Annex 1: Extract from the letter of findings on Oxfordshire's Joint Targeted Area Inspection (embargoed until 10th May 2016) .

- The MASH is currently operating as an information sharing forum; multi-agency decisions are currently made elsewhere. Thresholds for intervention are not generally well understood or appropriately applied by partner agencies, who have a limited understanding of how the MASH operates. Schools describe inconsistent responses to their referrals from the MASH, and they do not always understand how decisions are made. This results in the MASH receiving a high percentage of referrals (75%) that lead to no further action or are stepped down to early help. Many of these referrals should have been sent directly to the early intervention team. Whilst this practice ensures that children and young people are safe, processing of these additional referrals is time consuming and is not considered the best use of resources needed to safeguard children.

- The quality of information contained in referrals from agencies in particular schools when completing a referral was variable. Some was of a good standard, but others lacked key information. This again places additional pressure on staff with in the MASH to gather the required information. Representatives from schools spoken to during the inspection did not know who their agency representative was in the MASH. This is a missed opportunity to network, educate partners on thresholds and build relationships to ease the information flow.

- Information requests from the MASH to police, health and probation are dealt with quickly if any potential risk to a child has been identified. However, general requests for information that would support assessments are delayed. At the time of the inspection, the police had a queue of a 100 cases waiting to be processed and the national probation service (NPS) were only responding effectively in cases were risk had been identified.