

12 March 2026

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Dear Sarah

Monitoring visit to Nottingham City children's services

This letter summarises the findings of the monitoring visit to Nottingham City children's services on 10 and 11 February 2026. This was the seventh monitoring visit since the local authority was judged inadequate in July 2022. His Majesty's Inspectors for this visit were Margaret Burke and Gemma McNevin.

Areas covered by the visit

Inspectors reviewed the progress made in the following areas of concern identified at the last inspection:

- The front door services, including emergency duty and early help services, that receive contacts and referrals.
- Thresholds and levels of need.
- No further action/signposting.
- Step up/down in relation to the front door of services.

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

Headline findings

Since the monitoring visit that focused on front door services in the summer of 2024, children's services have experienced a period of instability. Several leadership changes have taken place, with the new Director for Children and Education Services (DCS) appointed permanently in February 2025. The DCS's commitment and determination have brought renewed focus to create the conditions for service improvement. Until recently, progress in developing front door practice has been limited. Strengthened quality assurance processes and learning from peer reviews are now helping leaders to build a more accurate understanding of practice. Leaders, with corporate and political support and investment, have taken robust action to

improve practice quality and consistency as they bring renewed focus to their improvement journey. More recently, children and families have received better responses from the front door service. Increased stability, clearer expectations and stronger and more visible leadership have created the conditions for a confident, settled front door workforce. These developments have contributed to early improvements and changes in culture.

Despite these improvements, weaknesses remain. The effectiveness of the front door service is improving but remains inconsistent. Timeliness of responses to requests for help, effectiveness of the early help pathways, quality of partnership information, analysis of risk and consistency of practice continue to undermine front door effectiveness. While children and families may now benefit from greater stability and more confident workers, many still do not receive timely or consistently well-analysed responses, particularly when presenting with early or emerging concerns that would benefit from earlier intervention.

Findings and evaluation of progress

When children are believed to be at high risk of significant harm, the initial response from the Multi-Agency Safeguarding Hub (MASH) service remains consistently strong. Prompt identification of risk and swift decision-making in the MASH ensure that requests for help are processed promptly and within agreed timescales. When children need further help, they are transferred quickly to the Duty team for follow up and support. However, when children need to be seen or a strategy discussion is required, these are not always consistently completed with the urgency required to secure timely action to safeguard children.

Threshold decisions for less urgent requests for help are also mostly appropriate. Management oversight is evident but variable in quality, with some oversight lacking professional curiosity or clear direction to ensure that children and their families are directed to the help and support they need.

Timeliness of response to initial requests for help, other than when children are considered to be at risk of significant harm, continues to be a significant weakness. Screening timescales are not measured from the point at which the first request for support was made. Children and their families therefore wait longer for support than performance data suggests. Families can experience further delay when work transfers to the Duty team, sometimes adding several more days before the assessment and follow up work begin. Some recording practices mask the actual delays families experience before receiving a service response.

Management oversight ensures timely scrutiny of initial requests for help (contacts). However, a significant backlog in screening and processing has resulted in additional delays for some children and families receiving services. Slow responses from wider early help services compound this delay, at times leading to repeated referrals while families wait for support to begin. Access to support from early help services, as

identified at a previous monitoring visit, remains inconsistent, and many families do not receive timely, well-coordinated responses to requests for assistance.

Once work is allocated, screening practitioners now make concerted attempts to routinely speak to parents to seek their views to inform decision-making, with some persistent even when initial contact attempts are not successful. While some attempts to speak to older children are evident, this was not consistent practice for all relevant older children, whose voice could helpfully inform the service outcome.

Parental involvement in the initial information gathering to inform the contact decision was an area highlighted for attention in previous inspection reports. Attempts are now consistently made to appropriately seek and consider parents' views when considering children's best interests, often demonstrating relational-based and sensitive discussions.

Practitioners in the MASH demonstrate an understanding of the impact of domestic abuse and recognise risks that enable them to better identify appropriate support to families. However, cumulative harm, including neglect, is not always fully considered or as well understood. Professional curiosity, history gathering and analysis are inconsistent; some children's cases are closed too early without a full understanding of family context, leaving them for prolonged periods without the right support to improve their circumstances. When screening and information gathering were seen to be done well, this led to robust decisions. Leaders acknowledge the need to ensure a more consistent high-quality screening response.

Challenges in partnership working further compound some of the shortfalls in the front door. The quality, gaps and timeliness of information provided by some partner agencies remain variable, with key details sometimes missing. The re-establishment of the MASH partnership board is seen by leaders as an essential part of their improvement journey to resolve some of these challenges, ensure shared accountability and strengthen multi-agency practice.

Many of the weaknesses across the MASH and follow-up services have contributed to elevated levels of repeat contacts, indicating gaps in early analysis and decision-making. Limited exploration of presenting issues and missed cumulative risk continue to lead to premature 'no further action' (NFA) decisions and repeat contacts. More recently, the authority has taken action that has resulted in a reduction in referral NFA decisions and re-referrals, showing early impact from steps taken to improve the initial response to requests for help.

The Emergency Duty Team (EDT) responds proportionately to out-of-hours requests for help and manages risk to support children and their families. Relationships between children's services, Family Help and EDT services have improved, and staff work more effectively together, which has enabled more responsive decision-making. Work is underway to secure a dedicated EDT service for children and to align working processes and recording systems.

While feedback to referrers remains a focus for the service, leaders are aware that their management systems do not track whether MASH closure actions are completed or that outcomes are routinely shared with referrers before cases are closed, resulting in gaps in follow through and inconsistent feedback to partners.

Despite all these challenges, the MASH practitioners demonstrate resilience, and the service has moved into a more stable phase, supported by increasingly visible and confident leadership that is helping to restore clarity, trust and consistency across the front door service. Training and the focus on reflective practice and supervision are also supporting this shift.

Quality assurance processes, including audits and peer reviews, are effective and demonstrate a strong commitment to reflection and learning. Practitioner involvement is a strength, although there are still gaps in audit timeliness, depth of analysis and the consistent follow through on actions.

Staff describe improved communication through newsletters, meetings and accessible senior managers and report rising morale alongside greater confidence in decision-making and challenge. Notwithstanding, some practitioners shared that they remain unclear about the key findings and learning from the recent peer reviews and the practice concerns that have triggered the volume of ongoing change.

Workforce stability has strengthened, with a high proportion of permanent staff in the MASH contributing to improved continuity as practitioner confidence grows. Ongoing work to strengthen partnership arrangements, and a clearer organisational direction, are contributing to an emerging cultural shift.

Overall, the effectiveness of the front door service is improving but remains inconsistent. Inspectors saw incremental steps forward and a workforce increasingly confident in its direction. While these developments are positive, many changes are still relatively recent and require sustained focus to embed fully. The pace of improvement has not yet resulted in consistently timely or effective responses for children and families.

I am copying this letter to the Department for Education.

Yours sincerely

Margaret Burke
His Majesty's Inspector