were also being excluded from MACE (or equivalent) panels and wider EFH processes, reducing their system's capability for early identification:

> *"We have some similar processes in place, but just not for the missing episodes. They're looking at the higher-level ones. They're not looking at the lower ones and that's the ones; I think we're missing an opportunity there."* (National interview)

> *"[We have data showing] in terms of things like understanding that care leavers are much more likely to be being exploited and the children that go missing are much more likely to be victims of child sexual exploitation.... but in terms of a response to that, particularly around sort of earlier intervention, I don't think we're there yet."* (National interview)

Finally, as noted elsewhere in this report, three case study sites reserved the use of child protection pathways for children and young people at risk of significant harm that was assessed as being attributable to the (in)action of their parents/carers. Therefore, children and young people impacted by significant EFH, not attributable to parenting, nor identified as related to exploitation, were largely without *safeguarding* operational multi-agency oversight in areas that reserved MACE (or equivalent) panels for exploitation.

Our dataset also raised questions about identification in respect of girls and young women for some harm types, boys and young men for other harm types, and in respect of racially minoritised young people. Such data was not consistently collected by MACE (or equivalent) panels. Just over half of respondents (52%) stated their panels collected protected characteristic data routinely, and another 16% collect it sometimes but not consistently. However, about one-third either do not collect it (18%) or were not sure (13%). Among the 42 respondents who stated their panels did collect data on protected characteristics, only 5% review it as part of every panel meeting, 50% review it at set intervals (e.g. quarterly), and 31% review it only on an ad-hoc basis. We observed such reviews in case study site meetings:

> *Overview discussion with PowerPoint slides:*
> *"male/female" – 7 male, 2 female children raised*

……of those cases 5 were risk graded as moderate, 2 emerging, 2 significant (which will be discussed in panel)
ethnicities presented – 2 black Caribbean, 1 south Asian, 1 north African, (slide moved on but all categories had one child apart from Black Caribbean, as an observer I'm interested in how this will be discussed – I missed how many young people were white)
In education – figures presented
5 Looked After Child, 4 Child in Need
7 for CCE, 1 CSE, 1 SYV
Additional needs: 5 yes, 4 no (Meeting Observation)

Various practitioners in case study sites commented on the 'invisibility' of girls and young women referred to services for serious violence – although they believed these numbers were increasing in three sites.

> *"So, we see predominantly boys who are criminally exploited within our services and they often are having a social care service but also a youth justice service. We predominantly see girls who are sexually exploited. That's almost 100%, not quite, but we definitely see that disproportionality in terms of gender… the majority of the young people that we see that are affected by EFH have some form of neurodivergence, whether that is diagnosed or either self-identified or perhaps identified by professionals."* (Focus group, case study site)

All case study sites identified elements of 'disproportionality' in their response to EFH; all bar one stated that a disproportionate number of Black children and young people were identified in their EFH processes. The one remaining site stated that children and young people supported via their MACE (or equivalent) panel was reflective of their local population, but their arrest statistics were disproportionate in respect of Black children and young people. This raised questions about the identification of safeguarding issues impacting the children and young people who were being arrested. Gypsy, Roma and/or Traveller young people, and those of Eastern European decent were also described as being disproportionately identified as impacted by EFH in some system mapping sessions. Asian children and young people were under-represented in many sites and were almost absent in system mapping discussions; but there was little confidence amongst site participants that this reflected what children and young people were experiencing. Yet when surveyed, most chairs felt the cohort of children and young people discussed at MACE (or equivalent) panels was broadly representative of their local population, with only around 4 in 10 stating they were either unsure or think there is a mismatch.

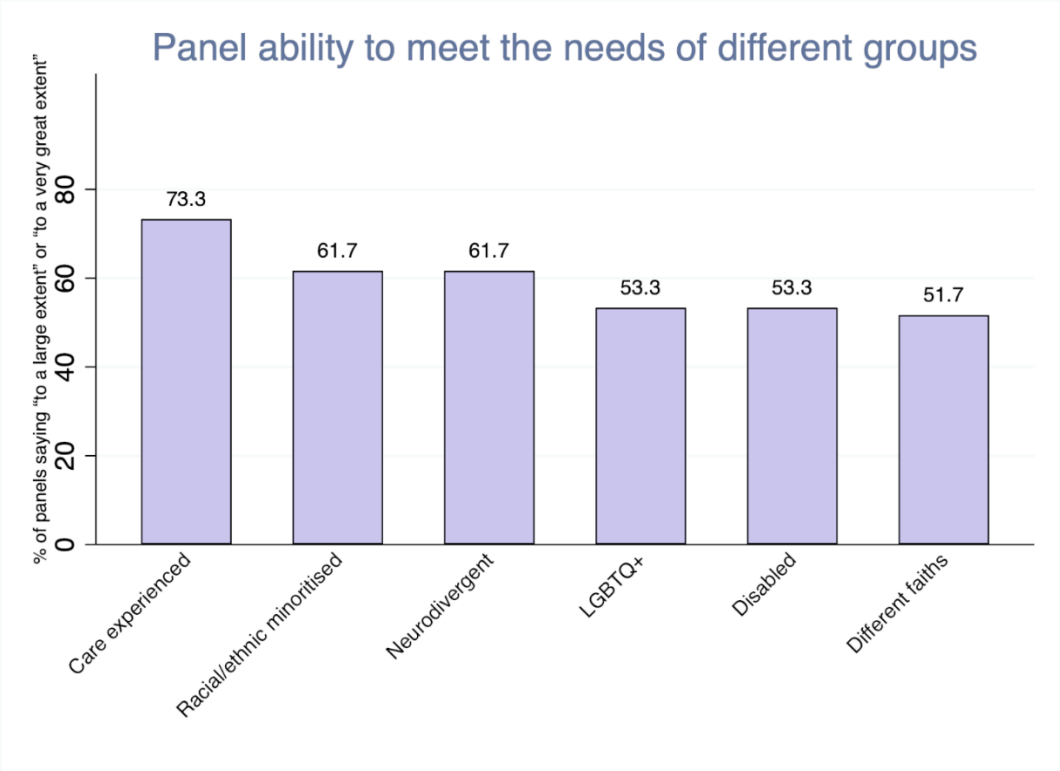
MACE (or equivalent) screening tools, wider system design features (such as the siloing of harm-types, and the reservation of child protection processes for familial forms of harm), and conceptualisations of who is harmed and in what ways, shaped the identification of children and young people impacted by EFH. Our dataset suggests we should question the results of these processes; it is likely that such processes and

practices are screening out children and young people in need of protection or screening them into criminalising processes only.

Protection

Around 73% of survey respondents believed that their MACE (or equivalent) panels were able to meet the needs of care-experienced young people to a large or very great extent. About 62% reported being able to meet the needs of neurodivergent and racially/ethnically minoritised children and young people to this extent. For disabled children and young people, LGBTQ+ children and young people, and those from diverse faith backgrounds, only half of panels feel they meet needs to a large or very great extent.

Figure 10 MACE survey results – panel ability to meet the needs of different groups



This account does not mirror what was found in case study sites, with participants in system mapping workshop expressing more confidence in how they would use local systems to safeguarding neurodivergent, LGBTQ+ and disabled young people than those who were racially minoritised (discussed in more detail later in this section).

As indicated elsewhere in this report, our dataset suggests MACE (or equivalent) panels were more information-orientated than action-orientated. It was unclear the extent to which the level of information sharing at MACE (or equivalent) panels aided the protection of children and young people, and the research team were also left with lingering questions about whether some information-sharing activities increased risk of harm to some children and young people (particularly harms associated with criminalisation and surveillance). Many of the actions tasked out of MACE (or equivalent)

panels were focused on further information-gathering, as described in section 4.1.3 and illustrated below:

> *CSC Chair: suggested the following action: "Support parents to understand grooming and how to report things that they see, because the more they report the better pic we have to share intelligence with police" [no mention of safeguarding here]* (MACE observation)

> *Police MACE panel member described young people's group behaviour as "joint enterprise", "young males purchasing weapons", and being "Out and about in community, wearing balaclavas, it's only a matter of time until someone is seriously hurt".* (MACE observation)

Overall, it was unclear as to whether these actions had had the primary goal of protecting children and young people or were more likely to contribute to police investigations (in situations where it was not always clear that such investigations would safeguard a child or young person's welfare).

Focus group participants from children's services also described pressure from policing to secure children when police investigatory options were limited, with their focus being on managing risk by removing it, as opposed to holding it:

> *"And you know, they will be followed up and I think some unhelpful comments that come out of this meeting is 'it will be far quicker for you to take action and secure this child than it will be for us to take this down a criminal route.'"* (Focus group, case study site)

> *"Over the past 15 years…I have a little drama piece that I do about it where we're in a meeting and all we do for 10 minutes is go 'why don't you PPO them? Why don't you secure them? Why don't you PPO them? Why don't you secure them?' back and forth in a meeting and we get nothing out of it? Because actually what we're talking about is removing people's human rights - this child's human rights just to reduce risk*." (Focus group, case study site)

Wider evidence on EFH suggests that it is possible to respond to EFH in ways that create opportunities to protect children and young people beyond restrictive or enforcement-based methods. These include providing children and young people with a consistent relationship with an adult that they trust (Lewing et al., 2018; Owens et al., 2024), ensuring they have access to safe and consistent education (YEF, 2024; Wroe et al., 2024 Lloyd, 2025), that they can safely spend time with friends and family (Cody, 2022; Farr et al., 2021), and that they can have any mental health or learning needs met by services in a timely and effective way (Franklin et al., 2023; Firmin, 2024). As summarised earlier in this report, much work to provide this type of support was described as being offered outside of MACE (or equivalent) panels, often coordinated by 'young people's', EFH or exploitation teams.

To an extent, MACE (or equivalent) panels were used as an accountability structure to accelerate actions around children and young people's access to education (summarised in section 4.1.3). However, outside of this, inconsistent representation

from sectors such as health and housing, and differing priorities of social care and policing, in addition to the large volume of children and young people considered being discussed, meant that MACE (or equivalent) panels were not the appropriate place for developing or reviewing plans to protect children and young people from EFH, nor for escalating concerns impacting a range of sectors who were not represented in the meeting. Examples of effective protective planning involved actions outside of the MACE process. While relationships between professionals or agencies who sat on MACE (or equivalent) panels may have facilitated such planning, we also gathered evidence equally effective planning without MACE (or equivalent) panels. As such it was unclear that the MACE (or equivalent) panel itself was the route to effective and protective planning in any given situation.

4.2.3 Are the alternative approaches used in place of MACE (or equivalent) panels in some areas performing better?

Given the difficulties in answering the question above, it is equally challenging to state whether areas that were using alternatives to MACE (or equivalent) panels were 'performing better'. Nonetheless we did note some differences between the practice features of a MACE (or equivalent) panels and local alternatives, which may create the conditions for improved performance.

Greater attention to welfare needs

Meetings that considered one child or young person, or one duo/trio of connected children and young people, at a time, and convened a group of professionals who knew them to agree a plan, appeared to provide sufficient time for professionals to discuss, and plan to meet, the children and young people's welfare needs. This appeared less feasible in MACE (or equivalent) case-oversight panels where the large volumes of children and young people being discussed, and the fact that many professionals in attendance did not have a relationship with every child and young person who featured, meant such meetings featured short, tasking discussions around onward referrals and information-gathering, than detailed, reflective open-ended needs-focused conversation. Finally, co-chairing between policing and social care, and joint purposes around investigation and welfare on MACE (or equivalent) panels, created the potential to drift away from considering welfare-needs during discussions. For example, despite being chaired, at least in part, by children's services MACE (or equivalent) panels were often structured according to policing frameworks, such as the 'VOLT' models, or featured police-orientated language of 'intelligence' gathering and/or police-orientated practices, such as 'task-and-finish' activities, that are not a feature of child-welfare assessments.

Involvement of children, young people and families in planning processes

We were not informed of a MACE (or equivalent) panel which involved children and young people and/or their families. Two reasons were given for this. The first was that because

multiple children and young people were discussed in MACE (or equivalent) panels it was not the appropriate space for children, young people and families to contribute. The second was that children, young people and families could not hear the information shared in MACE (or equivalent) panels given the proportion of which was police intelligence. Both these features were absent in some of the alternative meetings that sites had established, particularly those that were more welfare-orientated as outlined above. Involving children, young people and families in meetings appeared to shape their nature; the information shared often came from children, young people and their families rather than from services or systems, and plans were agreed upon by those that they impacted. The presence of children, young people and families also appeared to influence the tone of meetings.

We observed some MACE (or equivalent) panels in which professionals were prompted to 'imagine the young person was in the room' in respect of the language they used. Such meetings came closer to a caring or welfare-orientated tone:

> *[Youth work manager] says that "we need to remember he's a child, he's 15 - he might be a cheeky chappy but he's only 15 and we need to be careful with this." Social worker then says he acts like he's younger and the Chair picks this up and says "this shows how vulnerable he is."* (MACE observation)

> *The police state that "yes it seems like CCE from evidence of drug, but incidents of theft and motorbikes might not be an exploitation scenario" and instead might be a "per choice scenario." The chair responds by stating "but this is still harm …and we don't know if it is also EFH" and then highlights that it is important to consider as wider picture*. (MACE observation)

However, such a tone was challenging to sustain when it relied on individuals prompting colleagues throughout a meeting, rather than being baked into how meetings were designed from the outset.

Greater space for inter-agency challenge

Alternative meetings used to coordinate, and oversee, plans for individual children and young people (both those focused on welfare (in Site 5) and those focused on disruption (in Site 6)) appeared to feature greater interagency challenge and debate than what was observed on MACE (or equivalent) panels.

Many of the difficulties faced by children and young people impacted by EFH are often shaped by system design or access to services. At meetings focused on and individual child or young person it was easier to have direct conversations about these issues as their education provider may be present, for example, or specific actions taken against that child or young person by the police could be discussed in detail. At MACE (or equivalent) panels, general representation for schools was often provided by an inclusion lead, a representative from the policing 'exploitation' or 'safeguarding' team would attend (rather than those taking decisions around serious violence, organised crime, or

neighbourhood policing), and a safeguarding nurse might represent all health services, (rather than the specific services that any individual child or young person was accessing or needed to access). While these representatives were potentially well-placed to take back escalatory actions, the size of their sectors/organisations, or the way they were governed, meant this was not always feasible. Few had the level of detail to meaningfully discuss specific issues with services that a child or young person needed to be addressed.

It is important to note that all the above variations were only noted in meetings led by children's social care or youth work. These variations were not observed in meetings convened by Community Safety Partnerships to discuss anti-social behaviour, serious violence or location-based responses to harm. Children, young people and families were not present in those meetings, welfare was not held as paramount, and there was no evidence of greater interagency challenge in those meetings than in a MACE (or equivalent) panel structure. On the contrary, in these meetings professionals talked about adults as well as children and young people from the perspective of the risks they posed rather than faced, and were largely, if not wholly, focused on disruption, dispersal and sanctions rather than also about meeting needs and/or providing support

> *Discussion on 'demand drivers'- one rough sleeper with prior military service and mental health markers. Worker shares they went over to his tent but he won't leave his cat even though he has a key for accommodation. Worker told to keep him on your radar as he shouldn't be begging as he should have benefits sorted out. Someone else comments "animals become a barrier" (*Community Safety Locations Meeting observation*)*

> *Discussion around an individual – someone wonders if this is a reflection of behaviour being out of desperation? Further discussions around she's currently missing; is her behaviour antisocial? Can we escalate it? Can we give a fixed penalty notice? I wonder where we can go with her? Discussion around displacement from city centre - attendees discuss where she has been seen and by who. Someone says "she's a really difficult one - she could be subject to a [sanction/order] if begging in city centre, this wouldn't be a bad thing."* (Community Safety Locations Meeting observation)

4.2.4 Is the operation and delivery of MACE (or equivalent) panels conducive to protecting all children and young people (including those from Black, Asian and Minority Ethnic communities)?

Our dataset does not suggest that the operation and delivery of MACE (or equivalent) panels is conducive with protecting all children and young people. Rather we found occasions where MACE (or equivalent) panels either struggled to achieve this or on some occasions may have created conditions that exacerbated the risks children and young people faced. These challenges are reflective of, and to an extent created by, the national conditions in which local responses to EFH have developed. Local areas are developing responses to EFH in a landscape of stretched resource and financial constraints (ADCS,

2025) and without a national framework that integrates safeguarding, justice, education and health policies relevant to EFH. These polices which shape the delivery of interagency operational responses to EFH, and a national landscape, in which racially minoritised children and young people, and those with special educational needs, are disproportionately represented in school exclusion and criminal justice data (Lammy, 2017; Kent et al., 2023; Davis, 2025).

Across our dataset, and in keeping with recent publications (Davis, 2025), there appeared to be a silence on racism. In national interviews and in case study sites, the general issue of 'race' was only discussed when prompted by researchers. For some participants racism was disputed as an issue:

> *"I don't think there's any disparities [...] in terms of like race, age, those sorts of things, I don't think we see any difference in how people are treated or discussed or how we respond as a multi agency."* (National interview)

For others, when this discussion was prompted it was often followed by a notable discomfort amongst research participants, or a general challenge in naming racism. In observations and interviews the term 'racism' was rarely used, instead participants talked about 'disproportionality'.

> *"So, she (professional) will kind of take that data and do some analysis of that data and see what needs to be addressed. She has been working very closely with our unaccompanied asylum-seeking children team because there is a disproportionate number of refugee children who have been impacted by EFH within [area] as well, and in terms of the safeguarding partnership."* (Focus group, case study site)

> *"– only X% of [local area] is Black, so very disproportionate, either more targeted or more arrested, that's what we need to go into, because significantly higher than actual populus of [the LA]."* (Meeting observation)

During system mapping workshops all case study sites noted racial 'disproportionality' in some parts of their safeguarding system, whether that be in criminal justice responses to young people impacted by EFH, or in the profiles of children and young people discussed at MACE (or equivalent) panels, or in alternative arrangements. However, when asked questions about this, participants in five out of the six system mapping workshops and in multiple national interviews/focus groups often moved on to talking about other protected characteristics, particularly gender and disability.

Individual professionals in system mapping workshops attempted to talk about discriminatory practices in system responses and tried to encourage colleagues to do the same despite appearing hesitant or resistant to do so. However, when discussing disproportionality, participants largely presented it as something that happened outside of MACE (or equivalent) panels/processes, rather than as something that MACE (or equivalent) panels/processes might contribute to and/or would need to mitigate. For

example, participants suggested that disproportionately was caused by the familial backgrounds or socio-economic status of children and young people impacted by EFH, as expressed by this police officer:

> *"…lot of behaviours come from poverty and socioeconomic status, can we get these figures from education? Home life – lots have tragic home lives with close family members dying, violent crime, difficult to pin down exact reasons but need to understand why this is happening."* (Strategic Meeting observation)

Or they concluded that disproportionality was the consequence of decisions made by other services in their local area, particularly schools, as participants associated disproportionate exclusions from education as a driver of EFH:

> *"the young person who was part of the Black ethnic minority group…he was found with a large amount of cannabis on him and the school wanted to exclude him. Do you know what I mean? And we had to challenge that and say 'well actually we've got the police officer saying he's been exploited'. You know, we have to be mindful of all the kind of risks around that. And the school had to change their position and look at a managed move other than excluding."* (Focus group, case study site)

All such examples suggested that racially minoritised children and young people were impacted by factors outside of MACE (or equivalent) panels that the panels then had to contend with, rather than these factors being something that MACE (or equivalent) panels and wider EFH responses may influence.

This led to confusion as to how MACE (or equivalent) panels may be used to 'act' on issues of racism. Of 35 survey respondents who stated they reviewed information on protected characteristics, 29% stated they always take action when disproportionality is identified, 54% sometimes. 11% say they do not take steps, and 6% are unsure. When describing actions in case study sites, 'disproportionality' was addressed strategically – either through tracking datasets in strategic groups (as explained in the quotes above) or addressed through training, particularly on adultification.

This confusion was further exemplified during system mapping workshops. In each workshop participants were asked whether anything about the local response to EFH that they had mapped would look different if they were responding to a racially minoritised young person. In all sites the initial response given was that nothing about the local response would change. Yet all could offer practical examples for how they might work differently in their local systems for other groups of young people, for example: utilising specific services when supporting LGBTQ young people to ensure their response to EFH would best meet their needs; and, drawing upon additional partners when supporting neurodivergent young people to challenge discriminatory decisions or to expediate service provision. Some sites also outlined steps they were taking to better recognise the victimisation of girls and young women, noting that some of the services they provided or their approach to assessment in their current system risked screening girls and young

women out of services until harm was severe, and that this required attention. Similar practical examples of how to systematically mitigate the challenge of racism within services and processes used to respond to EFH were not offered by participants; no services that specifically supported Black children and young people or their families were named, nor were parts of system responses that posed particular risks to Black children and young people amended/monitored.

This was interesting, given that all had identified 'disproportionality' in their system. In one site, for example, we were informed that while the young people discussed at their MACE (or equivalent) panel reflected their local demographics, but that there was disproportionality in their arrest data, and lack of trust amongst Black children and young people of the police. Given this context we wondered how, for example, youth workers in the area may approach talking with Black children and young people about experiences of EFH if those children and young people were told that the information they shared with youth workers would be discussed with the police at the MACE (or equivalent) panel, despite these children and young people not trusting the police with said information.

Some participants described individual examples of advocating for Black children and young people when they believed that they were being treated unfairly by various services. As noted earlier in this report we also observed, and were told about, such advocacy in some alternatives to MACE (or equivalent) panels or in wider interagency team responses to EFH developed outside of MACE (or equivalent) processes:

> *"I would often challenge in the court forum and with district judges, other stakeholders, police and so forth about, you know, outcomes for children. And what I mean by that sometimes you might get a child arrested, a Black child, for example, a white child arrested for the same offence, say a knife offence. You know an outcome for the white boy might be, you know, an out of court prevention programme and for the Black ethnic minority group may mean a six-month statutory programme or, at times, meeting the custody threshold and getting a custodial sentence*." (Focus group, case study site)

> *"So a lot of our young Black children are not necessarily like seen or treated as children. And so I think sometimes what I find myself reminding other professionals is that we are still dealing with children and that often tends to, I guess, kind of like stop other professionals in their track and make them reconsider, you know, how they are treating other young people."* (Focus group, case study site)

We also observed a meeting in one site in which an action was proposed to educate schools around impact of racism on young people's access to services following racist rioting in the area:

> *"Chair: Any more to add? Mindful of recent racial assault, got flags all over area (assume England flags), worries about whether family feels able to return, is this a location of concern? Lots of arrests, cash and weapons seized, need to do work with YP around this*

time of year (Halloween), going to do educative work in schools by police around behaviour in community." (Meeting observation)

However, these reactive steps to challenge isolated practice examples are different to approaches in which MACE panels or other meetings are designed to mitigate, and to not reproduce, unequal outcomes in safeguarding systems; such approaches were not identified in this study in respect of racially minoritised young people. This was particularly concerning given: a) the tendency of MACE (or equivalent) panels to serve an information sharing function; b) the potential for information-sharing to increase 'police intelligence' on children and young people; c) and the disproportionate criminalisation of racially minoritised children and young people, including those impacted by EFH. As one participant noted, MACE (or equivalent) panels and wider safeguarding processes sometimes masked the ongoing criminalisation of Black children and young people:

"And what I've seen across the six years is, in the beginning we had lots of arrests of children. We jumped up and down and said 'this is wrong! Your crime statistics are all about children being arrested'. Police said 'OK then, after three years, we're not going to do this anymore - we're going to identify children as victims, who we arrest and put them through the front door, and we're going to identify adult offenders in our operations'. Then we had a really successful year apparently. But if you dug deeper and you actually looked at who they arrested, they were adults in law who were 19 or 20 who used to be our children, who were known for us before. So yet again, we've just waiting for them to turn 18 and then we've got so much information on these, we can arrest them." (Focus group, case study site)

In this context, racism would need to be explicitly considered and intentionally addressed through the design of both MACE (or equivalent) panels and the wider systems in which those panels operate.

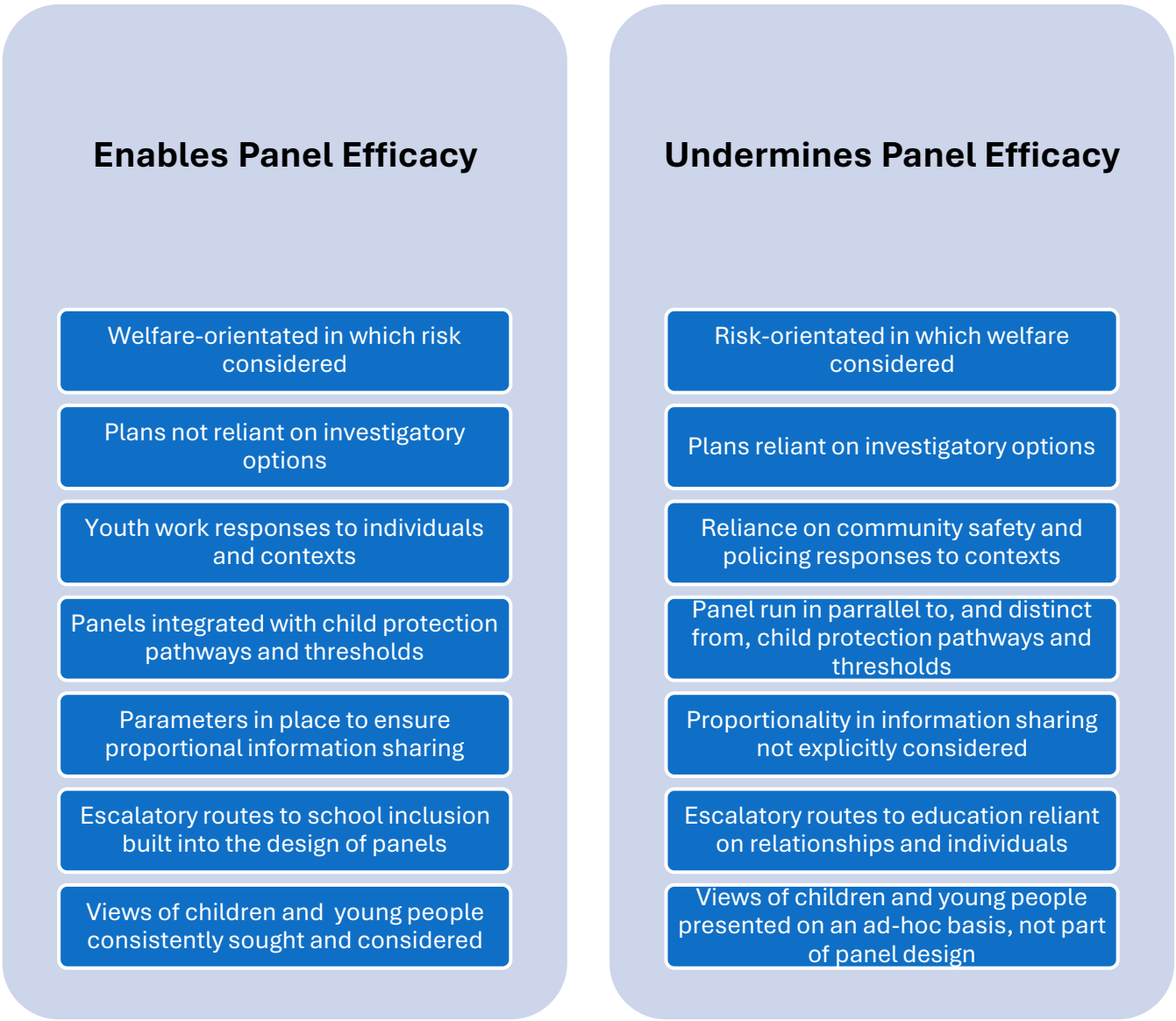
4.2.5 Are there examples of best practice delivery of MACE (or equivalent) panels?

Our study surfaced less about best practice delivery of MACE (or equivalent) panels, and more about a) examples of effective interagency practice that occurred outside of such panels (which the accountability structure of MACE (or equivalent) panels may have facilitated), and b) features of MACE (or equivalent) panels, or alternatives to them, which supported practitioners to move beyond talking about children and young people impacted by EFH and towards taking actions to address harm the they faced, meet their needs, or build safety around them.

As noted previously, survey respondents shared examples of effective responses to EFH, which they situated with their MACE (or equivalent) panels (see section 4.1.2). For the most part, these practices did not describe the panels themselves but may have been facilitated by them; both the interagency relationships that such panels could foster, and the accountability mechanism panels could fulfil, particularly in sites for which these children and young people were not afforded oversight and monitoring via child

protection processes. However, we were also informed of effective interagency working in areas that did not have a MACE (or equivalent) panel in place. The existence of a MACE (or equivalent) panel, particularly that which fulfilled a case-oversight function, did not in-and-of-itself appear key to effective responses to EFH; as monitoring, review and oversight was also provided by other means. When we look at the data from case study sites that both had a MACE (or equivalent) panel, and did not have a MACE (or equivalent) panel, it is possible to identify seven features of effective delivery, which were also discussed to differing extents in national interviews. These are illustrated in Figure 11 and further detailed below.

Figure 11 Factors that enable and undermine panel efficacy



1. **Welfare and needs-orientated approach to assessment**: using a welfare-orientated framework that considered young people's needs, mitigated the risk of

MACE (or equivalent) panels authorising increased restrictions on children and young people rather than increasing protections around them. MACE (or equivalent) panels that were *solely* informed by 'risk' assessments and risk scores, were focused on responses that would reduce or mitigate that risk, even if such steps compromised children and young people's welfare in other ways (reduced time with friends for example) or left them with unmet needs (displaced them from public spaces where they socialised or accessed internet). Those structures that intentionally engaged with the language of need and welfare, engaged with risk as part of a wider planning discussion rather than leading with it.

2. **Having processes to agree plans to support young people that did not rely on there being investigatory options**: when panels required investigatory options to consider children and young people impacted by EFH they screened out some young people in need of protection and support. This appeared particularly acute for children and young people impacted by serious violence as opposed to exploitation, as well as children and young people who felt unable to safely tell practitioners about the abuse they were experiencing. Panels that recognised safeguarding options in respect of wider youth and community responses to groups/contexts, as well as safeguarding options around meeting need, reduced the risks of screening children and young people who were in need of support out of systems until an opportunity arose for a policing response.

3. **Having a strong youth work offer available, including in responses to contexts**: case study sites that had youth work available, particularly that which was detached, had the agility to respond to trend/group/location issues identified at MACE (or equivalent) panels with a trend-oversight function. Such panels were also able to draw upon youth work to respond to thematic issues in ways that went beyond referring them into community safety mechanisms or relying on interventions that policed or dispersed young people from contexts where they should be safe. Youth work presence in panel meetings opened space to discuss these alternative responses to EFH and kept responses to groups and contexts under the auspices of children's services. When MACE (or equivalent) panels had to rely on community safety responses to groups/locations, these responses were also orientated under a crime and disorder framework, rather than a safeguarding one, and often lacked leadership from children's services in how outcomes were measured.

4. **Being connected into a child protection pathway rather than parallel to, or in place of, it**: ensuring panel activity was integrated into a child protection pathway – for example using categories of significant harm, rather than alternative risk

measures – avoided systems in which children and young people impacted by EFH were excluded from core safeguarding pathways. It also offered opportunities for holistic responses to children and young people impacted by EFH which recognised all safeguarding issues they may be facing, and ensured accountability was framed through the paramountcy principle for all children and young people regardless of the nature of the harm they were experiencing. Practically, this integration also avoided duplication of effort. In sites with parallel processes, two assessments/forms had to be completed at different points in the system (one for EFH specifically and one for children/ young people and families more generally), different meetings had to be convened around the same child/ young person – one focused on child protection or child-in-need individual planning, and one on EFH via a case-oversight panel– and confused lines of responsibility/oversight in the process.

5. **Having parameters around who is being discussed**: most MACE (or equivalent) panels that we observed had minimal parameters around which children and young people were discussed in meetings, and what level of information-sharing was proportionate (particularly for peers of children and young people who were not open to any statutory services, and whose families were not necessarily aware they were the subject of professional conversations). Meetings around individual young people, particularly ROTH pathways, were more contained, and so raised fewer questions for the research team in respect of protecting children and young people's trusted relationships. Meetings focused on one child or young person, rather than a list of multiple children and young people, and having the child/young person and/or their family there, created conditions for children and young people to know that professionals were meeting to talk about the situation they were in; and offered clarify for professionals about the information they needed to share to identify avenues of safety for a child or young person.

6. **Escalatory routes around education**; given that the vast majority of children and young people featured in our dataset were either excluded from school or on reduced school timetables, the ability to address needs associated with education are key to any response to EFH. Panels connected into school inclusion processes, and who utilised them to de-escalate risks of school exclusions and reduced timetables, and to expediate plans to support children and young people with additional learning needs, appeared more action oriented. Such connectivity appeared to work best when designed into the structure of the panel, and the wider system, as opposed to being the result of individual relationships outside of meetings (which could change when people moved into different roles).

7. **Views of young people sought and considered**: it is notable to us that in some case study sites children, young people and/or their families did not attend any meetings held to coordinate the support they received. While we did not observe a MACE (or equivalent) panel that involved children and young people or families, we did observe some which built in ways to have their views heard and considered. This largely came in two forms. The first was bringing children and young people's safety maps, or other activities through which they had shared their views, into the MACE (or equivalent) meeting. The second was by having practitioners who knew children and young people, and their wider communities, in the meeting. Both of these were unusual in MACE (or equivalent) panels – given the volume of children and young people discussed in any meeting. However, some panels did invite individual practitioners into the meetings when support was being discussed for children and young people that they knew. Practitioners were also better supported to fulfil this role when the purpose of the meeting (investigatory or welfare) was clear, and when people were encouraged to tell children, young people and families that these meetings were held. Neither of these options for bringing children and young people's views into the panels appeared to produce the same effects as having children, young people or their families in the meetings themselves. In meetings that were intended as an alternative to MACE (or equivalent) panels, children, young people, and families shared their views directly with those charged with their care and protection.

4.2.6 Efficacy of MACE (or equivalent) panels and alternatives: a conclusion

The findings from this study illustrate that MACE (or equivalent) panels, and alternatives to them, are being developed in local and national contexts that are not conducive to effective practice. As such, evidence of efficacy was found in local practices that had developed *in spite of* system conditions, rather than because those conditions supported them.

MACE (or equivalent) panels are rarely coordinated with wider safeguarding systems, as those systems themselves lack coordination in respect of EFH. Various forms of EFH are responded to under different assessments/panels/pathways, some of which are overseen by policing and community safety partnerships, and others overseen by children's services. Each local area currently operates differently in this respect.

The above challenges in coordination impact the ability of MACE (or equivalent) panels to effectively identify and protect *all* children and young people affected by EFH. As designed, panels are best placed to identify some children and young people impacted by sexual and criminal exploitation; those impacted by serious violence, violence in intimate relationships and peer-sexual abuse are at risk of falling outside of MACE pathways and in some instances being left without children's services oversight. However, even in respect of exploitation, girls and young women who were criminally

exploited, boys and young men who were sexually exploited, racially minoritised children and young people, and those whose exploitation 'presented' as something else – such as serious violence - were all considered at risk of under-identification.

In terms of protection, we received varying views. Some survey respondents displayed confidence in their ability to protect children and young people discussed at MACE (or equivalent) panels, however information from focus group participants and site observations highlighted risks of MACE (or equivalent panels) related to the criminalisation of children and young people impacted by EFH, and tensions between policing and children's services regarding whether secure placements and other restrictive interventions were appropriate for children and young people's protection.

Alternative approaches to MACE (or equivalent) panels appeared better able to involve children, young people and families in decision-making; consider the welfare and needs of children and young people impacted by EFH, and challenge partners on decisions that were not in the best interest of children and young people.

Professionals delivering MACE (or equivalent) panels them struggled to explain how their response to EFH could be adapted to mitigate the risks of negative impacts for Black and other racially minoritised young people. A general silence on racism left it confined to discussions about monitoring disproportionality statistics, commissioning training on adultification, or individual practitioners advocating for Black children and young people in processes outside of MACE (or equivalent) panels. MACE (or equivalent) panels themselves, and particularly the volume of information shared at them (see section 4.1.2) did not appear to be designed with (in)equality impacts in mind.

Despite the challenges summarised above, data from this study suggested seven ways in which conditions could be created for the effective use of MACE (or equivalent) panels and alternatives to them:

- The use of welfare-orientated assessments, in which risk could be considered
- Planning support in ways that were not reliant on investigatory options
- Using youth work responses to individuals and contexts
- Ensuring panels were integrated with child protection pathways and thresholds
- Using clear parameters to ensure proportional information sharing
- Building escalatory routes to school inclusion into the design of panels
- Consistently seeking and considering the views of children and young people during panel discussions

4.3 Improvements to multi-agency operational panels

RQ3 for this study asked, *how can MACE (or equivalent) panels be improved?* It is difficult to talk about improvements to MACE (or equivalent) panels, and alternatives to them, without discussing improvements required in the wider systems in which those panels exist. As such, in this study we have identified ways to improve the role of MACE (or equivalent) panels that recognise the interdependence between these issues and those surfaced for both local strategic arrangements (section 5 of this report), and national systems more widely (sections 6 and 7 of this report). In this section we share these findings on improvements in regard to:

4.3.1 Local practical changes to improve delivery
4.3.2 National system changes to improve delivery

4.3.1 What changes can be made at a local, practice level to support and improve the delivery of individual MACE panels?

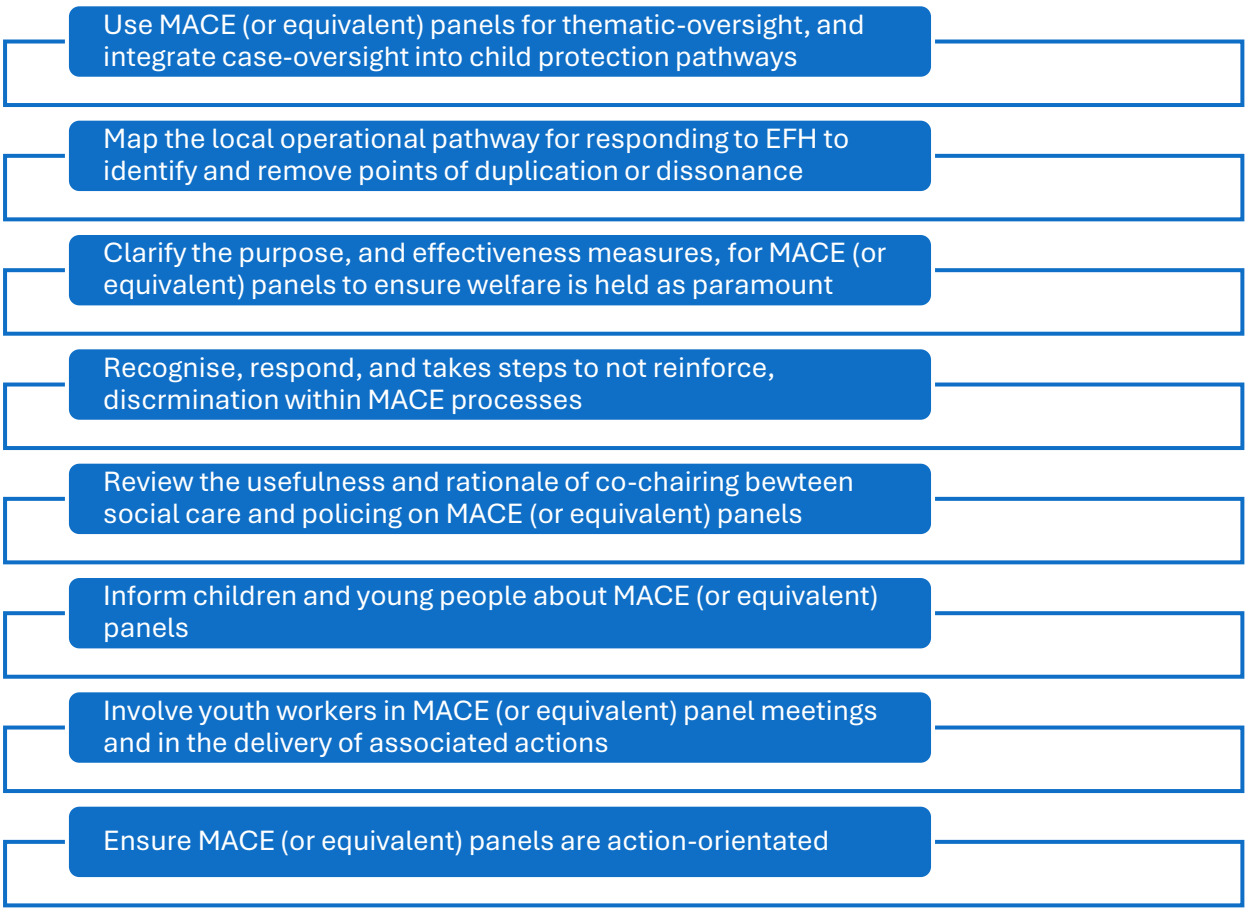
Recommending changes that could be made at a local practice level to improve the delivery of individual MACE (or equivalent) panels, assumes an inherent value in maintaining them as an essential feature of the local service landscape. The results of this study suggest there is a legitimate question to be asked regarding the ways in which MACE (or equivalent) panels are used, the purpose(s) they serve, and whether, within the current national context, they should be maintained. This is particularly true for panels that are serving a case-oversight function. The case oversight function of MACE (or equivalent) panels has been important at times when children and young people impacted by EFH were screened out of children's services pathways, including child protection processes. However, this does not necessarily mean that case oversight should sit in a separate MACE (or equivalent) panel structure. In the case study sites where EFH was more integrated into children's services and child protection pathways, using MACE panels to fulfil a case-oversight function risked duplicating efforts, introduced parallel planning processes, thresholds and risk assessment categories, and involved sharing information about large numbers of children and young people with large networks of professionals that they did not know.

Many participants cited that MACE (or equivalent) panels were important for: coordinating partners; providing an accountability mechanism; ensuring oversight of safeguarding responses to EFH; and being a structure through which information was shared. However, a 'panel' is not necessarily the only infrastructure for these activities. We collected data from two sites which didn't' use a MACE (or equivalent) panel at all – for example using a ROTH child protection pathway alongside an interdisciplinary young people's team (Figure 6), or having plans coordinated by interdisciplinary teams and using meetings to coordinate disruption activity as required for individual children and young people (Figure 7). In these alternative local models', information was shared,

accountability pathways had been generated and there was oversight (to differing degrees) of safeguarding responses. Moreover, regardless of whether sites had a MACE (or equivalent) panel in place or not, information was also shared, and partners also coordinated their actions, via co-located teams or strong relational working across partners with clear roles and responsibilities. Integration of multi-agency activities with wider children's social care frameworks also provided accountability; and arguably some practices observed in MACE (or equivalent) panels required specific quality assurance and accountability measures to ensure they practiced in ways that held children and young people's welfare as paramount.

The data gathered suggests that there is a) potentially a continued role for MACE (or equivalent) panels to fulfil a thematic/trend-oversight function only (as they did in case study site 2, and were felt to be missing to different extents in case study sites 5 and 6), if they can be orientated more explicitly to child/young person-welfare goals, and integrated accordingly into children's services safeguarding pathways. In this regard we have identified eight practices that could contribute to local conditions in which multi-agency panels can be used effectively as part of whole-system responses to EFH – summarised in Figure 12 and detailed below.

Figure 12 Actions to support the effective use of multi-agency panels in response to EFH



1. *Use MACE or equivalent panels for thematic oversight, and integrate case-oversight into child protection pathways*

Presently, many MACE (or equivalent) panels, and some alternatives to them, operate outside of established child protection pathways (see figures 4, 5 and 6). This approach builds duplication into systems, including duplicate assessment forms, assessment categories, thresholds, and meeting structures; all of which operate in parallel, rather than being integrated with one another. Such an approach pushes EFH, and the children and young people affected, outside of child protection frameworks, despite statutory guidance in both England and Wales recognising EFH as a safeguarding issue. This study has illustrated that the positioning of EFH pathways outside of child protection pathways has created operational contexts of confusion in respect of the purpose of the pathway, and the paramountcy of children and young people's welfare who are impacted by it. 'Significant harm' is an established threshold for statutory intervention to safeguard children and young people. This language can equally apply to situations of EFH; we did not collect evidence as part of this study to suggest that alternative categorisations of 'high risk', 'red', or numbered scores provided something additional. The case study two sites who used the language of 'significance' to categorise thresholds of need and risk – one with a MACE (or equivalent) panel and one without –came closest to a child welfare response to EFH that was integrated into a children's services pathway.

Outside of this study we have also been made aware of multiple LAs who have been amending their children's social care single assessment, to integrate specific queries related to EFH and therefore facilitate implementation of an integrated ROTH child protection pathway. These moves towards integration create the conditions for a single safeguarding pathway for all children and young people impacted by violence and abuse - regardless of the context where that harm occurs. If support for children and young people is coordinated via a single child protection pathway, this creates space for MACE (or equivalent) panels to solely fulfil a thematic-oversight function, for coordinating responses to thematic issues escalated from multiple children and young people's individual plans.

2. *Map the local operational pathway for responding to EFH*

All six case study sites participated in a workshop in which they worked with researchers to map their operational response to EFH (represented in Figures 2-7). On each occasion professionals commented that the exercise helped them 'see' things about their local response to EFH which had not been visible from their own perspectives previously. It was a particularly important exercise to clarify the number and purpose of all meetings held to coordinate and oversee operational responses to EFH, the coordination (or lack thereof) between EFH processes and broader safeguarding structures, and the implications of the various system pathways for professional workload and capacity, as well as the children, young people and families impacted by the response. During the research period we were informed that four of the six sites had initiated actions following the system-mapping workshops to change features of their local process. Having the space to reflect on structures that have often developed over time, and in response to different agendas, created opportunities to identify priority areas for redesign or reform.

3. *Clarify the purpose of MACE (and equivalent) panels and associated measures of effectiveness*

We found it difficult to reach conclusions about the effectiveness of MACE panels, as it was not always clear what they were trying to achieve. As detailed in previous sections of this report, study participants largely described the purpose of MACE (or equivalent) panels in three ways –information sharing, multi-agency coordination and a place to share worries/concerns or to seek reassurance from others about those concerns. However, the extent to which these three things were being achieved across MACE (or equivalent) panels, and whether achieving these things supported safeguarding responses to children and young people impacted by EFH, was unclear. Moreover, the overarching purpose of these activities – whether to build police intelligence or to assess/respond to children and young people's needs, was also often largely unclear. Both these broad purposes are considered relevant to safeguarding goals, but they entail different things and can have different consequences for marginalised or under-served children and young people, including those who are racially minoritised or have learning needs. Therefore, it is important that the purpose of MACE (or equivalent) panels, or

alternatives to them, for both case-oversight and theme-oversight are agreed, and that the purpose is defined in such a way that leaders will know if it is being achieved.

4. *Recognise and respond, and take steps not to reinforce, the discrimination faced by young people impacted by EFH*

For MACE (or equivalent) panels to effectively safeguard children and young people impacted by EFH, those involved must be working to recognise discriminatory processes/impacts and address them. All case study sites identified that a disproportionate number of children and young people identified as being impacted by EFH were racially minoritised and neurodivergent, and that there were inconsistencies in how young women and young men impacted by different forms of EFH were identified and supported. Therefore, service leaders and practitioners need to be supported to identify where features of local service design, including the purpose of multi-agency activities, the influence of policing and community safety practices, and the nature of commissioned services, may exacerbate or mitigate the impact of discrimination. Neutral approaches, which claim to 'treat everyone the same' will by default treat marginalised children and young people differently, and risk safeguarding approaches lacking direct engagement with the causes and consequences of racism and other forms of discrimination.

5. *Review the usefulness and rationale of co-chairing between social care and policing on MACE (or equivalent) panels*

The rationale and/or benefit of social care and police co-chairing MACE (or equivalent) panels was unclear to the research team. Practically it largely involved swapping responsibilities for chairing conversations, but had not extended to agreeing co-cultures, co-goals or a co-purpose for MACE (or equivalent) panels across policing and social care remits. As a result, MACE (or equivalent) panels could become forums where tensions between social care and policing were present but not resolved, or where one culture or purpose (most often policing) shaped the practices of all partners, often without this being explicitly intended. The evidence gathered for this study suggests that having a single organisation chairing meetings can help set the tone and culture of EFH panels. Local partnerships (see section 5) should therefore be explicit about who chairs these panels, why, and what culture, purpose and approach the chairing model is intended to support. This should be agreed strategically across the partnership, so that everyone involved is clear about the panel's purpose and way of working.

6. *Introduce standard approaches to informing young people of MACE (or equivalent) activities*

While practitioners do not necessarily need a child or young person's consent to share information about them at a MACE (or equivalent) panel, children and young people should be aware that such meetings happen and that information they provide for other

purposes may be used in this way. Having to communicate this with children and young people as standard builds ethical and relational practices into the design of MACE (or equivalent) processes and also requires that the rationale for sharing information in this setting, and the implications of doing so, have been fully considered by all of those involved. Do children and young people know, for example, when attending their local youth club, that youth workers may be asked to share information about what those children and young people have talked about in the youth club at a MACE (or equivalent) panel – as means of 'building a picture' of violence or exploitation locally?

7. *Involve youth workers in MACE (or equivalent) panels and actions from panels*

Collaboration between youth workers and social workers, both in MACE (or equivalent) panel discussions, and in response to issues identified in panel meetings, created opportunities for welfare-orientated responses to themes/locations. These responses prioritised activities that would identify and meet children and young people's needs, build opportunities for community guardianship, and address environmental drivers of harm, in collaboration with them. Without youth work involvement in panels, we observed a reliance on community safety and policing responses to groups and locations, such as interventions that disrupted or dispersed children and young people, or increased surveillance of them, often with limited community knowledge about children and young people's views and needs outside of intelligence datasets.

8. *Ensure MACE (or equivalent) panel meetings are action-orientated, with access to clear accountability and escalatory routes*

To move MACE (or equivalent) panels beyond primarily being a structure for sharing information and towards a structure that facilitates actions which safeguard children and young people, they need to be designed in a manner that prompts this. Presently, much of the paperwork reviewed by the research team that supports MACE (or equivalent) panel functions, such as recording/agenda templates, assessments and protocols, encourages practitioners to ask what more they need to know, but not necessarily what action they can and should take based on the information they already hold. Actions associated with information-gathering need to be associated with a secondary clearer goal. For example, finding out information about this child or young person's friends *to develop an offer of support to the friendship group / or to find an activity that they can do together*, rather than information in and of itself being the goal. One way that MACE (or equivalent) panels appeared more geared towards actions was when they were connected into clear escalatory routes, such as into structures associated with school inclusion. These routes created options for MACE (or equivalent) panels to provide an accountability structure, and in doing so unlock barriers social workers were facing when trying to meet the needs of children and young people impacted by EFH.

4.3.2 What system changes (e.g. to regulation, funding, inspection, guidance and training) can be made at a national level to improve the delivery of MACE (or equivalent) panels across England and Wales?

The efficacy of MACE (or equivalent) panels is informed, and undermined, by a lack of clarity on the position of EFH in wider safeguarding systems.

Firstly, in both Wales and England, we found examples of children's services departments in which children and young people at risk of significant harm due to EFH did not have their support coordinated on statutory social work plans (via child protection processes – or an equivalent) unless the harm they faced was attributable to their parents/carers. In our study, MACE (or equivalent) panels, or some alternatives to them, filled this oversight gap and ran in parallel with child protection pathways rather than be integrated with them. Such panels represent locally driven workarounds to national system insufficiencies, rather than consistent, thought-through ways of organising safeguarding support to young people impacted by EFH across Wales and England.

Secondly, multi-agency working is often described as a neutral activity in policies and frameworks that guide local practices; as something which is useful and that happens when people work together. Yet our data demonstrates how multi-agency working is often not a neutral activity for children and young people impacted by EFH. These children and young people often straddle victim/perpetrator binaries; and therefore, straddle competing legal and practice frameworks. Specific thought and associated policy direction is required to offer guidance on how to respond, when these binaries are blurred, through a stated commitment to welfare-orientated responses to all children and young people impacted by EFH.

Given these challenges, our study suggests that MACE (or equivalent) panels, and alternatives to them, would be best supported by six system changes implemented nationally.

1. *Introduce a consistent statutory social work pathway for coordinating and monitoring support for children and young people impacted by EFH*
   Such a pathway should ensure that regardless of where a young person lives, and whether they come to significant harm within or external their families (or both), they can expect that the support they receive will be coordinated by a social worker, who holds their welfare as paramount using child protection legislation. Any panels utilised to coordinate responses to EFH must be integrated into that pathway and be subsidiary to it – rather than running in parallel to the pathway or determining the nature of the pathway or its existence. In England this needs to be considered urgently as part of the children's social care reforms; to ensure the creation of multi-agency child protection teams, and family hubs, do not further reinforce parallel processes which exclude EFH.

2. *Clarify the relationship between the serious violence duty and paramountcy principle for children and young people impacted by EFH*

   Presently two legal duties underpin local responses to EFH, and the relationship between them (particularly when they are in conflict with each other) is unclear. There is a need for national guidance on the relationship between the paramountcy principle and the serious violence duty, upon which multi-agency groups can coordinate their local response. Such a clarification must promote appropriate, consistent, oversight of children and young people impacted by all forms of EFH, including serious violence – rather than the siloed approach that currently exists.

3. *Provide detailed guidance on 'information-gathering, information-sharing, information-recording and acting on information shared' in the context of EFH*

   Such guidance needs to move beyond blanket statements that professionals should 'share for safeguarding reasons' and instead help to resolve key operational tensions that sit underneath such statements. These tensions include: clearly stating the sub-purpose of information sharing (for example is it to build police intelligence pictures or is it to inform an assessment of young people's needs); when and how information should be shared about young people's peers, including in situations when those peers are not open to children's social care; consideration of proportionality, what would be disproportionate in terms of balancing rights to privacy and rights to protection; advice on information recording, including sharing via Teams chats for example, and having a trace from when information is shared and when it is acted upon; and consideration of the relationship between sharing information and taking action – compared to sharing information as an action in-and-of-itself. The government's guidance on the information sharing duty, out for consultation at the point of writing this report, would be an appropriate initial home for such clarification.

4. *Clarify the primary purpose of multi-agency EFH panels within statutory safeguarding guidance*

   Presently, MACE (or equivalent) panels can fulfil different functions: assessing, categorising and monitoring plans for individual young people; coordinating responses to themes, trends, groups and locations; and/or providing an escalation route within and across partnerships for themes associated to EFH and for the individual children and young people who are affected. These different purposes shape how often panels meet, how long such meetings last, and the practices that take place within them. If MACE (or equivalent) panels are to remain

a key feature of local EFH systems, their purpose needs clearer definition in national guidance which in turn should aid greater local consistency.

The function of MACE (or equivalent) panels that appears to address the clearest gap in child protection and wider safeguarding pathways is oversight of themes and trends. In situations of EFH multiple children and young people may be impacted by the same drivers of harm, in ways that siblings may be affected in a family. However, traditional child protection practices are not designed to hold oversight of extra-familial themes and trends in the way that they do for familial patterns or points of escalation. As such, MACE (or equivalent) panels could play an important role in identifying and coordinating responses to trends, groups and locations impacting the safety and welfare of multiple children and young people who are not related to each other.

If the purpose of MACE (or equivalent) panels were specified to focus on trends/themes, the findings of this study also suggest that such work should be guided by frameworks that consider children's needs and welfare, rather than be reflective of community safety responses to crime, disorder and anti-social behaviour which have not been designed with child safeguarding in mind. Disruption could still be coordinated in such an approach. It would feature as *part* of wider responses to locations/trends that consider children's needs and welfare, and therefore the primary purpose (and test) of proposed disruption activity would be to promote the welfare of children and young people. Orientating disruption in this way could mitigate the risks of that children and young people in need of protection will be criminalised in the process of intervention.

If multi-agency safeguarding plans for individual children and young people were coordinated via a single children's services and child protection pathway (insight 1 above) then the case-oversight function of MACE (or equivalent) panels could become redundant, and space would be created on the panel meeting agendas for reflective, needs-focused discussions that welfare-orientated practice requires.

5. *Recognise the clinical supervision needs of the EFH workforce and monitor the ways in which this is addressed via inspection processes*

EFH can be trauma-inducing for professionals tasked with responding to it. We observed this trauma in our data collection activities and were also told how MACE (or equivalent) panels can act as a container for the anxiety and worry of professionals involved in mounting a response. However, the nature of MACE (or equivalent) panels also suggested there was risk that they themselves could

aggravate or escalate these anxieties, particularly in respect of the sheer volume of children and young people being discussed, and the nature of what was happening to them. Rather than rely on MACE (or equivalent) panels to provide a response to professional worry or to offer professional reassurance, there may be merit in national recognition of the need for a) clinical supervision for practitioners who are responding to EFH and b) a wider reflective learning culture amongst those managing EFH practice and strategy (including through peer review and peer group reflective spaces). Such support may mitigate acts of over-sharing of information observed during this study, which appeared to relieve pressure momentarily for the professionals involved but left us asking questions about protection of young people's dignity and rights within safeguarding structures – particularly those from which they were excluded, and ways that could compromise trust in services without providing increased safety.

6. *Produce a cross-government strategy on either EFH or safeguarding adolescents, led by DfE and with child protection legislation as its basis*

The challenges with local operational responses to EFH are in part a consequence of a lack of national leadership and coordination on both this issue specifically, and on approaches to safeguard adolescents more broadly. As a research team we did not reach a conclusion about which of these topics most warranted a cross-government strategy, but the absence of a strategy on either currently feels untenable. Leadership and strategic clarification is required in terms of: a) the relationship between welfare and justice goals of local multi-agency partnerships (rather than separate messages being offered on each from different government departments presently); b) responses to children and young people who straddle victim-perpetrator services and legislative frameworks; c) ways to develop an integrated, comprehensive approach to different forms of EFH which currently have their own independent government strategies; and d) connecting responses to EFH with national policies on school inclusion, behaviour, special educational needs and neurodivergence, to avoid inconsistencies in the approach to these issues and the children and young people affected - particularly those who are racially minoritised.

5 Findings: Multi-agency strategic arrangements

Unlike MACE (or equivalent) Panels, Local Safeguarding Partnerships (LSCPs in England and RSBs in Wales) exist for reasons far beyond EFH. This broader remit of Local Safeguarding Partnerships (referred to as LSPs for the remainder of this chapter) is evident in the data we collected about multi-agency strategic arrangements for EFH. There is often far more distance between the work of LSPs and the specific system issues of responding to EFH, than there is for the work of MACE (or equivalent) panels. Nonetheless, we also identified points of synergy between the nature, and challenges of, strategic arrangements for EFH provided by LSPs, and the operational dynamics of MACE (or equivalent) panels, and alternatives to them, detailed in chapter 4.

As summarised in chapter 2, research into LSPs is limited, and this is even more acute in respect for studies on the role of LSPs in responding to EFH. The research that exists is often based on practice reviews and reflects the challenges for and barriers to strategic partnership working (RiP, 2024, CSPR, 2024, DfE, 2021), including a lack of resources, capacity and training needs, the different expectations, approaches and understandings of responsibilities between partners, and geographical complexity (often spanning different agency remits). The literature also raises concerns about and challenges of information sharing between agencies but does not resolve them. Recommendations in the literature (including practice and government commissioned safeguarding reviews) focus on tackling the issues summarised here, including improved communication and shared understanding between partners, the need to develop collaborative cultures, and the importance of clear and supportive leadership at strategic and managerial levels.

This study builds on that evidence base, by asking specific questions about the role of LSPs in respect of EFH. To do so we answer questions in the following five sections:

5.1 The expectations for LSPs in respect of EFH
5.2 The extent to which LSPs are meeting expectations related to EFH
5.3 Factors that facilitate, or create barriers to, LSPs meeting expectations related to EFH
5.4 The extent to which LSPs are addressing racial disparities in their strategic response to EFH
5.5 System and practice changes that are required to improve the response of LSPs to EFH

Before we answer questions under each of these sections, it is important to set our findings in context. As detailed in chapter 4 there are a range of system challenges impacting how children's services, and their partners, respond to EFH. Few of these challenges can be resolved by LSPs, and many of them impact the capacity of LSPs to create strategic contexts in which operational responses to EFH are effective. Key contextual features include; the introduction of the serious violence duty under

Community Safety Partnerships, which marks serious violence as distinct from other forms of EFH and situates it more squarely under a community safety policy framework; broad national policy statements about multi-agency working that do not clarify the relationship between social care and policing (and their associated outcomes frameworks) in responding to EFH; and system anxieties and pressure to respond to EFH despite huge budgetary pressures. Some of the challenges we document in this chapter therefore are more a reflection of the systems LSPs operate in rather than of the LSPs themselves. When developing insights for change, therefore, we focus on challenges that LSPs have greatest leverage to resolve or mitigate.

5.1 LSP expectations

The study asked three questions about expectations on LSCPs in England and RSBs in Wales in relation to strategic responses to EFH. The first of these, RQ1, asked what were the expectations of LSPs in response to EFH?

5.1.1 LSP expectations in general

According to English law and policy, the LA, the police and integrated care board are the three statutory 'Safeguarding Partners'. 'Working Together to Safeguard Children' (England's statutory safeguarding guidance) also recommends that education plays a significant role alongside these statutory partners. A range of other partners, including probation, housing, public health and voluntary sector agencies, form an area's local safeguarding children's partnership (LSCPs). Based on our policy mapping (see section 2.2), it appears LSCPs in England are expected to:

- **Coordinate** the work of all partner agencies involved in safeguarding children
- Develop and agree upon multi-agency **policies and procedures** to guide local safeguarding practices, such as developing a shared threshold document
- **Monitor and evaluate** the effectiveness of safeguarding practices, for example by completing joint audits of case files to identify areas for improvement
- **Commission reviews** of serious cases (Child Safeguarding Practice Reviews) and child deaths, share learning and implement recommendations
- Ensure the availability of single-agency and multi-agency **safeguarding training**
- Participate in the **planning and commissioning** of services that are required to safeguard children
- **Ascertain the views of children and their families** regarding local safeguarding activities, and consider these views when changing/developing local approaches

Each partner on the LSCP also has a set of specific responsibilities which include a duty to cooperate in the LSCP, ensuring strategic representation on the LSCP to facilitate

accountability and policy development, sharing information to support learning, and challenging each other to ensure children's welfare remains held as paramount.

In Wales, Regional Safeguarding Boards (RSBs) are expected to fulfil a similar set of expectations. Set out in the Social Services and Wellbeing Act (Wales) Act 2014, these expectations also include responsibilities to **coordinate** agencies, undertake **practice reviews and case audits** and action the recommendations, and meet **training** needs. Commitments to understanding and responding to young people's views include responsibilities to **co-produce** solutions with children and families. RSBs also have an additional responsibility in Wales to provide bilingual information and support. The work of RSBs in Wales is guided by five underlying principles: Paramountcy principle (as in England), Parental Responsibility, Prevention, Partnership and Protection. Membership includes regional representation from Local Authorities, Police, Health Boards and Public Health Wales, Education representatives, Probation and Youth Justice services and the Welsh Ambulance Service.

This top-line account of expectations of LSCPs in England and RSBs in Wales – collectively referred to as LSPs – is reflected in our wider dataset. Our national interview and focus group participants described the role of LSPs as overseeing operational responses to EFH – as they do all other safeguarding issues:

> *'An oversight collective, if you like' (National Focus Group)*

Similarly, during system mapping workshops participants from all case study sites offered general descriptions about how local strategic arrangements contributed to their responses to EFH. LSPs, and their relevant sub-groups, were described as offering general oversight of the operational activity taking place in each site, rather than specifically contributing to ongoing improvements in their response to EFH. Strategic sub-groups, mapped during system mapping workshops in case study sites, varied, and were determined by site; they included groups focused on exploitation, vulnerable people, audit and quality assurance, policy development, and training.

This general narrative is unsurprising. National policy frameworks do not dictate overarching expectations for LSPs specific to EFH. Expectations, as set out in policy, are more high-level than this. As such, the research team approached the question of LSP expectations by asking specifically whether any of the general responsibilities set out in policy (and summarised above) should be leveraged to guide responses to EFH specifically – and if they should, which ones and how. For example: should *training* commissioned by the LSP include EFH? Are the LSP responsible for *ensuring services* needed to safeguard children and young people from EFH have been commissioned? Should the LSP seek and respond to the *views of children, young people and families* impacted by EFH? Should the LSP *complete audits* and commission case reviews for EFH? How should LSPs track their responses to EFH-specific case reviews and audits?

Should every LSP have an action plan, protocol, and/or threshold document for coordinating multi-agency responses to EFH?

5.1.2 LSP expectations related to extra-familial harm

Our REA and analysis of SCRs and Rapid Review reports suggested that expectations for LSPs specifically related to and are found in recommendations produced following national or local reviews of serious incidents as opposed to being a feature of national policy frameworks. As is the case with MACE (or equivalent) panels and alternatives to them (chapter 4), the detail on how LSPs should organise their response to EFH has been left largely to local discretion, and therefore is subject to local variation, rather than guided by national frameworks. Minimal guidance is provided specifically about EFH for LSPs. Documents sourced through the REA and in our policy mapping activities make recommendations, largely based on case reviews, and focus on improving understanding, threshold application and evidence of impact. For example, the Child Safeguarding Practice Review Panel (CSPR) Annual Report for 2023 to 2024, which included a specific focus on EFH, recommended LSPs play a role in: ensuring supervision, support and training are in place for practitioners working with children and young people experiencing EFH; improving collective understanding; establishing clearer thresholds for accessing support; and developing a robust evidence base of what works. The Government's eight practice principles for responding to CCE and other forms of EFH (Gov, 2023) are also pertinent here (see chapter 2). They, like a further CSPR report (2022) and Wood Review (2021) include recommendations to improve strategic multi-agency safeguarding responses, including good attendance at strategic meetings, information sharing, effective joint working and better communication between adult and children's services.

Before we consider the extent to which LSPs are meetings these expectations, it is also important to note what is currently not expected from LSPs, but which the results of our study into MACE (or equivalent) panels (chapter 4) would suggest are important.

5.1.3 What is not presently expected of LSPs in relation to extra-familial harm

There are a number of ways in which national expectations for the strategic work of LSPs does not meet the demands of multi-agency responses to EFH.

LSPs are expected to coordinate multi-agency working and maintain children and young people's welfare as paramount within this; with recommendations that the serious violence duty is realised in collaboration between the LSP and Community Safety Partnership. However, options for resolving the specific tensions inherent in achieving this, specifically those related to coordination across policing and children's social care (and the distinct objectives to which they work), are not stated in national guidance (and are arguably reinforced by siloed legislation and policy). This leaves room for multi-

agency working to be interpreted as everyone attending meetings and signing-off high level policy, but in the absence of a shared framework for agreeing how to manage distinct organisational priorities in respect of EFH.

The role of LSPs in facilitating information-sharing and sharing strategic information is noted as important in national policies. However, the nuanced and critical conversation needed to support professionals to consider how they record and act on information that is shared (rather than simply the act of sharing it) and the specific governance around such activities as they apply to children and young people's peers (including those not open to children's social care) are not stipulated.

Finally, explicit requirements to address discrimination in the delivery of safeguarding activity are largely absent from national policy. Instead, for example, LSPs have responsibilities to identify and monitor trends. We saw this level of responsibility being enacted in our six case study sites, with most referencing strategic work that was underway (often via sub-groups of the LSP) to track disproportionality using datasets produced by operational panels such as MACE (or equivalent). Undertaking equality impact assessments on local EFH arrangements or actively embedding an anti-racist approach to recognise and respond to discrimination in the system response to EFH is not a requirement of LSPs.

As such, given their generic nature, LSPs could meet some of their national requirements – such as the provision of training or the development of policy in relation to EFH –while not providing sufficient strategic oversight to support effective practice in ways our Chapter 4 findings suggest are required (and that are summarised in the preceding paragraphs). Moreover, the nature of these strategic activities and their focus needs to closely relate to local needs in respect of EFH. For example, many professionals who participated in this research required reflective spaces to understand what welfare-oriented approaches to EFH might entail, and their role in providing this, rather than solely receive general training on the nature of EFH.

5.2 To what extent are local safeguarding partnerships meeting expectations related to extra-familial harm in practice?

The extent to which LSPs from our study are meeting the expectations outlined in section 5.1 varies; both in terms of each expectation (as it applies to EFH), and the depth with which it is being met. In this section we consider each expectation in turn.

5.2.1: Requirement to provide strategic leadership

In terms of the overall requirement for key statutory partners (the LA, police and health) to lead safeguarding responses there are two key findings to note of relevance to EFH. From a national policy perspective, representatives from police, the LA and health

comprise equal statutory partners in LSPs and therefore hold equal responsibility for the safeguarding response to EFH. However, strategic leadership of EFH is largely held between children's social care (the LA) and policing. This was the case in all six case study sites and was also reflected in the 39 completed LSP survey responses. 100% of LSP survey respondents felt that LAs fulfilled their strategic duties in respect of EFH, 93% felt the same about the police and just 72% felt this about Integrated Care Boards (ICBs) as the LSP health representative. Given recent cuts to the budgets of ICBs and the resultant pending changes to health oversight, this survey result was both unsurprising and mirrored data from national interviews and site case studies. Across our dataset much of the strategic and operational response to EFH appeared coordinated between social care and policing, with the contribution of health organisations being less established. This is not to suggest that there is no role for health agencies in response to EFH. Children and young people impacted by EFH, who were identified by statutory services in case study sites, were reported to be disproportionately neurodivergent and/or have additional learning needs. Experiences of EFH also impact children and young people's physical and mental health, with clear implications for sexual health and mental health. However, the diffusion of different health services, and the changing geographical coverage of ICBs, makes it challenging to identify who from the 'health sector' could provide sufficient representation at LSP level in respect of EFH. This challenge was cited in every system mapping workshop completed in this study. Similarly, while not specific to EFH, in Wales, a key recommendation for boards in the McManus et al. (2023) review was to establish a unified health record given the complex and fragmented nature of health agencies within safeguarding.

The second factor to consider relates to the roles played by non-statutory partners. Publications in the REA, and data from one of our case study sites, suggested that reducing the size of LSP membership could reduce fragmentation. However, several non-statutory partners appeared key in contributing to strategic oversight of effective responses to EFH and in offering leadership in terms of access to services such as housing, as part of local responses to EFH. In national interviews, education was described by others as equivalent to the three statutory partners (LA, Health and Police) in terms of importance, yet their leadership in strategic arrangements was described as limited or inconsistent:

> *"Potentially one gap in terms of multi-agency working [... is] education [...] It is tricky in terms of they aren't a stat partner. However, we want them to be"* (National interviews)

During system mapping workshops in case study sites, participants described how it was difficult to identify the right education representative(s) at senior levels to participate in the LSP given that different schools and academy trusts had their own safeguarding leads. Education interview participants echoed this concern and felt that they were missing channels to influence decision-making on EFH in their local areas. Likewise,

youth work providers (both statutory and non-statutory), and wider voluntary sector organisations, who were key in enabling operational responses to EFH, had inconsistent input in shaping the strategic approach that LSPs took in response to EFH. No single organisation could sufficiently represent the views, experiences, or operating frameworks of organisations in the youth work and/or voluntary sectors within a strategic partnership.

5.2.2 Requirement to provide strategic coordination

Survey data suggests a level of confidence that LSPs are meeting expectations regarding the coordination of partners. 77% of survey respondents felt that activities to safeguard children at risk of EFH were mostly or fully well-coordinated across LSP partners, while 23% reported only partial coordination.

Survey respondents appeared equally confident about the specific roles of different partners. Among the 44 survey respondents who answered these questions, 73% felt partners shared a common understanding of roles, while 14% disagreed and 14% were neutral. However, survey respondents queried whether these roles worked well together. Of 46 respondents who answered this question, 41% felt the roles of partners in the LSP were often complementary, whereas 57% felt roles were *sometimes* complimentary, creating room for duplication or gaps.

This idea that partners participated in (i.e. attended) activities, but did not necessarily coordinate effectively, was also reflected in national interviews and case study data. Across this dataset the narrative was that both LAs and the police assume leadership roles in respect of EFH, but that these roles are not well-coordinated with each other, and are rarely complimentary, given that they operate to different legal frameworks, cultures, and KPIs. Whereas health largely plays a secondary role, in ensuring services are provided, or agencies attend training, to participate in the approach that the LA and/or the police coordinate. As such they often have an unclear role in leading the coordination of interagency strategic responses to EFH.

In national interviews and focus groups, both police and children's social care representatives viewed themselves as the lead partner responsible for EFH and to a degree were also seen by others in this way. Such leadership was described in terms of the burden of the work and decision-making; in one person's words due to their 'financial contribution, driving actions forwards'. Interview participants also described documentation that had been created to formalise partnership coordination, such as Memorandums of Understanding (MOUs), strategies, terms of reference, joint processes and protocols. In different ways these documents were framed as tools to guide an area's approach to coordinating across agencies. It was these local documents, rather than a specific piece of national policy or guidance, that interview participants generally referenced as guiding their local responses to EFH. In this way local strategic

arrangements are influencing operational approaches and how partners coordinate in this respect – potentially more than any national policy expectations.

In case study sites we observed the ways in which local and regional strategic documents (and associated processes) were determining local operational coordination. In all case study sites, the LSPs had some responsibility for signing off the operational safeguarding model for responding to EFH. However, the geographical remit for this coordination often sat at a police-force level, rather than at LA level; and so, police-force protocols for responding to different forms of EFH were adopted by the LSP. This meant that the operational activities of individual children's services departments in response to EFH were often led by the protocols introduced by the police-force in which their LA was based.

This police-force-led approach to designing safeguarding operational models meant that when children's service developed alternative safeguarding pathways for responding to EFH (Section 4.1.4), they mostly then did this in parallel with force-wide requirements for how partners would coordinate their activity, rather than the pathways they created being viewed as the primary way partners coordinated safeguarding activity. This was evident in the parallel operational processes we detailed in chapter 4, for example introducing thresholds for consideration at MACE (or equivalent) panels that related to R-A-G-colours, scores, or different risk categorisations, as distinct from nationally adopted thresholds for social work intervention.

Beyond geographical boundaries, police leadership in case study sites was also evident in the culture of local partnerships, expressed through the language LSPs used (such as 'intelligence') to describe partnership priorities, and the datasets they drew upon to track activities (reported crime data). Moreover, the inclusion of serious violence within LSP responses to EFH did not appear, in most cases, to significantly influence strategic plans around serious violence developed within policing or wider community safety structures, which were shaped by their own organisational/partnership cultures, priorities and legal frameworks. We identified attempts to resolve this. In one site for example, the Executive Director of the LA was overseeing the strategic coordination of responses to EFH locally, which involved community safety partners as well as children's services. However, as this strategic work was operationalised it separated again with a distinct policing and community safety meeting held to coordinate responses for 'habitual knife carriers' independent of the safeguarding plans/assessments for the children and young people who were discussed at that meeting. This operational splintering did not reflect strategic efforts in the site to integrate responses to children and young people impacted by EFH. As such, coordination between police, social care and Community Safety Partnerships was a complicated terrain strategically as well as operationally.

In some respects, the fact that we completed parallel studies on operational panels (chapter 4) and strategic arrangements (this chapter), enabled us to see the challenge of

ensuring strategic activities to coordinate safeguarding partners translated into operational coordination. What we observed across the dataset was strategic leaders, and their operational counterparts, attending and participating in partnership activities, but those activities not necessarily resulting in coordinated operational approaches. This was evident in our analysis of case review reports. SCRs, Local Safeguarding Children Practice Reviews (LSCPRs) and Rapid Reviews documented various challenges in coordinating multi-agency support to young people impacted by EFH. Some reviews cited non-attendance from some partners at meetings as hindering potential for collaboration. Others noted that while all agencies participated in meetings, these meetings failed to generate tangible actions. Others found that involvement of an overwhelming number of agencies undermined efficacy:

> *"Although there was some evidence of cooperative working it was stated that there was limited strategy discussions, some representatives did not show up during meeting and most of the work was done via emails and telephone." (SCR 22)*

> *"It was good practice that some of the warning indicators to [young person's] safety and well-being outlined above were regularly shared between the statutory agencies, risk assessed by individual agencies and plans were established within organisations within their own assessment frameworks. However, there is no evidence that his known vulnerabilities or the information shared about him led to effective multi-agency plans which improved life for him." (SCR 42)*

> *"Mum recalls lots of different workers from Youth Justice, Social Care or Youth Work were trying to get him involved with different activities; but it was a bit like a 'merry-go-round' of different people arriving and then leaving." (SCR 4)*

The nature of the strategic or operational collaboration between partners that was praised in SCRS was often in the form of information sharing between professionals or agencies (particularly social care and policing), or having protocols in place to facilitate this activity, rather than the consequential outcomes of these activities for children and young people. In short, the act of speaking to each other was framed as the good practice in and of itself without attention to what happened as a result of that activity in terms of the plans and support for, or protection of, young people.

Challenges in identifying 'who' from health, education, youth work and the voluntary community sector (VCS) should participate in multi-agency strategic activity, also undermines consistent coordination of those agencies operationally. The complexity of what 'coordination' actually means is sometimes resulting in superficial interpretations of coordination – everyone attending the same things or talking to each other – rather than working to a shared culture, a coherent set of cross-agency objectives, a singular pathway for organising safeguarding responses to EFH, or a set of shared measures against which all agencies involved in that response are measured.

Our data suggests, therefore, that LSPs are often successful in bringing agencies together around EFH through meetings, policies and protocols. However, as our findings on MACE (or equivalent) panels illustrated in Chapter 4, this does not necessarily amount to effective *coordination* or create the conditions in which children and young people are protected.

5.2.3 Policies and Procedures

When asked about the development of EFH strategies or policies, of the 41 business managers who responded to this part of the LSP survey, 24% (10) said they had a standalone plan; 44% (18) said that their plan for EFH was within a wider strategy; 29% (12) said such policies were in progress; and one respondent stated that they did not have one.

Harms featured in LSP strategies

Four of the six case study sites had named some form of EFH as a strategic priority. One of these was specifically focused on sexual abuse and exploitation, rather than all forms of EFH, whereas the other three related specifically to 'harm outside of the home' or 'risk outside of the home'. Of the two areas that did not name EFH as a strategic priority, one was prioritising 'neurodivergence' and the other 'transitional safeguarding' – both of which relate in different ways to the issue of EFH.

Analysis of the 10 strategies submitted with survey returns, and the additional 11 purposively sampled by our research team for geographical diversity across survey respondents, showed variation in what is included in EFH strategies. All strategies shared by survey respondents (n=10) primarily focused on exploitation. Of these:

- 40% also made explicit reference to serious youth violence and detailed their response to it
- An additional 30% mentioned serious violence but noted the approach to this issue was featured in a separate strategy that they did not share with the research team
- The remaining 30% of the documents provided either no-or-limited reference to serious violence.

Of the 11 additional strategies sampled only two offered detailed consideration of serious violence in their EFH or exploitation strategies, and a further four said that this issue was planned for in a separate strategic document.

LSP support to agree thresholds across agencies

In respect of policy documents that communicated the 'threshold' for safeguarding intervention in situations of EFH, as indicated in chapter 4, this varied by area. In our six case study sites alone, three required EFH to be attributable to parenting to reach a threshold for a child protection pathway, whereas the other three were using a child

protection pathway in all situations when EFH presented a risk of significant harm to a child or young person.

A lack of strategic consistency on thresholds across case study sites is interesting given that in some respects national guidance in both England and Wales is clear. In Working Together to Safeguard Children 2023 all forms of EFH are named as 'child protection issues', and in All Wales guidance documents on CCE and CSE refer to 'the development or review of a child protection and/or care and support plan for the child' in response. This national policy position was not consistently reflected in the operational approach of our case study sites. In the areas that were not using child protection pathways for EFH, there was no written threshold statement that explicitly communicated that this was the position; yet there was a consistent verbal account that it was in system mapping sessions and observations. This lack of clarity and consistency around how child protection thresholds applied in situations of EFH also appeared to inform threshold application in other services, including education, police and health services:

> *"So I don't know whether it's training that school staff seem to need, or the way school staff seem to interpret their training from all the various frameworks and policies that we have coming through every year and the training that we do, that sometimes puts us... I wouldn't say at odds with.... but I think we have a different level of personal threshold about what is a safeguarding issue than sometimes other partners do because we live and breathe it and we're dealing with the consequences."* (Focus group, case study site)

In national interviews, education participants commented on this lack of clarity around shared thresholds, stating they were concerned that the thresholds for support services are very high, and they struggled to get support from other services especially children's social care. There was a concern that they were being left isolated, with responsibility for risks that exceeded their capacity to respond and, in some cases, fell outside their areas of expertise, including exploitation.

Challenges around children and young people impacted by EFH not reaching various thresholds for support is well documented in SCRs and Rapid Reviews and were also documented in studies included in our REA. This applied to thresholds for mental health services, child protection arrangements, and specific consideration at MACE panels:

> *"...but did not meet the threshold for accessing CAMHS services and was referred to Educational Psychology".* (SCR 25:11)

> *"incidents of significant harm including financial Child Criminal Exploitation and serious (non-violence-related) personal injury did not meet threshold for Child & Family Assessment and/or s.47 child protection investigations on a number of occasions*." (SCR 30: 20)

Most areas have some form of EFH protocol – or at least one for CSE and CCE, or for their MACE panel (or equivalent) – that outline operational arrangements for responding to EFH (and for some the threshold for being considered at a MACE panel). However, such

protocols appear insufficient in establishing a broader consistent and coordinated understanding of 'threshold' across services for children and young people impacted by EFH; both in terms of the levels of harm/need of the children and young people affected, and what this means in respect of access to different types of services. Key matters warranting consideration are the need for:

- Integrated understanding of thresholds of significant harm for all forms of EFH – rather than requiring certain features (such as grooming) which would rule some harms out based on their nature rather than significance
- Cross-service review of thresholds – for child protection, for school exclusions, for mental health access, for operational panels, to build an understanding of how these may intersect, and impact, multi-agency responses to young people impacted by EFH
- Clearly stated position by all LAs as to whether they are compliant with stated national expectations that children and young people impacted by EFH are entitled to a child protection response when risk of harm is significant

5.2.4 Monitoring, evaluation and case auditing

LSPs rely heavily on case review reports, inspection reports and targeted audits to monitor and measure their response to EFH; however there is no baseline or set of expectations against which to benchmark what they find.

Role of case review reports

The last five years have seen a significant increase in the number of case reviews completed on the topic of EFH. The GCCS have developed a database of SCR/LSCPR reports related to EFH. For this database, we identified 49 review reports that were completed between 2010 and 2020, whereas we identified a further 40 completed between 2020 and 2024. This suggests an increase (from on average five a year, to ten a year) in the rate at which reviews on the issue of EFH have been undertaken in recent years. Of the 330 rapid reviews submitted to the National Child Safeguarding Practice Review Panel in 2023-24, 78 (23.6%) featured incidents of EFH. Case review activities, and the reports produced, therefore, are being used by LSPs to understand how effectively they are responding to EFH and how they may improve responses in the future.

Analysis of SCR, LSCPR, and Rapid Review, reports completed as part of this study identified recommendations for improving, and tracking, the performance of LSPs in response to EFH. Review reports routinely recommend that LSPs increase their strategic oversight of, and develop more coherent multi-agency approaches to addressing, EFH. Review report authors suggest this would be achieved through improved information-sharing, continuity of support for children and young people (particularly at transition points), and strengthened mental health, substance misuse, and therapeutic support. Reviews also routinely recommend improved partnership approaches to school

attendance and exclusion for children and young people impacted by exploitation and serious youth violence. From an LSP perspective, their responsibilities should in-part facilitate this; such as through detailed guidance on information sharing (as recommended in the previous chapter) and reviewing how partnership resources are used to commission services that appear most needed by children and young people impacted by EFH. Although the most recent review of child practice reviews in Wales (McManus et al., 2023) does not discuss EFH, the recommendations for LSPs in Wales echo those above and call for clarification of expectations, thresholds, and evidence, for demonstrating the effectiveness of multi-agency safeguarding arrangements.

Developing and agreeing outcome measures

When asked how they monitored the impact of their response to EFH locally, LSP survey respondents most frequently cited tracking: the rates of missing episodes (70%); levels of school attendance (65%); and the outcomes of case audits (54%), as proxy indicators for EFH. Far fewer respondents stated that their LSP used safety surveys with children and young people, tracked criminal justice outcomes or monitored A&E presentations. 17.4% reported having no formal impact indicators to measure the effectiveness of their local arrangements in respect of EFH. For the most part, current approaches to monitoring do not consistently and clearly tell LSPs whether their responses to EFH are improving safety or whether their actions are resolving operational challenges.

In terms of tracking their own activities, particularly performance on their strategic plans, 76% of LSP business managers who responded to this survey question (N =41) agreed that action points from strategic meetings are followed and reviewed to ensure accountability and progress, whereas 10% disagreed with this statement. One of the case review reports analysed as part of this study recommended that the LSP create joint arrangements for 'monitoring the impact and effectiveness of revised working arrangements' (SCR, 22). In the absence of detailed national guidance, inspections were also cited as a key source of information about what is considered 'required' or 'effective' in respect of EFH. 83% of survey respondents stated that they were using inspection frameworks, and associated reports, to inform the development of their strategic response to EFH.

Monitoring strategic activity – conclusion

In respect of monitoring and impact therefore our study suggests that case reviews and audits are a central feature of how LSPs review the efficacy of local strategic and operational arrangements. However, there is no clear baseline against which the findings or these processes can be measured – neither for an individual LSP nor in terms of national performance. Recommendations may be, and have been, made, via case review and inquiry processes; but this is often based on what may have assisted in any given

individual situation rather than to ensure alignment of LSP performance with a set of national expectations. Moreover, it is unclear what a good set of LSP outcome measures would be in respect of EFH. For example, children and young people having access to an adult they trust is considered important for those impacted by EFH; but it is not clear if any LSPs are tracking the extent to which children and young people open to local services due to EFH believe that they have access to such a relationship. Or for issues such as 'disproportionality', which have been routinely identified in studies into EFH, the current approach of LSPs to track this dataset is not a clear means of measuring efficacy in terms of addressing racism within the delivery of systems and services.

5.2.5 Training

Training was referenced as a facilitator of practice improvement across our dataset.

82% of survey respondents stated that the LSP had been able to develop and offer CPD as part of their local response to EFH.

In the six case study sites, participants described the provision of training as a key LSP function and noted that general training on the nature of different forms of EFH, and the language used to describe both the harm and the children and young people affected, was a key tool in building a shared understanding of the issues across local partnerships. National interview participants also commented on training as a means by which to agree 'partnership expectations around language'. Case review reports also routinely noted, or recommended, the use of training for raising awareness of the nature of EFH. A more specific feature of this form of training pertained to the issue of 'adultification'. 10 case review reports in our database addressed the issue of 'disproportionality' by making recommendations for training on adultification. Such training was positions as a lever for assisting practitioners to recognise the vulnerability of racially minoritised children and young people, and the ways in which their own approaches may leave such children and young people without support or protection.

In short, training was viewed as a core LSP offer, with potential to build a shared understanding of harm and help professionals reflect on how their language, assumptions and responses to particular groups of children and young people can affect the ability of services to offer protection. Some case study sites reported that training on EFH had been commissioned regionally, and that doing so had supported key partners to build a shared understanding of the nature of EFH across a larger geographical area. However, approaches to training shared with the research team in many ways mirrored the established evidence base in REAs – it was focused on the nature of EFH and the children and young people who were affected rather than the nature and limitations of local systems and processes. This study has shown that there is a real need to move research, training and policy beyond explaining to professionals what EFH entails, and

towards what a response to EFH should entail; particularly when that response is gradually developing and requires significant system and service transformation.

Study participants also identified a need for training on the practice approaches taken to safeguarding children and young people from in EFH in their local area. As noted previously in this chapter, professionals commented on a need for training to assist, for example, in how 'thresholds' were understood and applied locally, given that the position on this differs across LAs. Those directly involved in multi-agency arrangements also called for specific training, and space to reflect, on their specific roles within those arrangements:

> *"I don't think there's any specific training really when you take over as chair, or when you take over as a member of those panels, that says this is what's expected of you, this is what you come in and this is what the need is. Obviously, we've got the [anonymised] Protocol that's being released or it will be released soon to kind of give some guidance, but again there needs to be some specific training [on]... knowing what you should be bringing and what is used for those meetings."* (National focus group)

We identified pockets of more specific training on ways of responding to EFH; for example, in one area participants talked through their training offer on 'community guardianship', as a means to building networks of trusted adults in local communities:

> *"And we offer kind of, you know, that community guardianship training package....it feels like a really, really good piece of work when you actually get out in the community and you talk to people who know what they're talking about. It's good. It is good."* (Focus group, case study site)

However, such examples were an exception, rather than a rule, and were driven by those involved in local operational approaches rather than consistently commissioned by those overseeing strategic arrangements, such as LSPs, in line with strategic priorities. Our evidence suggests that there was a need for shared understanding of *responses* to EFH, whereas training was more likely to be focused on building a shared understanding of the nature of EFH. Understanding the nature of EFH is a good starting point to building cultural norms conducive with effective safeguarding responses to these issues; however, how the issue is responded to also shapes that understanding. Opportunities to learn and reflect on the nature of responses appeared a critical gap in many areas who participated in this study. All case study sites commented on the usefulness of mapping out and reflecting on local strategic and operational arrangements as part of this study, and how they had not had an opportunity like that to date.

5.2.6 Planning and commissioning

When asked what factors were facilitating responses to EFH, only 53% of survey respondents identified that they had the resource or capacity to effectively respond (compared to 82% who had access to training). All case study sites noted that pressure

on local resources and stretched capacity undermined the efficacy of their responses to EFH; concerns that were mirrored in national interviews.

Resource challenges raised by study participants included:

- Challenges related to housing, both overcrowding pushing children and young people into public places with peers, and resource-gaps making it challenging to rehouse families impacted by serious violence (raised by case study sites and national interviews)
- Pressure on special educational needs and disability services, particularly waiting lists and ongoing delays in ASD assessments, and the ongoing impact on providing suitable and stable education placements for children and young people (raised in all six case study sites, case review reports and national interviews)
- Limited access to mental health and public health services – such as lengthy waiting lists for mental health support associated with trauma, of services that lacked the agility to meet children and young people where they were at (raised in case study sites and case review reports)
- Pressures on the care system, particularly limited local options to place children and young people in or near their home community care, limited secure beds, and the high costs of specialist placements (raised in case study sites, case review reports and national interviews)

Across case study sites there were also variable levels of investment in youth work. Three had increased investment in youth work as part of their response to EFH, whereas others struggled to offer a sufficient youth work service for children and young people impacted by EFH.

> *"Gone are the days where we had services that were resourced to look at safeguarding as a public health agenda."* (National focus group)

> *"Once we build that trusted relationship with the child, which is sometimes like maybe one of the most difficult things to do, but we're all pretty good at that here, it's like then what? What else can we now offer this family? Over them trusting us to tell us what's going on. But if we've not got the resources and the ability to respond to that, to help them fix that situation, that's just something I really struggle with."* (Focus group, case study site)

Nonetheless, participants in case study sites often framed resource challenges as national rather than local issues. It wasn't clear that professionals believed LSPs could influence and address gaps in services available for children and young people impacted by EFH.

> *"We're all really compromised at the moment financially and so resources are, you know, resources are becoming smaller because of the financial climate that we're in.....and I don't think it's a lack of willing on anyone's behalf, but I really do think that, you know, so for example, in [LA] at the moment we've seen a significant rise in children requiring a level of*

special education, so alternative provisions etc, well that requires significant investment from the Council in order to do that." (Focus group, case study site)

As was the case with findings on training, the limitations and challenges in local systems are reflective of the limitations in research. Our REA surfaced only a small number of studies specifically on system-responses to EFH. Much of the available research has examined the efficacy of discrete interventions that target children and young people but has not focused on the wider systems in which those interventions are delivered. The resource needs identified by participants in this study were not related to EFH-specific or manualised interventions. They were instead related to wider service provision in terms of access to education, housing, health and relational support via youth work not tied to a specific EFH concern. Commissioning for responses to EFH are often driven by national decisions about various funding streams, and these in turn are drawn upon by LSPs to resource local practices; even when what is being commissioned is not what is needed. For example, a local area may know many children and young people in their local area who are impacted by EFH and who need expediated assessments for ADHD or access to safe housing. However, the resource they have access to is to fund time-limited interventions, such as knife-crime awareness activities or mentoring services, that appeared to be available in many of the areas who participated in the study but were not described as the types of responses that children and young people had requested:

"When, again, central government doesn't join up the dots itself.....it just funds us and, even within the serious youth violence space, I think we've got six or seven programmes at the moment that are being funded, all doing different things and what we're trying to do is to bring them together to say 'who are you working with, which young people, what's your end of the threshold, what are you doing, are you doing mental health, are you doing skills, employment, which bit of government do you speak to, the health and well-being aspects?' .....trying to make sense of it locally relies on people wanting to work together ... Otherwise, we end up with kind of mutual loathing, suspended in pursuit of cash because we don't know when funds reduce, which partnerships are going to be funded or, you know, what's the next bit covered by the Duty. But we don't know when that funding is going to end." (Case study site)

These resource challenges may well intensify further with current cuts to ICBs and forthcoming reforms to children's social care in England, which may all impact staff capacity.

5.2.7 Views of children and young people

Children and young people impacted by EFH, and their views on services, rarely appeared to shape strategic activities of LSPs. Of the 21 strategies analysed for this study only 10% (n=2) shared the views of children and young people. 53% (n=11) of the strategies referred to the importance of children and young people's voices in service development and/or evaluation but did not illustrate how this recognition was acted upon in terms of strategic planning. When children and young people's participation was framed as

important, national strategies were often referenced to support this position. Two strategies also included goals around hearing from children and young people, as something to work towards and an outcome measure of success, rather than something that had informed strategic thinking to date.

When children and young people's views were included, some quotes focused on their experiences of harm rather than what they needed or wanted from services. When recommendations to services were made, children and young people focused on: the importance of consistent relationships; being seen as a whole person rather than a 'case'; and needing professionals to be creative in supporting them as well as maintaining a 'calm' approach to planning support given that other elements of their lives were 'scary' enough. One of the two strategies that directly referenced children and young peoples' views also linked those views clearly to strategy development. Another strategy listed capturing *"the voice of the child to inform service delivery and development"* as a positive 'measurable' outcome. 29% (n=6) made no mention of the children and young people's voices at all.

In national interviews we were offered one example of a local area that used national research to summarise what young people had already shared about experiences of EFH and then took that summary to their young mayor to engage children and young people in a discussion more widely.

The low visibility of children and young people's views in strategic approaches to EFH mirrors what we also found in operational arrangements. Only two of our six case study sites had children and young people attend *any* meetings where support for them was discussed/agreed. Many participants were not confident that children and young people could be safely or effectively involved in meetings, or had to rely on practitioners to represent them instead:

> *"We were starting to think around how young people are excluded from the conversation at the minute and trying to bring their voices into the discussion more. We have some challenges in terms of our practice at the minute so often that voice is missing. So, we've talked about how we can be a bit more formal in terms of bringing the young person on the agenda and ensuring that the practitioner has a conversation with the young person, definitely."* (National interview)

> *"We do get the child's voice on that. They're not part of the meeting but usually the social worker will get the child's voice and obviously the parents are spoken to about it [safety planning] as well and get their point of view."* (National interview)

To this extent then the strategic priorities of areas often reflect practitioner concerns/priorities, for example improving information-sharing arrangements, as opposed to children and young people's priorities such as being heard in decisions that affect them. LSPs appear to need much more support to identify ways to meaningfully hear children and young people's views and act upon them, rather than solely needing

support in getting children and young people to tell them things. Those children and young people whose views were shared already noted that they did not want to repeat themselves to different people. As such the question is not only how LSPs hear from children and young people impacted by EFH, but also how do they respond to what they had been told already and reflect that they have done this in strategic priorities and operational arrangements?

5.2.8 LSP ability to meet expectations: conclusions

In summary, therefore, our study identified that LSPs were meeting some expectations in relation to EFH more than others. In many respects the work of LSPs needs greater depth to create the conditions conducive with effective operational practice responses to EFH.

Children's services and the police are providing leadership in strategic responses to EFH; however, such leadership between the two agencies is at times in conflict. Policing leadership on EFH, particularly in terms of protocols, thresholds and risk categorisation, in sometimes taking precedent over social care thresholds, without evidence that LSPs have discussed the operational implications of this approach. It is also challenging to establish consistent and effective leadership from health, education, housing, youth work and VCS services due to resource constraints and fractured levels of influence; yet their involvement is essential to effective responses to EFH

The above challenges in leadership are reflected in work around strategic coordination. Most data on coordination focused on partner involvement in meetings, sign-up to procedures, and engagement in information sharing, rather than surfacing and resolving the challenges that come with these activities in respect of EFH.

LSPs are inconsistent in their approach to develop EFH strategies and policies. Many do not include all forms of EFH in current strategies, such as excluding serious violence or harmful sexual behaviour, and some do not have any form of EFH as a strategic priority.

LSPs are using audits, case reviews, inquiries and inspection reports to review their approach to EFH; and the rate at which they are doing so is increasing. More work is required to develop shared outcome frameworks or markers of efficacy against which they can monitor strategic and operational performance in respect of EFH.

LSPs have invested in training, and most participants noted this as a consistent contribution that LSPs have made in developing local responses to EFH. To date, most training has focused on the nature of different forms of EFH; supporting professionals to identify the harm, particularly amongst children and young people less likely to be perceived as vulnerable (such as those who are racially minoritised, older or male). However, training now appears most needed in how to respond to EFH; with recognition of local variations in approach, and associated strengths and challenges.

The views of children and young people impacted by EFH do not appear to have consistently shaped the strategic direction of local responses to EFH. LSP strategic priorities are more likely to reflect the views of practitioners – such as improving information sharing – which do not always reflect the views of children and young people – such as reducing churn in the relationships they trust.

As such, while activity is underway in most areas of LSP responsibilities, there is space to either add depth, build consistency, or work with complexity, to facilitate effective operational responses to EFH.

5.3 The facilitators and barriers to meeting these expectations of LSPs

RQ3 asked what facilitated, or acted as a barrier, to LSPs meeting the expectations as outlined above. Across out dataset we identified fewer factors that were facilitating strategic leaders to meet their expectations, than factors that were acting as barriers. The absence of key facilitators in case study sites meant that some participants identified barriers locally, even though addressing them would require action at a national level.

LSP survey respondents stated that they required additional national guidance on multi-agency governance arrangements in respect of EFH (30%), followed by data-sharing requirements and legal gateways (17%), commissioning responsibilities or funding (11%), the role of ICB/Health Boards (9%), the interface between safeguarding and disruption activity (9%), and thresholds for identification or referrals (6%). These needs reflect in part, current facilitators of, and barriers to, effective practice of MACE (or equivalent) panels, and alternatives to them, detailed in chapter 4. However, there are also things that practitioners would look to the LSP leadership to resolve.

In total we identified five themes across our dataset that reflected both barriers to, and facilitators of, LSP responses to EFH:

- 5.3.1 Leadership
- 5.3.2 Duplication or gaps in strategic arrangements
- 5.3.3 Information sharing and shared terms of communication
- 5.3.4 A reactive landscape with lack of space to reflect
- 5.3.5 Lack of, or limited, resource

We detail each of these in turn before sharing insights about local and national changes that could address the barriers identified in this section.

5.3.1 Leadership

Information gathered across all data collection activities suggested that leadership is an important facilitator of effective strategic responses to EFH. However, our study surfaced varying views on the extent to which such leadership was being provided by LSPs.

Survey respondents were mostly confident in the ability of LSPs generally to provide leadership on the issue of EFH. 95% felt that leadership commitment was currently helping the development of local approaches. When asked about national policy expectations for LSPs, 79% of survey respondents felt that national expectations on policing were clear, 73% felt the same for LAs, 65% for ICBs (England only) and 64% for LSPs as a whole.

This complex and inconsistent viewpoint was also reflected in national interviews, case review reports and case study sites. LSP members are often organisational or sector 'leaders' and so by default demonstrate some form of leadership. However, the MACE (or equivalent) element of this study (chapter 4) indicated a need for LSP leadership on key matters relevant to EFH such as the relationship between justice and welfare goals, or on setting a shared culture for multi-agency safeguarding practice. All partners attending meetings, or sharing chairing responsibilities, will not in itself facilitate effective safeguarding practice if a shared culture and shared goals/outcomes for EFH have not also been established. This level of detail is not afforded sufficient attention in national guidance. Consequently, it is not a level of detail against which performance of LSPs might be assessed or considered.

What was more common in local areas was effective leadership being provided by individuals (rather than any specific sector or LSP member). These individuals had varying levels of responsibility, and were not necessarily members of the LSP, however they championed and led the local response to EFH. Participants in national interviews and focus groups stated that it was often leadership provided by these individuals that impacted local responses to EFH:

> *"Where I see really successful partnerships working, it's where those individuals have got a passion and a commitment and prioritise the partnership of all the things within their core business shall we say. So, they're always at meetings, they're always there, they're driving it, they are visible, they champion it."* (National interview participant)

> *"[At a recent meeting] the Chief Super was amazing in terms of their input into it, really taking responsibility for cross cutting themes and whatever. So, if you get the right people with the right skills, even when they're juggling, they'll escalate internally."* (National interview participant)

One social care participant reflected that in playing this unifying role, they worked across agencies to develop a shared approach or set of priorities, stating "*I always say I'm trilingual. I can put things in health language and police language"*. 97% of survey respondents recognised the influence of individual organisational leads, and the impact they had on local responses to EFH.

We observed this influence from individuals who championed or pioneered the work in case study sites. Often the same individual would be present at various key meetings. They took a particular interest in EFH and championed the issue amongst wider partners whose interests/concerns were often broader than EFH. In geographically smaller case study sites this approach created good synergy between operational and strategic arrangements. We observed the same professionals who were chairing operational panels attending strategic planning meetings on EFH in four of the six sites. When this type of connectivity was not possible, often due to the geographic/population size of a site, operational challenges were not necessarily understood, recognised or prioritised by strategic groups. In some sites individuals provided a bridge between operational and strategic structures, but this was not possible in others.

Relationships were often cited alongside leadership as facilitative of effective approaches. One participant in the national interviews and focus groups shared that their relational approach had been praised by inspectorates. A restorative approach of working across agencies was embedding a culture of relational practice across various levels of service leadership. Similarly, a participant in a case study site commented on the time it takes to build effective relationships across partnerships:

> *"So when we are thinking about kind of our work with our partners it can take a long, long time and a lot of continued concerted effort to have those relationships at a really effective point, and I think that there does need to be an effective relationship in order to influence effective multi agency working."* (Focus group, case study site)

This narrative of trusted relationships is again a common feature of wider research into EFH – but in research this is largely considered in respect of what children and young people impacted by EFH need, as opposed to what professionals who support them also require.

5.3.2 Duplication or gaps with other local strategic arrangements

As illustrated in the maps produced at system mapping workshops (Figures 1-6), LSPs held strategic oversight of EFH in a complex and busy landscape. A central challenge of this was overseeing an operational process that straddled the responsibilities of safeguarding and community safety partnerships. Each entity is underpinned by distinct legal frameworks, and although those frameworks suggest each should coordinate with the other – and that children and young people's welfare should be paramount – the lack of clarity about how this might be achieved is evident in local arrangements.

Beyond this gap, the issue of EFH also straddles various other issues, and can be embedded therefore in different LSP sub-groups, policies or commissioning decisions, rather than solely being addressed in its own right. Examples of this, both in case study sites and in samples of LSP strategies, included intersections with strategic oversight of:

- Neurodivergence and/or special educational needs
- Transitional safeguarding – support to vulnerable 16–25-year-olds
- Child sexual abuse (in which extra-familial sexual abuse would be included)
- School attendance and inclusion
- Racism, disproportionality and race equity
- Serious violence and/or organised crime
- Domestic abuse (the impact on both children and young people of abuse who experienced between caregivers, and children and young people who faced abuse in their own relationships)

Responses to some of these issues are coordinated under the LSP, some are coordinated under Community Safety or Safer Communities partnerships and others under Adult Safeguarding. We identified attempts by LSPs to build unified strategic oversight at the intersections of these issues, but we did not identify evidence that these attempts were effective – or were resolving the complications of operational responses outlined in chapter 4.

In this context local and national datasets evidenced duplication in the system.

> *"What are we looking to achieve and is it trying to do too much? Is it trying to cover off too many things in one meeting space and is it duplicating on processes that are currently already in place or may not be happening other places…"* (Focus group, case study site)

Welsh participants noted further complications in respect of safeguarding arrangements being determined by devolved policy, while community safety arrangements were shared across England and Wales. This further reduced the capacity of local leaders to build a coherent, integrated, strategic framework in which operational processes could be consistent. Instead, practitioners were creating workarounds based on their own understanding of local need, rather than waiting to find resolution across the various levels of decision-making at England/Wales, Pan Wales, Police Force and LSP levels:

> *"It doesn't feel that we'd wait for something to come from the board. We just crack on with it ourselves and kind of understand and we, you know, I think sometimes [anon] Police because they cover the [multiple] authorities that they would like a more uniform [area] wide approach…. except that [our area] we are in a bit of a hotspot, so they focus their thoughts and energies on some of the responses that we're looking at and we look at these quite creatively because we have too."* (Focus group, case study site)

At the local level, differing geographical boundaries between services were also described as a source of frustration, contributing to inconsistent operating models and difficulties with information sharing. LSPs were described as operating with and withing the following levels of geographical borders:

- LA level – with some LAs determining their own safeguarding arrangements/pathways for young people impacted by EFH – as was evident in all

six case study sites, with each LA developing a slight variation on their safeguarding pathway (and its relationship to wider panels).

- LSP level boundaries – sometimes with multiple LAs held under a single LSP. These arrangements often agreed additional protocols – including pathways and assessments – that governed operational approaches and put in place information-sharing MOUs.
- Police force level – which sometimes covered more than one LSP area and also had their own protocols, arrangements and teams; devolving different types of EFH to different command structures (decided at force level – which will likely change again as the structuring of police forces is set to change) and setting their own thresholds for involvement in safeguarding activity;
- All Wales and England-only level – safeguarding legislation/policies (and reforms);
- Pan England-and-Wales level – arrangements in terms of policing and community safety legislation.

5.3.3 Information sharing and shared terms of communication

Information sharing was viewed as critical in developing effective strategic responses to EFH. Most case review reports in our dataset recommended that LSPs demonstrate leadership in clarifying expectations related to information-sharing and/or by putting in place information-sharing protocols to facilitate local practice. Some site case study participants expressed how useful this had been in improving coordinated responses:

> *"I would say definitely a key marker [of effectiveness] is open communication, but it's just so fantastic when a group of professionals, we're kind of all working together, all sharing relevant information, obviously, and you know appropriate consent, but it just is so helpful for us to get the big picture, especially contextually because, you know, every professional has got their own little bit, haven't they? It's like a big jigsaw. It's like the proverbial jigsaw of information."* (Focus group, case study site)

However, local LSP representatives and national interview participants, described how challenging this was to realise:

> *"One of the challenges I have is how effectively we can work to safeguard young adults who have their own, you know, have their own rights and care leavers and information sharing. And, you know, the absence of protocols in relation to that."* (Focus group, case study site)

> *"Every single time, information sharing and consent are the biggest issues. A reluctance to share a reluctance to store information, a reluctance to talk about children that are related to or linked to children who are not residing in their local authority area."* (National focus group)

National survey respondents echoed the same concern: only around half experienced current data and information-sharing arrangements as an enabler of safeguarding practice. Moreover, LSPs were focused on the topic of sharing 'data' in respect of mapping local patterns and needs, as well as establishing protocols for sharing

operational information to coordinate practice responses to children and young people and the situations that they were in.

Moreover, case review reports and national interviews raised a challenge around information sharing across borders. Specifically, they cited an inability to share 'data' or 'information' about individual children and young people across borders when those children and young people were placed in other LAs or were educated across LA boundaries, particularly in respect of education and health, preventing services from knowing what they needed to in order to develop protective plans.

The strategic views about information-sharing offered in interviews, national policies, and case review reports, did not reflect the operational needs we summarised in chapter 4. Strategic work on information sharing has prioritised communicating a need to share information, to ensure that all partners share the same expectations in regard to this need, and to unlock any identified barriers in the process – as has the most recently published draft guidance on the new information sharing duty (HM Government, 2026). In short, the strategic narrative is about ensuring information is shared. Whereas the operational challenges identified about information-sharing (chapter 4) relate to clarifying the purpose(s) of information-sharing, and needing guidance on information-recording, acting upon information that is shared, and proportionality when sharing information in terms of what is shared and about whom.

5.3.4 Reactive landscape without space to reflect

Some participants reflected upon the reactive landscape in which LSPs were trying to meet expectations placed upon them, and how little time this gave for them to reflect on their approaches and respond accordingly. As stated elsewhere in this report, in all six case study sites, system mapping workshops afforded partners a rare opportunity to reflect upon the pathways they had in place to respond to EFH, as well as identify gaps and points of duplication.

Without this space, local leaders found themselves reacting to various pressures within and around systems – which risked further fracturing operational approaches – and introducing more policies, protocols and requirements into a system that was already extremely busy.

> *"… it's missing the point but hitting the target type of thing, I feel that's what happens. So, it's like going full loop and then it will change again…this is why I describe it like quicksand because it changes so quickly for professionals who are engaged in the process, they often disengage because they're not sure about what their role is."* (Focus group, case study site)

"So, at one point it would be predominantly CSE, then it would predominantly be CCE. Then there's a focus on serious youth violence and knives." (National focus group)

"Very powerfully I feel the lack of space to reflect on effectiveness - what's the point of strategic meetings if you're not having any impact on children's safety, need to do some 'radical rethinking', split between strategic and operational but need to be both, need to see change 'on the ground." (Focus group, case study site)

LSPs have not necessarily had the space to pause and think about the various requests they have responded to in respect of EFH – and the extent to which, what they are prioritising strategically, is what is needed operationally. In the absence of this space to pause, key strategic priorities may be addressed through short-term tasks, such as the commissioning of training, rather than deep thought and associated system redesign. The LSP response to the safeguarding needs of Black children and young people is one such example of this (see sub-section 5.4 below).

5.3.5 Lack or loss of wider services

Finally, as detailed in the point on resources in the previous section, LSPs are hindered by constrained budgets and the consequential loss of services:

"Why don't we get our heads together and we embed this because we can, do you know what I mean? And then there's like things that we could potentially embed if we had like a wish list of X amount of money." (Focus group, case study site)

"Sadly, because we have got less resources. Like nationally, I don't mean just (Site Name) in general. You know we're not able to refer to services that maybe 10 years ago, 15 years ago existed. But you're still working with practitioners that remember those services from 10-15 years ago. And it's like, yeah, we're in a different world now." (Focus group, case study site)

The funding landscape is often short-term, drives the use of intervention and issue-focused responses. Whereas partnerships often require the resourcing of core services to take a need-focused approach to supporting young people across the various 'issues' under which EFH is categorised. It was not clear from our dataset how LSPs might resolve this type of challenge; it is more a factor for them to be aware of and seek to mitigate.

All the barriers identified in this section of the report we see replicated at operational, strategic and government levels; and as such they would require resolution at all those levels for LSPs to meet expectations as they apply to EFH.

5.3.6 Facilitators and barriers to meeting expectations: conclusion

To facilitate improvements in LSP responses to EFH, and address barriers, this study identified five key issues.

The first of these is leadership. Our data suggests that relational, restorative and trusted leadership can facilitate LSPs in fulfilling expectations regarding EFH. However, evidence collected across case study sites suggests that strategic leaders need to address tensions between social care and policing and establish a shared culture between these sectors in which children and young people's welfare is paramount. This is necessary if LSPs are to provide leadership that improves inter-agency operational responses to EFH.

Second is duplication or gaps in strategic arrangements. LSPs need to be intentional in addressing the relationship between safeguarding and community safety legislation, and processes, to create the conditions for consistent operational approaches. Current duplication, particularly on serious violence, between Community Safety Partnerships and LSPs creates strategic conditions in which parallel rather than integrated operational approaches will develop. Further consideration is required of what this means in a Welsh landscape, where children's services responsibilities are devolved but community safety and policing are not.

Third, LSPs require space, and support, to offer detailed and more nuanced leadership on information sharing; that sets out the purpose, parameters, and partnerships in which information is shared, with a primary purpose of safeguarding children and young people's welfare.

Fourth, LSPs require support to move beyond reactive responses to EFH and reflect on what an integrated approach to these issues means. This includes mapping local arrangements, and understanding the tensions within them, across various harm types.

Finally, LSPs require resource to do all of the above; particularly in ways that ensure children's social care are resourced to meet children and young people's needs, and where youth services are available to respond to EFH in context. Presently, budget across LSPs and Community Safety Partnerships for EFH responses have not been drawn together, creating conditions in which policing responses can be better resourced than those that are welfare orientated.

5.4 Addressing racial disparities in support

RQ4 asked whether current law, guidance and practice guiding the work of strategic partners, was exacerbating or reducing racial disparities in support for children and young people impacted by EFH. In keeping with the conclusions of the 2025 CSPRP Panel report on race and racism in child safeguarding, and the data collected about MACE (and equivalent) panels (chapter 4), our findings on the work of LSPs evidenced a general silence on racism, and an oversimplification of the drivers of racial disparities, which both risked exacerbating issues faced by racially minoritised children and young people.

Various reports and campaigns have identified racism as a safeguarding issue (Agboola and Firmin, 2023; CSPRP, 2025; Davis, 2026), yet this specific assertion is not reflected in safeguarding guidance or law. In terms of the law, the key legislative tool is the Equalities Act 2010, which establishes race and ethnicity as a protected characteristic. In this regard responses to EFH could be subjected to an Equality Impact Assessment, but this does not seem to have been undertaken in our case study areas or nationally. Wider research evidence suggests there would be merit in doing this.

Hood et al.'s (2023) analysis of children's social care assessments has found England-wide trends in the application of child protection processes for racially minoritised children and young people impacted by EFH. They found that children and young people assessed as only impacted by risks outside of the home were disproportionately Black, older, male and rarely progressed to child protection plans. Whereas children and young people assessed as impacted by both risks outside of the home and within the home were disproportionately White, female and were more likely to be supported by child protection plans. Moreover, the annual report of the National Child Safeguarding Practice Review panel (CSPRP, 2024) and their thematic report on Child Criminal Exploitation (CSPRP, 2020) cited disproportionality in respect of the identification of Black children and young people impacted by serious violence and criminal exploitation. It will be the case therefore that these children and young people will also be disproportionately impacted by local activity undertaken in response to the Serious Violence Duty, and the associated oversight from Community Safety Partnerships that will come with the enactment of that duty. However, no such equality impact assessment has been completed to understand or address this risk.

Safeguarding guidance provides limited direction on how to address these issues. Working Together to Safeguard Children 2023 made five references to 'protected characteristics' in general. Updates to the document in 2026 include four explicit references to racism, and the need to adopt anti-racist approaches in practice. These insertions create a strong basis for multi-agency operational and strategic safeguarding partnerships to pay greater attention to the nature of the response they deliver; however, the document itself does not offer much in the way of detail about how this might be achieved. In respect of LSPs, the guidance cites the Equalities Act when it requires that 'safeguarding partners must assess and where appropriate put in place measures ahead of time to support all children and families to access services, overcoming any barriers they may face due to a particular protected characteristic' (2023: 13). In Wales, CSE guidance references 'ethnicity' on three occasions, stating:

> *"…ethnicity can affect the degree to which services can be considered equipped to meet the needs of children who are Black, Asian and Minority Ethnic. To work effectively with children from Black, Asian and Minority Ethnic communities it is crucial that practitioners have an understanding of any additional vulnerabilities and particular barriers to reporting CSE faced by children."* (Welsh Government 2021: 41)

At this stage, supplementary guidance, such as Home Office CCE guidance for example doesn't engage explicitly with race, racism, ethnicity or minoritised young people but it does specifically make comment on disability; therefore lagging behind safeguarding guidance.

Data from this study indicates that local areas are finding these broad policy statements and legal frameworks challenging to implement for children and young people impacted by EFH. LSPs largely enact any responsibilities to address racial disparity through the provision of training and the collection of data to monitor trends. In terms of training, national interviews, case study sites and case review report data all referenced investment in training on adultification. In relation to data, participants commented on the challenges of building a dataset to sufficiently identify and understand disproportionality in local systems:

> *"So, in an ideal world, all we need is ethnicity mandated on the system [for victims]. That's a simple answer, and it's been explored multiple times and it's not that simple."* (National interviews)

> *"I don't think we're there yet with any confidence to look at profiles of ethnicity and exploitation."* (National interviews)

> *"Data is our biggest barrier to effectiveness…They need to also understand data in locations and disproportionality – the need to be asking the right data to know if they are making a difference, are they having an impact."* (Focus group, case study site)

As summarised in chapter 4, across all case study sites, participants stated that their systems did not operate differently when responding to Black children and young people, despite all identifying disproportionality in elements of their systems.

Surrounding this view was a broader discomfort and difficulty with knowing how to talk about racism, and respond to it when identified:

> *"Have we got problems with practice as a result of either legislation or guidance in relation to race?' The honest answer is we don't know. We can't tell you. The reason being when we are reviewing cases, even at the very start when I'm asking agencies contributing information to reviews: 'what were the protected characteristics of this individual? How did you adapt your response accordingly?' They can't even tell me what the protected characteristics are. And quite often they don't know what that means. So they'll return some information, for example, that says 'no, they didn't have any', which obviously isn't the case. So (A) organisations not knowing what protected characteristics are, (B) they're not recording them and (C) they're not able to evidence how they've responded to families as a result of their particular characteristics. So we don't know is the answer."* (National interview participant)

> *"Disproportionality is a national issue and evidence is available to suggest that this has been a reoccurring priority area for the UK Government dating back to 1995, with all reports concluding with some elements of being complicated and difficult to unpick, whereas*

fundamentally disproportionality is about how boys and girls from minority ethnic groups are treated unequally by systems that should be equally applied to all." (SCR 14:21)

A very small number of participants were able to name ways in which they had taken strategic action to recognise and respond to systemic drivers of disproportionality in their response to EFH – particularly in respect of school exclusions and language:

> *"[We're] looking at the groups of children that are overrepresented in various different parts of the system, understanding what anti-racist and anti-discriminatory practice should look like. And that's not just in service delivery but how we engage with each other in the workplace as well. How we understand anti-racism and the context of what's currently going on in the world for our children, young people and how we racialize issues within schools that lead to children being outside of the system. So, it's something that we're active about. We know that we need to do more and we are doing more. But we have to start have to start with the basics. All of us within our own organisations, examining the role of racism and discriminatory practice within our own systems that contribute to children being in a place of risk."* (Focus group, case study site)

> *"Making sure we're writing about them in a child centred way, ensuring that we're not kind of using criminalising language or adultification language and our police partners are really on that now."* (Focus group, case study site)

However, case review report authors noted that while data on issues like school exclusions evidenced discrimination, partnership action to address the issue was noticeably lacking. National interview participants from VCS organisations commented that they were seeing fewer preventative referrals for children and young people who were racially minoritised. As a result, often more serious incidents involve these children and young people, who had not benefitted from earlier support.

In short, when it comes to racially minoritised children and young people, LSP practice largely focuses on gathering and monitoring data on disproportionality, and commissioning training on adultification to change attitudes. LSPs need to build upon this by reviewing the design of systems (locally and nationally) to identify, and address, sources of discrimination *within* responses to EFH. A lack of attention to system design risks exacerbating the issue of racial inequality and fails to give professionals a language through which to understand why disproportionality exists. The CSPRP (2025) report on race and racism was referenced by some professionals who participated in this study, as a useful talking point to initiate a move to action on racial disparity in this direction, but these examples were rare and in the early stages of development.

5.5 System and practice changes

As was the case with findings related to MACE (or equivalent) panels and alternatives to them (chapter 4), the system and practice challenges identified for LSPs are shaped by wider, national system shortcomings. As such, while we have identified changes to law, guidance, funding and inspection that have the potential to improve the work of LSPs,

such changes are less about those partnerships and more about the conditions in which such partnerships operate.

5.5.1 What changes should be made in law, guidance, funding and inspection to improve LSP responses to EFH?

The findings of this study suggest that LSPs are working within a crowded and inconsistent policy landscape. Additional policy and guidance are unlikely to resolve this issue, and could complicate it further:

> *"We definitely don't need more policies. If anything, it's about taking a step back and seeing what we have got and how they all fit together. But it is about bridging that gap between policy and practice for me."* (National interviews)

What our study has evidenced is the need for better integration of existing legal and policy frameworks that shape strategic responses to EFH. At present, integration is being attempted locally, but on each occasion, it takes extensive resource and is complicated each time a new national announcement is made; be that prevention panels for children and young people, or the prioritisation of 'knife crime' or 'incel culture'.

As such, our data suggests that LSPs would benefit from four changes to national law, guidance and funding to improve their response to EFH:

- The Government to provide a framework that unifies legal tools used to respond to EFH
- The Department for Education to lead on a cross-government strategy to respond to EFH
- The Government to work with LSPs and Community Safety Partnerships across England and Wales to build a shared outcomes framework for responses to EFH
- National funders and commissioners of services (including What Works Centres and Violence Reduction Units) to resource responses to EFH that meet children and young people's needs and go beyond discrete interventions

We detail the rationale for each of these below.

1. *Government to provide a framework that unifies all legal tools relevant to the issue of EFH*

   Such a framework would assist LSPs in making sense of how to fulfil legal duties related to children and young people safeguarding, equalities, serious violence, crime and disorder, adult safeguarding, and educational exclusion in situations of EFH. At present these frameworks to address these different topics are drawn upon independently of each other, and when they are in conflict there is no clarity around which should take precedence. As such, any unified framework needs to provide clear direction of the use of the paramountcy principle in situations of EFH, and how to realise this for children and young people who straddle victim-perpetrator identities.

This would mean that where a Black child or young person is criminally exploited, both experiences and uses serious violence, is subject to civil orders linked to perceived anti-social behaviour, has been excluded from mainstream education, and is approaching adulthood, there would be one coordinated policy response to draw upon in response to their situation rather than several disparate and potentially conflicting ones. These scenarios are highly complex. LSPs may therefore need a nationally integrated framework to support the development coordinated responses, rather than being expected to resolve overlapping and potentially conflicting policy expectations locally.

2. *The Department for Education to lead the development of a cross-government strategy on EFH*

   A cross-government strategy on EFH would provide opportunity for greater cross-government alignment on various tensions surfaced in this study. For example in: clarifying the relationship between welfare and crime policies when responding to children and young people impacted by EFH; drawing together work on prevention panels and ROTH child protection pathways to form an integrated approach to EFH across the spectrum of children's services support; removing the separation of teenage relationship abuse and criminal exploitation policy coming from the Home Office, and sexual exploitation policy led by the Department for Education; including consideration of government priorities around special education needs support; providing a unified account of the resourcing available for services for children and young people impacted by EFH which would include youth work, housing and access to education; and in providing an equality impact assessment of all of the above.

3. *Department for Education to work with LSPs and Community Safety Partnerships to develop a Shared Outcomes Framework for monitoring efficacy in response to EFH*

   LSPs would benefit from access to a shared outcomes framework for EFH to which all strategic partnerships, and individual strategic leads, report. Such a framework would offer guidance on outcomes that could be pursued across safeguarding and community safety partnerships, and across children's services, policing, health and education services. These outcomes should reflect and resolve the current operational tensions associated to EFH as well as what children, young people, and families impacted by EFH have stated they most need from services.

   > *"That's a really clear barrier. So even when there was a shared agreement around safeguarding, you know, thinking about police, thinking about education, everyone comes with their own organisational kind of like norms and their own priorities. And that can be really difficult sometimes to align them and make sure that we're all seeing the child first before we think about our own agendas."* (Focus group, case study site)

4. *National bodies need to resource responses to EFH that go beyond discrete interventions – and consider children and young people's needs holistically*

   LSPs require resource to take action on the issues known to impact children and young people experiencing EFH. This would include ensuring children and young people have access core services which are often lacking in responses to EFH, but are identified in assessments of children and young people's needs including increased access to education, assessments and associated plans for needs associated to learning, neurodivergence and mental health, access to housing and the provision of youth work. This type of support is not provided through time-limited and EFH-specific interventions aimed at fixing the behaviours of young people impacted by EFH (such as educative interventions on EFH). For LSPs to meet children and young people's needs in this manner children's services need to be resourced to coordinate support. Data collected during system mapping workshops illustrated that often resource is filtered through community safety and policing structures rather than children's services, limiting the extent to which the support available can be orientated towards needs and not solely (or principally) crime prevention. Our data suggests that there is an appetite to move beyond talking about need and towards addressing it, but current resource restrictions in addition to the approach taken to how available resource is used, impedes local areas from achieving this.

5.5.2 What should Directors of Children's Services do to improve the work of local safeguarding partnerships in safeguarding children from EFH?

Our findings identify a specific role of Directors of Children's Services (DCS's) in three key matters related to the efficacy of LSP responses to EFH: 1, ensuring strategic priorities reflect local operational needs even when they are not aligned to national narratives; 2, ensuring the views of children and young people are shaping strategic priorities; and 3, demonstrating opportunities to hold welfare as paramount. We consider each of these in turn.

Firstly, there was often a gap between national narratives on what was needed in respect of EFH, and operational priorities. It is critical therefore that DCS's, and the partners with whom they work, do not rely on national statements to identify local priorities and instead engage directly with children, young people, families and practitioners to understand what sits underneath those statements in respect of their local services. A good example of this would be the narrative of information sharing. Case review reports and national interviews in this study, along the results of national policy mapping, imply that the key issue with information sharing in response to EFH is that it is not happening. If this was the case the focus of DCS's, and their LSP partners, would be to get more people sharing information. However, the data we gathered on practice in case study sites offers a different picture. Data from case study sites evidenced that a lot of information was being

shared, but often without action being taken as a result. We found far less evidence in our dataset about work happening strategically to address the gap between information-sharing and taking-action. LSPs taking time to map local arrangements, and where within these arrangements information is shared, for what purpose, how it is recorded, and how actions are monitored once information is shared, would be an initial first step.

Secondly, the views of children, young people and families were not as prominent in our dataset as national policy expectations on LSPs would suggest that they should have been. In the context of significant pressure on local services, the concerns of practitioners and service leaders often appeared to drive local responses, over and above what children and young people had said they needed. This study found limited evidence that action to prioritise additional data collection was connected to what children and young people said they needed, but the view of many local leaders was that information and data was the biggest barrier to them providing effective support. DCS's could play a role in narrowing the gap between what children and young people say they need and what services appear to prioritise. To do so, DCSs will also need to consider the data they draw upon to establish priorities. At present, when 'data' is used to justify or shape decisions, it is often derived through service data, such as reported crime data, re-referral data, exclusions data and so on. Such datasets do not necessarily reflect information collected directly from children and young people, such as safety maps and surveys, or their accounts of trusted relationships. While there is a place for both sources of information, DCSs could play a far more central role in creating balance about what is prioritised, and what information is sourced to establish those priorities.

Finally, DCSs play a critical role in holding children and young people's welfare as paramount in all decisions of the LSP and challenging strategic decisions that do not achieve this. This role could go some way in intentionally working through the tension between welfare and criminal justice cultures, goals and language that characterise strategic and operational responses to EFH. In this respect, for example, rather than general training on EFH, DCS's could ensure that the LSP commissions training on what a welfare-orientated approach to EFH might entail and could support the social work workforce in holding this line as a sign of social care leadership in EFH responses.

In summary therefore DCSs could play a role in enhancing LSP responses to EFH by:

- Exploring the extent to which national narratives about system challenges in response to EFH reflect the operational difficulties at play in their local areas
- Ensuring the views of children and young people are sourced and considered when identifying system priorities in response to EFH
- Leading on ways to hold children and young people's welfare as paramount in partnership decisions

5.5.3 How should the government implement the measures in the Children's Wellbeing and Schools Bill to ensure LSPs are protecting children from EFH?

In England, the Families First reforms to children's social care are not EFH-specific. While the 2026 guidance on the reforms reference EFH in respect of multi-agency child protection teams, an absence of detailed discussion on this matter for children and young people in care and in family support structures means the reforms remain at risk of EFH being an afterthought. Such a scenario would reinforce some of the current challenges with LSP expectations regarding EFH: national policies do not stipulate how LSP structures may be enacted specifically to address service challenges in safeguarding children and young people affected by EFH. National interview participants were relatively optimistic about the potential for new arrangements to be used to address some of the barriers surfaced in this study. However, the Government must consider ways to fully integrate EFH into the reform agenda at this juncture, rather than rely on local areas to do this as a localised add-on to wider system re-design.

As such this study raises the following four insights about the ways to approach the implementation of the Children's Wellbeing and Schools Bill:

1. It is important that consideration is given to how EFH will be integrated into the work of multi-agency child protection teams (MACPTs). 2025 and 2026 guidance on the reforms has begun to do this and offers some clarity around EFH being a child protection issue warranting a child protection response. Further clarity is required as to whether this structure will require consistent application of threshold and a unified language for significant harm across partnerships, regardless of the source of that harm. As part of this, consideration must be given to whether any MACE or equivalent panels currently used to coordinate responses to EFH (as detailed in chapter 4) will be integrated into the work of MACPTs so as to avoid parallel case-oversight processes.
2. MAPCTs need to be a structure in which the relationship between social care and policing cultures and practices is managed and resolved. Evidence from this study suggests they will need to operate to a shared multi-agency outcomes framework for EFH against which effectiveness can be considered, and in doing so work through the tensions that currently exist in welfare-crime binaries.
3. MACPTs need escalatory routes that they can access when responding to EFH. LSPs may be able to play a role in developing a consistent shared accountability framework for identifying and responding to system/service drivers of harm as a matter of escalation for children and young people at risk of significant harm due to EFH.
4. The bill enshrines Family Group Decision-Making into local safeguarding practices but is yet to stipulate explicitly whether this will this apply in situations of EFH. For example, it is not clear whether children and young people can expect that wider

community networks of peers and trusted adults could be convened around them for situations where significant harm exists beyond the influence of a family, and increased community guardianship is required. One cannot assume that this application of Family Group Decision-Making will happen without that stipulation.

These insights point to more operational than strategic opportunities of social care reform. Nonetheless, LSPs will need to understand and mobilise on these opportunities in the implementation process to understand what actions they can take to facilitate this direction of travel. Directors of Children's Services currently provide quarterly returns to central government on delivery plans and data in respect of reform implementation. There may be merit in those reports expressly considering EFH in respect of the above insights. Any forthcoming strategic action plans for LSP implementation of social care reforms will need to identify their role in commissioning, training, policy development, coordination, and hearing the views of children and young people, specifically in relation to EFH to avoid this issue being an afterthought in the reform process.

6 Findings: Combined Results

MACE (or equivalent) panels (chapter 4) and LSPs (chapter 5) face similar challenges in responding to EFH; challenges that are informed by system-wide shortfalls. In this sense, the issues we uncover in this report are not simply about MACE (or equivalent) panels or LSPs. Our findings reflect: a) the practice conditions in which the use of panels to respond to EFH have grown over the last 15 years, and b) the policy conditions in which EFH has gradually grown as an area of responsibility for LSPs. We have therefore combined the results of both studies to identify five overarching themes (Figure 13) that characterise these conditions; themes that warrant attention if we are to improve safeguarding responses to EFH across England and Wales.

Figure 13 Combined thematic priorities for MACE panels and LSPs

6.1 Beyond and underneath 'information-sharing'

At the time of writing this report the UK has issued draft statutory guidance that sets out the new information sharing duty and seeks to help organisations interpret and apply that duty in practice. The guidance, and associated duty, reflects concerns of case review reports and previous policy documents associated with EFH which suggest that barriers to sharing information are preventing effective safeguarding practice. To do this, the new guidance reasserts the position that consent is not needed to share information,

information can be shared across agencies, and that neither data protection nor human rights legislation is a barrier to information sharing for the purposes of safeguarding and promoting the wellbeing of children.

However, the findings of this study suggest that rather than further reinforce messages about the need to share information to address EFH, national governments and local strategic partnerships should support practitioners to discuss a series of questions associated with the act of *effective* sharing of information (summarised in Table 7).

Table 7: Questions to guide information sharing

What information is shared?	During this study we observed vast amounts of information shared between professionals, not all of which appeared necessary for safeguarding purposes. This included, for example, sharing significant detail about a young person's skin condition and the weight of another young person, with professionals who did not know them and did not require this level of detail about their health to develop a support plan. It was also not evident that such information changed decision-making in the meetings observed. It is essential that professionals are supported to critically reflect on what is shared and identify the extent to which some information sharing may compromise the privacy and dignity of children and young people with no safeguarding benefit. National polices and local protocols also need to offer distinct advice on sharing information about individuals, sharing information about trends and themes warranting an operational response (that does not include information about individual children and young people) and sharing service data to shape strategic decisions.
How is information shared?	When information was shared in MACE (or equivalent) panels this often took place in large forums of professionals who did not know all the children and young people being discussed. In these scenarios professionals often had to keep looking up children and young people's information on computers as they had no personal connection with them. When personal information was shared in these vast and lengthy forums it was often treated with less care and humanity than in meetings in which one child or young person was being discussed by a group of professionals who knew them and could advocate for them. Large expansive panels therefore appeared better suited to sharing non-personalised and more thematic information about EFH, with individual-focused meetings better able to demonstrate care when talking about children and young people in need of support.
How is information gathered?	MACE (or equivalent) panels often generated actions for practitioners, including youth workers, education staff and social workers, to gather more information. It was not always clear that children and young people would be informed as to the purpose of this information gathering, and whether it was to inform police investigations or broader safeguarding plans. We had questions about the legality and ethics of such actions that warrant further investigation. Do children and young

	people know, for example, that by going into a youth club anything they discuss in that setting that is overheard by a worker, or maybe shared with a worker, may be brought into a multi-agency forum and treated as 'intelligence'? This complex issue requires significant attention from policymakers, particularly in scenarios where professionals are intentionally asked to gather further information without informing children and young people about the purpose for which they are doing this.
How is information recorded?	The move to online meetings meant that some information about children and young people (and their peers) was shared in chat functions during meetings that we observed, as well as verbally and in written reports provided pre-and-post meetings. The processes for storing this information was not clear and, given the potential implications for children and young people (including in the context of AI), this needs greater clarification.
Are children and young people informed about information being shared?	When asked, many practitioners in case study sites stated that children and young people did not know about MACE (or equivalent) panels and so were not aware that they were being discussed in these forums. While consent to share is not be needed for safeguarding reasons, in accordance with Privacy Notices there may be a need for practitioners to ensure that children and young people are aware of panels such as MACE and that information about them is shared with other professionals in these structures. In alternative meetings, particularly those that involved children, young people, and families, this notification was often already in place, as children, young people and their families were invited into those meetings.
Who is information shared about and why?	When MACE (or equivalent) panels held a dual remit – to assess risk for individuals and to identify themes and trends – practitioners shared information about children and young people's friends. On more than one occasion this information included the names, schools and addresses of children and young people who were not open to children's social care, and whose families had not been spoken to about concerns regarding EFH. It was not always clear what would happen as a result of this information being shared, and therefore the purpose of sharing it in the first place. These practices were less prevalent in panels that were solely focused on themes – as themes could be discussed without sharing personal information about individual children and young people. National policies need to clearly state the purpose and legal basis for sharing personal information about children and young people for safeguarding purposes in multi-agency forum, who are themselves not open to, or being referred into, children's social care. Moreover, the actions that are required after such information is shared also needs to be clarified.

What action is taken when information is shared?	The vast quantities of information being shared in panels did not always result in actions being taken. In many observations conducted most of the actions agreed at panels were more focused on gathering further information than coordinating support for a child or young person or addressing the harm they faced. This raises the question of proportionality. If action is not being taken as a result of information shared, often due to a lack of resources or appropriate services, then is it proportionate to continue to share, and record, even more without the likelihood of a response? MACE (or equivalent) panels need to play a far greater role in ensuring information is acted on – and acted on in a manner that safeguards rather than criminalises children and young people. If these actions are not evidenced, it is not clear that the information is being shared for the purposes of safeguarding. Moreover, strategically we were aware that 'data' is being monitored – such as data on the ethnicity of children and young people impacted by EFH – however it wasn't clear what impact this monitoring had, or what actions were taken as a result of this data.

6.2 Coordinated action and accountability

Multi-agency meetings, whether operational or strategic, do not necessarily result in multi-agency actions. The findings of this study suggest significant gaps in the capacity of local partnerships to ***act*** in ways that safeguard children and young people. The presence of a MACE (or equivalent) panel gives a place to an area's 'response' to EFH, and any required escalatory oversight. Yet many of the best practice actions we were informed of did not happen in the MACE (or equivalent) panel - nor was it evident that a MACE (or equivalent) panel was required to facilitate them. These actions took place in multi-agency practice teams described in chapter 4, sometimes co-located, and particularly ones with youth work and social work leadership in which welfare-orientated solutions could be designed and delivered. The findings of this study suggest two ways that local systems can move from multi-agency discussions to multi-agency actions in response to EFH.

Firstly, accountability structures are essential. In some areas, particularly those with a large geographic footprint, there was some distance between operational and strategic arrangements. MACE (or equivalent) panels provided a mid-way point; however, we rarely saw them fulfil this accountability function, due to challenges with attendance from education, health and housing, tensions between social care and policing leadership, and the volume of children and young people being discussed. To improve this situation, a clear, nationally consistent, child protection pathway is needed for situations of EFH. Such a pathway should facilitate accountability across agencies and offer escalatory routes in situations of inaction, where the inability to provide services a child or young person needs is resulting in escalating risks (for example a persistently delayed assessment for ADHD or ongoing delays to facilitate a housing move). With such a

pathway in place to oversee plans for individual children and young people, MACE (or equivalent) panels could be principally used to understand and respond to themes – and agree actions in this regard – including unlocking intractable operational barriers. Both barriers and themes could then be reported to LSPs to inform decisions about what is needed in terms of commissioning, planning, training and policy.

Secondly, representation from policing in response to EFH requires further attention. Practitioners often commented that they had good working relationships with 'exploitation' or 'safeguarding' officers, but continued to face challenges from neighbourhood policing, and those working in serious and organised crime, whose remit was not safeguarding, and who at times viewed children and young people principally as a source of risk rather than also being a child at risk. Safeguarding in relation to EFH needs to be understood and applied consistently across all policing commands, not just within specialist safeguarding or exploitation teams. Without this, it is unclear how policing as a sector can be held accountable for enacting their duties to safeguard children and young people experiencing EFH.

6.3 From identifying disproportionality to designed anti-racist systems

The language of 'disproportionality' in both strategic and operational responses to EFH creates contexts of silence and discomfort around the topic of racism; it appeared easier for professionals to talk about disproportionality in their system (the perceived product of racism that occurred outside of their system), rather than discuss and address racism as the cause of the disproportionality. It is critical that practitioners and system leaders are supported to recognise that treating everyone the same, or assuming that this happens, in systems that reproduce inequality, is not sufficient. To be anti-racist, organisations also need to know how to respond differently to mitigate the impacts of racism on children and young people's welfare. While training on 'adultification' is a helpful step in providing practitioners with the space to understand how systems can fail racially minoritised young people impacted by EFH, training alone cannot change the systems in which they work, and of which they are a part. Given the persistent, disproportionate numbers of racially minoritised children and young people identified by services in relation to EFH, it is critical that the following questions are considered by children's services leaders, LSPs more broadly, and national policymakers responsible for EFH:

- Why is serious youth violence currently treated as distinct from other forms of EFH legally (via the serious violence duty) and in local strategic arrangements by not being consistently included in EFH strategies (as detailed in chapters 4 and 5)? How does having distinct, criminal justice-led response to serious violence impact the safeguarding plans for racially minoritised children and young people?
- How do multi-agency panels identify what children and young people impacted by EFH need or experience? Do they gather this information from services that

racially minoritised children and young people use and trust, or from services they are less likely to use or trust?

- Could local assessments screen racially minoritised children and young people in or out of specific services because they require the identification of certain indicators of vulnerability?
- How are multi-agency partners involved in safeguarding meetings, when those partners are disproportionately impacting the welfare of racially minoritised children and young people? For example, how are police forces that disproportionately arrest and charge, or schools who disproportionately exclude, racially minoritised children and young people involved in these meetings?
- How have racially minoritised families experienced statutory interventions in the local area historically? How have any negative experiences been recognised? How has the traumatic impact of negative experiences been mitigated to support the engagement of families going forward?
- What local services are available to support racially minoritised children and young people? How might they be drawn upon when providing support and advocacy?

Such questions are relevant for various features of a local response to EFH, including the delivery of multi-agency panels, and for the national frameworks in which those responses are developed. In terms of panels, these questions are relevant for decisions about who attends panel meetings, the nature of the information drawn upon to inform decisions at those meetings, the approaches to assessing risk and need in those meetings, and the services that are commissioned to support children and young people discussed at those meetings.

6.4 Workforce pressures and impact

Professionals involved in responding to EFH are under significant pressure. The children and young people they are supporting are at risk of significant, and sometimes fatal, harm. They express tangible worry for these children and young people and are acutely aware that they are working in contexts of stretched resources which compromise their ability to adequately meet children and young people's needs. It is somewhat unsurprising therefore that despite the challenges raised in this report many raised concerns about the idea of losing a MACE (or equivalent) panel. While these panels may not be necessary to coordinate multi-agency safeguarding plans for individual children and young people, they do, in some ways, provide a forum to share worries and seek/provide reassurance about those plans. Our findings suggest therefore that those who deliver MACE (or equivalent) panels, and or deliver LSP strategic oversight of such panels, need to identify ways to alleviate the pressure on the EFH workforce and the impact of that pressure in three ways.

Firstly, various studies have evidenced that relationships between children and young people and adults that they trust are a key feature of any safeguarding response. It is critical that multi-agency responses to EFH therefore value these relationships and do not jeopardise them. In our dataset we observed panel discussions in which it was recommended that professionals, including youth workers, social workers and voluntary sector staff, use their trusted relationships with a child or young person as a route to gather further information, without explicit consideration of what that same panel could do to further support that relationship to flourish and be protective. It is critical that MACE (or equivalent) panels do not pose a risk to children and young people's relationships by prioritising safeguarding-information over safeguarding-action. This is not to imply that the two are mutually exclusive but is to suggest a need to balance them in ways that support relational working.

Secondly, many participants in this study talked about 'trauma-informed practice' and expressly attempted it when challenging each other on the language used in meetings to describe children and young people. However, the meetings we observed, the practices described to us in interviews, and the accounts detailed in case review reports, had the potential to themselves be 'trauma-inducing'. Similar to the findings related to information sharing, we noticed a distinct difference between the discussions and actions in respect of trauma. Lengthy meetings, in which professionals discussed multiple children and young people facing significant risks to their safety, appeared containing in some respect and anxiety-invoking in others. Clinical supervision and reflective spaces may give practitioners a more appropriate setting to process anxiety, uncertainty and distress, rather than relying on MACE (or equivalent) panels to perform this role.

Thirdly, LSPs play a role in monitoring staff wellbeing in response to EFH, and its impact on the young people they serve. Professionals who are anxious or under pressure may, as we observed in our dataset, recommend multiple referrals for a child or young person simply to show they have tried everything; or share reams of information about a child or young person without clear rationale for doing so – or request others to do the same. In addition to monitoring staff sickness, senior leaders could invite discussion about practitioner confidence in local responses and ability to express and reflect on worries they have.

6.5 Resolving the crime and welfare binary

The above four findings are all informed by the fact that operational and strategic responses to EFH currently straddle criminal justice and welfare legislation, policy, leadership, practice models and cultures, which present a binary between child welfare and community safety goals. This was evident in our dataset when:

- Information was shared for the purposes of policing children and young people as well as safeguarding them
- Criminal justice data was used to guide safeguarding responses, but did not necessarily reflect the experiences or needs of children and young people impacted by EFH
- Actions were taken in response to EFH, particularly disruption, which risked dispersing and criminalising children and young people in need of protection
- Panels to address serious youth violence were always positioned outside of local safeguarding pathways. This meant that children and young people impacted by this form of EFH, and those who are being exploited but for whom violence was all that was initially identified, would often receive a community-safety led response over a child welfare response
- Children and young people impacted by EFH were often screened out of child protection pathways when their parents are protective (three out of six case study sites), and were referred into EFH pathways that were jointly led by policing and social care (and therefore pursue the goals of both sectors)
- LSP coordination of local safeguarding responses to EFH were both informed by criminal justice priorities, and at times overwhelmed by them, such as their limited influence on serious violence strategies in local areas, and their use of crime data to shape safeguarding plans.
- MACE (or equivalent) panels were used to both inform safeguarding plans for young people impacted by EFH and build policing intelligence and associated investigations.

These above practice features were not neutral, specifically in the context of EFH. Children and young people impacted by EFH have been historically criminalised by services, and a core goal of developing safeguarding responses to this issue has been to offer protection over punishment. Our findings suggest that this is yet to be fully achieved, despite extensive local efforts, due to intractable national challenges that require resolving.

EFH does not fit well into systems with welfare and crime binaries – and when the children and young people impacted by EFH straddle those binaries. As such strategic and operational partnerships cannot hold a neutral stance on the relationship between the two. Social care leadership is required to position welfare as paramount, and active steps are required to mitigate the impact of criminalisation through the production of a singular, shared, safeguarding outcomes framework to which all parties operate. Some alternative meetings, particularly those chaired by children's social care only, and orientated to child welfare and child protection goals primarily, demonstrated the impact of intentionally trying to resolve this binary. In sites trying to do this, there was also visible involvement of

youth work and voluntary organisations, and on occasion reduced visibility of policing (in respect of delivering safeguarding plans for young people).

The welfare-crime binary is enshrined into various facets of legislation (such as the serious violence duty) as well as in approaches to how services are measured, funded and guided. At a policy level division persists between the Home Office and equivalent safeguarding government departments in England and Wales, with the Home Office often leading policy on what are ostensibly safeguarding issues, including child criminal exploitation and teenage relationship abuse (therefore situating them under a policing brief). The implications of these persisting policy divides were illustrated in the ways different forms of EFH were considered, or overlooked, by both LSPs and MACE (or equivalent) panel. In terms of the current Government's 'missions', these tensions are also reflected in the relationship, or lack thereof, between what happens under 'Safer Streets' and 'Break Down Barriers to Opportunity' – the former having the potential to criminalise the same children and young people impacted by EFH, and the latter mission seeking to protect them. Presently, local resolutions are being attempted within these ongoing national silos and are therefore be hard to sustain.

7 Conclusions and implications

This study has provided a rare opportunity to focus on systems and services used to coordinate responses to children and young people impacted by EFH, as opposed to studying those children and young people or the harms they face. By examining both operational and strategic structures, we have shown that their approaches, and the challenges they face, reflect significant gaps and areas of confusion in national policy responses to EFH across England and Wales. While Welsh LAs operate within a distinct safeguarding model and policy framework, many of the challenges identified in England were also evident in Wales.

Local areas have undertaken a vast amount of work to respond to EFH; largely in the absence of comprehensive national guidance and direction on this. Gaps in national guidance, and complexity caused by siloed (and misaligned) policy and legislative frameworks, created the conditions for the inconsistency identified. Most local areas are working to their own arrangements, sometimes coordinated regionally or by police force area. Even when certain structures like MACE (or equivalent) panels are present across local areas, they often vary in terms of harms they include, the way they assess need or categorise risk, and whether they function to oversee plans for individual children and young people or for responses to trends, themes and locations. Despite these variations, there is much that local areas share in common. It is these points of commonality that we draw most attention to in this report. We believe that these points of commonality provide a clear indication of what systems and services need to do to improve responses to EFH in the future.

In conclusion, the findings presented in this report evidence that, building on 15-years of gradual reform four key improvements are needed in safeguarding responses to EFH. Local systems, and the policy frameworks to which they work, need to:

1. Strengthen the relationship between information-sharing and taking action on information that is shared. Through clearer national guidance, and robust local protocols that consider the purpose, storage, and use of information, safeguarding responses to EFH must ensure that information-sharing supports clear safeguarding decisions, actions and accountability.
2. Use MACE (or equivalent) panels to coordinate those actions that address locations and trends impacting multiple children and young people, while creating distinct ways to recognise and respond to the anxiety and worry of individual practitioners who are supporting the children and young people who are impacted;
3. Ensure processes to oversee plans for children and young people impacted by EFH are integrated into local child protection pathways;

4. Intentionally resolve the harms caused to children and young people impacted by EFH when both racism and persistent welfare/crime binaries in local and national responses are left unaddressed.

The insights we offer in this report identify ways for local partnerships to achieve these improvements. However, such improvements must be visible in, and facilitated by, national policy frameworks, if such changes are to produce consistent improvements in local responses to EFH in the future.

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Appendix A: Rapid Evidence Assessment Protocol

YEF Rapid Evidence Assessment (REA) objectives

The first work stream is to enhance understanding around multi-agency child exploitation (MACE) and equivalent panels, in England and Wales, and what factors influence their ability to assess and support children effectively.
The second work stream is to enhance understanding around Local Safeguarding Partnerships, across England and Wales, including expectations set out in law, policy and practice and the extent to which these are met in practice.
Part of the research design is to conduct a rapid evidence assessment (REA) of academic and grey literature to establish;

(a) what is already known about MACE (or equivalent) and wider multi-agency panel meetings in England and Wales.
(b) the policy landscape in England and Wales, identifying appropriate insights into research questions relating to Local Safeguarding Partnerships (LSP).

In this project we use these key terms:

Term	Interpretation
Multi-agency Exploitation (MACE) or equivalent panels	Multi-agency Exploitation (MACE) or equivalent panels, which follow processes of strategic, partnership planning to address exploitation of children. Activities of the multi-agency, parentship panels may include coordinated information sharing, risk assessment, planning and interventions to disruption and protect against forms of extra familial harm to children, particularly sexual exploitation and criminal exploitation.
Local Safeguarding Partnerships	Safeguarding partnership arrangements in a local authority (LA) area, defined under Children Act (2004), as (a) the local authority, (b) an integrated care board for an area any part of which falls within the local authority area, and (c) the chief officer of police for an area any part of which falls within the local authority area. The three safeguarding partners work together to coordinate local services, strategic leadership to support and engage others and implement local and national learning to protect the welfare of children and young people.
Children and young people	Child or young person who is under the age of eighteen.

Exploitation	Different forms of abuse where a child or children or young people are forced or coerced into doing things for the benefit of others. Manifests in various forms including sexual exploitation where a child/ young person or children/ young people are coerced, manipulated or deceived into sexual activity, often in exchange for things that may be physical, financial, relational or emotional.
Extra-familial harm	A broad term to describe different forms of harm that occur outside the home including risk of or experiencing physical, sexual, emotional abuse and exploitation in extra familial contexts.

Research Questions

Work Stream 1: MACE & equivalent panels	**Work Stream 2: Local safeguarding partnerships**
RQ1. How prevalent are MACE and equivalent panels, how do they typically operate, and what other approaches are local authorities using in their stead? c) How do MACE (or equivalent) panels typically operate and how does this vary across areas? (this should include a description of the threshold for referral, and which children MACE panels are serving)	**Part one: The current context** RQ1. What are local safeguarding partnerships currently expected to do to protect children at risk of involvement in CCE and EFH across England and Wales? (As set out in law and guidance). This should include a description of the expectations on: • The Local Authority (LA) (including Children's Services) • Integrated Care Boards • The Police • The collective LSP (including any other non-statutory partners)
RQ2. How effective are MACE (or equivalent) panels? b) Are MACE or equivalent panels successfully identifying and protecting children who are being exploited? c) Are the alternative approaches used in place of MACE panels in some areas performing better?	RQ2. To what extent are local safeguarding partnerships meeting these expectations in practice? (This should assess the performance of each of the three main statutory partners, in addition to the collective partnership). a) Is safeguarding activity occurring in response to CCE and EFH (e.g.

d) Is the operation and delivery of MACE conducive to protecting all children (including children from Black, Asian and Minority Ethnic communities)? For instance, are racially and ethnically diverse perspectives represented and are they influencing decision-making?	identification, referrals, planning, support)? b) Is activity appropriately tailored to the specific risks and needs associated with CCE and EFH (e.g. providing safety in contexts where harm occurs)? c) Is activity coordinated across statutory and non-statutory partners, with clear roles, responsibilities, and follow-through?
RQ3. How can MACE or equivalent panels be improved? a) What changes can be made at a local, practice level to support and improve the delivery of individual MACE (or equivalent) panels? b) What system changes (e.g. to regulation, funding, inspection, guidance and training) can be made at a national level to improve the delivery of MACE (or equivalent) panels across England and Wales?	RQ3. What are the facilitators and barriers to meeting these expectations? (this could include resource, confusion around policy and guidance, competing priorities or other challenges or facilitators).
	RQ4. Does current law, guidance and practice exacerbate or reduce racial disparities in support?
	Part 2: System and practice changes that would improve safeguarding of children at risk of CCE and EFH RQ1. What changes should be made in law, guidance, funding and inspection to improve the safeguarding of children from CCE and EFH by local safeguarding partnerships? RQ2. What should Directors of Children's Services do to improve the work of local safeguarding partnerships in safeguarding children from CCE and EFH?

	RQ3. How should the government implement the measures in the Children's Wellbeing and Schools Bill to ensure LSPs are protecting children from CCE and EFH?

This Rapid Evidence Assessment will follow five key steps:

1. Development of search protocols
2. Identification of relevant literature
3. Screening
4. Data extraction
5. Quality appraisal

Step One: Developing search protocols

(Search terms organised according to a modified Population, Intervention, Comparison, Outcome and Study Design (PICOS) framework

	WS1: MACE		**WS2: LSPs**	
	Inclusion	**Exclusion**	**Inclusion**	**Exclusion**
Population	Children, adolescents, teenagers, youth, young people, aged 0-18	Studies/guidance/documentation focused only on young adults age +18 years or only children aged 0-11 years	Children, adolescents, teenagers, youth, young people, aged 0-18	Studies/guidance/documentation focused only on young adults age +18 years or only children aged 0-11 years
Activity	Operation & delivery of MACE panels or equivalent approaches to child exploitation in local authority areas	Studies/guidance/documentation that do not explicitly focus on multi-agency approaches to child exploitation.	Frameworks, operation & practice around LSPs related to protection of children at risk of involvement of CCE &EFH	Studies/guidance/documentation that do not explicitly focus on local safeguarding children's arrangements or multi-agency approaches.
Context	England & Wales	Scotland, Northern Ireland or outside of UK	England & Wales	Scotland, Northern Ireland or outside of UK
Outcomes	Explicit focus on:		Explicit focus on: Expectatio	

	Typical operation, delivery & variation with and between alternative panel approaches. Effectiveness including identification & protection. Performance including consideration of MACE with alternative approaches. Outcomes sensitised to equity and protection (guided by trauma-informed, intersectional principles with a specific emphasis on race equity)		ns on partners & partnerships Extent to which expectations are met in practice (including identification, referral, planning, support, coordination, focus on contextual risk & need) Identification of facilitators & barriers to meeting expectations on LSPs Understanding of racial disparity including relationship to current law, guidance & practice Identification of potential systemic & practice changes to improve	

			safeguarding	
Setting	Anticipated evidence from a range of sectors that relate to child exploitation including social services, police, health, education, specialist & commissioned services, non-statutory services and housing.	Settings which are not children/youth focused or exclude children and young people	Anticipated evidence from a range of sectors that relate to child exploitation including social services, police, health, education, specialist & commissioned services, non-statutory services and housing.	Settings which are not children/youth focused or exclude children and young people
Study Design	Primacy sources including quantitative, qualitative and mixed methods studies; systematic reviews, REAs, reviews of reviews (RoR); multi-agency strategic and operationa	5. Blogs, opinion pieces, editorials, etc.; strategic and operational documentation unrelated to: children and young people, key agencies, child exploitation	Primacy sources including quantitative, qualitative and mixed methods studies; systematic reviews, REAs, reviews of reviews (RoR); strategic and operational document	6. Blogs, opinion pieces, editorials, etc.; strategic and operational documentation unrelated to: children and young people, key agencies, child safeguarding

	l documentation (policies, strategies, plans)		ation (policies, strategies, plans)	
Year	2015 – present (2025)	Studies and documentation pre-2015	2015 – present (2025)	Studies and documentation pre-2015

Only papers in English will be considered.

Search Strategy

We propose a search string that consists of the following elements. The other inclusion/exclusion criteria will be captured in the screening process. Search terms will be agreed with whole team and YEF and related search strings edited.

Population
"Child" OR "children" OR "young person" OR "young people" OR "young adult" OR "youth" or "youngster" OR "preteen*" OR "teen*" OR "adolesc*" OR "preadolesc*" OR "pre-adolesc*" OR "juvenil*"

Multi agency child exploitation panel
"Multi agency child exploitation panel" OR "MACE" OR "Multi agency child exploitation meeting" OR "Multi agency sexual exploitation panel" OR "Multi agency sexual exploitation meeting" OR "MASE" OR "Multi Agency Operational Safeguarding Arrangements"

Local safeguarding partnerships
"safeguarding partnership*" OR "local safeguarding partnership*" OR "local safeguarding children partnership*" OR "LSP" or "LSCP" OR "local safeguarding children board*" OR "local safeguarding board*" OR "LSB" OR "LSCB"

Safeguarding and exploitation
"Safeguard*" OR "child protection" OR "child exploit*" OR "criminal exploit*"OR "commercial exploit*" OR "sexual exploit*" OR "exploit*" OR "forced criminality" OR "forced criminal activit*" OR "CCE" OR "CSE" OR "Extra familial harm" OR "EFH" OR "missing" OR "human traffick*" OR "Modern slavery" OR "County lines" OR "gang" OR "Organised crim*" OR "violence" OR "serious" OR "Forc*" OR "coerc*" OR "deception" OR "debt*" OR "groom*"

Context
"England" OR "Wales" OR "UK" OR "United Kingdom" OR "Britain"

Search fields: Title, key words, abstract

- Scopus
- Web of Science
- ProQuest

We will also explore grey literature that support the implementation of multi-agency child exploitation panels and alternatives and local safeguarding partnerships, including:

- Research in Practice
- Contextual Safeguarding
- The association of Safeguarding Partners
- Vulnerability Knowledge and Practice Programme
- HM Gov.uk (including Ofsted, Care Quality Commission, HM Inspectorate of Constabulary and Fire and Rescue, HM Inspectorate of Probation)
- Child Safeguarding Practice Review Panel
- Violence Reduction Units
- Home Office
- Commission on Young Lives
- Modern Slavery and Human Rights Policy Evidence Centre
- NSPCC
- What Works Centre on Crime Reduction
- Foundations – What Works Centre for Children and Families
- Local Government Association
- https://tce.researchinpractice.org.uk/
- Google Scholar (first 50 results)

Study selection and data extraction

A structured search to identify relevant literature and studies will be conducted with process clearly documented. All relevant sources identified will be recorded.

Screening will then be undertaken to remove duplicate sources then title and abstract screened against inclusion and exclusion criteria. Screening will be undertaken by one reviewer (PDRA) with second reviewer (Co-I King) screening any 'maybe'/unclear sources and screening sample of sources screened to ensure consistent application of criteria. Third reviewer brought in over any continuing uncertainty over criteria and inclusion for full review.

Data extraction will be recorded in Excel form with summary information finalised after identification of sources for full review. Some sources may not provide all summary information points so available data will be extracted. This is a draft list of summary information that will be extracted and recorded.

	WS1: MACE (or equivalent) panels	WS2: LSPs
Bibliographic information	• Title • Author • Year • Publication type (published/unpublished) • Source	• Title • Author • Year • Publication type (published/unpublished) • Source
Population	• Sample size • Age range • Demographics • Manifestation/context of harm	• Sample size • Age range • Demographics • Manifestation/context of harm
Activity	• Field of research (e.g. social services, police) • Description of panel activity • Focus of multi-agency panel (e.g. CCE, EFH) • Composition of muti-agency panel	• Field of research (e.g. social services, police) • Description of LSP • Focus of partnership (e.g. CCE, EFH) • Frameworks, operation & practice
Context	• Country • Local authority (if identified)	• Country • Local authority (if identified)
Study design	• Study design or method	• Study design or method
Outcomes	• Typical operation, delivery & variation with and between alternative panel approaches. • Effectiveness including identification & protection. • Performance including consideration of MACE with alternative approaches. • Outcomes sensitised to equity and protection (guided by trauma-informed, intersectional principles with a specific emphasis on race equity)	• Expectations on partners & partnerships • Extent to which expectations are met in practice (including identification, referral, planning, support, coordination, focus on contextual risk & need) • Identification of facilitators & barriers to meeting expectations on LSPs • Understanding of racial disparity including

		relationship to current law, guidance & practice • Identification of potential systemic & practice changes to improve safeguarding

Quality Appraisal

We will conduct a quality assessment of the included research sources. We will use the Maryland Scale for quantitative sources, the Critical Appraisal Skills Programme (CASP) Checklist for qualitative sources, and the modified Joanna Briggs Institute critical appraisal checklist for systematic reviews and research syntheses.[1] However, for strategic/operational/guidance documentation relating directly to MACE (or equivalent) panels and LSCP/Bs, sources will be included based on relevance and inclusion/exclusion criteria.

Synthesis of findings

Synthesis of findings from WS1 and WS2 will be tabular with a narrative commentary. Where applicable, we will compare and comment on the connections identified between the two workstreams. Synthesis will address the key research questions outlined above for each workstream.

Appendix B: REA Results

MACE Literature			
Author	**Title**	**Year of publication**	**Location**
Creaney, S. and Burns, S.	The Achilles heel of Child First: High-risk panels in youth justice service policy and practice	2025	England and Wales
Wilson, A.V. and Mueller-Johnson, K.	Discovering a Predictive Mechanism to Identify Risk and Harm in Extra-Familial Child Exploitation	2024	England
Radcliffe, P., Roy, A., Barter, C., Tompkins, C. and Brooks, M.	A qualitative study of the practices and experiences of staff in multidisciplinary child sexual exploitation partnerships in three English coastal towns	2020	England
HM Government (co-badged Uni of Bedfordshire, Research in Practice Tackling child exploitation support programme, The Children's Society)	Multi-agency Practice Principles for responding to child exploitation and extra-familial harm	2023	England
Lloyd, J., Manister, M. and Wroe, L.	Social Care Responses to Children who Experience Criminal Exploitation and Violence: The Conditions for a Welfare Response	2023	England
Ibbetson, K. and project team (London Adolescent Safeguarding Overview Board) **Sourced via research team suggestion**	Peer Review of MACE Arrangements in London	2022	England

LSP Literature			
Author	**Title**	**Year of Publication**	**Location**

Department for Education Cogley, E., Azarbadegan, M., Ozan, J. and McManus, M.	Safeguarding Children Partnerships Yearly Reports Analysis 2023-2024	2025	England
Baroness Casey of Blackstock DBE CB	National Audit on Group-Based Child Sexual Exploitation and Abuse	2025	England and Wales
IFF Research with recommendations from Research in Practice	Child Safeguarding Practice Review Panel: Impact evaluation summary	2025	England
Research in Practice, Fish, S.	Making the Local Practice Review Process clearer for everyone	2024	England
Child Safeguarding Practice Review Panel	Child Safeguarding Practice Review Panel: annual report 2023 to 2024	2024	England
Ball, E., McManus, M., McCoy, E. and Quigg, Z.	Implementation of Multi-agency Safeguarding Arrangements Regarding Exploitation of Young People: Aligning Policy and Practice Using Normalisation Processing Theory	2024	UK
HM Government	Working Together to Safeguard Children 2023	2023	UK
McManus, M., Ball, E., Almond, L.	Risk, response and review: multi-agency safeguarding A thematic analysis of child practice reviews in Wales 2023	2023	Wales
Rogers, C. and Thomas, G.	Spare the rod! Implications for community safety partnerships in removing the reasonable chastisement defence in Wales	2022	Wales
Driscoll, J., Hutchinson, A., Lorek, A. and Kiss, K.	Future Proofing Multi-Agency Child Safeguarding Practice Briefing	2022	England
Local Government Association	Tackling Child Exploitation: Resources Pack	2021	England and Wales

Child Safeguarding Practice Review Panel	The Child Safeguarding Practice Review Panel: Annual Report 2021	2021	England
Wroe, L.	Young people and “county lines”: a contextual and social account	2021	England
Department for Education, Kantar Public	Multi-agency reform: Key behavioural drivers and barriers	2021	England
Kings College London: Driscoll, J., Lorek, A., Kinnear, E. and Hutchinson, A.	Multi-agency safeguarding arrangements: overcoming the challenges of Covid-19 measures	2020	England
Racher, A. and Brodie, I.	Joining the dots? Tackling child exploitation during Covid-19	2020	England
Dudau, Q. and McAllister, L.	Failure in welfare partnerships – A gender hypothesis: Reflections on a serendipity pattern in Local Safeguarding Children Boards	2018	England
Frost, N.	From “silo” to “network” profession – A multi-professional future for social work	2017	England
Wood, A.	Wood review of local safeguarding children boards	2016	England
Centre of Excellence for Information Sharing Department for Education	Information sharing to protect vulnerable children and families	2016	
Machura, A.	Inter- and Intra-Agency Co-Operation in Safeguarding Children: A Staff Survey	2016	Wales
Phillips, C.	Wales’ safeguarding policy and practice: a critical analysis	2016	Wales
Dudau, A. Fischbacher-Smith, D. and McAllister, L.	The Unsung Heroes of Welfare Collaboration: Complexities around individuals' contribution to effective inter-agency working in LSCBs	2016	England and Wales