OSCB
Oxfordshire
Safeguarding
Children Board

Annual Report
2020/2021

Foreword by the Senior Safeguarding Partners

This is the second year of our revised partnership arrangements and has been a year shaped by the pandemic. Our focus has been to ensure that vulnerable children 'have been kept in sight' and that all risks and opportunities have been considered.

We welcomed the Jacob CSPR, which took a constructive look at our local systems and has helped define the work that we need to do to keep children safe from harm outside the family home. Reviews have shown us the compassion and commitment that local practitioners have to keep children safe. We share this ambition.

It is clear from our analysis that system change is still needed to improve our working to address neglect, child exploitation and to keep children safe in education. We are committed to achieving system change in the year ahead.

The need to listen and communicate well with children in section 7 stood out. This will be something to improve on, with the guidance of our young Safeguarding Ambassadors, in 2021/22.

Observations of the OSCB Independent Chair, Derek Benson

Since taking on the role of Independent Chair in November 2020 I have seen evidence of a strong and effective partnership that has the wellbeing of children and young people at the heart of what it does.

The impact of the pandemic required a flexible and agile response, and the partners in Oxfordshire have responded positively to that challenge. There is a shared determination from the practitioners through to senior leaders to drive further improvements and the learning identified through the recently published reviews is central to that. The OSCB will continue to hold partners to account so that our children are as safe and well as they can be.

Derek Benson,
OSCB Independent Chair

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APPENDICES

1. Introduction

The government guidance, 'Working Together 2018', requires safeguarding partners to publish an annual report. The intention is to 'bring transparency for children, families and all practitioners about the activity undertaken' (by the safeguarding partners).

The Senior Safeguarding Partners and the OSCB have three aims: to provide leadership for effective safeguarding practice; to drive forward practice improvement and to challenge in order to ensure that children are kept safe.

This report sets out what we have done as a result of the vision and arrangements, as well as how effective we have been in practice.

2. **Children in Oxfordshire:** what we know about safeguarding needs

- **146,123** young people are estimated in live in Oxfordshire. This is an increase of 7% over the last ten years and sits alongside a high demand on the statutory system.
  11% of children and young people are living in poverty before housing costs which rises to **21%** once housing costs are included
- **10,127** children are eligible for free school meals
- **26%** of the school age population are from ethnic minority groups. They are more likely to be represented in the social care system, however this is driven by the fact that they are more likely to live in areas of economic deprivation.

At the end of March 2021:

- **475** children were the subject of a child protection plan
- **66%** of child protection plans have neglect as the main reason
- **776** children were cared for
- **933** children were electively home educated

The last year has been dominated by the impact of Covid and lockdowns. Our partnership has focused on children's wellbeing. We saw an increase in:

domestic incidents and domestic crimes involving children

mental health issues including rise in self-harm attendances at A&E

referrals to the multiagency safeguarding hub

We saw a decrease in **early help assessments** due to the closure of schools to the majority of their pupils

Provisional data on **care leavers** shows improvements for children who remained looked after till their 18th birthday in terms of education, employment and training and those in suitable accommodation. However, the level of care leavers in education employment and training remains below the national level.

Safeguarding partners have developed their priorities with this context in mind.

[1] Source ONS Mid-Year Estimates for Oxfordshire for people aged 0-17 2007 & 20

3. Providing leadership for effective safeguarding practice

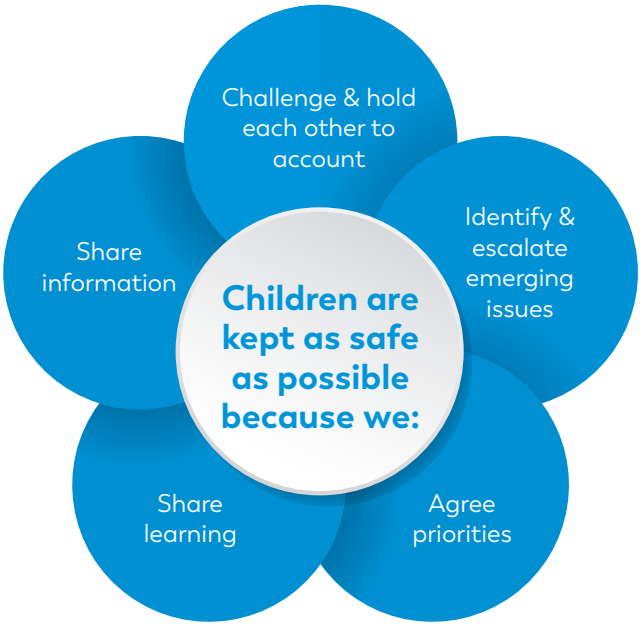
Yvonne Rees,
Chief Executive of
Oxfordshire County Council

James Kent, Accountable Officer and Executive Integrated Care System Lead, Buckinghamshire, Oxfordshire and Berkshire West Clinical Commissioning Group

John Campbell,
Chief Constable,
Thames Valley Police.

The leadership of safeguarding arrangements is at chief executive level across the local authority, health and police. They are the Executive. They are responsible for, and oversee, these arrangements even where they may have delegated direct input to senior officers to attend the Executive Group.

The Oxfordshire Safeguarding Children Board (OSCB) sits beneath the local leaders. Led by an independent chair it brings together the local organisations, which deliver services that affect families' and children's lives.



Our **membership, structure, partnership links** and funding can be accessed online via links at the end of this report. OSCB work is driven through a series of subgroups. The people on these groups are from our partner organisations.

The **partnership** is not responsible or accountable for delivering child protection services, but it does need to know how well the safeguarding system is working.

The **Executive Group**, chaired by the Chief Executive Officer of the County Council, has:

- ✓ responded quickly to the issues emerging from Covid through a risk and opportunities register
- ✓ worked effectively through increased online meetings
- ✓ brought strategic ownership from our agencies to this work
- ✓ overseen the arrangements for learning from the Child Safeguarding Practice Review on child exploitation
- ✓ worked with young people to recruit a new independent chair to lead the board
- ✓ commended five practitioners for good safeguarding practice
- ✓ challenged and improved the information sharing process for the licensing of taxi drivers
- ✓ reviewed the local safeguarding arrangements to include membership from the local military
- ✓ recruited a board member from the local community

EFFECTIVENESS OF LEADERSHIP IN SUMMARY:

- ☑ strategic ownership of safeguarding
- ☑ added value in terms of direction, decision making and connection
- ☑ raised profile of safeguarding work
- ☑ momentum generated by leadership through Covid

4. The effectiveness of safeguarding arrangements: priorities, progress & escalation

PRIORITIES FOR PRACTICE IMPROVEMENT

- **Neglect:** We knew that this was the main reason that children are subject to a child protection plan and that it is not always picked up early enough.
- **Safeguarding in (and out of) Education:** We knew that we needed to develop a shared vision with all partners.
- **Child exploitation & keeping children safe outside of the home:** We knew that the local arrangements needed to be improved.

NEGLECT

What went well	Even better if
✓ Early help training run for GPs, police ✓ Neglect e-learning course developed ✓ Work with schools on developing kits and resources – audit tool, good practice case studies, guidance ✓ Improvement seen in virtual case conference attendance ✓ New online system for sharing chronologies ✓ Agency actions in place to improve how they each identify and address neglect	• The system for monitoring case conference attendance functioned better • More practitioners used the OSCB resources and the online system for chronologies • More organisations did early help assessments • Challenge Event can evidence a change in the way of working by individual agencies as well as in partnership

SAFEGUARDING IN (& OUT OF) EDUCATION

What went well	Even better if
✓ Additional capacity into home education service leading to some children returning to school (mediation process for parents and schools) ✓ Information pack for parents on home education ✓ Improvements leading to speedier resolution for children missing education ✓ Good learning points identified through the Jacob CSPR	• Improved relations to speed up requests for direct admissions to academies • Sign up by whole education community that children cannot remain out of school • The recently established 'child missing education' assurance panels prove that they are effective

CONTEXTUAL SAFEGUARDING AND CHILD EXPLOITATION	
What went well	**Even better if**
✓ New Youth Justice and Exploitation service ✓ Improvements in joint working when supporting children going missing / being exploited ✓ New multi-agency action groups to respond to Jacob CSPR	• 'Contextual safeguarding' is more widely understood and services were able to adjust to addressing risk and harm outside of the family • There is a shared vision and strategy for this work • There is greater consistency re best practice across community safety partnerships • More practitioners use the exploitation screening tool • The evaluation of local processes leads to greater improvement in 2021/22 • The new prevalence and intervention reporting leads to a more targeted way of working

EFFECTIVENESS OF DRIVING FORWARD PRACTICE IN SUMMARY:

- ☑ Improvements made in all three priority areas
- ☑ Limitations of progress also noted - a push is needed by all partners to keep these gains
- ☑ Neglect, safeguarding in education and child exploitation should remain priorities

5. Learning from Reviews

RAPID REVIEWS

A Rapid Review is triggered when a child is involved in a serious incident, which is notified to Ofsted. Local organisations quickly collate information, analyse how well they worked together and tie down actions and learning points as clearly as possible to bring about improvements.

The OSCB has looked at nine serious incidents or cases of concern to consider if an in-depth child safeguarding practice review (CSPR) should take place.

A case may refer to more than one child e.g. a sibling group.

OVER THE YEAR 2020/21	OUTCOME
• 8 were 'serious incidents' for a 'Rapid Review' and 1 was a case of concern	• 2 Child Safeguarding Practice Reviews and 1 Partnership Learning Review

This is very small cohort of incidents. However the pattern and themes are reflected at national level in the National Panel's **Annual Report 2020**.

Learning points from the last 12 months:

- Maintain face to face contacts where possible
- Ensure that professionals maintain good contact with each other when making decisions on risk
- Think about the whole family e.g. share information across different parts of the health service
- Safeguarding risks on co-sleeping should be explained to both parents
- Look for 'reachable moments in adolescent children's lives'
- Children are safer when they are in education

Themes for children up to 5 ys

Co-sleeping, physical abuse, parental substance misuse.

Themes for children aged 15-17ys

Children being vulnerable to abuse or exploitation from outside their families, missing from home and school, not engaging well in school life and being electively home educated. Long-term impact of neglectful parenting as children grow older.

CHILD SAFEGUARDING PRACTICE REVIEWS

The OSCB has worked on ten reviews. Some of the reviews started before 2020. They concerned twelve children. Four were female and six were male. Two of these children were transgender. The local pattern and themes are reflected in the National CSPR Panel's **Annual Report 2020**.

Babies & children up to 5 ys:

In two of the three reviews on children under 5 years the child suffered physical abuse.

Children aged 10 - 15ys:

In three of the reviews on adolescent young people, mental wellbeing and suicidal behaviours were contributory factors. Sadly, two of the reviews concerned children who are deceased. In three of the reviews on adolescent young people, mental wellbeing and suicidal behaviours were contributory factors.

SAFEGUARDING THEMES AND MESSAGES FOR LOCAL LEADERS FROM THE RECOMMENDATIONS:

Early help for families

Messaging needs to be clear. A combination of risk factors can build up over time in family homes (mental health, domestic abuse and drug and alcohol misuse).

'Help at an early point across all services can make a difference. An early help assessment is the means to do this.

Addressing neglect of children in the family home

We need to respond collectively to neglect.

Practitioners should be supported to name, discuss and respond to neglect confidently.

Minimising Risks to children outside the home

Oxfordshire organisations need a 'system response' to work better together on the safeguarding risks that exist in the child's environment.

Children can become trapped in a world that they cannot escape.

We must look for 'reachable moments'

Keeping children safe in schools and settings

Schools should be supported to keep children safe

...to notice potential harm

... to alert other agencies

.... to challenge decisions.

In total there were over 30 recommendations being monitored and challenged through partnership meetings.

FEEDBACK

We involve families directly in all of our reviews. Their experiences tell us how our safeguarding system works in practice. Grandparents, parents, siblings, carers and children have talked to us.

Their views have shaped: the new child exploitation framework; our conversations with young people; training on consent and sexual behaviour.

'A local child who suffered extreme neglect would like professionals to remember that: ...the future will always change'

Families have said that they want to take part to ... 'help another child in the same situation'

Two reviews were published: **Child K** and the **Jacob CSPR**. They had local and national recommendations which are detailed in full in both reports.

REGIONAL AND NATIONAL LEARNING INCLUDES:

- There is a lack of homes (placements) for children with a range of complex needs. These children are often the most vulnerable that we care for and are unable to be close to their family home.
- The legislation concerning children educated at home places barriers in the way of keeping children safe
- We need 'sign-up' from the whole education community that children cannot remain out of school

EXAMPLES OF ACTIONS TAKEN BY THE PARTNERS TO IMPLEMENT THE RECOMMENDATIONS:

- ✓ Sharing concerns with the Dept for Education, MPs and local politicians regarding national policy and guidance (stated above)
- ✓ Launching an online system for 'Multi-agency chronologies' to build a full picture of what is happening in the life of a child /family who is subject to child protection planning
- ✓ Improving the system use to work out the thresholds of need for a child by including more family background information and making connections between services
- ✓ Improving how the police communicate and feedback to children who disclose sexual abuse so that children know that they have been listened to
- ✓ Developing the multi-agency bruising protocol so that practitioners know what to look out for when caring for babies and don't miss key signs
- ✓ Creating a kit for schools to help them understand what 'good looks like' when supporting a child who is at risk of experiencing neglect; the kit includes a checklist and good practice case study
- ✓ Improving the system used to 'screen' risk factors of child exploitation
- ✓ Setting up Youth Justice and Exploitation Service within the County Council
- ✓ Development of county-wide missing and exploitation panel and area based multi-agency networks

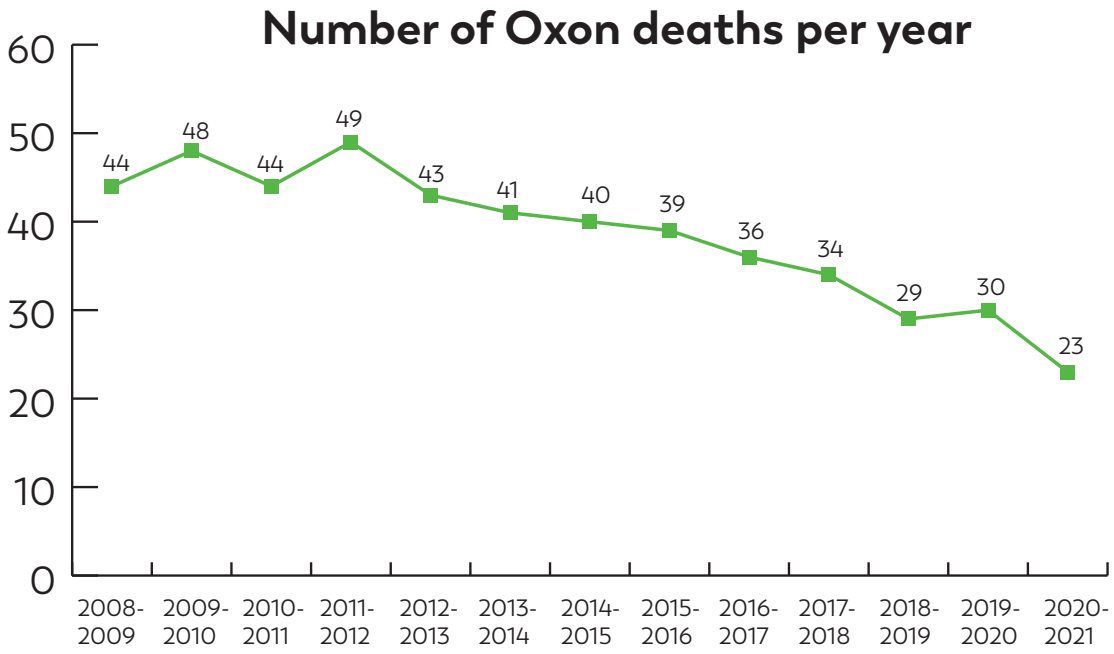
EFFECTIVENESS OF LEARNING FROM PRACTICE REVIEWS

- ☑ 100% reviews directly involve families and practitioners
- ☑ Analysis is independent and constructive
- ☑ Families and practitioners are directly involved
- ☑ Learning points apply to both systems and practice
- ☑ Recommendations can be evidenced as changing systems and services
- ☑ An annual report summarises the learning and aspects for improvement

CHILD DEATH OVERVIEW PANEL (CDOP)

In 2020/21 the Oxfordshire and Buckinghamshire CDOP system received 23 notifications for children who lived in Oxfordshire.

The aim of the Child Death review process is to prevent future child deaths. It is encouraging to see that the number of deaths of Oxfordshire children has almost halved in the last 13 years.



The Oxfordshire CDOP panel met on four separate occasions in 2020/21 to review child deaths. The deaths of 28 children whose usual residence was in Oxfordshire were reviewed.

THEMES RAISED BY THESE REVIEWS INCLUDED:

The complexity of coordinating bereavement support when a child dies in another regional hospital. The Designated Doctor will liaise with key service areas to develop a pathway to improve the coordination.

A number of Sudden Unexpected Deaths in Infancy, where although the total number had not increased, there were more cases where co-sleeping was a factor. This was in spite of clear evidence that advice had been given about the risks of co-sleeping. Services have re- shared the information and resources widely and committed to using all contacts with families to discuss this issue.

6. Impact of learning and improvement framework

ANALYSIS OF KEY MESSAGES

Messages for practitioners are set out in this poster and in an OSCB short-animated film

Recorded webinars on Jacob CSPR and Child K are online. Approx. 300 practitioners attended. Feedback included:

"it enabled me to think more about how the voice of the child can be captured and used to inform practice. It cemented my view that open joined up practice is the key to safeguarding children."

"confidence to ask about a lead professional in health if a child has significant health needs. Better understanding of elective home education - overall better professional knowledge of 'how these things work' so more able to challenge and question"

LEARNING	
1	Jacob CSPR (2021)
2	Young parent with complex needs (2021)
3	Child K (2020)
4	Understanding a child's lived experience (2020)
5	A child's identity needs (2020)
6	Neglect (2020)
7	Understanding a child's world (2020)
8	Parental vulnerability (2020)
9	Physical abuse (2020)

Learning summaries have common themes which lead to new resources e.g.

Use of chronologies
Single and Multi-Agency Chronology Practice Guidance
MAC 7-minute guide and MAC Tutorial for Agency Professionals

Reflective thinking, supervision and meeting as professionals
Safeguarding Conversations poster
Professionals Only Meeting guidance

Physical abuse
A Protocol for management of bruising in pre-mobile babies/children and leaflet for parents and carers

Working with fathers
Top tips for working with fathers and male carers

EMBEDDING LEARNING THROUGH TRAINING

The OSCB responded rapidly to the impact of Covid. Training moved online and never stopped.

New safeguarding e-learning courses from April 2020

Over 12,500 e-learners in total

New Covid volunteers course May 2020

Over 600 covid volunteer learners within 3 months of launch

Trainers 'trained' to work online from June 2020

Over 40 volunteers learnt how to train online

New safeguarding webinars from September 2020

Over 2,500 webinar learners in total

15,000 + trained overall

Impact: "A phrase used to describe what happens at Case Conferences stuck out for me: **"What can be done to improve or sustain the journey of change?"** I will use this perspective when discussing specific cases in school."

Impact: As a GP trainee **I plan to take an active role in more safeguarding referrals and helping junior staff/ medical students** etc.

Impact: "Working as a volunteer in a Youth Cafe **I have learnt that safeguarding is everyone's responsibility.** Everyone has the responsibility to report a concern"

SPECIALIST COURSES HAVE BEEN DEVELOPED IN RESPONSE TO LEARNING FROM OUR REVIEW WORK:

- Child Exploitation
- Safeguarding disabled children
- Sexual Abuse
- Healthy & Unhealthy sexual Behaviours
- Supporting LGBT young people
- Overview of Mental Health Difficulties for young people
- Self-harm workshop

IMPACT: 'LEARNING GAIN'

Every learner evaluates their confidence in safeguarding knowledge **before & after** training.

We consistently see a confident starting point and an even better end point which is called 'Learning gain'.

Impact: "...I have already identified a couple of students where I need to explore further with them around them being online ...and gaming".

OSCB training is delivered by **volunteers**.
They work in the health services, early years settings, schools, in local charities, the community and local authorities amongst others.

They give time out of their working day to train others in the safeguarding network.

Very special people. Thank you.

EFFECTIVENESS OF EMBEDDING LEARNING IN SUMMARY:

- ☑ Learner gain is recorded
- ☑ Feedback can evidence how learning will be applied
- ☑ Multiple resources demonstrate how partners share key messages
- ☑ Training is delivered by local volunteers, with pace and volume, so that learning is embedded through the local network
- ☑ The partnership is responsiveness to training need e.g. launch of the volunteers' course within 5 weeks of lockdown

7. Evidence and assurance

The OSCB gets a system-wide view on safeguarding work through the lens of audits, assessments, data and the views of practitioners, children, young people, families.

Audits	Assessments	Data
12 local services **2** multi-agency audits focused on • neglect • young people and domestic abuse (experiencing or witnessing)	**15** local services undertook high quality evaluations **1** challenge event for **15** services to evidence and evaluate their assessment	The OSCB regularly checks the facts and figures against local targets for Oxfordshire's most vulnerable children

WHAT DID THESE LENS HIGHLIGHT?

Issue	What does the OSCB need assurance on?
Issues emerging from Covid	...that issues regarding mental health and domestic abuse are addressed with pace and purpose. The 'deficits' from Covid need swift and decisive action e.g. school attendance and learning.
Neglect	... that health, police and social care and other safeguarding partners support early identification of neglect. The OSCB Neglect challenge event in September 2021 should check what shift there is in the underlying issues around neglect, poverty, economic drivers, housing etc.
Case conferences	... that health, police and social care partners consistently contribute to decision making for the care of the most vulnerable children. Monitoring of attendance should be a key metric in individual agencies performance reporting and assurance governance.
Increased safeguarding and domestic abuse referrals	... that there will continue be enough resources in the Multi-agency Safeguarding Hub to respond to this increase in need. An increase in the volume of domestic abuse incidents will need tackling by a system wide including - Increasing reach and volume by county & district councils working together - Potential further investment into the system - Recognising the impact of the domestic abuse workers in the new county council team and securing long term sustainable funding
Waiting times for children needing mental health	... that children are not waiting longer than the expected timeframes to access mental health support. The volume of mental health needs in children & young people will need a system wide strategy to meet the scale of need, which has been exacerbated by the pandemic.

HOW HAVE WE USED FEEDBACK FROM CHILDREN AND YOUNG PEOPLE THROUGH THIS PROCESS?

We involve young people wherever possible in service evaluation.
We have examples of where their feedback:

- is informing those working with young people who experience or witness domestic abuse
- has shaped parental experiences when caring for sick children in local hospital
- is informing information and accessibility to GPS and remote consultations

WHAT HAVE PRACTITIONERS SAID?

An annual survey of practitioners asks them to assess what is impacting on their capacity to deliver.

Practitioner have told us that group supervision is helpful to reflect on practice and good decision making

Positive findings were as follows:

✓ **75%** felt that there had been visible safeguarding leadership during Covid

✓ **95%** had undertaken safeguarding training within the last 3 years

Areas for improvement were

- Use of multi-agency tools when making decisions. However we could see that awareness of the multi-agency chronology has increased by 100%.

WHAT HAVE AGENCIES HAVE TOLD US FROM THE ANNUAL IMPACT ASSESSMENT?

Top three financial and organisational pressures	Top three things that would make it easier
• Increasingly vulnerable people and complex cases • Increasing volume of work and demand on services • Service funding (gathering, securing as well as income generation)	• Improved joint working (e.g. communication between agencies) • Space for frank conversations and consultations • Understanding of operational pressures across agencies

EFFECTIVENESS OF QUALITY ASSURANCE:

- Qualitative and quantitative evidence which brings a full picture of the system
- Progress is evidenced: use of new resources; escalation of issues to strategic safeguarding partners e.g. increase in domestic abuse.
- Improvements and concerns are known e.g. Case Conferences, mental health waiting times, identification of neglect
- Partners are sighted on potential safeguarding issues emerging from Covid e.g. mental health, stresses in home life manifesting in domestic abuse

8. In conclusion the partnership knows

The local safeguarding issues where collective action can make a difference

- ✓ Working to identify and act where we see neglect
- ✓ Improving our strategic efforts to deal with the exploitation of children
- ✓ Better connectivity with schools and shared sign up to the same safeguarding principles

The bigger safeguarding issues which we need to escalate regionally and nationally

- ✓ Availability of homes close to Oxfordshire for children who have a complex set of safeguarding needs
- ✓ Legislation regarding home-schooling, which would assist identifying any safeguarding concerns.

The ongoing concerns in our system

- ✓ Waiting lists for children's mental health services
- ✓ Multi-agency contribution to decision making meetings for the most vulnerable
- ✓ Attendance at school of the most vulnerable children

Areas for learning

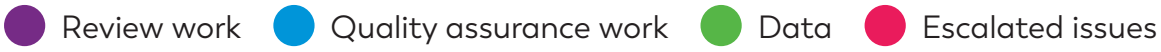
- ✓ Over 15,000 people have been trained on safeguarding topics over the last year

The report sets out evidence of progress made and impact that the safeguarding arrangements have had over the last 12 months.

There is still work to be done. These are the key messages for local leaders reading this report:

1. **We need traction on changing practice.** The whole system must work together to effect change, which means each organisation must take responsibility for embedding change and learning. We are doing a lot of things to improve how we work together but the challenge is making it sustainable.
2. **The Jacob CSPR shows that we need to improve how we work together across our whole partnership.** This includes community safety, children's safeguarding, education and health. We need to bring strategic leadership and direction to this work to make it easier to keep children safe from harm outside the home.
3. **Post-pandemic interventions will need to be at scale and volume.** Pace and purpose is needed to deal with the emerging issues such as increased safeguarding referrals, visibility of children through school attendance, increased referrals for mental health and domestic abuse concerns.
4. **Education settings are key partners.** Whilst they are not named as senior safeguarding partners in the guidance 'Working Together 2018', we are clear in Oxfordshire that our education colleagues are central to keeping children safe. They must be part of our conversations and actions for us to work better together.

Appendix A: Matrix of safeguarding concerns



Safeguarding concerns that need regional and national attention	
Availability of homes close to Oxfordshire for children who have a complex set of safeguarding needs and cannot live at home	
Legislation regarding home-schooling which would assist in identifying any safeguarding concerns	
...that are about our systems and how we work together as a whole	
Shared vision and connectivity with schools about keeping children safe	
County-wide effort to deal with the exploitation of children outside of their home	
Cultural shift in helping families at an early stage collectively to tackle neglect in the family home	
Shorter waiting times for children who need help with mental health problems	
Multi-agency contribution to decision making meetings for the most vulnerable (known as Case Conferences)	
...that are about our practice	
Straight talking with families to identify and name neglect	
Using the same resources to help families at an early stage e.g., early help assessment	
Thinking about safeguarding all family members – parents, children, siblings – when you may have contact with just one family member	
Better sharing of safeguarding information across different health information systems	
...that are repeat themes	
Lower exam grades for the most disadvantaged children	
Children being visible to others and kept safe in early years settings and education during the day	
Complex range of safeguarding issues that children face	
...that have come to the fore through the pandemic	
Importance of keeping sight of the most vulnerable children	
Emerging issues of domestic abuse and mental health concerns following lockdowns	
Increased volumes on frontline services as demand increases post lockdown	

Appendix B: The Oxfordshire Safeguarding Children Board budget

	End of year figures
Funding streams	
Public Health	-£30,000.00
Income	
Foster carer training	-£2,550.00
Non-attending delegates	-£4,850.00
Other platform fees	-£1,609.00
Contributions	
OCC Children, Education & Families	-£202,300.00
OCC Dedicated schools grant	-£64,000.00
NHS Oxfordshire CCG*	-£60,000.00
Thames Valley Police	-£21,000.00
National Probation Service	-£1,410.00
CRC	-£2,500.00
Oxford City Council	-£10,000.00
Cherwell DC	-£5,000.00
South Oxfordshire DC	-£5,000.00
West Oxfordshire DC	-£5,000.00
Vale of White Horse DC	-£5,000.00
Cafcass	£0.00
Public Health (see above)	£0.00
TOTAL INCOME	**-£420,219.00**
Expenditure	
Independent Chair	£35,548.00
Business unit	£287,125.00
L & I work	£7,451.00
Training & learning	£37,949.00
Subgroups	£9,523.00
All case reviews	£31,662.00
TOTAL	**£409,258.00**
Available reserves	£63,013.00
Drawdown	£0.00
Add to reserves	£10,961.00
Reserves Balance	£73,974.00

* NHS Oxfordshire CCG also funds the Child Death Overview Process at a cost of £76,774 per annum

Appendix C: Links to information about the board

OSCB
Oxfordshire
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www.oscb.org.uk

Images used in this annual report are stock images