Warwickshire Safeguarding

ANNUAL REPORT

2021 - 2022

Published: Jan 2023

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01 INTRODUCTION

This annual report reflects on our safeguarding practice across the partnership during what has continued to be a hard time for children, vulnerable adults', and families. The report seeks to provide insight into how well local systems and organisations across Warwickshire help and protect children, young people, and vulnerable adults.

It is clear to me that Warwickshire Safeguarding has established a clear identity and role in both driving and challenging the effectiveness of safeguarding. However, there is more to be done to enhance the impact and effectiveness of both local and national learning.

This report has three important and recurring messages of particular importance to the Warwickshire Safeguarding Board and its Executive.

Firstly, evidence suggest that we continue to struggle to address stubborn and perennial problems in multi-agency child and adult protection practice. Issues such as weak information sharing and effective escalation of concerns continue to impact on our ability to protect children and vulnerable adults and to help families.

Secondly, we continue to struggle to make sense of the voices and life experiences of children, young people and vulnerable adults. Really hearing what children and families say and mean involves both time and skill. We all have responsibility for creating the conditions in which the talents and resources of practitioners can prioritise understanding what life is like for children, adolescents. and vulnerable adults.

Thirdly, we need to understand and evaluate the impact of learning from Warwickshire rapid reviews as well as local and national Child Safeguarding Practice Reviews (CSPRs). Along with excellent professional participation in CSPR and SARs, our thematic audits evidence our capacity to reflect and learn. The partnership is positive in moving away from an emphasis on simply reporting, to inquiring into and learning from situations. This is very positive; however, we continue to struggle with embedding learning into practice. We frequently see evidence of a failure to embed recommended change in current reviews.

The Warwickshire Safeguarding Business Team has developed a robust and well received approach to disseminating learning through lessons learned and seven-minute briefings. As we look forward towards 2022-2023 I would suggest that it is time for the Board and the Executive to address the difficulty inherent in embedding change in practice continue building on good practice by asking:

- Why do we see recurrent issues and themes in rapid reviews? Do we understand the key barriers to embedding learning and how to address them?
- How can we make better use of national reviews to support local learning and improvement across Warwickshire?
- How can we work together to give practitioners a sense of confidence and support in addressing the stubborn challenges in safeguarding?

I continue to be so impressed by the evolving culture of 'togetherness' across Warwickshire. This is underpinned by the effectiveness of the Executive team in working together, the Business team in relentlessly sharing information and every practitioner who works with such care to support and protect children, adolescents and vulnerable adults across Warwickshire. I would like to thank all members of the Board for their professionalism, commitment, and support. I would also like to say thank you to all partners and frontline staff for the incredible work that they do to keep vulnerable adults and children safe from abuse and neglect.

Finally, having emerged from the challenges of the pandemic period, we will find ourselves working with families and individuals coping with the impact of the cost-of-living crisis. Learning from the pandemic will help us to be alert to the creation of hidden harms as people cope with increased stress in their families and homes. It will remain as important as ever to be informed and committed to providing the best safeguarding practice for individuals.

Elaine Coleridge Smith
Independent Chair & Scrutineer
Warwickshire Safeguarding

Warwickshire Safeguarding Adults

Key Facts

Individuals involved in Safeguarding concerns

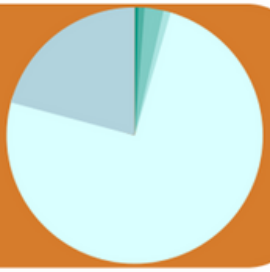
Demographics

1090 Male

1443 Female

105 Aged 95+
524 Aged 85-94
608 Aged 75-84
377 Aged 65-74
926 Aged 18-64

Other Ethnic Group	11
Black African/Carib / Black British	20
Asian / Asian British	61
Mixed / Multiple	23
White	1898
Undeclared / Not Known	530



3146
Concerns Received
(2279 in 2020/21)

279
S42 Enquiries Received
(385 in 2020/21)

Concluded S42 Enquiries - Top 2 Locations or Risk:
Own Home & Community (excluding Community Services)

Top 3 types of Abuse for concluded S42 Enquiries:
1. Financial or Material - 29.6%
2. Psychological - 20.6%
3. Physical - 13.7%

19
Enquiries involving strangers
(15 in 2020/21)

S42 Enquiries - Top 3 Primary support reason:
Physical Support
Support with Memory & Cognition
Learning Disability

32
Alleged abuse by social care staff
(18 in 2020/21)

268
Source of risk known to victim
(223 in 2020/21)

Warwickshire Safeguarding Children

Key Facts

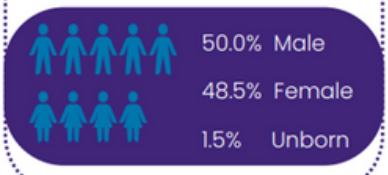
16,502 Contacts Received (14,243 in 2020/21)

5,700 Referrals Received (5,525 in 2020/21)

Last year Warwickshire finished the year with an increase of 106 children in care (14.1% increase) when compared to the previous year end. However, this year there was a decrease in the number of children in care, reducing by 38 children (4.4% decrease).

Demographics

Gender of Children subject to CP Plans



50.0%	Male
48.5%	Female
1.5%	Unborn

Age group of Children subject to Child Protection Plans

Unborn	1.5%
Under 1	9.5%
1 to 4	25.8%
5 to 9	25.5%
10 to 15	32.3%
16 to 17	5.5%

White British/Irish/Other	83.8%
Minority Ethnic	14.8%
Unborn	1.5%

Referrals received for Children with a disability 2.6% (2.6% in 2020/21)

24.0% of referrals to Children Social Care were referred by Police

6,326 Statutory Child Social Care assessment started (6030 in 2020/21)

130 of Warwickshire Children in Care missing (123 in 2020/21)

482 Missing Children (449 in 2020/21)

Number of referrals by District 2021/22

N. Warwickshire	381
Nuneaton & Bedworth	551
Rugby	385
Stratford	262
Warwick	409

Top 3 types of abuse for children subject to Children Protection Plan:

Neglect	Emotional	Multiple
39.5%	37.0%	12.8%

03 SAFEGUARDING THROUGH THE PANDEMIC

Partnership working has remained strong throughout the past year with excellent engagement with all partners, providers and colleagues from across the partnership. Regular weekly meetings were triggered between senior managers in the police, Children's Services and Health to look at demand during the pandemic. These meetings continued post pandemic and are seen as a positive.

There has been clear evidence of engagement through the commitment of agencies to work together to effectively respond to the increasing number of safeguarding referrals received by the partnership throughout this period. This enabled Rapid Reviews and local safeguarding reviews to be considered within a timely manner.

Whilst the pandemic forced meetings to go online, this has continued post pandemic and on the whole, this is seen as positive, it is more efficient and enables more safeguarding partners to contribute. More learning events moved online; this is more cost effective whilst at the same time allowing increased attendance ensuring wider distribution of localised learning.

04 DELIVERING OUR STRATEGIC PRIORITIES

During the course of 2021-2022 the focus of Warwickshire Safeguarding's work has continued to centre around it's three strategic priorities ensuring that safeguarding arrangements across the partnership are effective in helping to keep children, young people and adults with care and support needs safe from abuse and neglect and achieving positive outcomes.

EXPLOITATION

Children in Care Providers' Information Packs	•Developed a Children in Care Providers Information Pack, the pack raises awareness around the responsibility of care providers when a child goes missing, the pack includes raising awareness around the Philomena Protocol.
Training	•Delivered a week of focused bitesize learning events around the topic of Exploitation, in all its forms to help Warwickshire partners develop their collective understanding and confidence in combatting and responding to exploitation.
Missing Protocol	•Launched the Philomena Protocol, an initiative to help locate and safely return children and young people in care as quickly as possible when they are missing. The scheme is aimed at saving the lives of our vulnerable people, by working with carers and staff in residential homes to establish patterns of behaviour, places they frequently visit, and if they do go missing completing a standardised form which will make the emergency services response to the enquiry more efficient.
Modern Slavery & Human Trafficking	•Warwickshire Police have developed and provided specialist Modern Slavery and Human Trafficking training to a core of investigators to act as tactical advisor to staff investigating offences affecting adults and children.
Something's not Right Campaign	•Warwickshire County Council, Warwickshire Police, Warwickshire Safeguarding, Barnardo's and the Police and Crime Commissioner re-launched the Something's Not Right campaign which aims to raise awareness of child exploitation in Warwickshire and to encourage parents, carers, professionals and the wider community to understand what child exploitation is, how to spot the signs and to report concerns of child exploitation, as well as helping children and young people to understand what child exploitation is and encourage them to speak out against abuse

CORE SAFEGUARDING

Thresholds	•Warwickshire Safeguarding replaced the existing Thresholds document with the newly developed 'Spectrum of Support' Document. The new Spectrum of Support guidance document aims to strike the right balance between supporting practitioners from all settings to identify situations where children and young people might require support, recognising the vital role of professional judgement in assessing the impact of risk and protective factors on positive outcomes for children and young people. The Spectrum of Support details the process for the Early Help Pathway to Change Plan and the type and level of early help services to be provided, and the criteria, including the level of need, for when a case should be referred to children's social care for assessment and for statutory services
Risk Assessments	•Warwickshire Police refreshed their Adult Risk Assessment processes to raise awareness amongst practitioners of the requirements of Making Safeguarding Personal, the Mental Capacity Act and the Care Act. The Child Risk Assessment processes were also refreshed to raise awareness of the need to capture the voice of the child and the need to explore the context rather than an incident based approach.
Learning from Reviews	•Learning from safeguarding reviews has been used to improve practice across the partnership to ensure key points of learning are cascaded through partner organisations to impact safeguarding practice moving forward. The review reports, Lessons Learned briefings and 7 Minute Briefings have been promoted for use as part of reflective team discussions, organisational safeguarding training, CPD events and workforce briefings and newsletters. A series of learning events have been delivered to targeted audiences to raise awareness of findings from reviews affecting their specific areas of work i.e. GPs, Social Care staff etc.

PREVENTION & EARLY INTERVENTION

Domestic Abuse

- Warwickshire Police refreshed and re-launched Operation Encompass to ensure schools receive timely referrals for children that may have been affected by domestic abuse
- Health partners worked with maternity services to ensure opportunities continued to be created to ask about risks and domestic abuse throughout the Covid pandemic

Information Awareness Raising

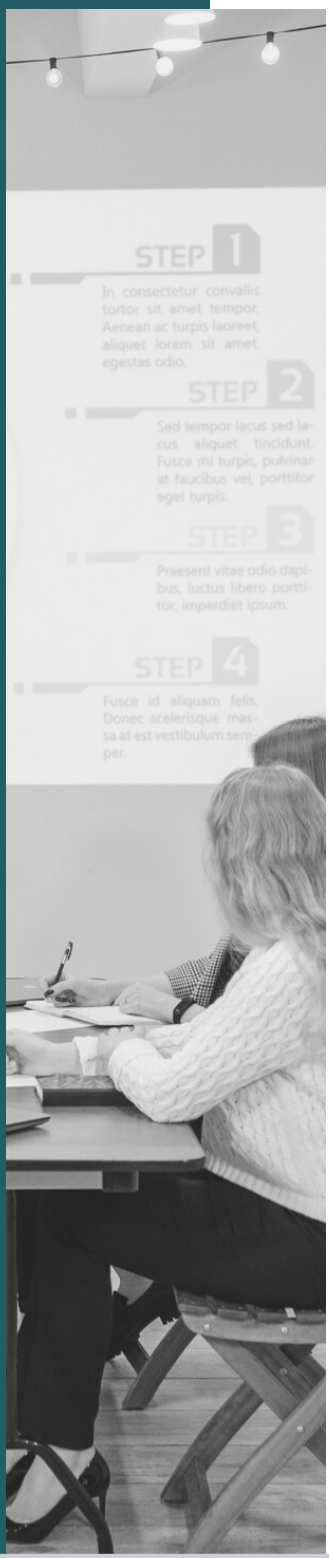
- Developed a number of Virtual Reality products on topics such as alcohol awareness and Violence against Women and Girls to help improve awareness and understanding of referral pathways
- Partners have worked closely with the Real-Time Suicide Surveillance Coordinator to raise awareness and improve the partnership response to suicide.

Professional Support

- Warwickshire Police introduced a mental health triage service to professionalise the police response to mental health related incidents
- A 'Safer Sleep' campaign and resources were rolled out jointly across Warwickshire and Coventry to support professionals working with families with new babies to identify where babies are most at risk of Sudden Unexpected Death in Infancy (SUDI) and provide advice on the steps that can be taken to prevent this from occurring.

05 LEARNING FROM REVIEWS

SAFEGUARDING REVIEWS



In keeping with its statutory duties under the Care Act 2014 and the Children's Act 2017 and Working Together 2018, Warwickshire Safeguarding considered a number of referrals for review by the partnership relating to children and adults who have either experienced significant harm from abuse/ neglect or have died as a result of the abuse/neglect and there are lessons to be learned about the way in which partners managed their involvement in these cases.

The legislation now defines these reviews as follows:

- **Child Safeguarding Practice Reviews (CSPR's)**
- **Safeguarding Adults Reviews (SARs)**

The increase in the number of referrals experienced during 2020-2021 continued throughout 2021-2022.Warwickshire Safeguarding continued to receive several referrals put forward by partner agencies, families/carers where the referrer considers the circumstances of the abuse or neglect caused to the individual could have potentially been managed differently, and where they believe lessons can be learned and improvements to practices identified and implemented.

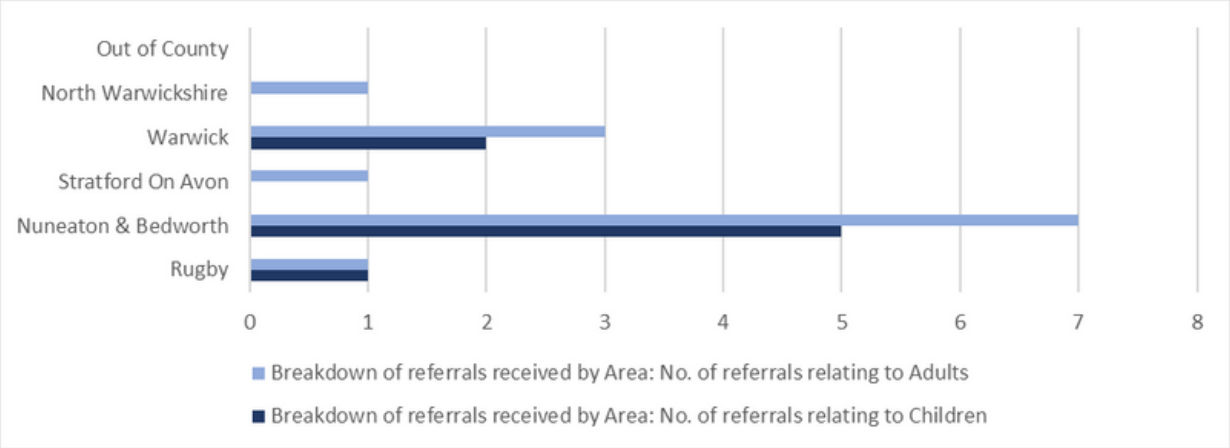
The reviews work is overseen by Warwickshire Safeguarding's Safeguarding Reviews Subgroup. The Subgroup is responsible for ensuring that SARs and CSPRs in Warwickshire are carried out appropriately and effectively so that issues and lessons are identified, disseminated, and acted upon. The Subgroup oversees the implementation of multi-agency and single-agency actions and provides update reports to Warwickshire Safeguarding's Executive Board.

Provided below is a breakdown of the referrals received by Warwickshire Safeguarding during 2021-2022 and their progression:

Total number of referrals for review received in 2021 - 2022:

»Children = **8** CSPR referrals
» Adult = **13** SAR referrals

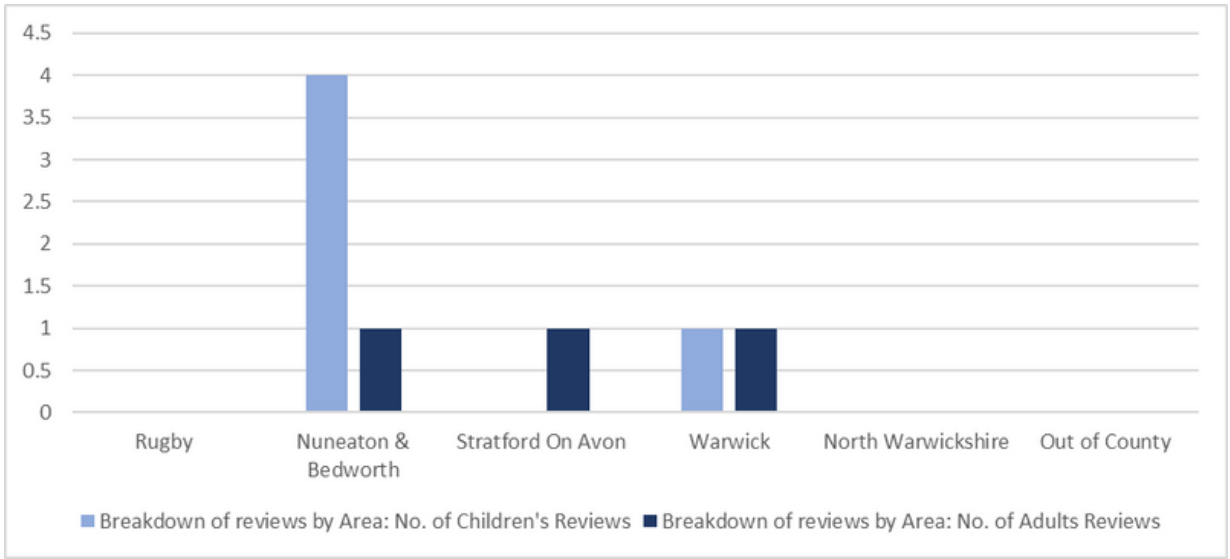
Breakdown of Review Referrals by Area



Total number of referrals <u>progressed</u> to Review in 2021 - 2021:

» Children = **5** CSPRs
» Adult = **3** SAR referrals were put forward for progression as reflective learning reviews / thematic reviews

Breakdown of Review Referrals by Area



COMMUNICATING THE LEARNING FROM REVIEWS

Publication of Review Reports

During 2021-2022, Warwickshire Safeguarding concluded **three** reviews which progressed to publication on its website to help raise awareness of the lessons drawn from the reviews, systemic learning and identification of actions which support continuous improvement in safeguarding practice.

Warwickshire Child Safeguarding Practice Review
JACK's Story:

Jack is a young teenager who sadly took his own life. In the time leading up to Jack's death the UK was in lockdown due to the Covid 19 pandemic. Just prior to the lockdown the process had begun for Jack to move to a new school following a number of fixed term exclusions. Jack's parents were divorced, and Jack had recently moved from living with his father and siblings to living with his mother. Jack was experiencing some difficulties in his life and was displaying some behaviours at home and at school. There was minimal multiagency involvement with Jack in the year preceding his death, although there were four referrals for the family to children's social care and one single assessment was completed; none of which resulted in intervention or support. Apart from school there were no other agencies involved with Jack at the time of his death. No school staff had any contact with Jack during the lockdown period prior to their death and there is no recorded information about them during this period.
The review focused on the following areas of consideration to help support improvement in practice:

- How well do safeguarding services and schools in Warwickshire identify and support teenagers with immerging vulnerabilities and risk-taking behaviour?
- How did the Covid-19 pandemic impact on support to teenagers with immerging vulnerabilities and risk-taking behaviour?
- What can we learn from this case about support to key workers and their children during the Covid- 19 pandemic and lockdown?
- How effective is the transfer of information about children when they move between schools in Warwickshire?

A copy of the full report and lessons learned briefing can be downloaded from the website by clicking here

Warwickshire Safeguarding Adults Review
ALAN's Story:

Alan was born 3 months prematurely at home and due to a lack of oxygen he suffered from brain damage causing him to have physical and mental health issues; he had learning disabilities, was on the autistic spectrum and suffered from bipolar disorder. Alan lived at home from birth up until he was admitted to hospital as an inpatient, in October 2018, having been sectioned under the Mental Health Act. Alan was discharged from the hospital in 2019, when he was housed in a Housing Association tenancy, achieved through the local authority, in his new home in Warwickshire where he was cared for by a local care provider. Alan was provided with 2 to 1 care 24 hours a day with 1 waking night and 1 sleeping night carer. Towards the end of Alan's life, the level of care at night was increased due to Alan's behaviour becoming more challenging. In December 2019, he was admitted to Warwick Hospital via the Emergency Department, having been found unconscious whilst sleeping. Alan passed away a week later. Alan was 44 years old at the time of his death.

The review focused on the following areas of consideration to help support improvement in practice:

- How well was the need to engage the family in the decision making, as detailed in the Court of Protection Order, understood by agencies supporting the adult?
- To understand how historic information is taken into consideration and shared between agencies on prescribed treatment pathways.
- What level of understanding did all services have on how the views of the family surrounding AS's best interests taken into consideration?
- To understand how the family's views on AS's best interests were taken into consideration regarding medication changes as detailed in the Court of Protection Order by agencies.
- How effective was management and oversight maintained of the adult's care plans? How was AS supported effectively and how were the medical needs identified in the care plan communicated proportionately between agencies and the family?
- To understand practitioner's knowledge of pain management. AS's family were reported to be able to identify when AS was in pain. Did all services seek the views of the family on establishing the level of pain AS may have been experiencing?
- To understand the multi-agency response to the escalation of the family's concerns.

A copy of the full report and lessons learned briefing can be downloaded from the website by clicking here

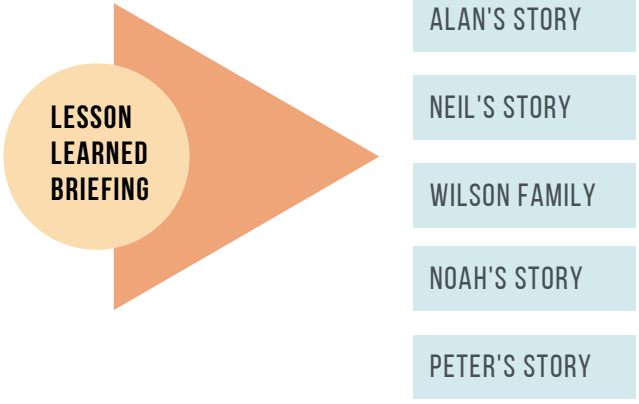
7-Minute Briefings

Throughout 2021-2022 Warwickshire Safeguarding continued to ensure key points of learning emerging from its reviews are shared across the wider partnership at all levels to encourage reflection and improvement in safeguarding practice. 7 Minute Briefings are developed to place the spotlight on specific themes emerging from reviews where improved understanding and awareness is required to support the safeguarding response. During 2021-2022 the following list of briefings were published:

Street Harrasment	Safer sleeping & co-sleeping for babies	Children of parents with mental health problems	Multi-agency risk assessment conferences
Domestic Violence & Abuse	Victim Blaming Language	Disguised Compliance	Children of parents who misuse substances
Escalation Protocol	Safeguarding children around dogs	The Links between animals and child / vulnerable adult abuse	Use of Alcohol in children and young people

Lessons Learned Briefings

Lessons Learned Briefings are published alongside all review reports and are targeted at both professionals working with children and adults, as well as the Warwickshire community at large. They serve to provide a brief synopsis of the case alongside the key points of learning identified. These can be used to support discussion and reflection within Team meetings, 1:1 supervision and learning events to support continuous improvement in safeguarding practices. During 2021-2022 Lessons Learned Briefings were developed to support learning from the following case stories:

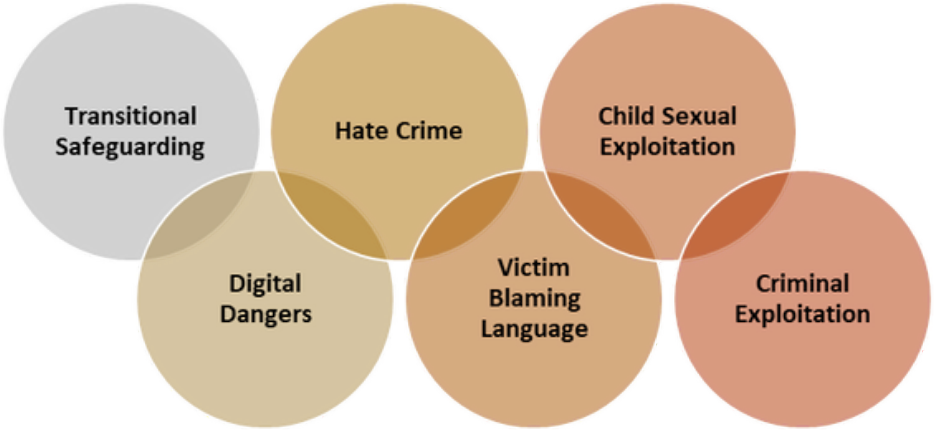


Training

WS Safeguarding Week – 'A Focus on Exploitation'

During Monday 21st to Friday 25th June 2021 Warwickshire Safeguarding held a week of online bitesize learning events around the topic of Exploitation. In line with the partnership's core strategic priority and recently launched Exploitation Strategy, we placed the focus on exploitation, and aimed to use this opportunity to help Warwickshire develop its collective understanding and confidence in combatting and responding to exploitation in all its forms.

Warwickshire Safeguarding invited a range of leading academics and speakers to share their knowledge and experience of exploitation on the following topics, as well as providing some local context:



303 delegates attended the training events over the course of the week from across all partner agencies representing the Health, Police, Children's Social Care, Adult Social Care, Housing &District Boroughs and Voluntary and Community organisations. **100%** of our attendees who completed the evaluation form indicated that the session they attended **"helped to improve their knowledge and understanding in the subject matter."** Provided below is some of the direct feedback from attendees:

"Lots of information and challenges to think about in respect of trying to work over boundaries"

"This made me think about the work that needs to be done to support children as they transition into adulthood."

"Very informative, and I would very much wish to promote this in the schools and with parents."

"I have been working so hard not to use VBL, the presentation made me realise there is lots more work required to make sure I never inadvertently use VBL. I felt like I came away from the session with homework- which must be a good thing."

"Everything was really thought-provoking. Made me reflect on current and past cases and how I could do things differently."

A focus on 'Safer Sleeping' for Babies saves Lives

Following the publication of the National Child Safeguarding Practice Review Panel Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm and the local alternative learning review for Noah, Warwickshire Safeguarding undertook a joint project with Coventry's Children's Safeguarding Partnership to ensure the learning from both reviews was disseminated to agencies.

To support practitioners to implement the learning from both the national and local reviews, the joint Coventry and Warwickshire Safer Sleep: **A Guide for Practitioners** was developed to help identify where babies are most at risk of Sudden Unexpected Death In Infancy (SUDI) and provides advice on the steps that can be taken to prevent this.

In July 2021 an interagency webinar was held to share the key learning from both national and local reviews, tips from The Lullaby Trust on how to have conversations regarding safer sleep for babies and infants with parents and families and to launch the Safer Sleep: A Guide for Practitioners.

Due to the success of the webinar in July where a total of 141 professionals attended, the session was held again in November 2021 with a further 45 professionals in attendance.

A focus on 'Advance Decision Making'

In 2021 Coventry and Warwick CCG (now ICB) launched a campaign entitled 'Leave no doubt' in partnership with 'Compassion in dying' to raise the awareness of advance decisions, advance care planning, mental capacity assessments and best interest decisions. The campaign encourages everyone to plan and document their choices on treatment and medical intervention should life suddenly change.

Warwickshire Safeguarding with Coventry Safeguarding Adults Board and Coventry and Warwickshire CCG hosted a joint learning event on this topic.

The national experts, who for many years have been raising awareness, spoke about how this relates not only to practice as professionals but as an individual.

This conference was carefully designed to cover some of the most important and sensitive issues surrounding the choices an individual makes, or which may be made on their behalf, when making decisions about their treatment and death. The conference focused on the following specifically:

The joint learning event encouraged attendees to think about not only how this relates to their practice as professionals but also for each of them individually and their family members.

A total of 97 delegates attended the conference representing all partner agencies operating from within Warwickshire and Coventry from Police, Health, Local Authorities, Voluntary & Community organisations.

Illustrated below is some of the feedback received from delegates who had joined the learning event:

“Thank you, so informative and a powerful afternoon. It has really made me think and i will be spreading the word”

“This topic is invaluable and not to be avoided by all”

“Really informative and thought provoking. A topic that you feel you don't need to think about - until it happens!!”

“Thank you, this was excellent, and so informative. Thank you for sharing the stories, helps give perspective”

06 WORKING WITH EDUCATION SETTINGS

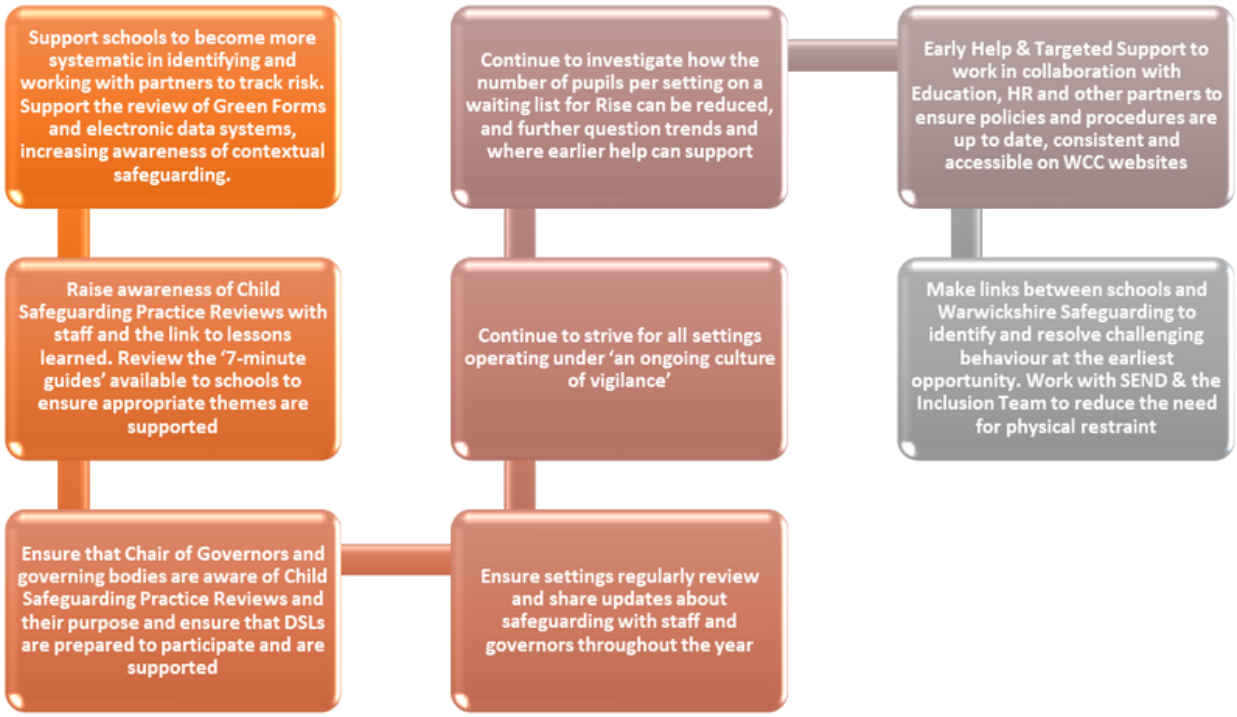
ANNUAL SAFEGUARDING AUDIT

Warwickshire undertook its annual section 175 audit of education settings to assess and evaluate the effectiveness of safeguarding arrangements. This year, a total of **269** responses were submitted from **294** contacted settings (i.e. Schools, colleges and alternative providers). The audit focused on scrutinising practice in the following five areas:

Each setting was requested to evaluate their arrangements by selecting one of the following options:

- **Emerging** – Aspects require initial or immediate action.
- **Developing** – Actions are being actioned and progressed but require further development to embed in the setting.
- **Established** – Aspects are fully embedded in practice and are consistent and effective

Based on the responses received the following recommendations for action were identified for Warwickshire Safeguarding; delivery against these actions is overseen and monitored by Warwickshire Safeguarding's Education Subgroup who provide the Executive Board with regular updates on progress and seek assurance on the impact on practice:



07 VOICE OF THE CHILD / ADULT

ADVOCACY

Local authorities have a duty to arrange for an independent advocate to be available to represent and support certain persons (Children and adults) for the purpose of facilitating those persons' involvement in the exercise of functions by local authorities. Advocacy is a process of supporting and enabling people to:

- Express their views and concerns
- Access information and services
- Defend and promote their rights and responsibilities; and
- Explore choices and options

These statutory advocacy services are delivering currently in line with activity pre COVID - providers have ensured that communications have continued to referrers to maintain awareness of the service, access, and eligibility. Both report that following restrictions being lifted the services have continued to deliver a hybrid model (utilising risk assessments to determine) - offering both virtual and face to face allowing customers a choice and saving travel time.

During 2021-2022 **a total of 64 adults with care and support needs** were supported by an advocate to help them with their safeguarding issues under Section 68 of The Care Act 2014.

A further **168 referrals for Children's Advocacy service were supported by Barnardo's** in 2021-2022 to ensure children and young people received the help and information they needed to enable them to understand their rights.

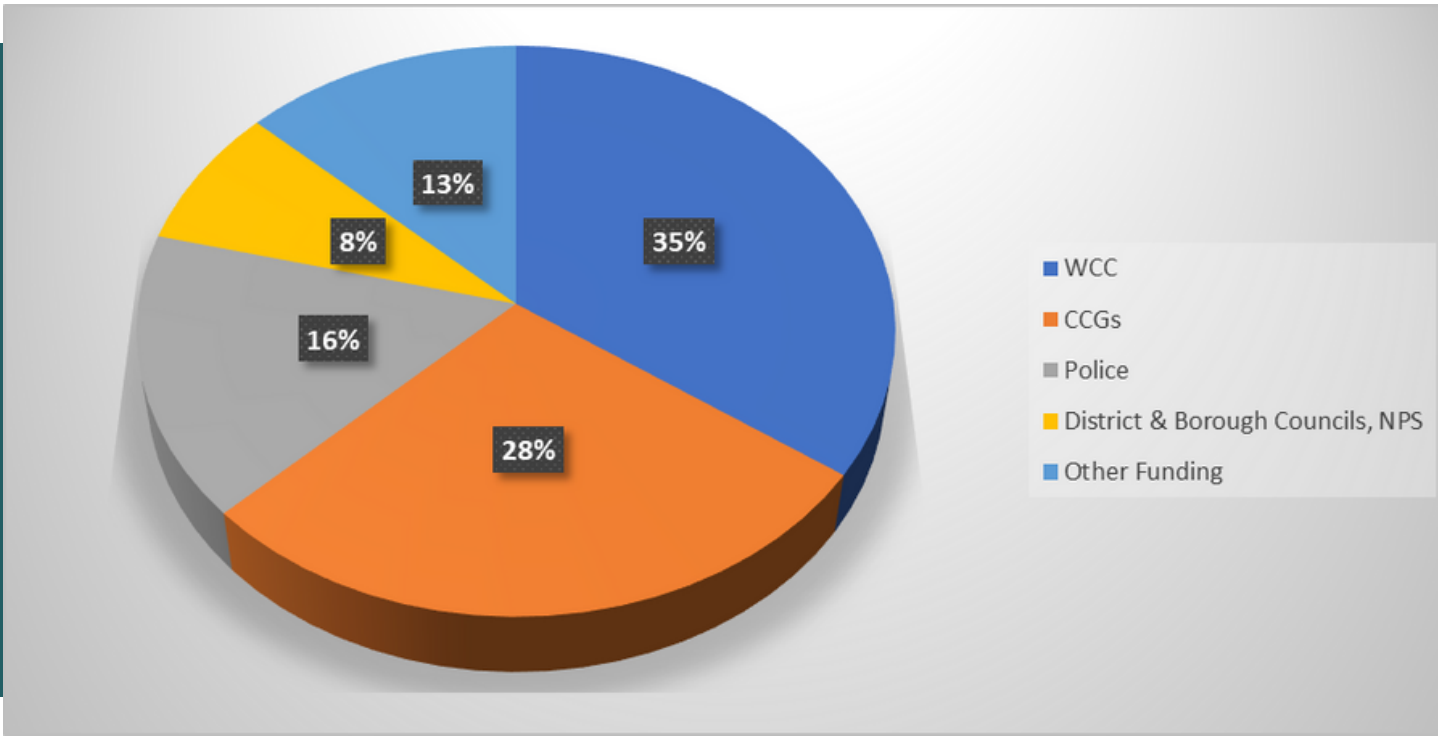
MAKING SAFEGUARDING PERSONAL

Making Safeguarding Personal requires partner agencies to ask individuals and/or their representatives what outcomes they would like to achieve from their safeguarding intervention. As part of its ongoing reviews work Warwickshire Safeguarding has continued to scrutinise whether the practice of Making Safeguarding Personal is evident within the safeguarding reviews it conducts. This is an area also explored with survivors of abuse/neglect and their families as part of their engagement with the review process.

Feedback gathered from younger survivors of abuse or neglect as part of the safeguarding reviews conversations suggests that practice is inconsistent, and the conversation about identifying their personal safeguarding outcomes does not always take place or inform the safeguarding decision making. Warwickshire Safeguarding's second Strategic Thematic Review focusing on 'Core Safeguarding Practice' has now commenced and will seek assurance from its partners in respect of their application of Making Safeguarding Personal and awareness and confidence in the use of this practice within their respective organisations. The findings of this Strategic Thematic Review will inform future learning and improvement work.

08 FUNDING THE PARTNERSHIP

The funding for the partnership has remained largely at the same level as previous years' contributions from partners. In 2021-2022 the partnership operated within a total agreed budget of £328,929 received from the following sources:



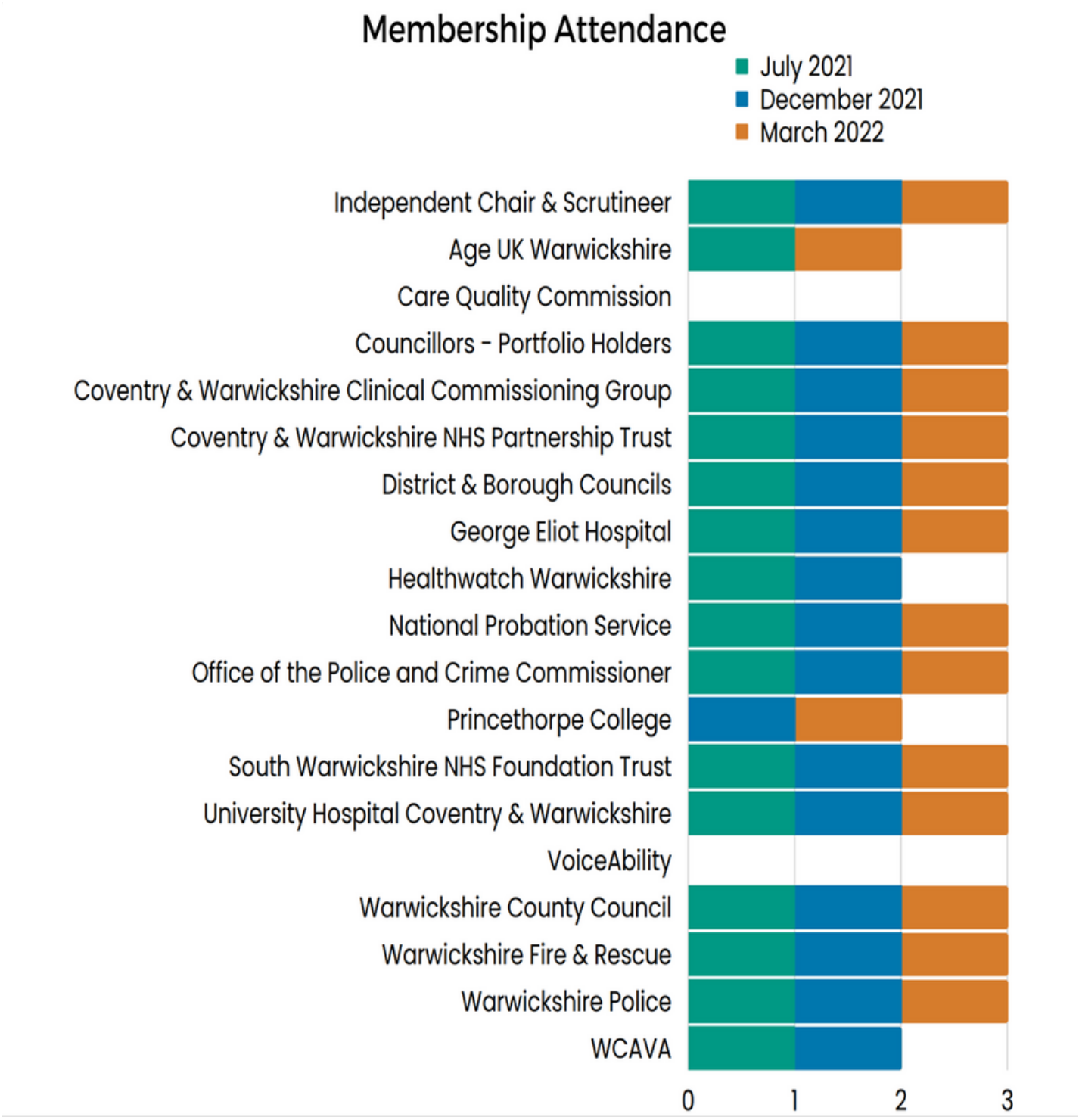
The primary part of this budget is allocated to staffing costs for the posts held within the Business Team, including the Independent Chair & Scrutineer:

(x1) Independent Chair/Scrutineer
(x1) Business Manager
(x2) Permanent Quality, Learning & Improvement Officers
(x2) Business Development Officers

The remainder of the budget covers all day-to-day costs associated with the delivery of the partnership's work, including the cost of safeguarding reviews. In 2021/2022 the partnership commissioned 4 new reviews through the use of external Independent Reviewers at an estimated cost of approx. £30,000.

09 MEMBER ATTTENDANCE

Partner attendance at meetings April 2021 – March 2022




Warwickshire
age UK


Care Quality
Commission


Warwickshire
& West Mercia
Community Rehabilitation Company
PROBATION


cafcass


WARWICKSHIRE
CAVA
COMMUNITY & VOLUNTARY ACTION


WARWICK
DISTRICT
COUNCIL


WARWICKSHIRE
FIRE & RESCUE SERVICE


NHS
George Eliot Hospital
NHS Trust


NHS
Coventry and Rugby
Clinical Commissioning Group


Warwickshire
County Council


NHS
University Hospitals
Coventry and Warwickshire
NHS Trust


Princethorpe
College


BOROUGH
RUGBY
COUNCIL


NHS
Warwickshire North
Clinical Commissioning Group


healthwatch
Warwickshire


NHS
West Midlands
Ambulance Service
University NHS Foundation Trust


VoiceAbility


National
Probation
Service


NHS
South Warwickshire
Clinical Commissioning Group


NHS
South Warwickshire
NHS Foundation Trust


North Warwickshire
Borough Council


Coventry and Warwickshire
Partnership
NHS Trust
NHS


Police and Crime
Commissioner
Warwickshire


STRATFORD-ON-AVON
DISTRICT COUNCIL


Warwickshire
POLICE


Nuneaton
&
Bedworth


The Polesworth School
ENSURING EXCELLENCE


NHS
England