

Found but NOT followed:

Key insights for practice

The thirteen insights below are grounded in the evidence from this research: a national practitioner survey of 129 respondents, interviews with 27 practitioners across 11 areas, and a rapid evidence review of 76 documents, of which 27 were fully synthesised. They are addressed primarily to safeguarding partnerships, Community Safety Partnerships, Violence Reduction Units, commissioners, and local authority children's services leads.

Governance and accountability

1

Name a lead practitioner for every child, with a welfare rather than a justice lens

The clearest finding across the fieldwork is that accountability needs a named individual, not just a named panel or team. Where the lead sits matters: a welfare lens sustains engagement better than a justice lens.

2

Design panels for decisions, with terms of reference that explicitly address oversight

Most multi-agency panels exist, but many produce discussion rather than decisions. Terms of reference should set out membership, decision rights and how oversight, not just planning, is carried between meetings.

3

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

When families decline a service, most areas treat this as the end of oversight. Separating consent for support from consent for monitoring keeps a child visible even when they are not receiving a service. Partnerships should consider the lawful basis for maintaining oversight and what information can be appropriately retained, or shared, and whether further contact is justified where families decline support.

Follow-up and monitoring

4

Create multiple entry routes and pathways that maintain visibility

Areas that rely on a single referral gateway miss children. Multiple entry routes widen identification, and an oversight pathway, unlike a referral pathway, maintains visibility of what happens next.

5

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

The period after a case closes is among the highest-risk. A named lead with reviews at minimum six-weekly during support, continuing after closure, is what the stronger areas have in common.

6

Involve children and families as participants in monitoring, not just subjects of it

The areas with the strongest outcomes treat families as participants in oversight, not just subjects of it, with clear routes to give feedback and raise concerns after a case closes.

Quality, escalation and outcomes

7

Start measuring outcomes against a minimum standard

Outcome tracking is a discipline, not a technology. Approaches can vary substantially across areas – from spreadsheets to automated dashboards – but what matters most is the decision to monitor outcomes. That decision requires deliberate commitment: leadership that prioritises outcome measurement, governance that requires data to be shared and used, and commissioning that builds data-return requirements into contracts.

8

Define escalation criteria rather than relying on professional judgement

In most areas escalation depends on individual judgement. Written criteria describing what pattern of concern triggers a more intensive response make escalation consistent and less person-dependent.

9

Match quality assurance to how demanding the work is

Quality assurance for these children should assume complex, multiple and long-standing needs, rather than treating these as simple cases, and should be designed for the actual difficulty of the work.

10

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

Within our research, no area disaggregated its oversight, panel or outcome data by ethnicity, sex, age or special educational needs. As a result, no area could say whether its oversight system is working equitably. Monitoring for disproportionality, now required by Working Together 2026, should be standard.

Implementation and capacity

11

Build oversight as a team function, not a coordinator role

Where oversight rests with one person, the partnership has a single point of failure. Building it as a team function protects continuity when individuals move on.

12

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

Short-term funding is the joint highest barrier in this research. Treating funding continuity as a governance risk, and commissioning in a way that supports oversight and not just service delivery, protects the relational continuity oversight depends on.

13

Build partnership maturity deliberately, and systematise what you build

Partnership maturity is built through sustained investment over years, not created by mandate. Areas should build it deliberately and systematise what works so it survives staff turnover.