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Dear Ms Coyle

Focused visit to Nottinghamshire children's services

This letter summarises the findings of the focused visit to Nottinghamshire children's services on 26 November 2025. The inspectors for this visit were Parveen Hussain, His Majesty's Inspector, and Nick Stacey, Ofsted Inspector.

Inspectors looked at the local authority's arrangements for the 'front door'.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework.

Headline findings

Some children who are referred to the front door receive an inconsistent response. However, most children's needs are identified early and for some this has resulted in suitable signposting to support services which has prevented their needs escalating. While many children progress appropriately, for some children who need statutory social work interventions, a lack of professional curiosity and multi-agency checks has resulted in some inappropriate decisions to take no further action. A lack of effective management oversight for children identified as having immediate need has resulted in some children being in situations of unassessed risk longer than necessary.

Once work progresses to the assessment team, children are seen promptly and their needs assessed in a timely way. For many children, this results in appropriate outcomes. There remain some children, especially those subject to ongoing neglect or repeat domestic abuse, whose needs are not met sufficiently, leading to repeat interventions.

What needs to improve in this area of social work practice?[1]

- Management oversight and timely progression of all contacts in the multi-agency safeguarding hub (MASH), including children identified as having immediate need. (outcome 3, national framework)

- The analysis of children's experiences and management challenge in assessments where children are exposed to neglect and repeat incidents of domestic abuse. (outcome 3, national framework)

Main findings

When children are first referred to the MASH in Nottinghamshire, initial information-sharing is effective. A range of professionals, along with early help coordinators, ensure that families are appropriately signposted to support via community hubs and targeted interventions to meet their needs. The early recognition of support needs prevents escalation for social work support for some families.

Social workers in the MASH make appropriate enquiries in most cases to inform decision-making. Parents and carers are contacted when needed to gather further information and discuss next steps. Social workers contact referrers and obtain necessary information from partner agencies to inform outcomes. Decision-making in many situations is balanced and well informed. In a small number of children's cases, too much weight is apportioned to parental self-reporting, with a lack of professional curiosity and checks with other sources before conclusions to take no further action are made.

Management oversight and decision-making is not consistently strong for all children who are referred to the MASH. When decisions are made to take no further action, management oversight is recorded and provides a clear rationale as to why further interventions are not needed. While children with the highest level of need are identified as requiring immediate attention, not all children in this category are progressed swiftly. A lack of managerial oversight means there is no rationale for the delay or assurance that checks are progressing in a timely way. This drift and delay in decision-making hinders progression to the assessment teams and has led to some children remaining in situations of unassessed risk for longer than necessary.

Children suffering neglect and domestic abuse are recognised in the MASH. Social workers apply motivational interviewing skills to engage families in the information-gathering process. At times, parental accounts are too easily accepted, preventing a thorough exploration of whether the risks to children are current or historical. The absence of professional curiosity about the implications to children and their lived experiences limits the understanding of urgency for children.

The areas for improvement have been cross-referenced with the outcomes, enablers or principles in the Children's Social Care: National Framework. This statutory guidance sets out the purpose, principles for practice and expected outcomes of children's social care.

A well-resourced emergency duty team (EDT) provides timely initial responses to concerns out of hours. The interface between managers in the EDT and daytime services is effective, with clear and seamless information-sharing which facilitates ongoing support when needed. EDT workers do not always visit children when further action is being taken out of hours. This lack of proactive engagement leaves children reliant on other professionals when they are most vulnerable. This precludes early engagement with children and families, preventing their wishes and feelings from being explored at critical moments.

When safeguarding concerns are identified, most strategy discussions in the assessment teams occur in a timely way. The relevant professionals attend and share appropriate information, enabling effective risk analysis and clear actions. Minutes of strategy meetings and discussions are well recorded, although the actions arising from strategy meetings are not always explicit. The subsequent child protection enquiries lead to appropriate outcomes.

The quality of children and family assessments varies, which is leading to inconsistent experiences for children. In most situations, children, parents and carers are seen quickly, their views are captured, and assessments are completed in a timely way. Better quality assessments gather information from a range of sources and provide a detailed understanding of family history and children's needs and experiences, leading to a clear understanding of need and risk. This is not present in weaker assessments that overlook important aspects of children's lives and underestimate children's vulnerabilities. This limits the depth of evaluation, and for some children leads to overly optimistic planning and recommendations. In these situations, a lack of management challenge or professional curiosity leads to children's cases being closed too early, and for some children, repeat periods of social work intervention.

Domestic abuse and neglect features strongly in most assessments, but the quality of safety planning is variable. When safety plans are effective, they demonstrate clearly defined actions and evidence multi-agency decision-making to support children's safety. Less effective examples contain unrealistic expectations for parents and lack clearly defined actions. When parents disengage or intervention is unsuccessful, the tendency is either to close the children's case or repeat the same plans rather than adapting and rethinking what this means for children's safety.

For a small number of children living with neglect, the responses are often too situational, focusing on immediate issues without recognising the acute and chronic harm endured by children. This lack of deeper analysis and re-evaluation of plans reduces the effectiveness of interventions and leaves children exposed to ongoing harm, undermining their well-being and long-term outcomes.

When children go missing or are at risk of exploitation, return home interviews and the use of exploitation toolkits strengthen social workers' understanding of risks. Timely referrals for intervention and support reduce the risk of harm to children.

Children are usually seen promptly. The variety of tools available to social workers helps them to elicit the voice and views of children through direct work. While the recording of this work can vary, inspectors saw some strong examples of direct work and visits to children. Children's records routinely captured this information to inform decision-making. In these records, risks are explored through respectful uncertainty, with social workers demonstrating the importance of keeping an open mind.

Management support for the workforce is strong, and social workers say that managers are accessible, and they receive regular supervision. Workloads in the assessment teams are maintained at a manageable level, which is supporting workforce stability. Social workers reported positively on working for Nottinghamshire. There is a culture of support where workers feel safe to practise. Senior leaders are prioritising and investing further in the recruitment and retention of a stable workforce.

Since the last inspection, senior leaders have introduced a new system of progressing contacts and referrals through a 'conversational model'. The changes have been incremental and are yet to be fully embedded into practice at the front door. Senior leaders are focused on bringing partners together to create a shared vision of working collaboratively.

There is a culture of learning and openness. This was reflected in senior leaders being receptive to the issues raised and the recently appointed director of children's services taking immediate action to address the areas of concerns. Senior leaders were aware of some, but not all of the shortfalls, and are committed to understanding how gaps might have developed in their oversight and quality assurance. There is a high level of auditing activity, with proposed changes to the quality assurance framework to enhance senior leaders' understanding of service quality.

Senior leaders have plans to adapt the services in line with the national reforms and their ongoing improvement work.

Ofsted will take the findings from this focused visit into account when planning the next inspection or visit.

Yours sincerely

Parveen Hussain
His Majesty's Inspector