



REPORT

Found but NOT followed

**Oversight of children vulnerable to violence below
statutory thresholds**

**Danielle Sharp, Monika Lesniewska, Dr Harjinder Kaur and
Kenya Lamb**

October 2026

CENTRE FOR
SAFER SOCIETY



About the Youth Endowment Fund

The Youth Endowment Fund (YEF) is a charity with a mission that matters. We exist to prevent children and young people becoming involved in violence. We do this by finding out what works and building a movement to put this knowledge into practice.

Children and young people at risk of becoming involved in violence deserve services that give them the best chance of a positive future. To make sure that happens, we'll fund promising projects and then use the very best evaluation to find out what works. Just as we benefit from robust trials in medicine, young people deserve support grounded in the evidence. We'll build that knowledge through our various grant rounds and funding activity.

And just as important is understanding children and young people's lives. Through our Youth Advisory Board and national network of peer researchers, we'll ensure they influence our work and we understand and are addressing their needs. But none of this will make a difference if all we do is produce reports that stay on a shelf.

Together we need to look at the evidence and agree what works, then build a movement to make sure that young people get the very best support possible. Our strategy sets out how we'll do it. At its heart it says that we will fund good work, find what works and work for change. You can read it [here](#).

For more information about the YEF or this report please contact:

Youth Endowment Fund
C/O Impetus
10 Queen Street Place
London
EC4R 1AG

www.youthendowmentfund.org.uk

hello@youthendowmentfund.org.uk

Registered Charity Number: 1185413

Acknowledgements

The Centre for Safer Society core research team who developed the national insights for practice were:

- Danielle Sharp, Chief Executive
- Monika Lesniewska, Associate
- Dr Harjinder Kaur, Senior Associate
- Kenya Lamb, Associate

With thanks to the core Youth Endowment Fund team supporting the work:

- Patrick Olajide, Senior Research Manager, Local Violence Prevention
- Katie Ryan, Senior Manager, Area Leaders Programme

In addition to the core team, we have benefited from the insights from a range of local partners, including through formal interviews, and broader discussions to shape our thinking.

We are grateful to the many local partners across the eleven fieldwork areas, and to others who shared their insight through interviews and wider discussions. Their expertise shaped this report. To protect their anonymity, individuals are not named.

Executive summary

This report focuses on children aged 10 to 17 who are vulnerable to involvement in violence, but who are not subject to statutory case management through child protection or youth justice. However, they may still be receiving non-statutory support through other local arrangements. This includes children at risk of being harmed, children who may pose a risk of harm to others or both. The report also considers risks and vulnerabilities around child criminal exploitation, child sexual exploitation, gang involvement, county lines and domestic abuse.

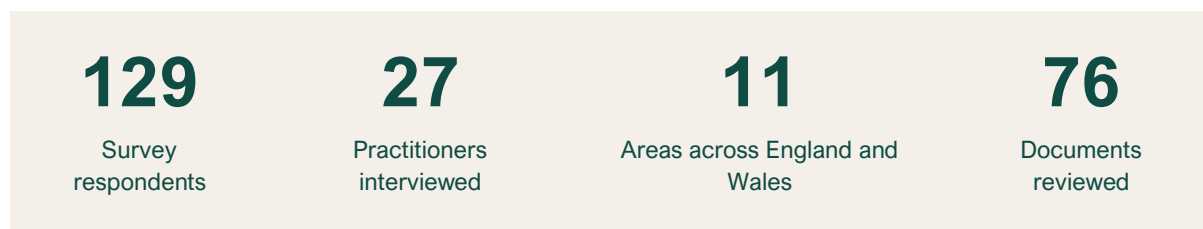
This research was designed to address a problem identified through the Youth Endowment Fund's work with local violence prevention partnerships:

1. Oversight of children who are vulnerable to involvement in violence, but who do not meet statutory thresholds for children's social care or youth justice intervention is often patchy or absent.
2. There is limited practical guidance for partnerships that want to improve oversight.
3. There is no single statutory framework that requires a named professional to keep track of these young people, to check whether the support they were referred to was ever accessed, or to record what happened next.

The findings in this report speak most directly to Local Safeguarding Children's Partnerships, Community Safety Partnerships, Serious Violence Duty partnerships and subgroups, local authority children's services leads, and commissioners. Across the eleven fieldwork areas included in this study, oversight functions were commonly held within children's services or youth justice teams, although in some areas they sat within policing, youth services or community safety teams. Several areas operated joint oversight arrangements across multiple agencies.

The evidence base

This research was commissioned by the Youth Endowment Fund as part of the Area Leaders Programme. It draws on three sources gathered between November 2025 and April 2026: a national practitioner survey, in-depth interviews across eleven local areas in England and Wales, and a rapid evidence review.



What we found

The research set out to answer four questions. The headline answer to each is set out below, and the evidence behind them is set out in full in the chapters that follow.

Research question	What we found
How do local areas identify and maintain oversight of children vulnerable to involvement in violence, but who do not meet statutory thresholds?	The system is good at finding these children and poor at staying with them. All eleven fieldwork areas have at least one mechanism for identifying children below the threshold and all have a process for initial review, though only eight of the eleven have panels with the authority to allocate a named lead and agree an action. Only six areas have any systematic way of checking whether a child is still engaging or whether their circumstances have changed, and 34% of survey respondents said children are not tracked at all after a threshold decision is made. Only three areas track outcomes in any structured way. 58% of respondents either did not know how outcome data was collected in their area or confirmed that none was collected systematically, and only 1 of the 85 practitioners who answered the survey was very confident that the support their area provides reduces children's risk of violence.
What barriers prevent effective oversight?	Unclear responsibility and short-term funding are the joint highest barriers to effective oversight, with each cited by a third of survey respondents. Limited capacity was also an important barrier and was cited by 26% of survey respondents. Only 9% of practitioners who answered the survey said roles and responsibilities for these children were very clear in their area. 26% said responsibility varies case by case, and the absence of a named lead practitioner for each child was the most consistent feature of areas where oversight broke down.
What approaches and conditions are associated with better practice?	There is no single model of best practice. What set the stronger areas apart was a small number of conditions held together over time: a named lead practitioner for every child; structured reviews at regular intervals, including after a case has closed; oversight of outcomes; strong relationships, and stable funding to sustain the work. Strong multi-agency relationships were the highest-rated enabler in the survey at 43%, but they were also the most fragile. Where responsibility for leading and coordinating oversight functions rested on one person it often collapsed when that person left.
What does the evidence show about race equity?	The evidence review and fieldwork found strong evidence that Black and Mixed Heritage children are overlooked when they need protection and highly visible when associated with harm, with adultification bias shaping threshold decisions (Huegler et al., 2025). Five of the eleven areas raised disproportionality as a live issue, but no area held data on its own below-threshold cohort broken down by ethnicity, only two of 129 survey respondents raised race or ethnicity in free-text responses, and no area disaggregates its oversight, panel or outcome data by ethnicity, sex, age or special educational needs. No area can therefore say whether its oversight system is working equitably.

Key insights for practice

The following insights are set out in full later in the report, grouped under the four building blocks of oversight: governance and accountability; follow-up and monitoring; quality, escalation and outcomes; and implementation and capacity.

Governance and accountability

1. Name a lead practitioner for every child, with a welfare rather than a justice lens.
2. Design panels for decisions, with terms of reference that explicitly address oversight.
3. Treat consent as a governance question, separating consent for support from consent for monitoring.

Follow-up and monitoring

4. Create multiple entry routes and pathways that maintain visibility. A referral that passes a child on to someone else; on its own it does not keep that child visible.
5. Establish structured review points, at least every six weeks, and post-closure follow-up.
6. Involve children and families as participants in monitoring, not just subjects of it.

Quality, escalation and outcomes

7. Start measuring outcomes against a minimum standard.
8. Define escalation criteria rather than relying on professional judgement.
9. Match quality assurance to how demanding this work actually is. Areas told us that cases below the threshold can be more complex than the statutory cases the system is built around, yet they receive lighter supervision and less case auditing.
10. Monitor for disproportionality across ethnicity, sex, age and special educational needs.

Implementation and capacity

11. Build oversight as a team function, not a coordinator role.
12. Treat funding instability as a governance risk and ensure commissioning supports oversight.
13. Build partnership maturity deliberately and systematise what you build. A mature partnership is one where agencies genuinely plan together rather than only sharing information; it grows out of years of stable relationships, and it lasts when it is written into systems rather than carried by one individual.

A note on evidence strength

Evidence strength is indicated throughout the report. Strong evidence reflects consistent findings across all three sources; emerging evidence reflects findings from one or two sources that require further corroboration; and an evidence gap is recorded where the absence of evidence is itself significant. The fieldwork areas with the strongest outcomes have not been subject to independent evaluation with a control group. While the association between strong oversight infrastructure and better outcomes is consistent across the fieldwork, it is not a causal claim, and the report is explicit throughout about the distinction between promising practice and established evidence.

Contents

Executive summary	4
The evidence base.....	4
What we found.....	4
Key insights for practice.....	6
A note on evidence strength	6
Contents.....	8
Methodology.....	10
Overview of the research approach	10
Rapid evidence review	10
National practitioner survey.....	11
Fieldwork interviews	12
Analytical approach and triangulation.....	13
Evidence strength framework.....	13
Limitations	14
Ethical considerations.....	14
What does it mean to maintain oversight of children below statutory thresholds?	15
Defining oversight of children below the threshold.....	15
What practitioners call this work	17
The four building blocks.....	17
Building Block 1: Governance and Accountability	20
Who is accountable? Named individuals, not just systems	21
Where oversight sits in the system shapes what it can do	22
Multi-agency coordination: meetings are not the same as oversight.....	25
Information sharing: the decision to share matters more than the technology.....	27
Consent: the gateway to sustained oversight	28
Race equity and governance: a significant gap.....	31
What this means in practice.....	32
Building Block 2: Follow-up and Monitoring	36
From reactive to proactive: how children come to attention	37
Sustained monitoring: what it looks like and where it breaks down	39
The children that monitoring systems miss.....	43
Families and young people as participants in monitoring.....	44

What this means in practice.....	45
Building Block 3: Quality, Escalation and Outcomes	49
Outcome monitoring: a discipline that most systems have not yet built.....	49
Escalation: informal, person-dependent, and largely without agreed criteria	53
Quality assurance: the thinnest component across the building blocks.....	55
What this means in practice.....	57
Building Block 4: Implementation and Capacity.....	61
Workforce: relationships over process	61
The single-coordinator risk: when oversight depends on one person	63
Funding: the joint highest barrier, and what is lost when it ends	64
Data systems: locally built solutions to a nationally unresolved problem	66
Partnership maturity.....	67
What this means in practice.....	68
Conclusion	72
What the evidence shows	72
What this study adds.....	73
Limitations	73
A final note	74
References.....	75

Methodology

This report draws on evidence gathered between November 2025 and April 2026: a rapid evidence review of the published literature, a national practitioner survey, and in-depth fieldwork interviews across eleven local areas. Together, this research provides a layered picture of what it takes for agencies to maintain oversight of children vulnerable to involvement in violence who fall below statutory thresholds: what the research already knew, what practitioners across England and Wales report at scale, and what areas that have begun to develop promising practice in this space have found from doing it. This section sets out how each research method was designed and conducted, how the evidence was brought together, and the framework used throughout to describe the strength of the findings.

For the purpose of this report, oversight means: the processes, mechanisms, tools, systems and governance through which agencies and practitioners maintain awareness of children vulnerable to involvement in violence as they navigate services, ensuring they access appropriate support, monitoring their engagement and progress, and responding when needs escalate or outcomes are inadequate.

Overview of the research approach

This research was designed to address a specific gap identified through the YEF Area Leaders Programme pilot, that effective oversight for children vulnerable to involvement in violence but who do not meet statutory thresholds is often patchy or absent, and that there is limited practical guidance to support partnerships seeking to improve. The research sought to answer key questions about which agencies take responsibility for oversight, what processes and tools are used, how outcomes are tracked, what escalation mechanisms exist, what governance arrangements work, and what barriers partnerships face.

Three research methods were used to answer these questions at different levels of scale and depth. The evidence review established what research and policy guidance already knew about structural barriers and promising approaches. The national survey provided a baseline picture of current practice across England and Wales. The fieldwork interviews provided the operational detail, case studies, and practitioner experience that give these insights their practical content. The three methods were then triangulated: where all three pointed in the same direction, the finding is rated as strong; where two methods aligned, as emerging; and where the absence of evidence was itself significant, as an evidence gap. This framework is explained in full below.

Rapid evidence review

A rapid evidence review was conducted between November and December 2025. Searches were conducted across academic databases and grey literature sources for evidence published between 2015 and 2025, with a primary focus on UK contexts and selective inclusion of transferable international evidence. The review prioritised evidence on oversight systems, multi-agency coordination, and governance arrangements for children aged 10 to 17 who are vulnerable to involvement in violence below statutory thresholds.

During and after the fieldwork period, several significant policy and research publications were released, including Working Together to Safeguard Children 2026 (DfE, 2026a), the Families First Partnership Programme Guide (DfE, 2026b), the Southport Inquiry Report (2026), and the Turnaround Programme independent evaluation (Turner et al., 2026). These

publications were released after the formal search period and were retrospectively added as context to a final version of our evidence review. Where relevant, they have been incorporated as contextual evidence and are clearly signposted throughout the report. The Turnaround programme evaluation (Turner et al., 2026) provides the most substantial evaluation evidence to date for a below-threshold programme, a large-scale independent process and implementation evaluation covering 38,704 children nationally, though it lacks a counterfactual comparison. For other below-threshold approaches specifically, no rigorous independent evaluation with a control group has been conducted.

Following screening of 496 citations, 76 documents met the inclusion criteria. Given the compressed timeframe, documents were quality-appraised and the highest-quality sources prioritised for full data extraction, with 27 documents fully extracted and synthesised. Evidence was organised around four building blocks identified from scoping: governance and accountability, follow-up and monitoring, quality, escalation and outcomes, and implementation and capacity.

Findings from the evidence review are woven into this report as additional context alongside the fieldwork.

National practitioner survey

A national practitioner survey was conducted in early 2026, receiving 129 completed responses from practitioners working with children vulnerable to involvement in violence below statutory thresholds. The survey was distributed through Violence Reduction Units, Local Safeguarding Partnerships, and sector networks across England and Wales. Respondents were asked about the oversight arrangements in their local area: who takes responsibility, what systems are used, what the barriers and enablers are, and how outcomes are measured.

The survey provides a broad picture of current practice at scale. It is not nationally representative, with the South East and London the most represented regions (41% of responses combined), with under-representation from the South West, West Midlands, and Wales. Children's services and youth justice respondents were overrepresented relative to education, health and policing, and the sample reflects the networks through which the survey was distributed rather than a random selection of all partnerships. The sector breakdown of respondents is set out below.

Sector	% of respondents
Children's services	33%
Youth justice	20%
Voluntary and community sector	13%
Health	10%

Sector	% of respondents
Local council	5%
Community safety	5%
Policing	5%
Violence Reduction Unit	4%
Education	3%
Office of the Police and Crime Commissioner	2%

Table 1: Survey respondents by sector (n=129) Percentages are rounded and may not sum to 100.

Survey findings are presented throughout as quantitative context for the qualitative fieldwork rather than as definitive national statistics. Where specific figures are cited, the denominator is given to allow readers to assess the strength of the evidence. A small number of survey questions were not answered by all 129 respondents; where the denominator differs from 129 this is noted. Cross-tabulations by sector are used at key points to identify where particular groups of practitioners, notably voluntary and community sector respondents, report markedly different experiences from the overall sample.

Fieldwork interviews

The fieldwork interviews are the primary evidence source for these insights. Between January and March 2026, interviews were conducted with 27 practitioners across eleven local areas in England and Wales. Areas were selected to represent a range of governance models, geographies and approaches to oversight of children below the threshold, including areas at different stages of development: some with more established systems and emerging outcome data, others still building their approach.

Within each area, interviews were conducted with the practitioners most directly responsible for designing or delivering below-threshold oversight, including prevention team managers, youth justice leads, exploitation coordinators, Violence Reduction Unit staff, and voluntary sector leads. In several areas, multiple practitioners participated in a single interview, providing complementary perspectives on the same local system.

Interviews were conducted using a semi-structured topic guide organised around the key questions set out in the research brief and the four building blocks framework. All interviews were recorded and transcribed with participants' consent. Analysis involved thematic coding against the building blocks and a set of cross-cutting learning themes, with a second-pass review to ensure findings were connected back to their implications for oversight systems specifically rather than for service delivery more broadly.

A document review was conducted alongside the interviews: forty supplementary documents were collected from nine fieldwork areas, including governance frameworks, operational protocols, panel terms of reference, evaluation reports, and data methodology guides. These documents substantially corroborated and extended the interview evidence, and in several cases provided quantitative data that interviews had described but not detailed.

Quotes in this report are attributed to role and to an anonymised area label (Area 1, Area 2, and so on). Neither individual practitioners nor their local areas are identified in the published report.

Analytical approach and triangulation

Evidence from the three methods was brought together using a structured analytical tool that triangulates all three sources against each of the report's key questions, recording what the evidence review found, what the survey showed, what the fieldwork described, where the sources converge or diverge, and the combined evidence strength rating. What the triangulation found is set out in the findings chapters rather than here.

Evidence strength framework

Every finding in this report is assessed against a three-level evidence strength framework, intended to be honest about what the evidence can and cannot claim.

Strength rating	What it means
Strong	Triangulated across all three research methods, with multiple fieldwork areas independently confirming the same finding
Emerging	Consistent direction across two research methods, or confirmed by two to three fieldwork areas. The finding is plausible but not yet conclusively established
Evidence gap	The absence of evidence is itself significant. Where no area can demonstrate a practice, or where a question cannot be answered, this is reported as a finding rather than a gap in the research

Table 2: Evidence strength framework used throughout this report

A note on promising practice

No area participating in this fieldwork has been subject to rigorous independent evaluation with control groups or randomised design. Where areas have outcome data, this is noted alongside the methodological caveats that apply. Such data is presented as promising practice, not as proven intervention: it demonstrates that systematic outcome tracking is achievable and that the early results are encouraging, not that specific approaches have been shown to reduce violence in a causal sense.

Limitations

Several limitations are important for readers to keep in mind throughout this report. They are drawn together, with the limitations of the study as a whole, in the conclusion.

- The survey sample is not nationally representative, and survey findings are treated as indicative context throughout rather than as definitive statements of national practice.
- The fieldwork areas are not a random sample. The report presents the range rather than claiming to describe a typical area.
- Race equity is the most significant evidence gap. The large majority of interviews did not discuss race, and only two of 129 survey respondents raised race or ethnicity in free-text responses. The absence of evidence on whether oversight systems operate equitably for Black and Mixed Heritage children, or whether they replicate adultification bias, is treated throughout as an evidence gap. The evidence review provides the most substantial evidence on race equity; fieldwork evidence is thin and this is acknowledged explicitly where it arises.
- Health practitioners are significantly underrepresented in the fieldwork. No dedicated health interview was conducted, and health appears peripheral to the core safeguarding, youth justice, and children's services arrangements that most oversight systems currently operate within. The survey cross-tabulation of health respondents, who disproportionately cited unclear roles and poor information sharing, is the strongest health-specific finding, and the gap is acknowledged explicitly in the implementation and capacity chapter.
- Finally, this report describes what practitioners told us was happening at the time of fieldwork. Several areas were in active transition during the research period, including changes to staffing, funding, and governance structures.

Ethical considerations

All interviews were conducted with the informed consent of participants. Participants were advised that the research would be published. In the published report, neither individual practitioners nor their local areas are identified. Recordings were stored securely and transcripts are retained for the purposes of this research only.

This report draws on data about children and young people, including data describing their police contact, safeguarding involvement, and reoffending. All such data is presented at aggregate or anonymised level. No individual child is identified.

What does it mean to maintain oversight of children below statutory thresholds?

The children and young people vulnerable to involvement in violence but who do not meet the criteria for statutory support are known to services but held by none. They have come to someone's attention and there is concern about their safety, but the frameworks that would trigger a formal, named, accountable response do not apply to them. No one is required by law to keep track of them, to check whether the support they were referred to was accessed, or to record what happened next. This report is designed to address how agencies and partnerships maintain oversight of these children.

The following section sets out the definition and framework used throughout these insights, reflects on the language practitioners use to describe this work, and introduces the four building blocks that structure the chapters that follow.

Defining oversight of children below the threshold

For the purposes of this research, oversight of children below the threshold means:

Oversight of children who fall below the threshold

The processes, mechanisms, tools, systems and governance through which agencies and practitioners maintain oversight of children vulnerable to involvement in violence as they navigate services, ensuring they access appropriate support, monitoring their engagement and progress, and responding when needs escalate or outcomes are inadequate. Oversight encompasses both individual-level monitoring (following specific children through services) and system-level coordination (ensuring coherent multi-agency oversight). It includes knowing who is responsible for each child, how information flows between agencies, what happens when children do not engage, and how effectiveness is assessed. Crucially, oversight is about system accountability, not surveillance of young people. The purpose is to ensure that services and systems are working effectively for each child, that referrals lead to appropriate support, that children do not fall through gaps between agencies, and that professionals can respond when support is not working or needs change. Oversight should serve the child's best interests by ensuring coordinated, timely, and appropriate responses from services, rather than functioning as surveillance or monitoring of the young person themselves.

These insights focus on children aged 10 to 17 who are vulnerable to violence, but who are not subject to statutory case management via child protection or youth justice. This covers children at risk of experiencing violence, children who may pose a risk of harm to others, and children who are both at once. These are not separate populations, and the Youth Endowment Fund's own guidance for children's services makes the same point, advising that local partners should avoid treating children as either victims or perpetrators in isolation and should consider both the risks a child is experiencing and the risks they may pose to others (Youth Endowment Fund, 2026). The Fund's survey of nearly 11,000 teenagers aged 13 to

17 in England and Wales found that more than half of those who had used violence, 53%, had also been victims of it, rising to 77% among those whose actions caused injury (Youth Endowment Fund, 2025b). The fieldwork for this research was scoped by whether a child sits below the statutory threshold rather than by which of those descriptions fits them, and the areas we spoke to hold oversight of children who arrive through both routes, including through youth justice prevention and diversion. They may still be getting non-statutory support through early help, prevention panels, MACE meetings, voluntary sector services or other local arrangements.

The risks and vulnerabilities covered include serious youth violence, child criminal exploitation, child sexual exploitation, gang involvement, county lines, and domestic abuse. We recognise that children below the age of 10 can experience violence and may also require oversight. The age range used in this research reflects the focus of violence prevention efforts and the age of criminal responsibility in England and Wales. These children and young people sit below the threshold for a statutory child protection plan and, in most cases, below the threshold for child in need support under section 17 of the Children Act 1989, although the Families First Partnership reforms are reshaping the boundary between targeted early help and child in need support (DfE, 2026b).

To make this definition practical, the research uses a framework of six operational functions. These functions describe what oversight looks like in practice, breaking down the abstract concept into the specific activities that either happen in an area or do not:

Function	The question it answers
Identification	How does a child come to the attention of the system? Through proactive data screening, referral from another agency, or only at crisis point?
Triage and decision-making	What happens once a child is identified? Is there a structured process for assessing risk and deciding what response is needed?
Allocation of responsibility	Is a named individual assigned responsibility for every child? Or does the child enter a system where no one owns their oversight?
Active monitoring	Is there a mechanism to check whether the child is engaging with support, whether their circumstances are changing, and whether the response is working?
Escalation	What happens when risk increases or a child stops engaging? Are there clear criteria and pathways for escalating the response?
Outcome review	Can the system demonstrate what happened to a child after involvement? Is there any evidence about whether the support made a difference?

Table 3: The six functions of oversight for children below the threshold

It is also useful to understand that the six functions operate at two distinct levels, both of which matter for effective oversight. At the individual level, they describe what a named practitioner does for a specific child: identifying them, allocating responsibility, monitoring their progress, and reviewing what happened. At the cohort level, they describe what a partnership does to maintain strategic visibility of all children below the threshold in its area: whether the partnership knows how many children are currently being tracked, who is responsible for them, and whether the overall approach is producing better outcomes over time. The individual level is primarily operational. The cohort level is primarily strategic. Both are necessary, and several of the insights in this report speak to one level or the other, or to the relationship between them. A partnership may have strong individual-level processes (named leads, review schedules, case records) but no strategic visibility of the whole cohort. Equally, a partnership may collect aggregate data without any of the individual-level mechanisms that give it meaning. Effective oversight requires both.

A consistent pattern from this research is that most areas have stronger approaches to the earlier functions than the later ones.

What practitioners call this work

Alternative language used by practitioners in this research

Oversight, sustained protective monitoring, assurance, keeping in touch, keeping visible, keeping safety in partnership, holding, maintaining a watching brief, staying alongside. All describe aspects of the same set of activities captured in the six functions framework.

Throughout this report we use ‘oversight’ as the main term, and reserve ‘tracking’ for where it describes the language used during the research or the original commission.

Terms such as ‘thresholds,’ ‘tracking,’ and ‘non-statutory oversight’ are not used consistently in practice or in academic writing, and many relevant studies required detailed reading to identify the systems and practices being described. This is not merely an academic inconvenience: it reflects a genuine absence of shared language and shared standards in the field, and is itself one of the review’s findings.

A number of practitioners reflected on the word ‘tracking’ and expressed reservations about it. One practitioner put this most clearly: *‘Tracking and monitoring, even the word doesn’t help. Because what are we tracking and monitoring and why is it all right to do that? Should it not be about relationships and understanding need, and experience, and opening up some kind of way of working that allows that to be the centre of it?’* The same practitioner, who held a regional role across a multi-area prevention programme, added that she would not want to promote the language, and that the tension between accountability and surveillance was not something she wanted to import into the culture of that work.

The four building blocks

These insights are structured around four building blocks, each of which corresponds to the six oversight functions and to a core question that any partnership seeking to improve its oversight should be able to answer. The building blocks were identified from the rapid evidence review at the start of this research and were confirmed by the fieldwork as the most useful way to organise the evidence.

The building blocks are not a hierarchy: all four are necessary for oversight to function effectively. In practice, however, they are not equally developed. Governance and accountability, the first building block, exists in most areas, though its quality varies considerably. Follow-up and monitoring, the second, is uneven: identification is well developed, but sustained monitoring is often weak. Quality, escalation and outcomes, the third, is where the most significant gaps were found across the eleven fieldwork areas, and the absence of systematic outcome measurement is one of the most significant findings in this research. Implementation and capacity, the fourth, is the structural layer that either enables or undermines everything else.

Governance and accountability <i>Who is responsible, and how does information enable accountability?</i>	Clear roles, named leads, multi-agency panels with decision-making authority, information-sharing arrangements, and consent frameworks. The foundational layer without which the other building blocks cannot function.
Follow-up and monitoring <i>How do agencies track access, engagement, and progress over time?</i>	The practice of oversight: how agencies check whether children access support, whether their circumstances improve, and what happens when they disengage. Includes proactive identification mechanisms (for example, a police analyst screening serious-violence cases to flag children early, or a multi-agency panel reviewing new referrals) and sustained post-closure monitoring.
Quality, escalation and outcomes <i>How do agencies know if support is working, and what happens when it is not?</i>	The feedback loop that drives improvement: how service quality is assured, how escalation is triggered, and how outcomes are measured. In this research, this building block was where the most significant gaps were found across all fieldwork areas.
Implementation and capacity <i>What does it take to make oversight work in practice?</i>	The organisational conditions that enable or undermine the other three building blocks: workforce skills and approaches, sustainable funding, data infrastructure, and the maturity of multi-agency partnerships.

Table 4: The four building blocks of oversight for children below the threshold

Figure 1 below shows how the four building blocks relate to each other and to the child and family at the centre of the system. The building blocks are not sequential: effective oversight requires all four to be functioning simultaneously. The diagram also shows four cross-cutting themes that run through every building block: race equity, child and family voice, relationships and trust, and proportionality. These themes are woven through the building block chapters rather than set apart in a separate section.

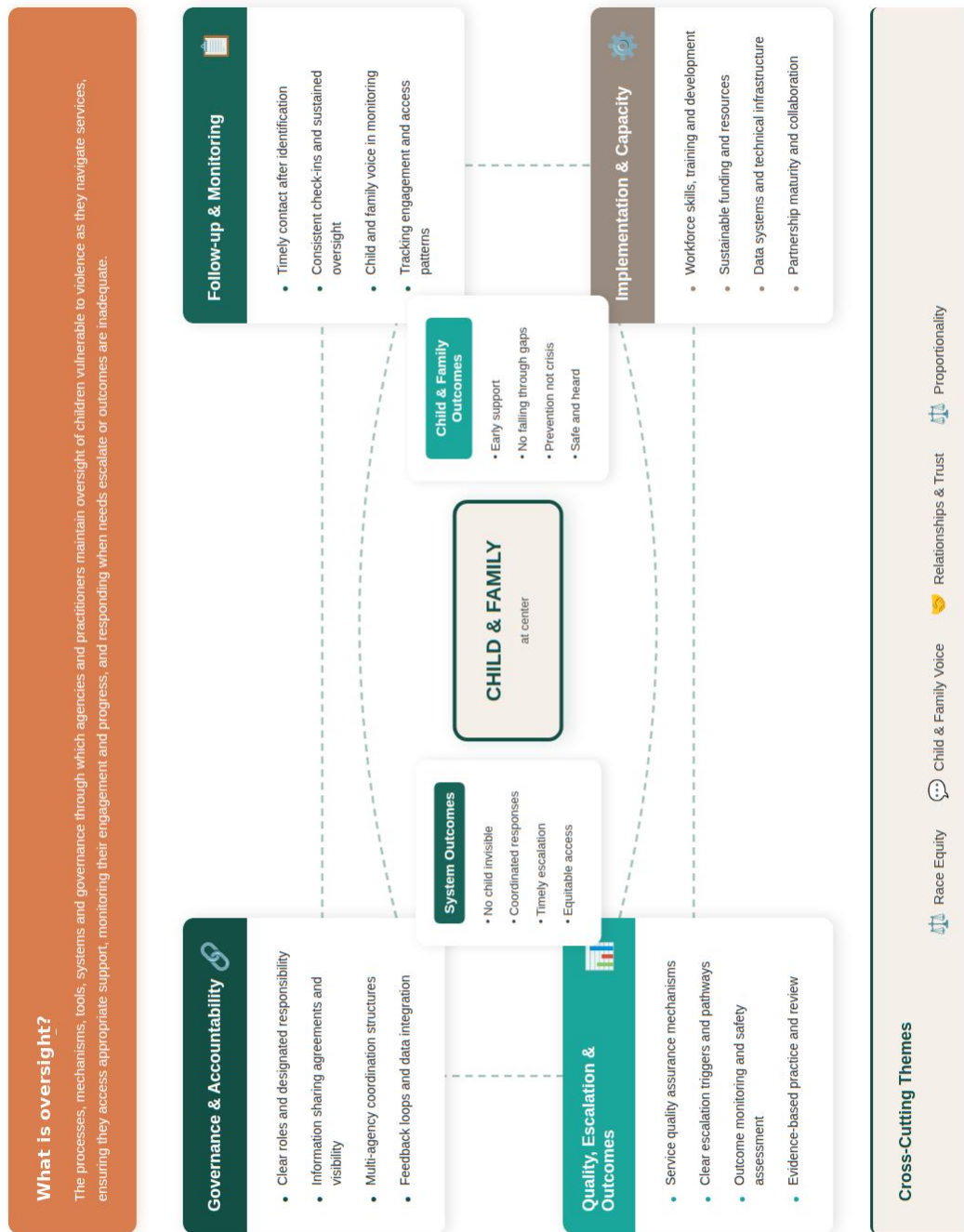


Figure 1: The four building blocks of oversight for children below the threshold

Building Block 1: Governance and Accountability

Core question: Who is responsible, and how does information enable accountability?

Governance and accountability is the foundation on which everything else rests. Without it, the other three building blocks cannot function: you cannot monitor children if no one owns their oversight; you cannot escalate if there is no structure to escalate to; you cannot measure outcomes if accountability stops at the point of referral. This chapter looks at what governance and accountability means in practice for children below the threshold, where the fieldwork found the most significant differences between areas, and what the evidence suggests enables more effective oversight.

The evidence review found that clear accountability for this group of children is often absent or spread too thinly across agencies in most systems, with no single person or team clearly in charge. A Joint Targeted Area Inspection (JTAI) found widespread confusion among professionals about who holds responsibility when cases do not meet statutory thresholds (Ofsted, CQC, HMICFRS and HM Inspectorate of Probation, 2023). Research by Lloyd and Firmin (2020) found that 81% of children experiencing significant extra-familial harm received No Further Action decisions from children's social care, because the Children Act 1989 requires harm to be linked to inadequate parental care before statutory child protection can apply. For children experiencing violence outside the home, the picture has shifted. Working Together 2026 now recognises extra-familial harm more explicitly and expects all children facing harm outside the home to receive a safeguarding response (DfE, 2026a). What it does not do is create a single, named, accountable owner for keeping sight of a child who does not meet a statutory threshold. The result is that, in practice, responsibility for checking whether these children are still being seen, whether the support they were referred to was accessed, and what happened next, can still fall to no one in particular.

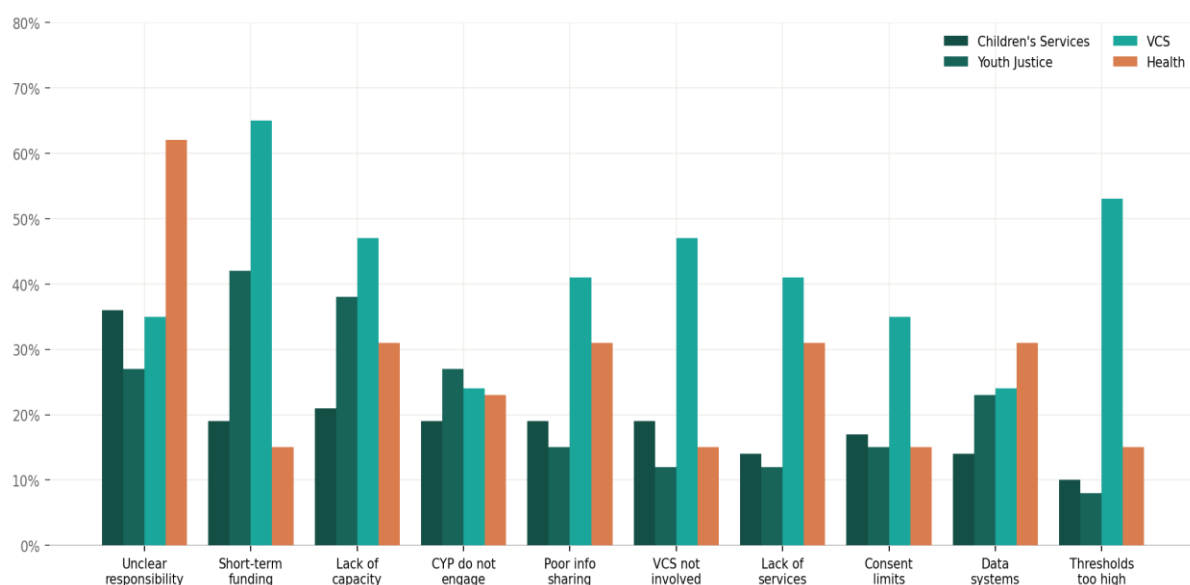


Figure 2: Barriers to effective oversight, by sector. Health 62% unclear responsibility; voluntary and community sector (VCS) 65% short-term funding, 53% thresholds too high. Source: Survey Q20 by sector.

The national survey confirmed this at scale. When practitioners were asked who takes the lead for oversight of children below the threshold in their area, the most common answer was ‘it varies from case to case,’ given by 26% of respondents. Only 9% said that roles were very clear. Around a third cited unclear responsibility as one of the main barriers to effective oversight in their area. Fifteen per cent described their area as having no consistent approach to tracking children below the threshold at all, and 11% reported that no one systematically checks whether these children’s risk levels change over time. The picture is equally thin when it comes to data: 58% of survey respondents either did not know how outcome information was collected in their area or confirmed that no systematic collection existed.

Who is accountable? Named individuals, not just systems

Strong	<i>Confirmed across all three evidence strands. Every fieldwork area with stronger oversight had a named lead. Every area that struggled did not.</i>
---------------	---

The clearest finding from this research is that naming a specific individual or team as accountable for every below-threshold child matters more than the particular governance structure those responsibilities sit within. Areas that have developed more effective oversight have a named person or team responsible for every child identified as vulnerable. Areas that struggle have panels, meetings, and mechanisms, but no named individual with clear responsibility for any specific child. In practice these leads took different forms: in one area a senior early intervention officer leading a dedicated youth-violence unit, in another a prevention-panel coordinator funded through Home Office Young Futures programme funding, in a third a district council panel lead who carried out initial home visits and held the tracking record, and in a fourth a service manager for an integrated youth justice and early support service. What mattered was that a specific person or team was accountable for each child, not the job title or where they sat.

This finding came through consistently across all the interviews. Practitioners described the same pattern in different ways: children discussed at a panel and then lost; referrals made with no one following up because nobody owned the outcome; cases that fell through gaps when a worker left because the accountability was personal rather than built into the system. A practitioner captured the challenge directly: the panel creates space to talk about children, but the question of who holds the case afterwards is left unresolved.

The accountability gap is not experienced equally across agencies. When the survey results are broken down by respondent role, 62% of health practitioners cited unclear responsibility as a barrier to effective oversight, nearly double the rate for children’s social care (36%), and the highest of any sector in the survey. This is significant because health professionals working in A&E departments, school nursing, Child and Adolescent Mental Health Services (CAMHS), and primary care are among the services most likely to see children below the threshold repeatedly over time. They see these children through routine contact such as school health and primary care and through crisis points such as A&E attendances, which is why they often hold sight of a child over time even when no single agency has taken formal

responsibility (Youth Endowment Fund, 2025a). If health practitioners do not know who owns oversight of these children, the system loses visibility of what happens next for that child. The survey data from health respondents points to a compounding pattern: 31% also cited no way to track outcomes as a barrier and 31% cited inadequate data systems. No fieldwork area described a model that had systematically addressed this.

The Southport Inquiry (2026) reached an identical conclusion from a very different starting point. Examining the multi-agency failures preceding a fatal attack, the inquiry found that ‘there was not (and still today is not) any specific multi-agency forum for considering and assessing the risk’ posed by children with complex profiles, and ‘no multi-agency process for assessing, sharing and recording risk of this kind’ (Vol 2, Ch 9, para 272). The inquiry described an ‘inappropriate merry-go-round of referrals, assessments, case-closures and hand-offs’ (Vol 1, para 18) that maps directly onto the accountability voids this research documents for children below the threshold. That case concerned a child who posed a risk to others, which is one of the routes by which children arrive in the group this report covers. The structural mechanism is the same: accountability dissipates at each transition between agencies when no single person or forum holds sustained responsibility.

“Our Commissioner recognised that within our county, we were waiting for children and families to be at a point where they were significantly not coping before any support was being put in place. He said: we’re going to fill that gap because it will have an impact on policing.”

Senior Early Intervention Officer, Area 5

Across eleven areas, at least six different governance models were found for below-threshold oversight. In Area 1, the prevention team sits within youth services rather than youth justice, as a deliberate decision. In Area 2, a Children’s Services exploitation team offers a consultation service that any practitioner can access without needing to meet a formal threshold. In Area 4, a district council Anti-Social Behaviour officer coordinates the only district council-led prevention panel found in the fieldwork. In Area 5, the Police, Fire and Crime Commissioner funded an early intervention service 8.5 years ago and co-located workers with police. In Area 6, named workers are allocated to every child referred to the youth justice service, within an eight-agency panel structure. In Area 10, youth justice and early support sit within a single integrated service with 78 to 89% of the caseload in the preventative space.

What these models share is not their structure but a common principle: if no one is named as accountable for a child’s oversight, that child will fall between agencies and nobody will act. The question every partnership needs to answer is not which agency should own this, but which specific team or person does.

Where oversight sits in the system shapes what it can do

Emerging	Consistent across multiple fieldwork areas. The decision about where oversight sits shapes whether families experience oversight as support or surveillance, and
----------	--

therefore whether consent is secured. It also shapes who the oversight team partners with and how.

Where the oversight function sits in the organisational structure is one of the most consequential decisions a partnership makes, because it shapes not only the approach to working with children and families but also the pattern of multi-agency relationships that develop around it. This was not something we set out to explore in the research design: it emerged from the fieldwork as practitioners in different areas described, independently and from different starting points, how the location of their team affected what they were able to do.

Where areas place this function varies more than might be expected. Across the eleven, it sits most often within children's services or youth justice, while others hold it within policing, youth services or community safety, and several run it jointly across more than one of these.

Area 1 is distinct in that its prevention team sits within youth services rather than youth justice. The team uses a youth work approach in which young people are offered support and choose to take it up. The prevention team manager described the approach as 'very much of a youth work approach because it's not mandated attendance,' and the service reports high rates of voluntary engagement as a result. As the team sits outside the statutory justice system, the team can engage more naturally with schools, voluntary sector partners, and families who have had difficult previous experiences of statutory services. What Area 1's experience points to is that families with difficult previous experiences of statutory services respond differently to an offer that does not come from one of them. That applies to children's services and early help as much as it does to youth justice, so the point is about how the offer feels to families rather than about youth justice being the wrong home for this work. Targeted youth support of this kind is a recognised model in many areas, sitting within children's services or youth services and operating through an open referral route rather than a justice gateway. It emerged from the Every Child Matters reforms and the Youth Matters and Aiming High for Young People strategies of 2005 to 2007 to identify vulnerable young people early and coordinate support around them before their needs reached statutory thresholds, typically through the Common Assessment Framework and a lead professional (DCSF, 2008; HM Treasury and DCSF, 2007). It was for many years a principal route through which areas kept a coordinated view of young people below the threshold who were at risk, including some at risk of involvement in violence. However, that infrastructure has since contracted sharply, in line with the wider decline in youth-service funding and capacity documented elsewhere in this report (Centre for Young Lives, 2025). This once-common vehicle for non-statutory oversight is now far less widely available.

"It doesn't sit within Youth Justice and I think we're one of the only local authorities where it doesn't. It sits more closely alongside youth services than Youth Justice."

Prevention Team Manager, Area 1

In Area 3, the pre-court team sits within youth justice services. In Area 6, police are co-located with the youth justice prevention hub and the oversight pathway runs through the Out of Court Disposals (O OCD) panel, which sits within the youth justice structure. In Area 10, the service manager leads both youth justice and early support within a single integrated team. These are all legitimate and workable arrangements, and in each case practitioners have thought carefully about how to make them work in ways that serve children well.

The contrast with areas where oversight sits within youth justice is not a straightforward one. Practitioners in Area 3, Area 6 and Area 10, were all thoughtful about the stigma question and had taken steps to address it: using the title ‘youth worker’ rather than ‘youth justice worker,’ writing plans in language that centres the young person rather than the system, and making clear to families that involvement is voluntary. One senior practitioner in Area 3 described youth justice involvement as ‘something really stigmatising,’ noting that the Turnaround programme had demonstrated what a prevention approach delivered outside youth justice could achieve, while acknowledging that it is not the right model for every child, and that some need the more universal services that the third sector can provide.

The independent process and implementation evaluation of the Turnaround programme (Turner et al., 2026) provides the most detailed evidence available on what voluntary, prevention-focused oversight looks like at national scale. Between December 2022 and December 2024, 38,704 children were referred to the programme through 155 Youth Offending Teams, all children who had come to the attention of the justice system but were not on statutory caseloads. The evaluation found the programme filled ‘clear gaps in existing early intervention, prevention and diversion provision’ (p.31). For this report’s findings on where oversight sits, the Turnaround model is significant because it operates through youth justice infrastructure but delivers a welfare-focused response, demonstrating that the location of the oversight function shapes but does not determine the approach. Importantly, the evaluation also found that just over half of referred children progressed to assessment, raising the same question as this research: what happened to those who did not?

The decision about where oversight sits also has implications for multi-agency working that go beyond the individual relationship with the child. Where oversight sits within youth services or a dedicated prevention function, the team tends to build a wider and more varied partnership network over time, including schools, voluntary and community sector organisations, and health. Where it sits within youth justice, the primary partnerships are more likely to be with police and statutory children’s services, which are valuable but narrower. In Area 1, where the oversight function sits within youth services rather than youth justice, the voluntary and community sector has a decision-making seat at the prevention panel, an arrangement that was less consistently described in areas where the function sits within youth justice structures.

There is an important trade-off here to consider. Where oversight sits outside youth justice, the transition for children who do eventually escalate to statutory youth justice can be abrupt, with a different team, a different approach, and no established relationship. The prevention team in Area 1 described this as an unresolved challenge despite multiple efforts to bridge it. The population affected by this transition is likely to be relatively small, with 92% of children in Area 1 for example, not progressing to youth justice. However, partnerships making the decision about where oversight sits should still think through this transition from the outset rather than discovering it after the fact.

Community Safety Partnerships have a particular relevance to this question. Established under the Crime and Disorder Act 1998, they bring together the police, the local authority, health, fire and rescue and probation as responsible authorities with a statutory duty to reduce crime and disorder. The Serious Violence Duty, introduced through the Police, Crime, Sentencing and Courts Act 2022, amended that Act to make preventing and reducing serious violence a specific responsibility of these partnerships, and in many areas they are the structure through which the Home Office’s Young Futures prevention partnership panels are now being delivered. This gives Community Safety Partnerships a clear stake in the oversight of children below the threshold. The challenge is the one that runs throughout this report. Community safety work has traditionally been organised around places and offences rather than around individual children, so a partnership can hold a serious-violence duty without anyone holding responsibility for a particular child. Translating that statutory duty into a named, welfare-led responsibility for each child below the threshold is exactly the governance step that the strongest fieldwork areas had taken and that many had not.

Multi-agency coordination: meetings are not the same as oversight

Strong	<i>Confirmed across all three evidence strands and all eleven fieldwork areas. Panel governance exists almost universally. What it produces varies enormously.</i>
---------------	--

Multi-agency panels and coordination arrangements exist in every area. They are the most commonly cited oversight mechanism in the survey, with 52% of respondents saying their area uses them to track children below the threshold. The value of bringing multiple agencies together to share information and agree responses is well established.

However, having a panel is not the same as having oversight. The JTAI found that the same children were discussed at multiple meetings without clear evidence of action (Ofsted, CQC, HMICFRS and HM Inspectorate of Probation, 2024). The fieldwork confirmed this at the level of individual areas. In Area 11, practitioners described a governance landscape that includes a MACE panel, prevention panels, a youth outreach programme, custody navigators, community wardens, and a strategic sub-group, supported by multiple governance documents. Yet the same practitioners also acknowledged that their team had never been fully established, that outcome tracking did not yet exist, and that post-panel monitoring depended on individual practitioner initiative rather than any systematic mechanism. One practitioner put this plainly: ‘We are not doing enough to monitor these children. We haven’t nailed that bit yet.’ This is offered not as a criticism but as an honest account of a pattern that many areas will recognise: structural investment in governance that has not yet translated into systematic oversight.

Area 2 offers a useful illustration of a different approach. A four-level adolescent exploitation framework operates on four risk levels, with defined criteria and review processes at each. A consultation model means that any practitioner can access specialist exploitation analysis without needing to formally refer. Rather than one monthly meeting, weekly intelligence meetings replaced the previous arrangement and reduced the time between intelligence

being flagged and action being taken from 30 days to 9. The governance framework is designed around producing decisions and actions, not just sharing information.

How Area 2 uses multiple entry points to avoid the binary

Area 2's SAFER consultation model means that any early help key worker, school Designated Safeguarding Lead (DSL), or voluntary sector practitioner can pick up the phone and access specialist exploitation advice without the child needing to meet a formal panel threshold. The consultation might result in a recommendation to escalate to MACE, a police visit to build a relationship with the child, allocation of an exploitation key worker, or simply advice and safety planning resources. No single referral route. No binary: referred or not. The outcome is matched to the specific child. A practitioner described the logic: 'By having multiple ways in and multiple partnership structures, the school can say I'm worried about Billy and the police can say we've had two bits of intelligence about Billy.'

Area 6 provides a further illustration of one aspect of what effective multi-agency coordination can look like in practice. The eight-agency Out of Court Disposals (OOC) panel meets weekly, with Child First principles embedded and assessments shared two days before the meeting. A particularly useful feature is the Youth Support Group, which meets fortnightly not to discuss new cases but specifically to check whether children referred at a previous meeting were actually picked up by the services they were allocated to. This simple mechanism closes the loop that most panels leave open, though as with most areas, outcome measurement for children below the threshold remains an area for further development. A practitioner described the principle: 'We don't just let them drift off.'

The survey evidence on feedback loops reinforces why this matters. When practitioners were asked how they find out what happened after referring a below-threshold child, only 23% described receiving routine feedback. For 26%, feedback varies from case to case. Around 17% reported either receiving no feedback at all or having to actively chase the receiving service to find out what happened. For many practitioners, the referral is the last point of contact: a child is sent into a system and there is no mechanism to check what happened next. Where feedback loops do not exist, the governance system loses visibility of the child at the point where one agency's responsibility ends.

The survey also showed that voluntary and community sector (VCS) organisations are significantly underrepresented in the governance structures where these decisions are made. Nearly half (47%) of VCS respondents reported being excluded from strategic planning and decision-making for children below the threshold, against 22% of respondents overall. This matters because VCS organisations are often the services maintaining the longest-running relationships with children and families, yet they are cut off from the governance structures that determine how those children are tracked and supported.

More governance structures do not mean more oversight

Having more panels, meetings, and processes does not mean more children are being tracked. It means more forums are discussing children without the connective tissue, named accountability, post-panel follow-up, and outcome measurement, that turns discussion into

oversight. The question to ask of any panel structure is not how many meetings it involves but what happens to each child after each meeting ends.

Information sharing: the decision to share matters more than the technology

Strong

Consistent across all three evidence strands. Technology increases information sharing capacity where the will to share exists. It does not create that will.

Information sharing between agencies is consistently cited as both a barrier and an enabler of effective oversight. In the survey, poor information sharing between agencies was cited as a barrier by 23% of respondents, while data-sharing systems were cited as an enabler by 22%. This framing of the challenge as primarily a technical one, requiring better systems or clearer guidance on data protection legislation, is understandable but partially misleading.

One reason information sharing failures persist is that agencies frequently cite legal and data protection constraints as the obstacle. Working Together 2026 addresses this directly, explicitly stating that data protection legislation is not a barrier to sharing information, and that consent is not required to share personal information where there is a legitimate purpose for doing so (DfE, 2026a, pp.24-25). If the legal basis for sharing is clearer than many practitioners believe, then the barriers that remain are cultural and decisional: whether agencies have built the relationships, the habits, and the accountability structures that make sharing the default rather than the exception. That is what this research found in the fieldwork.

The fieldwork found a wide range of approaches to information sharing, from manual to automated, and both ends of the spectrum produced effective oversight where the commitment to share existed. Area 1's information sharing is manual: a spreadsheet and a practitioner at the front door who cross-references police notifications against partner systems. Area 9 has built a Power BI dashboard using the Cambridge Crime Harm Index that automatically identifies children based on their cumulative contact with police services across 90 and 180-day windows. Area 5 uses an application that connects directly to the police records system without any manual input. All three approaches work.

The Southport Inquiry documented the consequences of poor information sharing with unusual precision: risk information was 'not adequately shared between agencies and was lost or diluted over time even within agencies' (Vol 1, para 20), there was 'no single point of truth for events relating to a child' across the authority's own systems (Vol 2, para 298), and the cumulative significance of multiple contacts was not recognised. These failures occurred in a statutory context with formal case management structures in place. The fieldwork in this research suggests the same pattern operates at the non-statutory level, but without even those structures to fall back on: information about a child's history, current involvement with other services, and previous contacts is routinely not captured in referrals, not fed back after a service ends, and not held anywhere in aggregate.

StreetGames, a national network supporting locally trusted organisations to deliver sport-based early intervention with young people at risk of violence, has developed referral guidance specifically designed to address this gap (StreetGames, 2024). The guidance sets out what referral agencies should include about a young person’s circumstances when making a referral, what feedback providers should give back about engagement and progress, and how both parties should review the pathway over time. It also distinguishes between formal, informal and self-referral routes, recognising that the young people hardest to reach are often those least likely to arrive through a structured referral process. That level of intentional design around information flow is the exception rather than the norm across the non-statutory landscape this research describes.

“Lots of them had come to our attention, not through being victims or suspects, but actually being linked to adults who were known to us. They were in the house for that domestic, or their parents had done something violent, or a sibling had done something violent.”

Police officer, Area 9

It is important to be clear about what data-driven identification tools of this kind can and cannot do. Early work in the contextual safeguarding field, including peer mapping approaches (Lloyd and Firmin, 2020), showed that data-led identification of children associated with known risk contexts carried a real danger of labelling and tracking children who had not themselves come to harm, and of using association as a proxy for risk in ways that could reinforce existing biases and widen surveillance nets inappropriately. This caution remains relevant. A cumulative harm dashboard is a tool for prompting professional attention and relational outreach, not for classifying or making decisions about children. The response to a child being identified through such a system should always begin with a relational question: does this child need someone to reach out to them? Not with a determination that they are at risk. The Area 9 practitioner was explicit about this: the dashboard changes the prompt, not the professional judgement.

Consent: the gateway to sustained oversight

Strong

The most extensively evidenced finding in this building block. Confirmed across all three evidence strands and all eleven fieldwork areas. Five distinct approaches identified.

Consent is the point at which governance structures meet the reality of working with children and families voluntarily. For children below the threshold, there is no legal requirement to engage: if a family declines involvement, there is no mechanism to maintain oversight regardless of the level of concern. This is the fundamental challenge that distinguishes oversight of this group from statutory case management, and no area has fully resolved it. The Southport Inquiry’s social care chapter found that, in cases not subject to a child protection pathway, which is the exact population this research is concerned with, ‘the

requirement of consent to work with a family can sometimes act as a bar to making appropriate progress' (Vol 2, Ch 9, para 304). An independent evaluation of the same authority found that 'on some of the more complex cases not following a child protection pathway, work is not progressed due to repeated lack of consent' and that 'the process for dispensing with consent needs to be tightened' (para 308). The relevance here is direct: children below the threshold are, by definition, children not on a child protection pathway, and the consent dynamic the inquiry describes, where declining involvement ends all contact rather than prompting a structured response, is the same dynamic this research found across multiple fieldwork areas. What the Southport findings add is that this gap reaches well beyond violence prevention partnerships. It is now recognised across the whole non-statutory tier of multi-agency working, and a statutory inquiry has identified it as something that needs deliberate governance design rather than being left to practitioner discretion. Consent, in other words, is a system design question, not a case-by-case judgement call.

What the fieldwork found is that how an area approaches consent shapes outcomes significantly, and that five distinct approaches exist across the areas we spoke to. These are not a hierarchy. Each reflects the service model and local context of the area that uses it. But they are meaningfully different, and the choice between them is a governance decision, not a procedural one.

Five approaches to consent

1. Seeking consent earlier	2. Written contact first	3. A youth-work framing	4. A repeated offer	5. Working around the barrier
Area 11 The partnership is thinking carefully about when in the process consent is sought, moving the conversation earlier so there is room for a fuller discussion with families before they are formally approached.	Area 4 A letter is sent to families rather than an unannounced visit, giving them time to consider the offer before they are asked to respond. The approach signals from the outset that the service will not push past a stated boundary.	Area 1 Consent is sought through a youth-work frame rather than a statutory one, and the service reports high rates of voluntary engagement. Young people are offered the service on their own terms. Where drop-off happened, it came earlier, when another service had framed the offer in less relational terms. <i>"The messenger and the framing mattered as much as the ask itself."</i>	Area 5 The service accepts that the first contact will not always succeed: two or three referrals may be needed before a young person engages. Rather than treating refusal as closure, it stays available and keeps offering support until the young person is ready. <i>"It is our job to engage that young person, not that young person to engage with us."</i>	Area 7 Detached youth work and contextual approaches maintain informal oversight through a trusted community presence when formal consent cannot be obtained.

The first approach, and the earliest in the process, is seeking consent earlier. In Area 11, the partnership is thinking carefully about when in the process consent is sought, moving the conversation earlier so there is room for a fuller discussion with families before they are formally approached. The second approach, written contact first, was developed in Area 4: a letter is sent to families rather than an unannounced visit, giving them time to consider the offer before they are asked to respond. The approach signals from the outset that the service will not push past a stated boundary.

“Sometimes it can feel a bit stuck... parents aren’t consenting to early help or to section 17, and then it’s like, oh, what do we do then? We still think that there’s a need, but it’s not threshold of section 47.”

Strategic lead, Area 11

The third approach is a youth-work framing, developed in Area 1. The service reports high rates of voluntary engagement, which the prevention team manager attributes to a relational model in which consent is sought through a youth work frame rather than a statutory one. Young people are offered the service as something for them, at their pace, on their terms. The prevention team manager described how the drop-off, where it happened at all, came not when families met the prevention team but earlier, when another service had described the offer in less relational terms. The messenger and the framing mattered as much as the ask itself. The fourth approach is a repeated offer. Area 5 accepts that the first contact will not always succeed: practitioners describe two or three referrals being needed before a young person agrees to engage. Rather than treating refusal as closure, the service stays available and keeps offering support until the young person is ready. A separate but complementary mechanism in the same area is the golden hour model, in which a worker attends the custody suite within an hour of a young person’s arrest. This is about reaching a child at the right moment, rather than reaching out repeatedly over time, and the two should not be treated as the same thing. The principle behind both, as one practitioner put it, is that ‘it is our job to engage that young person, not that young person to engage with us.’

“Consent is denied. You’ll see a lot coming through that then consent is denied. If a social worker phones up, I wonder if there’s a different approach at that point, a more relational approach.”

Strategic lead, Area 8

The fifth approach, working around the barrier, is visible in Area 7: detached youth work and contextual approaches maintain informal oversight through trusted community presence when formal consent cannot be obtained.

The survey found no significant difference between sectors in how practitioners experience consent as a barrier. It is cited at similar rates by police, children’s social care, education, health, and voluntary sector respondents. Consent is a system-wide feature of working voluntarily with this group rather than a problem that belongs to any single agency, and it requires a system-wide response.

Across the fieldwork, areas that found consent more difficult to navigate tended to share a common feature: the first contact was made by a statutory worker, in a statutory-sounding way, often with families who had long histories of involvement with statutory services and whose experience of those services had not always felt supportive. This is not a reflection on the skills of individual practitioners, but on how the service is framed and introduced to families. The evidence from Area 1 and Area 5 suggests that the solution lies less in improved follow-up procedures and more in who makes the first approach and how they

frame the offer. Recording consent refusals separately from No Further Action (NFA) decisions, as one fieldwork area had begun to do, is a simple step that makes the scale and pattern of consent barriers visible and something that can actually be acted on.

Race equity and governance: a significant gap

Evidence gap

15 of 17 fieldwork interviews did not discuss race. Only 2 of 129 survey respondents raised it. The absence of this conversation across all evidence sources is itself a finding.

The most significant governance gap identified in this research is that no area we spoke to could say whether its oversight system was working equitably, because none held the data that would show it. No area described systematically breaking down oversight or panel data by ethnicity. Only two of 129 survey respondents raised race or ethnicity in their free-text responses.

The evidence review showed that Black and Mixed Heritage children face a double bind: they are frequently invisible to services when they need protection, their vulnerability minimised or overlooked, yet they become highly visible when associated with harm or violence, and are more likely to receive responses rooted in the justice system rather than welfare. Adultification bias, where Black children are perceived as older and more responsible than their white peers, affects threshold decisions and means that Black children are less likely to be seen as needing protection at the point where oversight could prevent harm from escalating (Huegler et al., 2025).

Several areas recognised disproportionality as a live issue without yet having the means to act on it. Area 7 was working towards tracking adultification and disproportionality within its own cohort. In Area 6, the team deliberately matched workers to children, so that Black children could be offered a Black worker where that was likely to help. Area 11 measured disproportionality among victims and suspects, but not among the children it held oversight of. Area 9 noted that Working Together 2026 would require partnerships to break their data down by characteristics (DfE, 2026a), and was candid about not being sure it had good enough information to do so. Area 3 identified disproportionality as a structural barrier, particularly in relation to schools. What none of them had was data on their own below-threshold cohort broken down by ethnicity, and recognition without data is as far as this had reached.

A governance system that does not break down its data by ethnicity cannot know whether it is working equitably. It cannot know whether Black children are being tracked at the same rate as white children, whether they are more likely to receive No Further Action decisions, or whether they are less likely to be offered support and more likely to be referred to justice responses when needs escalate. This gap has practical consequences for whether oversight systems can identify and address inequity.

Three minimum standards for more equitable governance

Based on the evidence review and Area 3 fieldwork: all panel, referral, and outcome data should be broken down by ethnicity to make patterns visible. Panel decision-making should include

explicit consideration of adultification bias, with training and written guidance provided to all panel members. Areas should examine whether their consent approaches are producing different outcomes by ethnicity, given that families with difficult prior experiences of statutory services may include a disproportionate number of Black and minoritised families.

What this means in practice

The evidence across governance and accountability points to three insights for partnerships working to strengthen their oversight of children below the threshold.

Insight 1: Name a lead practitioner for every child, with a welfare not a justice lens

Every partnership should be able to answer two questions: which specific team is responsible for children below the threshold in our area, and which named individual is responsible for each child identified? Where the answer to either question is 'it varies' or 'it depends,' the governance foundation for oversight is not in place. This builds on the established 'lead professional' function in early help and Working Together rather than being a new role; what the strong areas shared was that the role was deliberately resourced, through a funded prevention-panel coordinator, a Police and Crime Commissioner post, or a programme-funded worker, rather than added to an existing caseload.

The fieldwork found that the named lead function can work across a range of structures: youth services, Office of Police and Crime Commissioner (OPCC), pre-court youth justice teams, dedicated exploitation teams, and district council functions. What the structure cannot be is absent or unclear. Prevention and oversight panels should have written terms of reference specifying which agency holds the lead function, what the maximum timeframe is for allocating a named worker after a child is identified, and what happens when that worker is unavailable.

The placement of the oversight function should be a conscious decision. Where it sits within statutory youth justice, partnerships should actively think about how to reduce stigma barriers for voluntary engagement: through the language workers use, the settings they work in, and how the offer to families is framed. Where it sits within youth services or a dedicated prevention function, partnerships should think through in advance what happens when children escalate to statutory services. Either arrangement can work. What matters is that the decision is made deliberately and its implications are managed.

Insight 2: Design panels for decisions, with terms of reference that address oversight

Multi-agency prevention and oversight panels should be designed to produce decisions and actions, not just information sharing. This means written terms of reference with defined membership, including a seat for the voluntary and community sector with genuine decision-making involvement. The survey evidence gives this clear support: nearly half (47%) of VCS respondents reported being excluded from strategic planning for children below the threshold, despite VCS organisations often being the services maintaining the longest relationships with children and families.

Panels should have a maximum number of cases per meeting to ensure adequate time for each child, explicit escalation criteria so that a change in a child's circumstances triggers a

change in response, and a systematic way of checking whether children discussed at one meeting were actually reached by the service they were allocated to before the next meeting. Partnerships should also look honestly at their existing panel landscape: where multiple panels discuss similar groups of children without clear differences in function or outcome, consolidating around fewer, better-designed mechanisms with stronger accountability is likely to produce better oversight than adding further layers of governance.

Insight 3: Treat consent as a governance question, separating consent for support from consent for monitoring

Every partnership should have a deliberate approach to consent that matches the service model, rather than treating it as a procedural step before the real work begins. The five approaches identified in the fieldwork, seeking consent earlier, written contact first, a youth-work framing, a repeated offer, and working around the barrier, offer different starting points depending on local context and workforce.

The evidence strongly suggests that who makes the first approach, and how they frame the offer, is the most important factor in consent outcomes. Partnerships that route initial contact through statutory workers with families who have complex histories should consider whether a different person, a youth worker, a voluntary sector contact, or a trusted school professional, would produce a different result. Keeping a record of consent refusals separately from NFA decisions is a simple change that makes the pattern of consent barriers visible and something that can be systematically addressed.

CASE STUDY

Area 1

A named team, a youth work approach, and a decision to measure: how clear accountability and deliberate placement support high rates of voluntary engagement and five years of outcome data

Area 1 sits within a larger area covered by a single police force and receives devolved violence-reduction funding. The prevention model operates within a force-wide framework that uses police data to check every 24 hours across the force area for any young person under 18 named as a suspect. Over a twelve-month period, the force recorded 15,796 crimes with children as named suspects, of which 70% were closed with no further action and no evidence of referral to support services. The framework was designed to make those children visible to services.

The area's local adaptation of the force-wide model is distinctive in three ways. First, the prevention team sits within youth services rather than youth justice, a deliberate decision with measurable effects: the service reports high rates of voluntary engagement, with the prevention team manager describing the approach as 'very much of a youth work approach because it's not mandated attendance.' Second, beyond the framework's two-incident threshold, the area placed a part-time prevention worker at the single point of access who screens all police notifications as they arrive. Third, referrals reach the model through three roughly equal pathways. The first is step-down from social care, where a child whose case is closing at the statutory level but who still needs oversight is passed across rather than simply discharged. The second is front-door screening, where children who are referred in but do

not meet the statutory threshold are routed to the below-threshold offer instead of receiving no further action. The third is a multi-agency panel, where partners bring children of concern who have not been referred through either of the other routes. Because the three routes carry similar numbers, the model does not depend on any single one of them working well.

Once a referral arrives, it is allocated to the most appropriate worker within three working days, matching worker skills and gender. The worker then has five working days to make contact with the family, with separate visits to the parent and the young person to explain the service and begin the assessment process. The assessment uses an adapted holistic framework that looks at root causes rather than just the presenting incident, covering home life, education, friendships, and health. A plan is co-created with the young person at their pace, reviewed through a Team Around the Family (TAF) every six weeks, with the option of flexible funding across five categories including education support, activities, and support to secure an Education, Health and Care Plan (EHCP).

The outcome tracking is the most complete found across all the fieldwork. Every prevention case, not just those receiving specific programme funding, is tracked at 3, 6, 9 and 12 months. The tracker captures age, address for ward-level analysis, lead practitioner, support offered, and outcomes. The area reports that 92% of young people do not progress to youth justice, with local reoffending of approximately 8% against a national rate of around 30%. These are the area's own figures and have not been independently evaluated, so they are best read as promising rather than as a proven effect of the model. The ward-level analysis has produced a finding that has directly shaped local investment: where a young person lives is a stronger predictor of involvement in violence than their age, school, or any individual characteristic, which has driven community-level as well as individual responses.

"Every young person gets a review at 3, 6, 9, 12 months to then help us look at not just our Turnaround young people, but all the cohort that have been through prevention. Our outcomes are really, really high compared to national."

Prevention Team Manager, Area 1

One consideration is worth noting for partnerships thinking about replication: the automated referral mechanism depends on the force's centralised data infrastructure across ten local authority areas. Forces elsewhere would need to build an equivalent automated screening capability at force level before this referral route could function, though the principle is transferable even where the exact mechanism is not.

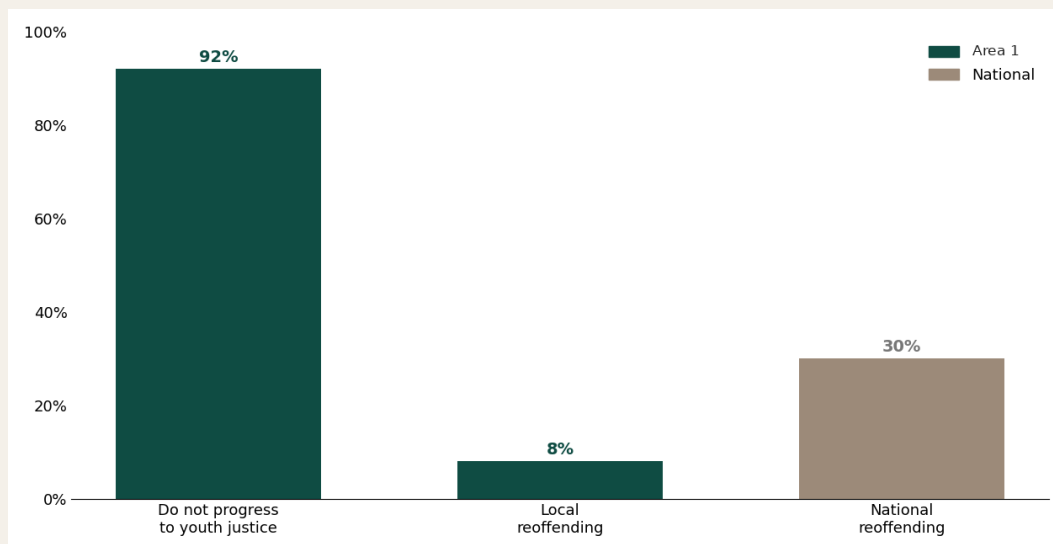


Figure 3: Area 1 outcome tracking. The area reports 92% non-progression to youth justice and local reoffending of approximately 8% against a national rate of approximately 30%. Source: fieldwork interview. Self-reported data, not independently evaluated.

Building Block 2: Follow-up and Monitoring

Core question: How do agencies track access, engagement, and progress over time?

If governance and accountability is the foundation, follow-up and monitoring is where that foundation is tested in practice. Multi-agency panels and oversight meetings can have written terms of reference, leads can be designated, and referral pathways can be mapped. The question that this building block asks is what happens next: whether the child actually accessed the support they were referred to, whether anyone is checking whether their circumstances are changing, and what happens as children move through and beyond services, whether they complete a programme, step down from support, or lose contact with services altogether. These are not administrative questions. They are the practical test of whether governance arrangements translate into sustained oversight in practice.

The evidence review found that sustained monitoring for children below the threshold rarely exists. Children receiving No Further Action decisions exit all systems with no follow-up arrangements. What research describes as a binary system, statutory intervention or nothing, means that once a child does not meet the threshold for formal case management, there is typically no mechanism to check what happens to them. Research examining child sexual exploitation found re-referral rates of 29% within twelve months (Shorrocks et al., 2020), suggesting that when initial responses do not include sustained monitoring, children return to services in greater difficulty.

The Oversight Functions Grid developed for this research rated eleven fieldwork areas across six oversight functions. The pattern it revealed is the central finding of this building block: identification (Function 1) and triage (Function 2) are present in every area, but active monitoring (Function 4) is strong in only three of eleven areas, and outcome review (Function 6) is strong in only two. Throughout this report, 'strong' refers to areas rated ✓✓ in the grid, meaning the function is systematic and embedded rather than present but inconsistent. The system gets progressively weaker as you follow a child's journey through it. Areas can find children at risk. Most cannot demonstrate what happens after they find them.

Area	F1 Identification	F2 Triage	F3 Allocation	F4 Monitoring	F5 Escalation	F6 Outcomes
Area 1	✓✓	✓✓	✓✓	✓✓	✓✓	✓
Area 5	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Area 2	✓✓	✓✓	✓	✓	✓✓	~
Area 9	✓✓	✓	~	~	~	~
Area 10	✓✓	✓	✓✓	✓✓	✓✓	✓✓
Area 6	✓✓	✓✓	✓✓	✓	✓✓	✓
Area 3	✓	✓	✓	✗	~	~
Area 7	✓✓	✓	~	✗	~	✗
Area 11	✓✓	✓	~	✗	✗	✗
Area 4	✓	✓	✓	~	~	~
Area 8	✓✓	✓	✓	✓	✓	✓

Areas present or strong (✓ or ✓✓)	11/11	11/11	8/11	6/11	6/11	5/11
-----------------------------------	-------	-------	------	------	------	------

Figure 4: Oversight functions heatmap. Identification (F1) is present in every area and strong in 9; active monitoring (F4) is strong in 3, escalation (F5) in 5 and outcome review (F6) in 2. Key: strong (dark green), present (light green), partial (amber), absent (red). Source: Oversight Functions Grid.

This chapter examines four dimensions of follow-up and monitoring: the spectrum from proactive to reactive identification; what sustained oversight looks like in practice and where it breaks down; the hidden cohorts that current monitoring approaches miss; and the role of children, young people, and families in the monitoring process itself.

From reactive to proactive: how children come to attention

Strong	<i>Consistent across all three evidence strands. Proactive data-driven identification reaches children that referral-based systems miss. The gap is what happens after identification in both models.</i>
---------------	---

The most consequential difference between fieldwork areas is not what they do once they are working with a child, but how they find children in the first place. Most oversight systems are reactive: they wait for a referral from a school, a police report, or another agency before a child comes to attention. A smaller number of areas have developed proactive approaches that use existing data to identify children whose cumulative pattern of contact suggests they need support, before a crisis triggers a referral.

The distinction matters because the children that reactive systems miss are often the children most at risk. A police officer described reviewing data on young people who had been involved in serious violence and finding that many had come to police attention years earlier. They appeared not as suspects or victims in their own right but as children connected to adults who were known to police: present when a parent was arrested, living at an address associated with a sibling's exploitation. No single incident was serious enough to prompt a referral. The cumulative picture was significant. A reactive referral system never sees the cumulative picture.

"There was a young lad linked to 43 or 46 burglaries. I'd never heard of him. The child was with his dad who was committing the offences. On all of those occasions, we'd missed that opportunity."

Police officer, Area 9

Area 9's Preventing Vulnerability Dashboard uses the Cambridge Crime Harm Index to score children's cumulative contact with police services across rolling 90 and 180-day windows, automatically flagging those whose accumulated harm score suggests they need someone to reach out. The dashboard was built by a practitioner from their own Master's thesis research, runs on Power BI that forces already have access to, and is described as low-cost

and replicable. The critical design principle is that the dashboard changes the prompt for professional attention, not the professional judgement: a child appearing on the dashboard should prompt a conversation about whether they need outreach, not a determination that they are at risk.

The force-wide screening framework operates a similar proactive approach at scale. Police systems are checked every 24 hours across the force area for any young person named as a suspect. Any child meeting the force-wide screening framework criteria, named as a suspect on two or more occasions within twelve months with indicators of trauma or invisibility to services, is referred to a weekly multi-agency panel. In one district, the only one with published inspection data, over 300 children have been supported through this mechanism who would previously have remained invisible to services.

Area 5 operates proactively through daily checks of the police records system, a golden hour model in which a worker attends the custody suite within an hour of a young person's arrest, and a girls pathway added after the team identified a gap in their referral cohort. Area 6 screens all Police Protection Notifications (PPNs) within 48 hours using a documented protocol with a professional curiosity mandate, and has expanded its reach to proactively offer its voluntary service to every young person receiving a community resolution.

At the other end of the spectrum, several areas described operating primarily on referrals. A practitioner responsible for oversight in one area described the reality directly: she was 'kind of almost waiting for them to come to my attention elsewhere as opposed to tracking them in any way.' In Area 3, the panel mechanism functions when staffed but has no proactive identification layer; between November 2025 and the time of the fieldwork, no new referrals had been made due to a loss of staffing. In both areas, children are found when another agency refers them in, not before.

"We shouldn't normalise that you've come to police attention several times in a 90-day period. Let's make sure you've got the support in place we would expect."

Police officer, Area 9

The proactive/reactive distinction matters, but it should not obscure a finding that applies to both: the gap is not in finding children, it is in what happens after they are found. A proactive system that surfaces a child who is then not followed up is no better, for sustained oversight, than a referral that nobody acts on.

Identification is the strongest part of the system, but not the solved one

Most areas, whether proactive or referral-based, can find children at risk. Identification was present in all 11 areas and strong in nine, but active monitoring was strong in only three of 11, and outcome review in only two. The challenge these practice insights are most focused on is not how to find children but what happens after they are found.

Sustained monitoring: what it looks like and where it breaks down

Strong	<i>The sharpest contrast in the fieldwork. Three areas have structured review processes. Most areas have no systematic mechanism for monitoring whether children they have identified are receiving support or whether their circumstances are changing.</i>
---------------	--

Once a child is identified and a referral made, the question that most oversight systems cannot answer is: what happened next? Did the child actually access the support? Is their situation improving? If their circumstances change, does anyone know? For the majority of fieldwork areas, the honest answer is that there is no systematic mechanism to find out.

The Southport Inquiry documented a specific mechanism driving the yo-yo cycle: the cumulative significance of multiple referrals was ‘not sufficiently taken into account’ because individual referrals were assessed in isolation, even when a case ‘kept coming back time and again’ (Vol 2, Ch 9, para 292). The inquiry recommended that policies ‘emphasise the significance of multiple referrals’ (Recommendation 43). This corroborates the fieldwork finding that proactive systems succeed precisely because they aggregate cumulative contact data rather than treating each referral as a discrete event.

The survey evidence on this is clear. Thirty-four per cent of practitioners who answered the question said that children are not tracked after a threshold decision is made. Thirteen per cent reported that cases below the threshold are simply closed with no further follow-up or monitoring arrangement in place. Fewer than one in ten said their partnership routinely tracks all cases below the threshold after a threshold decision. Twenty-two per cent said their area has no systematic way of tracking whether children are engaging with services, and 11% reported that no one in their area systematically checks whether these children’s risk levels change over time. When asked how confident they were that the support available to children below the threshold in their area actually reduces their risk of involvement in violence, only one respondent out of the 85 who answered the question said they were very confident. Over a third expressed a lack of confidence that the support available actually reduces risk. For many practitioners, the experience of referring a child mirrors what one community safety practitioner described: ‘We’re kind of relying on the schools to have that follow up with the young people around what benefit they felt the sessions had. They give us feedback but without names, so it’s redacted.’ Where feedback loops do not exist, the system loses visibility of the child at the point where one agency’s responsibility ends.

The Turnaround programme evaluation (Turner et al., 2026) provides evidence that sustained monitoring of children below the threshold is feasible at national scale. Between 2022 and 2024 the programme took 38,704 referrals. For those children it provided multi-agency triage, relationship-based support, and a defined route into statutory services if their circumstances worsened. Children reported that the relationship with their Turnaround worker was ‘pivotal’ to behaviour change (Turner et al., 2026, p.66). 91% recorded no proven offences after completing interventions. The programme demonstrated all four building blocks operating as an integrated system: governance through multi-agency triage panels; follow-up through relationship-based contact; quality through structured assessment; and implementation through multi-year funding. The evaluation does acknowledge significant

limitations: no counterfactual comparison, partly self-reported impacts, and 21% of partial completions were due to new offences leading to statutory transfer. Crucially, only just over half of the children referred went on to be assessed, which raises for the programme the same question this research asks of local areas: what happened to the rest?"

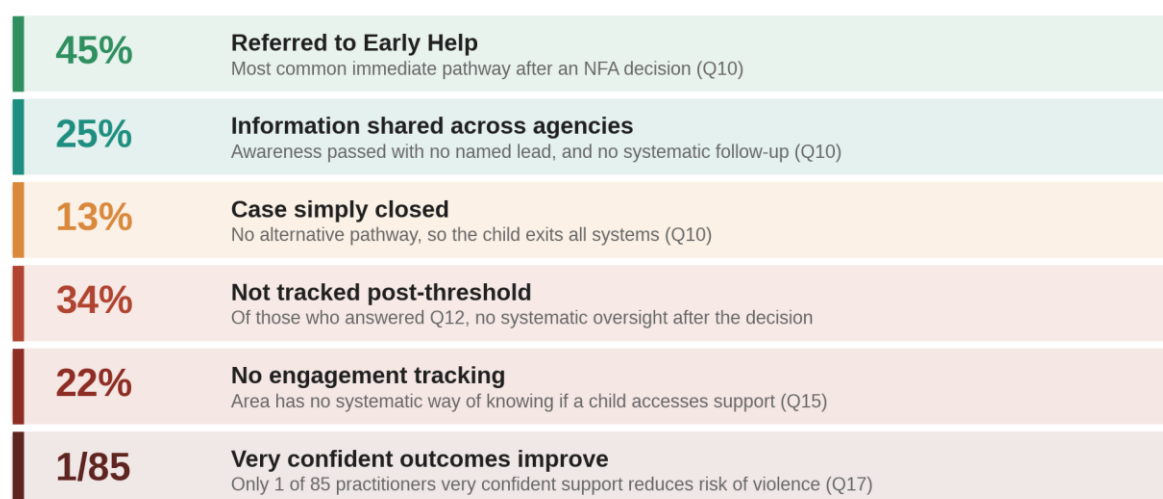


Figure 5: The funnel of disappearance. Note: different denominators at each stage. Sources: Q10, Q12, Q15, Q17.

Three areas stand out for having developed structured approaches to sustained monitoring: Area 1, Area 5, and Area 10, each detailed below. What these three areas share is not a single programme or being youth-justice-led (one sits in youth services, one is funded by a Police and Crime Commissioner, and one is a youth justice service), but sustained multi-year funding, a dedicated embedded team, and board-level accountability.

In practice: How Area 1 tracks every below-threshold child

Every child who comes through Area 1's prevention service, not just those receiving specific programme funding, is added to a comprehensive tracking spreadsheet maintained by the team. Children are first identified through police data, which does not require their individual consent, but the prevention support is voluntary: the team contacts the family within five working days of identification to seek consent, and the tracker then follows the cases of children whose families have agreed to take part. Where a child is already known to the youth justice service, police and that service decide jointly who is best placed to seek consent, recognising that some families have had difficult prior experiences of the police. The tracker captures age, home address for ward-level analysis, lead practitioner, support offered, and outcomes at fixed intervals.

Review points: Every case is reviewed at 3, 6, 9, and 12 months after the initial intervention. Reviews are conducted by the lead practitioner and recorded in the tracker. A Team Around the Family (TAF) meeting takes place every six weeks during active support.

What it produces: The service reports that 92% of children do not progress to the youth justice system. Local reoffending is approximately 8% against a national rate of around 30%. Ward-level analysis has shown that where a child lives is a stronger predictor of involvement in violence than age, school, or individual characteristics, directly shaping investment decisions. Five years of annual voice surveys, asking young people what makes them feel safe, feed into service design.

However, it is important to note, that without stronger evaluation evidence, we cannot definitively attribute the outcomes seen and reported by the service to their approach.

In practice: How Area 10 tracks outcomes across all the children it works with

Area 10's local offending and reoffending tracker captures all children who begin any intervention during a defined cohort period (January to March each year), whether voluntary, anti-social behaviour (ASB) related, or community resolution, and tracks their reoffending at quarterly intervals over 18 months.

Review process: Practitioners update the tracker monthly as outcomes become known. Results are reported quarterly to the board. A thematic deep dive is conducted for any child who becomes a first-time entrant to the justice system during the tracking period, looking back at where earlier intervention might have been possible.

What it produces: Five years of longitudinal data. The first-time entrant rate is 81 per 100,000 against a national average of 166. A 65.5% reduction in first-time entrants over four years. The 2022 cohort recorded 0% reoffending at three months. The methodology is published and has been adopted by other youth justice services in the same region.

In practice: How Area 5 uses automated data to track outcomes and trigger post-closure follow-up

When a young person is allocated to Area 5's Youth Violence Intervention Unit (YVIU), they are transferred onto the police records system with an occurrence tagged 'youth violence intervention engagement.' The data application identifies this tag and begins automatically tracking all subsequent police occurrences involving that young person, with no manual data entry required.

What it tracks: Police occurrences pre-intervention, during, and post-closure. Individual distance-travelled graphs are generated automatically for each young person and included in case closure summaries. A business support spreadsheet flags every case at the six-month post-closure point for a manual check-in call.

What it produces: A 72% reduction in police contact and estimated cost savings of £137,000 over 12 months. The six-month post-closure check-in was introduced because data application data showed that children who experience difficulty after an intervention tend to do so around that benchmark. The data improved the service, not just measured it.

Replicability: Requires police records system access and data application licensing. The six-month post-closure check-in process uses a flagged spreadsheet and requires no technology; it could be adopted immediately by any service.

"What data application has told us is that's when intel starts to creep in and if they're going to fall backwards, that's when it happens around the six-month benchmark."

Senior Early Intervention Officer, Area 5

Area 5's data application produced a finding that has directly changed practice. Area 5 operates without arbitrary time limits on engagement: the average case length is approximately six months, but the service remains available for as long as the young person needs it. By tracking police contact in the period after cases close, the data showed that children who are going to experience difficulty after the intervention tend to do so around the six-month mark. This led the area to add a proactive six-month post-closure check-in for every closed case. The tracking tool did not just measure outcomes: it improved the service by making a pattern visible that was previously invisible.

The gap between these three areas and the rest of the fieldwork is significant. In one area, a youth justice practitioner described the infrastructure problem directly: 'I don't have the infrastructure to properly follow up on reviewing some of these kids.' In Area 7, the practitioner responsible for oversight acknowledged being almost waiting for children to come back to attention elsewhere rather than actively tracking them. In Area 11, post-panel monitoring was acknowledged as the weakest element of an otherwise developed system, depending on individual practitioner initiative rather than any systematic mechanism.

Voluntary and community sector organisations provide a form of monitoring continuity that statutory services rarely match. VCS workers often maintain the longest-running relationship with a child, persisting across service boundaries, funding cycles, and practitioner handovers. Yet 47% of VCS respondents reported being excluded from the governance structures where monitoring decisions are made, against 22% of respondents overall. Where VCS workers are embedded in the oversight pathway, as in Area 1 and Area 6, they provide a relational bridge that sustains monitoring beyond formal intervention periods. Where they are excluded, the system loses its most durable source of ongoing contact with the child.

The evidence review helps explain why this pattern is so consistent. Time-limited services create a structural mismatch: the support these children need is often long-running and cannot be fixed in advance, which is why programmes designed for this group allow anything from a few weeks to several years of engagement, including open-ended support into adulthood (Turner et al., 2026). Most services are commissioned on shorter timescales, or on funding that does not allow for extended engagement. When funding ends, monitoring ends. This is not a failure of individual practitioners but a structural feature of how below-threshold services are designed and commissioned.

Voluntary and community sector organisations as continuity in monitoring

An Area 6 practitioner described a pattern that came through across multiple fieldwork areas: 'The VCS organisations are often the ones maintaining those relationships with young people long after statutory services have stepped back. They're the continuity in a system full of churn.' Where VCS workers have an established relationship with a young person or family, they often continue informal contact and monitoring well beyond the formal end of a statutory or funded intervention. This is valuable but fragile: it depends on individual relationships, is not systematically recorded, and disappears when VCS workers move on or when short-term contracts end. Acknowledging and building on VCS relational continuity, rather than treating it as a bonus, is one of the most immediately available mechanisms for strengthening sustained monitoring.

The children that monitoring systems miss

Strong

Four distinct hidden cohorts identified across the fieldwork, each through independent area evidence. Standard tracking criteria do not capture these children.

Standard framing of below-threshold oversight focuses on children identified through existing referral pathways: children referred to children's social care but not progressing to statutory case management, children receiving out-of-court disposals from police, children discussed at Multi-Agency Child Exploitation (MACE) or prevention panels. The fieldwork identified four cohorts of children who are consistently missed by these standard approaches, each surfaced by independent areas describing what they had found in their local data.

The first hidden cohort is children who are perpetrating violence against their parents rather than experiencing it in the community. In Area 4, the district council-led prevention panel was designed with serious youth violence in mind. When the panel started operating, the majority of referrals coming through were for child-to-parent violence, a pattern the team had not anticipated and for which standard tools and frameworks were not designed. This cohort does not fit the typical profile of a young person at risk of exploitation or serious youth violence, is less visible to police referral pathways, and tends to come to attention through schools or family support services rather than through the justice route. No other fieldwork area described a systematic approach to identifying or monitoring this cohort.

The second is children of parents who are in prison. In Area 5, the team developed a specific Prison Intervention Project after recognising that children with an incarcerated parent carry significant intergenerational risk that standard referral pathways do not capture. A practitioner described these children as 'quite silent': often not known to services, with their parent's imprisonment not recorded on any system they would typically be checked against, and the family's circumstances not visible to the oversight mechanisms that focus on the child's own contact with police or social care. No other fieldwork area described a systematic approach to monitoring this group of children and young people either.

The third is children known to agencies through association rather than through their own contact as victims or suspects. Area 9's dashboard was specifically designed to surface this group of children and young people: children who appear on police records because they were present at an incident involving an adult, lived at an address associated with exploitation, or are connected to someone under investigation, but who have never themselves been referred for support. As described in Building Block 1, standard referral systems are less likely to surface these children because no individual incident involving them crosses a threshold. Cumulative harm scoring across time does surface them.

The fourth hidden cohort is young women and girls at risk of involvement in violence. Area 5 added a dedicated girls pathway after reviewing its referral cohort and finding that girls were significantly underrepresented relative to local prevalence data. This was not a marginal adjustment: it required specific outreach, different referral routes, and workers with the right relational approach. The finding that girls were coming through prevention panels in higher numbers than expected also emerged in the survey cross-tabulations. Partnerships should examine whether their identification mechanisms systematically disadvantage girls who may

present with different risk profiles, through different services, and with lower visibility to police and justice referral routes.

These children are not the only groups that standard systems can miss: children who are victims or witnesses of domestic abuse, for example, are also at heightened risk and are often under-identified by violence-focused systems.

The practical implication is that monitoring systems designed only to track children referred through existing pathways will systematically miss these four cohorts. Partnerships seeking to strengthen their oversight should ask explicitly: what does our current referral and monitoring system not see? The Area 4, Area 5 and Area 9 examples suggest that the answer to that question is worth investigating locally, because what a system finds when it looks depends substantially on what it has been designed to look for. These four cohorts are illustrative rather than exhaustive: other groups are likely to be missed by violence-focused referral routes, including children who are victims or witnesses of domestic abuse, given how often child maltreatment co-occurs with domestic abuse in the same households (Herbert et al., 2023).

Families and young people as participants in monitoring

Emerging

Present in several fieldwork areas, most strongly in Area 1, Area 10, and Area 3. Largely absent from survey evidence. Child and family voice in monitoring is an area where practice is beginning to develop rather than being well established.

Monitoring is typically described in system terms: panels, trackers, check-ins, data. What the fieldwork also found, in several areas, is a different conception of monitoring in which children, young people, and families are not just subjects of oversight but active participants in it. This is both a more relational model of what monitoring can be and, practically, a more sustainable one: families persist across service boundaries, funding cycles, and practitioner handovers in ways that no agency can.

Treating families as partners in monitoring rather than as subjects of it builds on established practice rather than being new. The Ivison Trust (formerly Pace, Parents Against Child Exploitation) has worked for many years to position parents and carers as essential partners in safeguarding children from exploitation (Ivison Trust, no date; Hall and Marsh, 2025). The contextual safeguarding approach developed by Professor Carlene Firmin, now taken forward through the Global Centre for Contextual Safeguarding at Durham University, similarly works with parents and carers as partners and allies in addressing harm that occurs beyond the family home (Contextual Safeguarding Network, no date).

In Area 1, five consecutive years of annual voice surveys have asked young people what makes them feel safe and what the service could do differently. The results feed directly into commissioning decisions and service design. The prevention team manager described going back to the voice data after incidents to understand what signals had been present that the service had not acted on. This is monitoring used for learning, not just recording.

“We set our voice workers out on a task to talk to all young people that they could get their hands on to say, what makes you feel safe? Why don’t you feel safe if you don’t? What do you think we could do to support you in feeling safer?”

Prevention Team Manager, Area 1

In Area 10, assessments are written directly to the child rather than about them, a practice the service manager described as taking time to embed but producing genuine engagement: ‘It’s taken time but people are really into it now.’ In Area 5, life road journey maps are co-produced with young people and shared with parents, with the sharing described as a ‘lightbulb moment’ for many families who had not previously understood what their child had experienced. In Area 2, the parent-led programme operates as a universal offer in which parents self-identify for support around exploitation concerns, rather than requiring a professional referral, positioning parents as active agents in the identification and monitoring process rather than recipients of professional concern.

Area 3’s fieldwork produced the strongest account of families as monitoring participants rather than just monitoring subjects. A youth justice worker described the team’s approach to working with parents: ‘Focusing around skilling those parents up, if they can be the ones who hold a lot of that safeguarding. They know what to look for. They know where the mental health charities are. They can get in touch, they know how to refer back through to other things.’ Parents who have been supported to understand risk indicators and know how to access services become, in effect, an ongoing monitoring presence that continues well beyond any formal intervention period.

“Focusing around skilling those parents up... if they can be the ones who hold a lot of that safeguarding. They know what to look for. They know where the mental health charities are.”

Youth justice worker, Area 3

The evidence review we carried out to underpin these insights noted that children report feeling blamed when they disengage from services, and that what they value is workers who ‘see them’ as individuals rather than treating engagement as a compliance exercise (Davies, 2022). The fieldwork found only limited examples of this being systematically built into monitoring processes. Area 1’s voice work is the most developed. Most other areas described child voice as present in individual casework but absent from the oversight system itself: no area other than Area 1 described systematically collecting young people’s experience to inform how the monitoring system operates.

What this means in practice

The evidence across follow-up and monitoring points to three insights for partnerships seeking to strengthen their oversight of children below the threshold.

Insight 4: Create multiple entry routes and pathways that maintain visibility

There is a significant difference between a referral pathway and an oversight pathway. A referral pathway gets a child into a service. An oversight pathway maintains visibility of what happens to them once they are there, and after they leave. Partnerships should examine their existing systems and ask which of their mechanisms do the first thing, and which do the second.

Every area should have at least two routes through which children come to attention: one that responds to referrals when concern is expressed, and at least one that proactively identifies children who have not been referred but whose pattern of contact suggests they need someone to reach out. The fieldwork found several low-cost and replicable approaches to the latter: the force-wide screening framework's two-incident trigger, Area 9's cumulative harm dashboard, Area 6's daily police-system checks and proactive public protection notice (PPN) screening. These do not require major investment. They require a decision to look.

Partnerships should also examine who their referral and monitoring systems are designed to find. If the answer is children referred through social care or justice pathways, the four hidden cohorts identified in this research, children experiencing family violence, children of incarcerated parents, children known through association and young women and girls at risk of involvement in violence, are likely to remain invisible. Asking the question 'what does our system not see?' is a useful starting point for identifying these gaps.

Insight 5: Establish structured review points, at least every six weeks, and post-closure follow-up

Every below-threshold child should have a named lead practitioner and a structured review schedule. The fieldwork evidence points to reviews at least every six weeks during active support, with post-closure check-ins at three, six, and twelve months. Area 5's data application showed that the six-month post-closure period is when children's contact with police tends to increase if they are going to experience difficulty, which provides a data-driven basis for the timing of post-closure outreach.

The tool used for tracking matters less than the decision to do it. Area 1's tracker is a spreadsheet. Area 10's tracker is also a spreadsheet, maintained for five years and used for quarterly board reporting. Any area can build this. What requires commitment is the deliberate decision to review every case at fixed intervals, to record what happens, and to use that data to ask whether the approach is working. Area 10's practice of going back to examine the circumstances of any child who becomes a first-time entrant to the justice system, asking where the opportunity for earlier support existed, is a model any Youth Justice Service could adopt. Structured review points must be designed and experienced as supportive check-ins rather than as surveillance. For children and families who have had difficult experiences of statutory involvement, the distinction between being monitored and being supported is real, and the framing, setting, and language of any review process will shape whether families continue to engage voluntarily.

Insight 6: Involve families and young people as participants in monitoring

Partnerships should have at least one mechanism through which children and young people's own experience of the oversight system is collected and used. This does not

require a dedicated voice worker. It can be as straightforward as including a question about what the young person found helpful or unhelpful as part of a standard review, or as systematic as Area 1's annual voice survey.

Parents and families should be considered as participants in the monitoring process from the point of first contact, not as an afterthought. Area 3's experience of skilling parents to recognise risk indicators and know how to access services represents one approach. Area 5's practice of co-producing life journey maps with young people and sharing them with parents represents another. Both rest on the same insight: families have a continuity of presence in a child's life that no service can match, and investing in their capacity to provide oversight is likely to outlast any formal intervention period. This builds on established practice rather than being new: organisations such as the Ivison Trust have long worked with parents as active safeguarding partners, and tools such as the Graded Care Profile 2 (NSPCC, no date) are designed to be completed in partnership with families. These examples depend on a particular service design, skill set and intervention model, and are offered as illustrations of the principle rather than as models that can be lifted and replicated in isolation.

CASE STUDY

Area 2

A layered system for oversight below statutory thresholds: consultation without a threshold, co-located intelligence, and earlier intervention at the primary-secondary transition

Area 2 operates a layered oversight system with three distinct mechanisms, each serving a different function. Together they represent one of the more developed approaches to below-threshold oversight found in the fieldwork, with particular strengths in governance, identification, and the avoidance of binary referral systems. The area also illustrates, honestly, the challenge of sustaining promising approaches beyond project funding.

A four-level adolescent exploitation framework is the governance layer. It replaced previous exploitation panels and operates across four risk levels: green for emerging concerns, amber for significant risk, red for active exploitation, and blue for children in custody or temporarily out of area. All referrals enter through a single point of access. A screening hub reviews new referrals within one working day and decides between four options: accept to the operational meeting, decline with feedback, decline but offer a consultation, or request further information. The children's services exploitation team can decline a referral for formal involvement while still giving the practitioner who made it specialist advice on the case. This avoids the binary of referred or not referred.

The operational group meets monthly, co-chaired by a Detective Inspector and the Strategic Lead for Specialist Adolescent Services, with over twenty agencies represented including health, CAMHS, schools, the voluntary sector, and specialist police teams. Every child in the framework must have a plan with an objective specifically focused on reducing exploitation vulnerability, a named trusted adult, and explicit trigger criteria for when to report a missing episode. Social workers are required to update the child's plan within five working days of each meeting.

The police co-location pilot is the identification layer. A six-month police pilot, evaluated in November 2024, co-located a police detective inspector, detective sergeant, constable, and an externally funded caseworker with the Children's Services team. The pilot replaced monthly intelligence meetings with weekly ones and reduced the time from intelligence being flagged to action being taken from 30 days to 9. Over the pilot period, 226 intelligence logs were reviewed and a number of new safeguarding referrals were submitted that would not have been made without the pilot. The co-location enabled a pattern recognition that neither agency achieved alone: police operating on an incident model had not previously been able to see cumulative concern across multiple contacts for the same child.

"We essentially offer a consultation, an exploitation consultation and or a knife consultation. That is quite a clear pathway in that we would be approached by the early help key worker or the manager. The outcomes of those consults have been really broad. Sometimes it is for a step up."

Exploitation team practitioner, Area 2

The early-intervention pilot was the earlier intervention layer. A pilot led by the Contextual Safeguarding team, with police research support, it took referrals predominantly from primary schools to identify children showing early indicators of vulnerability to exploitation at the Year 6 to Year 7 transition. Over the pilot period, 79 children were identified through the early-intervention pilot's early screening approach, predominantly at the primary to secondary transition. A practitioner described what this earlier engagement produced: 'At that much earlier stage, you can do the work with children and you can see the impact in a much shorter period of time, because you're not firefighting.' The project ended when the external funding ceased. This is the most direct illustration in the fieldwork of the short-term commissioning paradox: demonstrated effectiveness and ended provision are not contradictory; they are features of the same funding model.

Three considerations are worth noting for partnerships thinking about replication. The consultation model, in which any practitioner can access specialist advice without a formal referral, is the most immediately transferable element: it requires a small team of specialists and a clear referral pathway, not a new panel or complex infrastructure. The co-location model has a low direct cost to the police force, with the caseworker externally funded and police staff drawn from existing establishment, but it depends on that external funding continuing. And the outcome tracking for Area 2, while strong on process measures, is weaker on whether children's safety actually improved: the co-location pilot evaluation counts disruptions and intelligence activity but does not track child-level outcomes post-intervention. This is a gap the area acknowledged.

Building Block 3: Quality, Escalation and Outcomes

Core question: How do agencies know if support is working, and what happens when it is not?

If Building Block 2 asks whether children are being monitored, Building Block 3 asks what is being done with what monitoring reveals. A system can know that a child is engaged with a service without knowing whether that engagement is making any difference. It can know that a child has stopped engaging without having any mechanism to respond proportionately to that change. And it can refer children to services for years without ever asking whether those services are effective.

This is the building block where the fieldwork found the most significant gaps. The Oversight Functions Grid rated escalation triggers (Function 5) as strong in only five of eleven areas, and outcome review (Function 6) as strong in only two. Quality assurance mechanisms were the thinnest of all: only one area described anything approaching a systematic approach to learning whether their prevention offer was working. This is a finding about the field rather than about individual areas.

This chapter examines three dimensions: how areas approach outcome monitoring and what the evidence shows is possible; how escalation works in practice and where it depends on individual judgement rather than agreed criteria; and what quality assurance looks like for below-threshold prevention work, which is the thinnest component across all areas. Area 10's case study illustrates what outcome tracking, retrospective learning, and board accountability look like when they are working together.

A note on the evidence base: the survey data for this building block is thinner than for the others. Only 12% of respondents cited lack of outcome tracking as a barrier, not because it is unimportant, but because practitioners who have never seen systematic outcome tracking tend not to recognise its absence as a problem.

Outcome monitoring: a discipline that most systems have not yet built

Strong	<i>Strong on the gap. Triangulated across all three evidence strands. Three areas demonstrate structured outcome monitoring is achievable with basic tools. Most areas cannot describe what happens to children after they receive support.</i>
---------------	---

The evidence review identifies outcome monitoring as the most critical gap in the effective oversight of children below the threshold. Research into serious case reviews found that most children who die as a result of abuse or neglect have not, at the time of the incident, crossed the threshold into the formal child protection system (Brandon et al., 2008). This is a whole-population safeguarding finding rather than one specific to adolescents or extra-familial harm, but the threshold argument applies directly to the children this report

concerns. Without outcome monitoring, agencies cannot assess whether their tracking and support activity for this wider group of children is preventing harm. The fieldwork confirms this. Across the eleven areas, only three had structured approaches to measuring what happened to children after they were identified and supported.

The Turnaround programme evaluation demonstrates what systematic outcome measurement looks like when implemented at national scale. The programme tracks proven offences, self-reported behaviour change, family relationships, school attendance, and reoffending. Across all regions, 91% of children had no proven offences after completing the programme, although the evaluation is careful to note that some children recorded as having no proven offences at the time of analysis may still go on to offend within the full follow-up period (Turner et al., 2026). The evaluation is a process and implementation evaluation, not a randomised controlled trial, and should be read as the strongest available indicative evidence rather than established causal effect.

The survey evidence reinforces the picture from the opposite direction. When practitioners were asked how confident they were that support for children below the threshold in their area actually reduces their risk of involvement in violence, only one respondent out of 85 who answered the question said they were very confident. Over a third expressed a lack of confidence that the support available actually reduces risk. This gap is sharpest among those closest to the work: 63% of frontline practitioners expressed a lack of confidence, compared with 25% of senior leaders, a 38-point gap. The people with the most direct experience of what happens after a referral are the most doubtful that it makes a difference. The relationship between tracking absence and practitioner pessimism is direct: respondents who reported no systematic tracking in their area were considerably less likely to express any confidence in outcomes than those whose areas had structured approaches. Fifty-eight per cent of survey respondents either did not know how outcome data was collected in their area or confirmed that no systematic collection existed. Yet only 12% cited lack of outcome tracking as a barrier. This gap between low confidence in effectiveness and low recognition of monitoring absence as a problem is itself significant. It suggests that most practitioners have not had the opportunity to see what systematic outcome tracking looks like in practice.

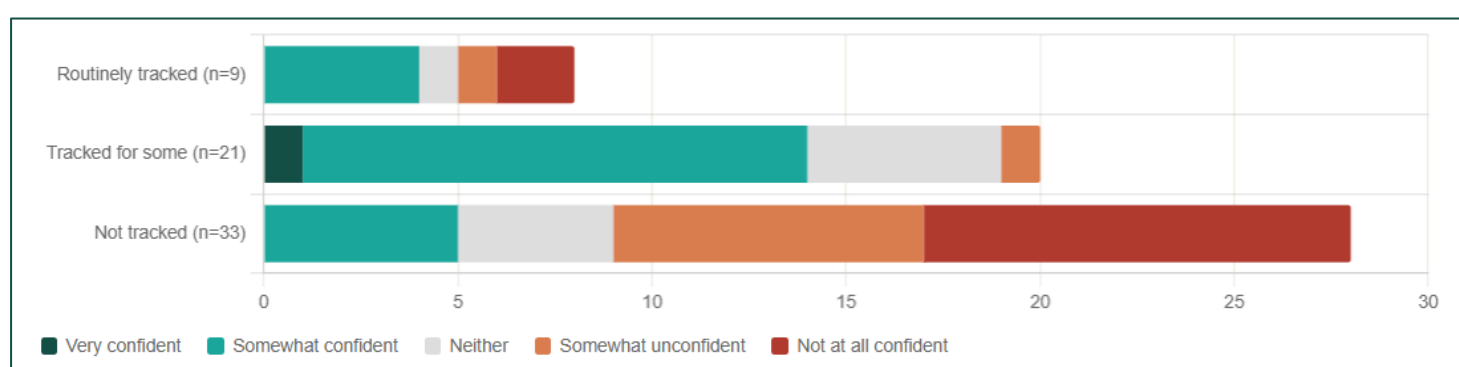


Figure 6: Tracking and confidence. Areas with no tracking: zero very confident. Source: Q12 x Q17, n=85.

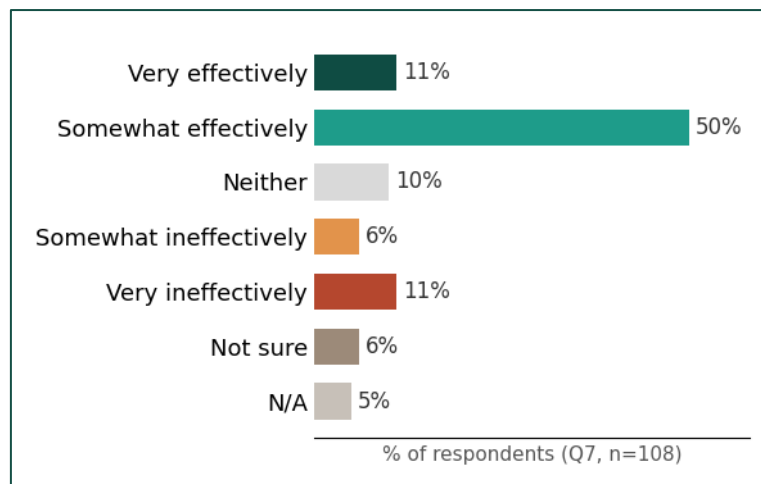


Figure 7: Effectiveness. 11% very effectively mirrors 11% very ineffectively. Source: Survey Q7, n=108.

“We will never, ever be able to measure... we don’t know would they have ever gone on to go to prison. There’s a high probability if they haven’t worked with us, but we’re never going to be able to know that. And that’s why people don’t stick at it for very long.”

Senior Early Intervention Officer, Area 5

A practitioner in Area 5 identified the emotional and institutional barrier to outcome tracking with unusual clarity, describing work whose value can never be proved and observing that this is why people do not stick at it for very long. The impossibility of the counterfactual, of proving what would have happened to a child without the intervention, can become a reason not to measure anything at all. The three areas that have developed outcome tracking approaches have resolved this differently: not by claiming to prove counterfactuals, but by tracking what is measurable and building baselines over time. Area 1 tracks progression to youth justice and local reoffending, and the service reports 92% of children not progressing to youth justice and approximately 8% local reoffending against a national rate of around 30%.

Area 5 tracks police contact before, during and after intervention through a data application, and the area reports a 72% reduction in police contact and estimated cost savings of £137,000 over twelve months. These are the area’s own figures and have not been independently evaluated. Area 10 tracks first-time entrants to the justice system across annual cohorts, reporting a first-time entrant rate of 81 per 100,000 against a national average of 166. None of these approaches proves that the intervention caused the outcome. All of them create a basis for comparison, for asking whether outcomes are improving, and for identifying when they are not.

The three-tier model that emerges from the fieldwork offers a starting point for areas at different stages. At the basic level, a manual spreadsheet tracker on the Area 1 or Area 10 model requires no technology investment and no specialist data skills. At the intermediate level, an automated connection between intervention records and police data, as in Area 5’s data application approach, eliminates manual data entry and produces real-time distance-travelled information. At an advanced level, Area 9’s Power BI dashboard demonstrates what cross-agency data integration can produce in terms of early identification. Each tier is

achievable independently. An area does not need to reach tier three before tier one produces value.

Tier 1	Basic: manual spreadsheet A spreadsheet updated monthly, tracking all children at fixed review intervals. Board reporting creates accountability.	Areas: Area 1, Area 10, Area 4 (partial)
Tier 2	Intermediate: automated police data integration Outcome tracking connected to police systems. No manual entry. Distance-travelled graphs generated automatically.	Areas: Area 5 (data application), Area 9 (Power BI)
Tier 3	Advanced: integrated wellbeing, justice and education Cross-agency outcomes combining justice data with validated wellbeing measures and education indicators. No area has fully achieved this.	Areas: Area 6 (SDQ), Tier 3 aspirational

Figure 8: Three-tier outcome measurement model. Tier 3 is aspirational. Source: CFSS analytical framework derived from fieldwork.

“Rather than just doing returns from the Youth Justice Board’s perspective on statutory cases, what we’ve done is had a local tracker in existence for probably five years now. So we’re able to say, this relates to the 18 months from that particular cohort.”

Service Manager, Area 10

Area 10’s tracker surfaces a finding that applies across all areas: outcome data is more useful when collected locally and promptly than when it arrives through national returns two years after the fact. A practitioner described the limitation of national Youth Justice Board data directly: ‘If you’re waiting for the outcome of the YJB returns, they really are perhaps two years out of date. So if you’re going back to try and learn the lessons, you’re going back to a different time where you may have lost the context.’ Local tracking, even with a basic spreadsheet, produces data that is timely enough to be acted on.

One dimension of outcome monitoring that no area had addressed systematically is disaggregation by ethnicity. The evidence review we carried out to underpin these insights found strong evidence of racial disparity in how children are identified, assessed, and responded to at the below-threshold level (Huegler et al., 2025). Without disaggregating outcome data by ethnicity, partnerships cannot know whether their oversight systems are

producing equitable outcomes or reproducing existing patterns of disparity. An oversight system that does not break down its data by ethnicity cannot know whether it is tracking equitably. This is an operational point about outcome data infrastructure, not only an equity argument. Without it, a partnership cannot know whether Black and Mixed Heritage children are progressing to youth justice, or receiving No Further Action decisions, at higher rates than their white peers after passing through the same service, which is how inequity compounds over time.

Outcome tracking is a discipline, not a technology

The three areas with the strongest outcome data all use simple tools: Area 1's tracker is a spreadsheet, Area 10's tracker is a spreadsheet, Area 5's data application approach automates data that already exists in police systems. The barrier to outcome tracking in most areas is institutional rather than technical: it lies in the decision to build a baseline, maintain it consistently, and use the data to ask whether the approach is working.

Escalation: informal, person-dependent, and largely without agreed criteria

Evidence gap

Moderate evidence base. Escalation in most areas depends on individual practitioner judgement rather than agreed criteria. Area 2 has the most structured approach in the fieldwork. The absence of formal escalation criteria is the finding, not a gap in the evidence.

Escalation, the process by which a child whose circumstances are worsening receives a more intensive response, is the bridge between monitoring and outcomes. A monitoring system that identifies deterioration but has no agreed process for responding to it provides visibility without accountability. The fieldwork found that in most areas, escalation from below-threshold to statutory support depends primarily on individual practitioner judgement, and that formal escalation criteria for this group are uncommon.

The survey evidence is limited on this point specifically: threshold concerns were cited as a barrier by 16% of respondents overall, but by 53% of voluntary and community sector respondents, the highest sector-specific barrier finding in the entire survey. This sectoral divergence suggests that practitioners closest to children in a relational capacity, and furthest from decision-making authority, experience threshold barriers most acutely. The child they are working with may be showing clear signs of escalating risk, but the mechanism to trigger a statutory response is not available to them. The evidence review characterised this as a systemic feature: in most systems, the only route to intensive support for this group of children and young people remains criminalisation.

"A child has been mentioned five times over the last three months in relation to exploitation. That one piece of intelligence on its own may not be enough to prompt a screening. But we will ask police to pull together an intelligence package."

Exploitation team practitioner, Area 2

Area 2 offers the most structured approach to escalation found in the fieldwork. The exploitation framework defines escalation not by a single incident crossing a threshold but by the cumulative pattern of concern: a child mentioned five times in three months in relation to exploitation triggers a request for an intelligence package and a structured screening decision. This approach reflects the contextual safeguarding evidence base, which has consistently found that children at greatest risk are often those whose individual incidents do not cross any single threshold but whose cumulative contact with services reveals a significant and growing pattern of concern (Lloyd and Firmin, 2020; Wilson and Mueller-Johnson, 2024). This cumulative-pattern logic mirrors established practice in domestic abuse multi-agency risk arrangements, where repeated incidents within twelve months trigger a referral so that the overall pattern, rather than each incident alone, is considered (SafeLives).

This approach also addresses a limitation of most escalation systems: that they are designed to respond to the presenting incident rather than the developing pattern. A child who comes to attention through five separate, apparently low-level contacts across three months may never trigger an escalation response in a system that evaluates each contact independently. Area 2's consultation model, where any practitioner can access specialist exploitation analysis without a formal referral, creates the conditions for pattern recognition to occur. Rather than passively waiting for thresholds to be crossed, it actively uses cumulative intelligence to reach children before crisis. This also reflects the call in the Youth Endowment Fund's Children's Services guidance to embed extra-familial-harm expertise across all parts of the multi-agency workforce (Youth Endowment Fund, 2026).

Outside Area 2, escalation from below-threshold to statutory support was described across the fieldwork as largely dependent on a practitioner knowing the right person to call, having an established relationship with the receiving service, and being persistent enough to push through a referral that statutory services may not initially accept. These are relational and personal factors, not systemic ones. When the practitioner who holds those relationships moves on, the escalation route is at risk of being lost. Several practitioners described this precisely, not as a criticism of individuals but as a structural feature of systems where escalation has never been formally designed.

The Southport Inquiry provides the most extreme documented example of what happens when escalation fails systematically. Volume 2 found a 'culture of institutional reluctance' to escalate from non-statutory to statutory services (Vol 2, Ch 9, para 286). An independent evaluation of the same authority found that threshold decision-making 'is not consistent for all children' and that 'the threshold between level 3 and 4 lacks clarity' (para 289). Children's Social Care 'repeatedly stepped down' a case to non-statutory Early Help, which then 'repeatedly closed' despite 'interventions having had no or no meaningful impact' (Vol 1, paras 7e-7f). That case concerned a child who posed a risk to others, and the escalation failure mechanism is the same one the fieldwork found for children below the threshold more widely: informal, person-dependent, and without agreed criteria.

A prevention team manager described an acknowledged gap even in the strongest prevention model in the fieldwork: the conversation between prevention and youth justice workers about a child whose needs are escalating does not happen as readily as it should. This is offered not as a criticism of Area 1 but as evidence of how pervasive the escalation gap is: even where prevention services are working well, the handover to statutory youth justice can be abrupt and unplanned. With 92% of children not progressing to youth justice,

this gap affects a small proportion of Area 1's cohort, but for those children, the absence of a planned escalation pathway is significant.

The VCS escalation gap: closest to the child, furthest from the decision

Fifty-three per cent of VCS respondents cited thresholds being too high as a barrier, compared to 16% overall. VCS workers are often the practitioners with the closest ongoing relationship with a child. They are also the least likely to have formal authority to trigger a statutory response. Escalation systems that do not include a clear VCS referral pathway into statutory decision-making are structurally dependent on VCS workers finding informal routes, which are fragile, inequitable, and invisible to governance.

Quality assurance: the thinnest component across the building blocks

Evidence gap

Weak evidence base by design: quality assurance mechanisms for below-threshold prevention work are largely absent. The evidence review finding that professionals rely on informal networks and personal experience rather than formal evaluation (Davies, 2022) is confirmed by the fieldwork. Only one area has systematic quality assurance.

Quality assurance, or QA (the mechanisms by which a service examines whether what it is doing is working, learns from what is not, and adjusts its practice accordingly), is the thinnest component across all four building blocks. This is a finding, not a gap in the evidence. The evidence review found no examples of formal tracking of whether below-threshold services were effective or evidence-based, and that professionals making decisions about which services to refer children to were relying on informal networks, personal experience, and word of mouth rather than any evaluative data (Davies, 2022). The fieldwork confirms this picture at the level of individual areas.

There is a structural reason why quality assurance is so thin in this space, and it is worth being explicit about it. Prevention work with children below the threshold is typically commissioned on the assumption that these are lower-complexity cases requiring lighter-touch responses, short programmes, time-limited interventions, early help pathways. The evidence from the fieldwork challenges this assumption directly. Practitioners in Area 6 and Area 10 independently described prevention cases as routinely more complex than statutory out-of-court cases, involving children with significant trauma histories, multiple disadvantage, and needs that extend well beyond any twelve-week programme. A practitioner in Area 4 was similarly struck: 'I was really surprised going into this panel. I thought it'd be people hanging around like the ASB criteria, low level. But actually the cohort was far more complex than expected'.

If the service model is designed for low complexity and the actual caseload involves high complexity, quality assurance frameworks built on that false premise will not produce meaningful learning. The absence of formal QA in this space is consistent with a wider pattern in which below-threshold prevention work has been commissioned as though it involves lower-complexity cases, when the fieldwork evidence suggests the opposite.

Area 10 is the only area in the fieldwork that described anything approaching systematic quality assurance. Quarterly board reviews examine outcome trends across the annual cohort. Thematic analysis of first-time entrants produces learning about where earlier intervention might have been possible. Practitioners described random sampling of cases for review alongside the structured quarterly reporting. The service manager described the approach to using retrospective data (below). This is learning-oriented QA: it is not primarily about compliance, but about asking whether the approach is producing better outcomes.

“Where children become first time entrants, we will go back and we will look at was there opportunities from our perspective of what worked for prevention, what didn’t work.”

Service Manager, Area 10

Across the remaining ten areas, quality assurance for prevention work was either absent or described in terms that applied primarily to individual casework rather than to the service as a whole: supervision, case review, peer reflection. These are necessary but not sufficient. They tell a practitioner whether a specific piece of work was done well. They do not tell a partnership whether the overall approach is identifying the right children, deploying the right responses, and producing better outcomes over time. That is the question that systematic QA is designed to answer, and the fieldwork found limited evidence of it being asked consistently.

Evidence gap

No area described disaggregating outcome data by ethnicity. The implications for equity monitoring are direct and practical.

Alignment with national frameworks

The outcome measurement and governance landscape for this group of children and young people has shifted significantly since this research began. Three national policy frameworks now directly shape the context in which these insights sit: the National Supporting Families Outcome Framework, the Centre for Young Lives report *Transforming Opportunities for the Most Vulnerable Young People* (September 2025), and the Youth Access *Blueprint for Young Futures Hubs* (March 2025). The alignment between these frameworks and this research is strong, and partnerships should be aware of three points of direct connection.

First, on post-closure follow-up. The Supporting Families Outcome Framework already requires ‘no re-referral into services six months following closure’ as a required outcome evidence measure (DfE and DLUHC, 2022), and recommends validated wellbeing measures including the Strengths and Difficulties Questionnaire (SDQ). The six-month post-closure check-in described in Insight 6, and the minimum outcome metrics in Insight 8, are therefore directly aligned with infrastructure that already exists in every area running the Supporting Families programme. Partnerships do not need to build this from scratch: they need to extend what they already collect to children below the threshold.

Second, on prevention panels and governance. Prevention Partnership Panels are explicitly part of the Young Futures programme. The Centre for Young Lives reports that the first Prevention Partnership Panels and eight early adopter hubs are being developed in 2025, with a further 42 hubs to be created before the end of this parliament (Centre for Young Lives, 2025). The multi-agency panels that fieldwork areas are running are not free-standing local innovations: they sit within a named national programme with a defined governance structure. Partnerships

designing or strengthening their panel arrangements should be reading this research alongside the Young Futures Hub guidance.

Third, on outcome measurement as a discipline. The Youth Access Blueprint (Youth Access and partners, 2025) states that ‘whatever measures are used, routine outcome frameworks need to be consistent and capture outcomes over time’, the same argument this research makes in Insight 8. The Blueprint recommends Goal Based Outcomes (GBO) as a validated tool through which young people set their own goals and rate their own progress on a 0 to 10 scale. This directly corresponds to the minimum metric in Insight 8: ‘the child’s own view of whether they feel safer.’ Practitioners in areas adopting Young Futures Hubs will find these frameworks reinforce rather than contradict what this research describes.

What this means in practice

The evidence across quality, escalation and outcomes points to three insights for partnerships seeking to strengthen this building block.

Insight 7: Start measuring outcomes against a minimum standard, whatever tools you have

No area needs to wait for a bespoke data system before beginning to track outcomes. Area 10’s tracker is a spreadsheet, maintained for five years, producing the strongest longitudinal outcome data in the fieldwork. Area 1’s tracker is also a spreadsheet. The minimum standard should be: every below-threshold child tracked at 3, 6, and 12 months post-identification for progression to youth justice, re-referral, and engagement levels. That standard is achievable with a shared spreadsheet and the deliberate commitment to update it. What we are recommending is a minimum standard for what areas measure, rather than a single way of measuring it. Areas hold and record their data differently, and the point is not that everyone captures it identically but that everyone is looking at the same things: whether a child progressed to youth justice, whether they were re-referred, whether they engaged, and how those patterns differ by ethnicity, using whatever ethnicity data the area already holds.

This is monitoring rather than evaluation. A tracker of this kind tells a partnership whether children are being kept sight of, whether they engaged, and what happened next. It does not establish that the support caused the change, and it should not be presented as though it does.

Partnerships that currently have no outcome tracking should start with Area 10’s model: define a cohort, track quarterly, report to the board. The quarterly board report is as important as the tracker itself, because it creates the accountability structure that sustains the discipline over time. Without board visibility, outcome data tends to be collected when there is capacity and abandoned when there is not.

Outcome data should be disaggregated by ethnicity from the outset. Building this in from the start is significantly easier than retrofitting it once a tracker is established. Partnerships should treat disaggregated ethnicity data as a minimum requirement, not an optional enhancement.

Insight 8: Define escalation criteria rather than relying on professional judgement

Every below-threshold oversight panel or mechanism should have written escalation criteria describing what pattern of concern triggers a move to a more intensive response, and what

that response looks like. Area 2's cumulative intelligence approach (five mentions over three months triggering an intelligence package and structured screening decision) is one model. It does not need to be replicated exactly. What it demonstrates is that escalation criteria can be defined in advance, communicated to all practitioners, and applied consistently regardless of who is in the room.

VCS workers should have a clear and formal pathway for triggering escalation discussions, given that they are often closest to children experiencing the most significant deterioration but furthest from statutory decision-making authority. Escalation protocols that require a statutory worker to initiate the process will systematically miss children whose primary ongoing contact is with VCS services.

Insight 9: Match quality assurance to how demanding this work actually is

Quality assurance for below-threshold prevention work should be designed on the assumption that these children have complex, multiple, and long-standing needs, not on the assumption that they are lower-complexity cases requiring lighter-touch responses. This means three things: review timescales should reflect actual case duration rather than programme commissioning periods; quality assurance frameworks should examine whether children's underlying needs are being addressed, not only whether they are engaging with a service; and learning from cases that did not produce positive outcomes should be systematised, as in Area 10's first-time entrant retrospective reviews, rather than left to individual reflection.

Partnerships should designate a named lead for QA of below-threshold prevention activity, with a specific remit to report to the board on outcomes and learning. Where that responsibility sits with no one, quality assurance will not happen consistently.

CASE STUDY

Area 10

Five years of outcome data, a culture of retrospective learning, and a spreadsheet: how board accountability and systematic QA produce the strongest outcome evidence in the fieldwork

Area 10's Youth Justice and Early Support Service, managed by its service manager, is distinctive in two respects that are directly relevant to Building Block 3: it has maintained a local offending and reoffending tracker for five years, producing the longest longitudinal dataset in the fieldwork; and it has built a culture of retrospective learning in which every child who becomes a first-time entrant to the justice system is the subject of a thematic deep dive asking where earlier intervention might have been possible.

The tracker captures all children who begin any intervention during a defined annual cohort period (voluntary, ASB-related, prevention, out of court, statutory, and custody release) and tracks their reoffending at quarterly intervals over eighteen months. The methodology is deliberately simple: a basic spreadsheet, updated monthly by practitioners, with outcomes inputted as they become known. Cases with no outcome yet remain in the tracker for discussion but are not counted in the outcome data until confirmed. The process starts again with each annual cohort, building baselines over time.

The outcomes the area reports are notable. The first-time entrant rate is 81 per 100,000 against a national average of 166, with a reported 65.5% reduction in first-time entrants over four years, and the 2022 cohort recorded no reoffending at three months. These are the area's own figures, drawn from five years of sustained local tracking across the whole cohort, and have not been independently evaluated. The service manager was candid about the limitations: the tracker measures reoffending, which is what the Youth Justice Board cares about, but does not systematically track child wellbeing, educational outcomes or family circumstances. The methodology is justice-system-oriented, reflecting the service's accountability to the Youth Justice Board. A more complete outcome picture would require a broader framework. Area 6 offers one example of a wider approach: the Out of Court Disposals panel uses Strengths and Difficulties Questionnaire (SDQ) scores before and after intervention, alongside reoffending data. That gives practitioners a standardised wellbeing measure sitting next to the justice outcomes, and it directly addresses the limitation that justice-focused measures do not capture whether a child is actually doing better.

The first-time entrant deep dive process is, in the service manager's description, as important as the tracker itself. When a child becomes a first-time entrant to the justice system, the service goes back through the case history asking: where was the opportunity for earlier intervention? What did we know, and when did we know it? What did we do, and what could we have done differently? This is learning-oriented quality assurance rather than compliance-oriented review. It does not seek to assign blame. It seeks to improve the system's ability to identify and respond to children before they reach the point of formal justice involvement.

Area 10's policy context provides structural support that English areas currently lack: a longer trajectory of embedding prevention within youth justice services in that part of the UK means Area 10 has had more time and more institutional backing to develop this approach than most English comparators. The tracker methodology itself, however, is entirely transferable. The service manager described it as a basic spreadsheet that any youth justice service could build. The methodology has been published and adopted by other youth justice services in the same region. Any area seeking to begin outcome tracking could use Area 10's published approach as a starting point.

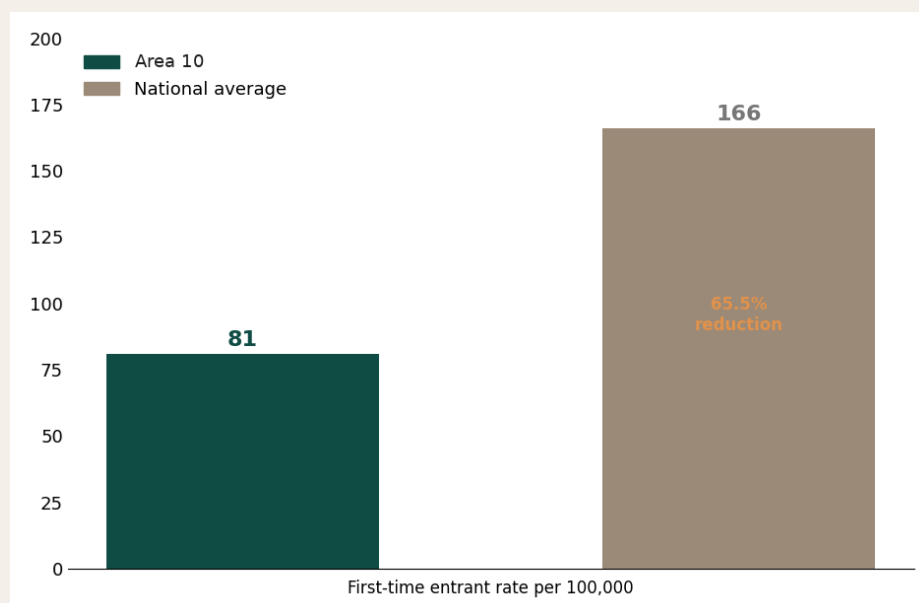


Figure 9: Area 10 first-time entrant rate (81 per 100,000) against a national rate of 166 per 100,000, a reported 65.5% reduction over four years. Source: fieldwork interview. Self-reported data, not independently evaluated.

Insight 10: Monitor for disproportionality across ethnicity, sex, age and special educational needs

No area in this research disaggregated its oversight, panel or outcome data by ethnicity, sex, age or special educational needs, and the data needed to identify disproportionality therefore did not exist in any area studied. Monitoring for disproportionality should be a standard part of oversight: disaggregating tracking, panel and outcome data, reviewing it at least annually, and giving panels explicit guidance on adultification bias. Working Together 2026 now requires partnerships to monitor whether groups of children are disproportionately over- or under-represented in services (DfE, 2026a), which gives this a statutory basis.

Building Block 4: Implementation and Capacity

Core question: What organisational conditions enable oversight to function?

The first three building blocks describe what oversight of children below the threshold should look like: clear governance and accountability, sustained follow-up and monitoring, and meaningful quality assurance with outcomes that can be measured. Building Block 4 examines the conditions that make any of that possible. Workforce, funding, data infrastructure, and partnership maturity are not peripheral to oversight. They are the conditions on which it either develops or does not.

The fieldwork found that the areas where oversight was more developed across building blocks 1 to 3 tended to share a set of structural features: dedicated prevention capacity that was not dependent on any single individual, funding that had been sustained for long enough to build institutional knowledge and partnership relationships, data systems that fit the work rather than being retrofitted to it, and multi-agency partnerships that had matured through years of deliberate investment rather than structural mandate. These are not quick wins. They are the result of decisions made and sustained through multiple electoral cycles.

This chapter examines each of the four implementation dimensions in turn, drawing on the survey evidence and fieldwork to describe both what enables oversight and what prevents it. Area 5 is the case study: the area with the longest-sustained dedicated prevention service in the fieldwork and the most deliberately planned approach to sustainability, including a response to the planned abolition of OPCCs that illustrates what thinking ahead about implementation looks like in practice.

Workforce: relationships over process

Strong	<i>Confirmed across all three evidence strands. The workforce model shapes whether children engage voluntarily. Relational skills and persistence matter more than professional qualification.</i>
---------------	--

The evidence review identified significant workforce gaps in this space: health professionals without sufficient training to identify safeguarding needs related to serious youth violence, assessment tools that did not include relevant risk factors, and training in contextual safeguarding that had not consistently translated into changed practice (Ofsted, CQC, HMICFRS and HM Inspectorate of Probation, 2024; Tyrell et al., 2020). The fieldwork added a different dimension: in the areas where oversight was working most effectively, the answer to the workforce question was not primarily about training. It was about the model of practice that the workforce was operating within.

Area 1's prevention team is staffed by youth workers rather than social workers, a deliberate decision that the prevention team manager described as fundamental to the approach. The

youth work frame produces a different kind of relationship with young people: one that is offered rather than imposed, available rather than obligatory, and built on the young person's terms rather than the service's. The team manager described this directly: 'Staff have got that youth work approach, they very quickly are able to form quite a deep relationship.' Area 5's team is OPCC-employed and deliberately diverse in skills: counselling, youth work, teaching, and knife intervention training all represented. Area 10's service manager described the single most important workforce quality as relational: staying flexible, persisting beyond a single offer, and treating the relationship with the child as the foundation of the work.

This finding has implications for how workforce capacity is understood. The survey identified capacity and caseload pressure as a barrier for 26% of respondents, behind only short-term funding and unclear responsibility. But capacity is a question of more than headcount: it is also about whether workers have the time, skills and organisational support to build and sustain the relationships that make voluntary engagement possible. The fieldwork evidence suggests that a large workforce operating within a model that does not prioritise relational continuity may not produce the same outcomes as a smaller team whose model is explicitly built around it.

"The biggest thing is about that relationship with children. Keep trying. Not just like one offer and didn't get anything. Be flexible in looking at offering most opportunities to children."

Service Manager, Area 10

Training on extra-familial harm and contextual safeguarding was cited as an enabler by 22% of survey respondents. The fieldwork found a more nuanced picture: training matters, but it is most effective when it is embedded in a practice culture that already prioritises relational approaches, rather than offered as a standalone intervention to workers operating within a compliance-oriented model. Several practitioners described training on contextual safeguarding that had not changed how their team worked, because the wider service model did not support the approach the training was advocating.

Co-location emerged as a specific workforce enabler across multiple fieldwork areas, and is addressed here as a structural condition rather than a data-sharing mechanism. A police officer described what co-location with youth justice workers and early help colleagues produces in practice: 'You pick things up that you'd never get from an email or a referral form.' one of the fieldwork areas described intelligence being shared daily rather than at monthly meetings. In both areas, the physical proximity of workers from different agencies created the conditions for informal, real-time information exchange that formal data-sharing agreements alone do not produce.

"The co-location is really key. Being sat with the youth justice workers, the early help workers, the VCS, you pick things up that you'd never get from an email or a referral form."

The single-coordinator risk: when oversight depends on one person

Strong

Identified independently across at least four fieldwork areas. When prevention oversight depends on one person's relationships and persistence, the system has a single point of failure.

Across the fieldwork, a pattern emerged that was not a research question but became one of the most practically significant findings. In several areas, the entire below-threshold oversight function, the panel coordination, the partner relationships, the institutional knowledge, the escalation pathways, was held by a single individual. When that person was available and engaged, the system worked. When they were not, or when they moved on, the system was at risk of stopping entirely.

A practitioner responsible for prevention panel coordination was direct: 'It's relied on a single person, really me. I'm doing all the strategic stuff and all of the operational work and that just squeezes the time you've got to really develop it.' In Area 7, the strategic lead for below-threshold oversight appeared to be a single newly appointed practitioner working to understand and develop a system that did not yet have clear infrastructure. In Area 3, the prevention panel mechanism had stopped entirely between November 2025 and the time of the fieldwork following a loss of staffing. In one of the fieldwork areas, a similar dependency on key individuals was described, with the strategic lead acknowledging the vulnerability that creates.

"One of the challenges as to how we've implemented this locally is that it's relied on a single person, really me. I'm doing all the strategic stuff and all of the operational work and that just squeezes the time you've got to really develop it."

Prevention manager, Area 11

The consequences of single-coordinator dependency extend beyond operational disruption. The escalation pathways built on personal relationships, the panel knowledge accumulated over years, the understanding of which partner agency will respond to which kind of referral, all of this is tacit knowledge held in one person. When they leave, that knowledge is not systematically transferred because it was never systematically recorded. The next person starts again.

This is not a criticism of the individuals involved, several of whom were carrying an evidently unsustainable workload with considerable skill and commitment. It is a structural observation about what happens when partnerships treat below-threshold oversight as a coordination task rather than a core institutional responsibility. The areas where this risk was lowest (Area 1, Area 5, Area 10) shared a common feature: the oversight function was embedded within a

team, had dedicated capacity across more than one person, and was accountable to a governance structure that would continue regardless of individual personnel changes.

Single-coordinator dependency: the structural risk

When oversight of children who fall below the threshold depends on one person’s relationships, knowledge, and persistence, the system has a single point of failure. Governance structures, panel mechanisms, and escalation pathways that exist primarily in one person’s working practice rather than in institutional processes are at risk when that person is unavailable, overburdened, or moves on. Oversight should be designed to be robust to personnel change, not dependent on it.

Funding: the joint highest barrier, and what is lost when it ends

Strong

Short-term and unstable funding was cited as a barrier by 33% of survey respondents, the joint highest barrier in the entire survey, equal to unclear responsibility. Confirmed across all fieldwork areas.

Short-term and unstable funding is the most pervasive structural constraint on below-threshold oversight. Thirty-three per cent of survey respondents cited it as a barrier, jointly the highest in the entire survey alongside unclear responsibility. The survey evidence also reveals a structural symmetry worth noting: the three factors most commonly cited as barriers to effective oversight (unclear responsibility, short-term funding, and lack of capacity) are near-exact inversions of the three factors most commonly cited as enablers. The system is not complex to diagnose. It requires the same short list of conditions, addressed from either direction. The fieldwork confirmed this at the level of specific, named consequences: not just that services ended, but what ended with them.

The Centre for Young Lives (2025) reports that expenditure on youth services has fallen by £1.2 billion since 2010/11, a 73% decline, with 1,243 council-run youth centres closing between 2010 and 2023, leaving just 581 in operation by March 2023. The Turnaround evaluation reinforces this at programme level: despite £71 million in total funding, Youth Offending Teams reported tight mobilisation timeframes, staffing shortages, inability to roll over unspent funds between financial years, and ongoing uncertainty about continued funding (Turner et al., 2026, pp.54-56), precisely the conditions this research identifies as destroying relational continuity.

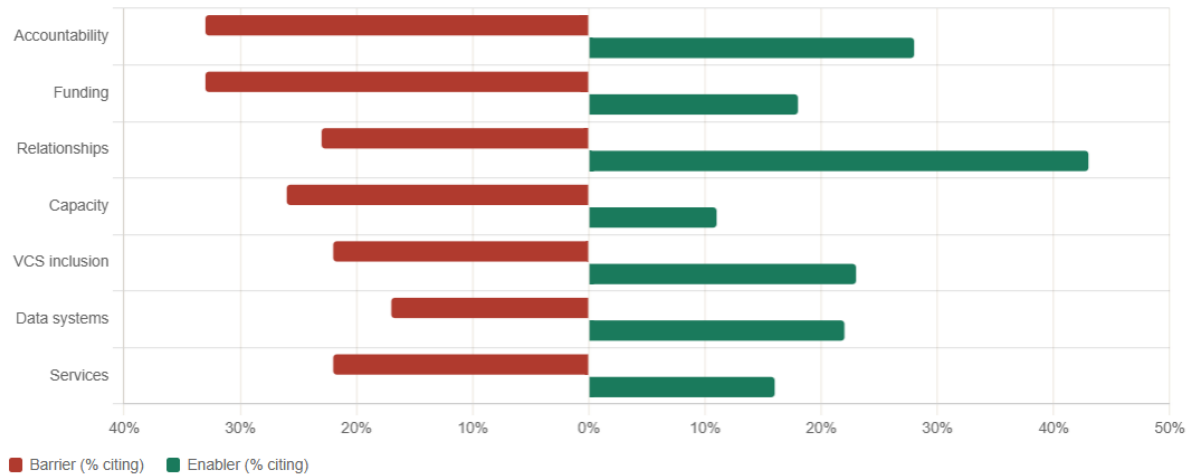


Figure 10: The same seven themes, cited as barriers and as enablers. Each bar shows the percentage of survey respondents naming that theme. Accountability, funding and relationships appear at the top of both lists, which suggests these are not separate problems and solutions but single factors that either work or do not. Source: Survey Q20 and Q21, multi-select, n=129.

The evidence review provides the structural context. Children’s services budgets have been reduced by approximately 50% since 2010. Youth services have been reduced by 60 to 80% in the same period (Lloyd and Firmin, 2020). This is the baseline against which prevention services are being built and sustained. The fieldwork found that every area with a strong oversight model had found a specific funding route that provided some degree of stability: devolved violence-reduction funding in one area, OPCC funding in Area 5, external project funding in Area 2. Each model remained subject to the funding decisions of the institution providing it.

“Short-term funding is the killer. You build something, it works, the funding ends. And it’s not just the service that disappears; it’s the trust, the relationships, all of that institutional knowledge.”

Youth justice practitioner, Area 6

Sixty-five per cent of VCS respondents cited short-term funding as a barrier, nearly double the overall rate of 33% and the strongest sector divergence on any single barrier in the survey. The fieldwork confirmed that VCS organisations, which provide the relational continuity that statutory services cannot replicate across service boundaries and commissioning cycles, are the most vulnerable to spot-purchasing, year-by-year funding decisions, and sudden contract endings. When VCS funding ends, the relationships end. A practitioner described this directly: the trust, the knowledge, and the relationships built over years disappeared when the funding ended. The survey evidence shows that the VCS experience of the oversight system is one of compounding barriers: 65% cite funding instability, 53% cite thresholds being too high to escalate through, 47% report being excluded from strategic planning, and 41% say there are no appropriate services to refer children to when they do identify need. No other sector in the survey carries this combination. The organisations most likely to maintain long-term relationships with children

and families face the most barriers to participating meaningfully in the systems designed to keep those children safe.

The most deliberate response to funding fragility found in the fieldwork is described in Area 5's case study below. Over eight and a half years, the Senior Early Intervention Officer has systematically aligned the service with police priorities and police infrastructure, on the explicit reasoning that if the OPCC, which funds the service, is abolished, the service needs to have made itself indispensable to an institution that will continue. This is sustainability planning as a proactive discipline rather than a reactive response to crisis. This level of deliberate sustainability planning was not a feature described in other fieldwork areas.

Data systems: locally built solutions to a nationally unresolved problem

The Families First Partnership programme begins to address the data infrastructure gap identified in this research. It establishes quarterly programme data collections with headline monitoring indicators, guidance on case management system changes to bring targeted early help and children in need into a single workflow, and through the Children's Wellbeing and Schools Bill, an information sharing duty and consistent identifiers across agencies (DfE, 2026b). These reforms represent meaningful progress. However, they do not yet extend to children who fall outside Family Help entirely. Children receiving No Further Action decisions who are not referred to any structured service remain invisible to data systems, so the tracking gap this research documents is not closed by these reforms alone.

Strong	<i>Data and IT systems were cited in 42% of open-text survey responses, the highest single theme. The evidence review identifies the absence of national recording standards as the root cause. The fieldwork shows locally built solutions are working, but the structural gap remains.</i>
---------------	--

The evidence review identifies an absence of national recording standards as a fundamental infrastructure gap. The clearest documented case is child criminal exploitation in county lines, where no national recording standards apply, with the result that the scale of the problem cannot be described accurately or progress against it measured (Ditcham, 2023). Our inference is that recording for children below the threshold, who carry no programme label at all, is likely to be less developed still. What the evidence does establish directly is that case management systems are built around statutory children's services rather than this group (Firmin, 2020), and that no research follows what happens to children after a No Further Action decision or links their records over time (Lloyd and Firmin, 2020). Without agreed standards, children appear in agency systems as isolated incidents rather than as individuals experiencing cumulative risk across time and across services. A child known to police through three separate contacts, to a school as a persistent non-attender, and to a voluntary sector worker through a referral that never resulted in statutory involvement may be visible to each of those agencies in isolation. Without shared recording infrastructure, no one sees the cumulative picture.

The survey evidence confirms that data and IT systems are experienced as the most pressing operational challenge: 42% of open-text responses cited them as a barrier or

development need, the highest single theme in the qualitative data. The gap between aspiration and current reality is significant. A social work team manager, newly in post and seeking to understand the local system, described the experience directly: ‘Our data is an area of development.’ The threshold for having meaningful data infrastructure is not high. But many areas are not yet there.

The fieldwork found that the areas with the strongest data approaches had all built their own solutions locally, without waiting for national standards. Area 9’s Power BI dashboard, Area 5’s data application, which integrates with the police records system, and Area 10’s and Area 1’s spreadsheet trackers are all locally designed, locally maintained, and locally accountable. None of them required national infrastructure. All of them addressed a local problem that national systems had not resolved. These approaches are described in detail in Building Blocks 2 and 3 and are not repeated here. The BB4 point is structural: the absence of national recording standards means that local innovation fills a gap that should not need filling locally, and that areas without the capacity or confidence to build their own solutions are left without any data infrastructure at all.

Partnership maturity

Strong	<i>Strong multi-agency relationships were cited as the highest enabler in the entire survey, by 43% of respondents. The fieldwork found that the strongest partnerships had been built over five to eight years of sustained investment. They were also the most vulnerable to personnel change and funding disruption.</i>
---------------	---

Strong multi-agency relationships were cited as an enabler by 43% of survey respondents, the highest single enabler in the entire survey. Good relationships with the voluntary sector were cited by 23%. The fieldwork explained why: in the areas where oversight was working, the partnership was not a structure. It was a set of relationships, built over years, that had reached the point where agencies were genuinely planning together rather than sharing information and hoping for the best.

A youth justice practitioner described the trajectory of partnership development with precision: it is built over years on personal relationships, not systems. Area 5 described eight and a half years of commissioner-sustained investment. Area 1 described five years of prevention activity within which the force-wide screening framework, the voice survey approach, and the tracker had all been built and refined. Area 10 described a prevention culture that had been developing for longer than most English comparators, supported by a policy context in that part of the UK that embeds prevention within youth justice in ways that England has only recently begun to adopt.

In each of these areas, the partnership maturity was not the starting point. It was the result of sustained investment, deliberate relationship-building, and persistence through electoral cycles and personnel changes. Areas that are at an earlier stage of development, Area 7, where the strategic lead is newly in post and acknowledges the system is still being built, or Area 11, where the panel infrastructure exists but the single-coordinator dependency creates structural vulnerability, are not failing. They are at a different point on a long journey that the stronger areas have been travelling for years. Area 11’s experience also illustrates that partnership density, having many panels, governance structures, and coordination

mechanisms, is not the same as partnership maturity. A large governance landscape can exist alongside limited post-panel monitoring and single-coordinator dependency.

“The partnership has matured. We’re not just sharing information anymore, we’re genuinely planning together. But it’s taken years to get to this point and it’s built on personal relationships, not systems.”

Youth justice practitioner, Area 6

The VCS dimension of partnership maturity deserves specific attention. The evidence review found that policymakers only sometimes included voluntary sector partners when planning strategies or awarding longer-term contracts, and that the sector was not consistently invited to exploitation and risk panels despite being a primary provider of services (Andell, 2023b). This matters because the voluntary sector is the part of the system children and families rate most highly, ahead of both police and children’s social care (Safer London, 2024), and is the best placed to maintain relationships across service boundaries. The survey confirmed VCS respondents reported being excluded from strategic planning at nearly twice the rate of other sectors. The fieldwork found that the areas with the strongest partnerships had addressed this deliberately. In Area 1, the VCS has a decision-making seat at the prevention panel. In Area 5, third sector organisations are embedded in multi-agency triage. In Area 2, the consultation model is explicitly open to VCS practitioners. Partnership maturity, in these areas, means including the VCS not as a recipient of referrals but as a participant in the governance of oversight.

The fragility of partnership maturity is its most important characteristic for commissioners and strategic leaders. A partnership built on personal relationships rather than systems is at risk when those relationships change. Area 3’s case illustrates this: when staffing was lost, the panel mechanism stopped. The relationships that had built up around that mechanism did not automatically reconstitute themselves around a different structure. The learning from the fieldwork is that partnership maturity needs to be systematised over time, embedded in governance documents, terms of reference, shared data systems, and formal commitments, rather than left to rest on the shoulders of the individuals who built it.

What this means in practice

The evidence across implementation and capacity points to three insights for partnerships seeking to strengthen the organisational conditions for effective oversight.

Insight 11: Build oversight as a team function, not a coordinator role

Where oversight of children below the threshold is held by a single individual, the partnership has a single point of failure. Every partnership should be able to answer: if the person currently coordinating our below-threshold oversight left tomorrow, what would happen? If the answer is that panel meetings would stop, partner relationships would be lost, or the tracker would no longer be maintained, the oversight function is personal rather than institutionalised.

Building oversight as a team function means: dedicated capacity across more than one person, with clear role descriptions that distribute the work; institutional processes (written

terms of reference, shared data systems, formal panel schedules) that exist independently of any individual's knowledge; and governance accountability that sits with a board or senior leader rather than with the coordinator alone. This does not require large teams. Area 1's prevention function operates with a small dedicated team. What makes it robust is that the function is embedded in the institution, not carried by one person.

Insight 12: Treat funding instability as a governance risk, and ensure commissioning supports oversight

Short-term and unstable funding is the joint highest barrier to effective oversight in this research. Partnerships and commissioners should treat funding continuity for below-threshold prevention as a governance risk that requires active management, not a background condition to be accepted. This means: commissioning prevention tracking infrastructure on minimum three-year cycles rather than year-by-year; designating prevention oversight as a core statutory partnership responsibility rather than a project funded by external grants; and planning explicitly for what happens when specific funding streams end.

Area 5's approach of deliberately aligning the service with police infrastructure and priorities, ahead of the planned abolition of the OPCC that currently funds it, represents the most proactive sustainability planning found in the fieldwork. The underlying principle (that a service should make itself indispensable to an institution that will persist, rather than depending on one that may not) is transferable to other funding contexts. VCS organisations providing relational continuity within oversight systems should be commissioned on multi-year contracts that reflect the time it takes to build the relationships on which their effectiveness depends.

Insight 13: Build partnership maturity deliberately, and systematise what you build

Partnership maturity is the product of sustained investment over years, not a structure that can be created by governance mandate. Partnerships at an early stage of development should not expect to reach the point of 'genuinely planning together' quickly. What they can do is make deliberate decisions that build the conditions for maturity over time: co-locating workers where possible, including VCS organisations in governance structures rather than limiting them to service delivery roles, maintaining consistent personnel in key relationship-holding roles for long enough to build genuine trust, and reviewing progress on partnership quality as a standing item at the partnership board.

Crucially, what has been built through personal relationships should be systematised before it is lost. When a key individual moves on, the relationships they held should be actively transferred rather than allowed to lapse. This requires documenting what those relationships are, who holds them, and what they produce, which in turn requires treating partnership maturity as something that can be described, measured, and improved, rather than as an intangible quality that either exists or does not.

Area 5

Eight and a half years of commissioner-sustained investment, automated outcome measurement, and deliberate sustainability planning: what implementation looks like when it is treated as a long-term discipline

Area 5's Youth Violence Intervention Unit (YVIU) was established 8.5 years ago when the then-Police, Fire and Crime Commissioner recognised that the county was waiting for children and families to reach crisis before any support was offered. The commissioner's personal championship was the founding condition: 'He said, we're going to fill that gap because it will have an impact on policing.' Five early intervention officers are employed by the OPCC and co-located with police, working voluntarily with young people at risk of county lines and knife crime. There are no time limits on engagement: workers stay for as long as the young person needs, with an average case length of approximately six months.

Three referral routes bring young people to the service: a golden hour model in which a worker attends the custody suite within an hour of a young person's arrest; school referrals; and self or parent referrals. A whole-family approach requires parental consent and involves parents from the first contact. The service deliberately operates without mandatory sessions: 'If they say no to cannabis support, we don't force them.' Plans are co-produced with young people at their pace, with flexible diversionary funding across five categories including education support, activities, and support to secure an Education, Health and Care Plan (EHCP).

The data application automates outcome measurement by connecting directly to the police records system. When a young person is allocated to the YVIU, they are tagged on the police records system, and the data application begins tracking all subsequent police occurrences automatically, with no manual data entry required. Individual distance-travelled graphs are generated for each young person and included in case closure summaries. Across twelve months, the service has recorded a 72% reduction in police contact and estimated cost savings of £137,000. A six-month post-closure check-in was added after data application data showed that children who experience difficulty after an intervention tend to do so around the six-month benchmark.



The sustainability planning that the Senior Early Intervention Officer has pursued is an example of particularly deliberate long-term thinking. In November 2025, the government announced that Police and Crime Commissioners, and the OPCCs that support them, will be abolished as part of its police reform programme, with the change taking effect at the end of the current electoral cycle in 2028. The abolition itself requires primary legislation, which the government committed to in the 2026 King's Speech but had not introduced by the time this report was completed. Where the functions transfer, they are expected to pass to combined authority mayors, or to new police and crime boards made up of local government leaders in areas without a mayor (House of Commons Library, 2026). For Area 5, this means the institution that has funded the youth violence intervention unit for 8.5 years will cease to

exist. The response to this has been proactive and strategic rather than reactive: over the course of the service's existence, the team has embedded itself within police infrastructure, aligned its priorities with police strategic objectives, and built a data tool that speaks directly to police systems and demonstrates its value in police terms. As the Senior Early Intervention Officer described it: 'I've worked really hard in the eight years to align ourselves with police, if we ever get to the point we don't have an OPCC, we're safe.' The institution it is aligned with will persist even if the funding institution does not.

Three limitations are worth noting for partnerships considering this model. First, the data application outcome data measures police contact only: it does not track child wellbeing, educational outcomes, or family circumstances, which means the 72% reduction figure, while compelling, represents one dimension of a multi-dimensional picture. Second, there is no multi-agency panel for post-closure oversight: the six-month check-in is managed manually via business support spreadsheet, and there is no panel mechanism equivalent to Area 1's Team Around the Family or Area 6's Youth Support Group. Third, while the commissioner-championship funding model has proved sustainable over 8.5 years, it depends on continued alignment with police priorities and on the strength of the relationships built with the force, conditions that could change with new police leadership or strategic direction.

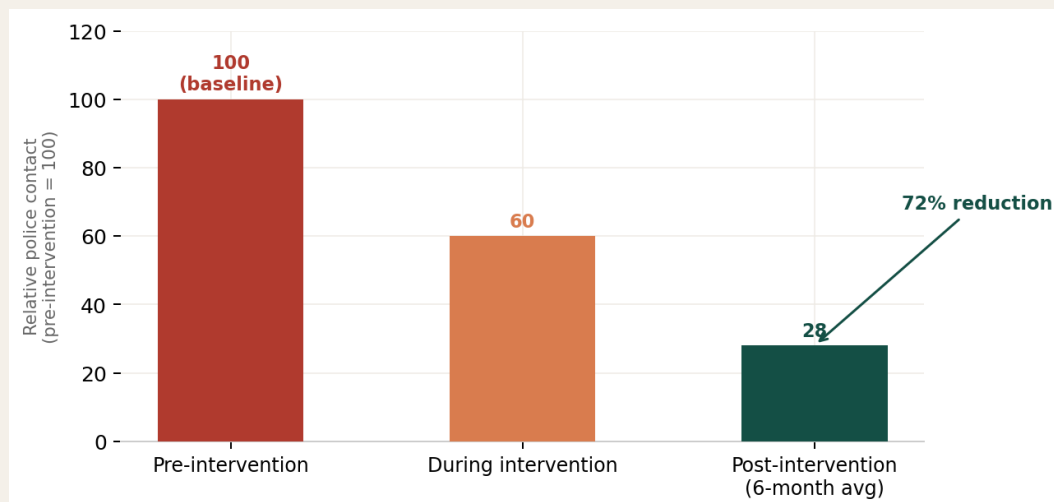


Figure 11: Area 5 police contact trajectory. A reported 72% reduction. Source: fieldwork interview. Self-reported data, not independently evaluated.

Conclusion

This research set out to answer a question: how do local areas maintain oversight of children and young people who are at risk of involvement in violence but do not meet the thresholds for statutory children's social care or youth justice intervention? What it found is that the gap between areas doing this well and areas that are not is larger than it first appears, and that the barriers to improvement are more tractable than many practitioners believe.

This is a system that is consistently good at finding children and consistently poor at staying with them. It is a system in which frontline practitioners are significantly more pessimistic about outcomes than their senior leaders, which is a warning about the feedback loops that senior leaders are and are not receiving. And it is a system in which the organisations best trusted by children and families, most capable of maintaining relationships over time, and most likely to notice when something is going wrong, are also the ones most systematically excluded from strategic planning and most vulnerable to losing their funding.

And yet the same evidence that describes these gaps also describes what closing them requires. The distance between a system that discusses children and a system that tracks them is often smaller than it looks.

What the evidence shows

All eleven fieldwork areas have at least one mechanism through which children at risk of involvement in violence come to attention. This is where the field is most developed. But the approaches vary enormously, from daily automated police data checks to monthly panels that respond to referrals, and several areas rely on identification routes that systematically miss children who are not referred through the standard pathway. The children who come to attention through association with a family member, through child-to-parent violence, or through patterns of low-level contact across multiple agencies rather than a single serious incident, remain at risk of being missed even in areas with strong identification infrastructure.

The system then weakens at each stage. By the point at which someone should be asking whether a child is safer than they were six months ago, only a minority of areas have a structured answer. Most areas, and most of the practitioners who responded to the survey, are working without the information that would tell them whether what they are doing is making a difference.

This is not primarily a technology problem. Two of the areas with the strongest outcome data track children on a spreadsheet. It is a question of leadership and partnership. The tool matters less than the decision to use it, and that decision requires deliberate commitment: leadership that says measuring matters, governance that asks for the data, and commissioning that builds data-return requirements into contracts.

The most telling finding in this research is that only one practitioner out of the 85 who answered the question was very confident that the support their area provides actually reduces children's risk of violence. Frontline practitioners were far more doubtful than senior leaders, which is not a reflection of pessimism but of the absence of the feedback loop that would tell them whether they are right.

What this study adds

Research on children below statutory thresholds has so far concentrated on two things: the threshold decisions themselves, and individual programmes. Lloyd and Firmin (2020) showed that 81% of children experiencing significant extra-familial harm received No Further Action decisions, and the Turnaround evaluation (Turner et al., 2026) showed what a single national programme can achieve with this group at scale. What the published evidence could not describe is what happens between those two points: how local areas, as systems, keep sight of these children once a threshold decision has been made and no programme label applies. Our evidence review found no research examining which governance arrangements work for this group, what happens to children after a No Further Action decision, or how oversight is sustained when children step down from support.

This study addresses that gap in three ways. It provides the first cross-area description of how oversight actually operates in practice, using a six-function framework applied consistently across eleven local areas and triangulated with a national survey of 129 practitioners and a rapid review of the published evidence. It documents promising practice in detail, together with the conditions that made it possible, so that partnerships can see what better oversight looks like and what it rests on. And it establishes the race equity finding at system level: areas increasingly recognise disproportionality, and none yet holds the data that would let them act on it, which turns a silence in the literature into a documented gap with a practical remedy.

What this study does not add is causal evidence. None of the fieldwork areas has been independently evaluated with a comparison group, and the consistent association we found between stronger oversight infrastructure and better reported outcomes is not proof that one produces the other. The contribution is a descriptive baseline and a set of testable propositions: the framework, the conditions and the minimum standards in these insights are what future evaluation should now examine.

Limitations

The survey provides breadth rather than national representativeness. The South East and London account for 41% of its 129 responses, education and health practitioners are underrepresented, and survey findings are treated throughout as indicative context rather than as national statistics.

The eleven fieldwork areas were not a random sample. Areas with established prevention infrastructure were more likely to take part, so the practice described here is probably ahead of what is typical nationally, and the barriers reported are, if anything, understated.

The outcome data areas shared with us is self-reported. Where areas cite reductions in reoffending or first-time entrants, those figures reflect their own monitoring rather than independent verification, and they are presented in this report as promising practice rather than established evidence.

The evidence review was rapid by design: 496 citations screened, 76 documents meeting the inclusion criteria and 27 fully synthesised, with searches run in November and December 2025. Significant publications released after that window, including Working Together 2026, the Southport Inquiry report and the Turnaround evaluation, were incorporated as clearly signposted context rather than through the formal search.

The race equity evidence from the fieldwork is thin, and this report has treated that thinness as a finding rather than disguising it. The most substantial race equity evidence comes from the published literature, and no area could provide disaggregated data about its own below-threshold cohort.

Finally, all fieldwork participants were sent the full draft of this report in May 2026 and invited to identify anything misinterpreted or missing, with a two-week window and the offer of a conversation. Any feedback received has been incorporated into this final version.

A final note

The practitioners who took part in this research were, without exception, committed to the children they described. What came through most clearly was not indifference or neglect but the experience of doing difficult work in systems that do not always give people what they need to know whether it is making a difference.

That uncertainty is a system design problem, not a personal one. A system that asks practitioners to maintain oversight without the infrastructure to know whether children are safer is a system that asks them to work on faith. The evidence from the areas where oversight is strongest is that what practitioners need is not more commitment (they have that) but the institutional conditions that let their commitment translate into something visible.

“We will never, ever be able to measure... we don’t know would they have ever gone on to go to prison. There’s a high probability if they haven’t worked with us, but we’re never going to be able to know that.”

Senior Early Intervention Officer, Area 5

The answer to that question is what this report is designed to support. The point is the child who does not become a first-time entrant. The point is the partnership that can show, five years from now, not just that children were discussed but that the area took accountability for ensuring they got the support they needed, that someone checked, and that something changed. The infrastructure for that exists. The evidence for what it requires exists. What remains is the decision to build it.

References

Studies marked with an asterisk () were among the 27 documents fully extracted and synthesised in the rapid evidence review (see Methodology).*

- * Andell, P. (2023a). Child criminal exploitation and community development in Bedfordshire.
- * Andell, P. (2023b). Waltham Forest research report: co-production in addressing child criminal exploitation.
- Brandon, M., Belderson, P., Warren, C., Gardner, R., Howe, D., Dodsworth, J. and Black, J. (2008). The preoccupation with thresholds in cases of child death or serious injury through abuse and neglect. *Child Abuse Review*, 17(5), 313-330.
- Centre for Young Lives (2025). *Transforming Opportunities for the Most Vulnerable Young People*. London: Centre for Young Lives.
Contextual Safeguarding Network (no date). Working with parents to address extra-familial harm. Available at: <https://www.contextualsafeguarding.org.uk/blog/working-with-parents-to-address-extra-familial-harm/>
- * Crest Advisory (2025). The role of key workers in supporting children and young people with experience of serious youth violence. London: Crest Advisory.
- * CSA Centre (2017). *Child sexual exploitation: multi-agency working*.
- * Davies, J. (2022). The barriers to and opportunities for hearing the voice of the young person in multi-agency work.
- * Davies, J. and Walker, J. (2025). Adolescent violence and abuse: findings from research of the Step Up intervention.
Department for Children, Schools and Families (DCSF) (2008). *Targeted Youth Support: A Guide*. Nottingham: DCSF Publications.
- Department for Education (DfE) (2026a). *Working together to safeguard children 2026*. London: Department for Education.
- Department for Education (DfE) (2026b). *Families First Partnership programme guide*. London: Department for Education.
- Department for Education (DfE) and Department for Levelling Up, Housing and Communities (DLUHC) (2022). *Supporting Families Programme guidance 2022 to 2025*. London: DfE and DLUHC.
- * Dickens, J. and colleagues (2022). *Learning for the future: final analysis of serious case reviews, 2017 to 2019*.
- * Ditcham, K. (2023). *Child criminal exploitation in county lines in England and Wales: challenges and controversies*. Doctoral thesis.
- * Edbrooke-Childs, J. and colleagues (2024). *Pre-evaluation assessment: the feasibility of different approaches to delivering an impact evaluation of the Turnaround programme*.
- * Firmin, C. (2020). *Contextual safeguarding and case management systems*.
- Hall, S. and Marsh, N. (2025). *Excluded to Included: Parents as Partners in Child Exploitation*. Ivison Trust.
- Herbert, K., Xi, Q., Feder, G., Gilbert, R., Powell, C., Howarth, E. and Morris, S. (2023). *Child maltreatment and parental domestic violence and abuse, co-occurrence and the effect on lifetime*

outcomes in the Avon Longitudinal Study of Parents and Children (ALSPAC). *SSM - Population Health*, 24.

HM Treasury and Department for Children, Schools and Families (DCSF) (2007). *Aiming High for Young People: a ten-year strategy for positive activities*. London: HM Treasury.

House of Commons Library (2026). *Police and crime commissioners. Research briefing SN06104*. London: House of Commons Library.

- * Huegler, N. and colleagues (2025). 'We were persistently othering them out': reconceptualising 'safeguarding' for young people.
Ivison Trust (no date). About Ivison. Available at: <https://ivisontrust.org.uk/about-ivison/>
- * Kirk, C. and Duschinsky, R. (2017). *On the margins of the child protection system: creating space for relational social work practice*.
- * Lloyd, J. and Firmin, C. (2020). *No further action: contextualising social care decisions for children victimised in extra-familial settings*. London: Contextual Safeguarding Network.
- * Maxwell, N. and Wallace, C. (2021). *Child criminal exploitation in Wales*.
- * Ministry of Justice (2024). *Turnaround programme: year one management information*. London: Ministry of Justice.
- NSPCC (no date). *Graded Care Profile 2 (GCP2)*. London: NSPCC.
- * Ofsted, Care Quality Commission, HMICFRS and HM Inspectorate of Probation (2023). *The multi-agency response to children and families who need help (Joint Targeted Area Inspection)*.
- Ofsted, Care Quality Commission, HMICFRS and HM Inspectorate of Probation (2024). *Multi-agency responses to serious youth violence: working together to support and protect children*. London: Ofsted.
- * Quigg, Z. and colleagues (2020). *Evaluation of the Merseyside Violence Reduction Partnership 2019-20, including the Navigator programme*.
- * Quin, M. (2023). *Against the odds: success and collaboration in safeguarding children*.
- SafeLives (no date). *MARAC referral criteria and form*. Bristol: SafeLives.
- Safer London (2024). *Who Cares?* London: Safer London.
- * Shorrock, S. and colleagues (2019). *Practitioner perspectives of multi-agency safeguarding hubs (MASH)*.
- * Shorrock, S. and colleagues (2020). *Profile of repeat victimisation within multi-agency referrals*.
- The Southport Inquiry (2026). *The Southport Inquiry: Phase 1 report, Volumes 1 and 2*. London: StreetGames (2024). *Making Referrals: Guidance and Toolkit to Support Locally Trusted Organisations*. Loughborough: Loughborough University (School of Sport, Exercise and Health Sciences), in partnership with StreetGames.
- Turner, E. and colleagues (2026). *Turnaround programme: process and implementation evaluation*.
- * Tyrell, K. and colleagues (2020). *Diversion, prevention and youth justice: a model of integrated decision making*.
- * Wilson, A. and Mueller-Johnson, K. (2024). *Discovering a predictive mechanism to identify risk and harm in extra-familial child exploitation*.
- * Wroe, L. (2021). *Young people and 'county lines': a contextual and social account*.
- Youth Access and partners (2025). *A Blueprint for Young Futures Hubs*. London: Youth Access.

- * Youth Endowment Fund (2024a). A review of the literature on how the systems of support available to young people work to prevent serious violence.
- * Youth Endowment Fund (2024b). Agency Collaboration Fund Round 2.
- * Youth Endowment Fund (2024c). Focused deterrence guidance.
- Youth Endowment Fund (2025a). Access to mental health support for children and young people involved in or at risk of serious youth violence across England and Wales. London: Youth Endowment Fund.
- Youth Endowment Fund (2025b). Children, violence and vulnerability 2025. London: Youth Endowment Fund.
- * Youth Endowment Fund (2025c). The role of systems of support in serious youth violence: evidence and gaps.
- Youth Endowment Fund (2026). Children's services and violence prevention. London: Youth Endowment Fund.