Bristol, North Somerset, South Gloucestershire and B&NES Partnerships

Section 11 Audit 2019-2020

Introduction

Section 11 was issued under the Children's Act (2004) and has been reinforced in Working Together to Safeguard Children 2018. Section 11 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

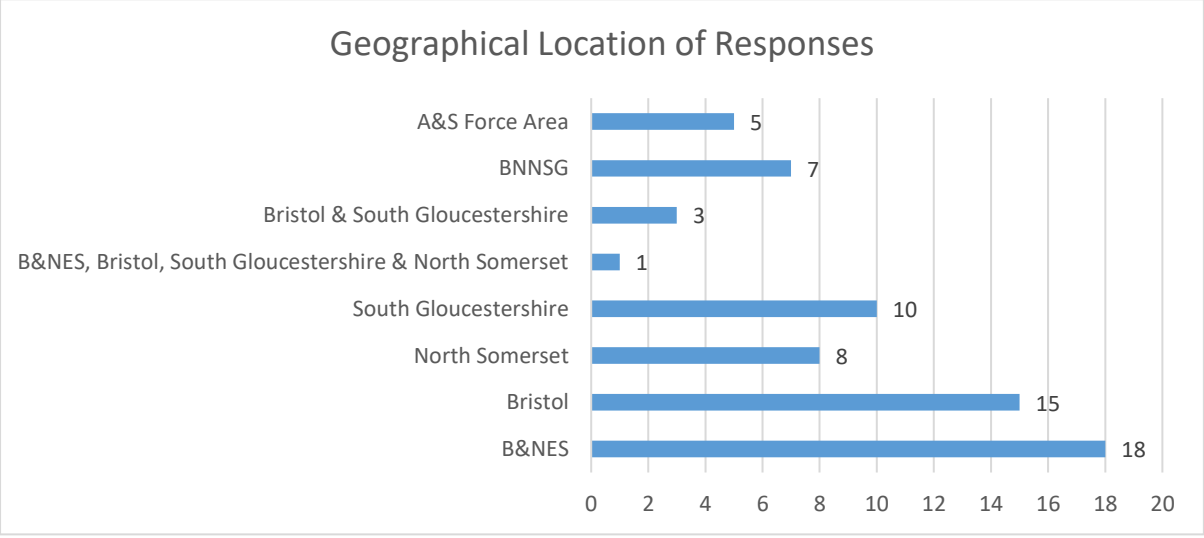
Section 11 places a duty on:

- Local authorities and district councils that provide children's and other types of services, including children and adult's social care services, public health, housing, sport, culture and leisure services, licensing authorities and youth services;
- Schools and colleges (under S.175 and 157 of the Education Act 2002);
- NHS organisations, including the NHS Commissioning Board and Clinical Commissioning Groups, NHS Trusts and NHS Foundation Trusts;
- The Police, including Police & Crime Commissioners and the Chief Officer of each police force in England;
- National Probation Services and CRC.

This year, the Section 11 self-assessment audit tool was circulated to all partners across B&NES, Bristol, South Gloucestershire and North Somerset, in January 2020, via Survey Monkey. The audit tool was devised to assess, monitor and evidence progress and achievements in relation to meeting safeguarding requirements. The Section 11 audit for 2019/2020 has taken place in the year that each region has transitioned from the old LSCB-style arrangements, to the new partnership arrangements, following the changes to Working Together to Safeguard Children 2018.

The aspiration for future audits is that all five of the partnership areas across Avon & Somerset geographical footprint will produce one combined audit report for the region. In order to achieve this consistent approach, the timescales for the audit will be streamlined to ensure all five partnerships are able to work effectively together.

The audit received 37 responses in total, with some organisations working across more than one local authority area. Names of these organisations are included in Appendix One; a number of key organisations did not submit a response.



Organisations were required to make a judgement as to how well each question is being achieved, based on the following rating:

0 - Inadequate
1 - Requires Improvement
2 - Good
3 - Outstanding

For each question, organisations were also asked, `What's Working Well?', `What are you Worried About?' and `What Needs to Happen?'. This is following Signs of Safety methodology and employs strength based principles:

`What's Working Well?'	**`What are you Worried About?'**	**`What Needs to Happen?'**
Describe existing strengths and safety factors which are in place. Provide evidence of good practice, including where any audit activity has been undertaken.	Provide evidence of any unmitigated harm, any future dangers and/or any complicating factors. Evidence can be drawn from existing practice and/or audit activity.	Detail evidence of any progress against action plans, and in your opinion, what best practice will look like once attained.

Questions and Responses

Organisational Structure and Responsibility

This section asked questions about the structure surrounding each organisation and in particular, the provision of someone who is a designated lead for safeguarding. The first three questions are not reported as they were demographic information questions about completion of the audit.

Q4. Does your organisation have a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children?

There were 33 responses to this question with an almost equal split between 2 (Good) and 3 (Outstanding). All agencies reported that they had clear governance in place with strong lines of accountability.

Concerns, in the `What are you Worried About?' section ranged from a lack of consistency in approach to assessing safeguarding, along with 22% of respondents having concerns in relation to resource, capacity and abstraction rates.

Given that 22% of respondents were concerned about resources and abstraction, naturally, recruitment featured heavily in the `What Needs to Happen?' section. Comments were also made in relation to the safeguarding partnership, and improved and joined up communication from partnership boards is requested. Training and workforce development also featured, with respondents stating that either more training is required, or existing training needs to become embedded.

Q5. Does your organisation have a senior lead with the required knowledge, skills, expertise and experience who has leadership responsibility for the organisation's/agency's safeguarding arrangements?

Again, responses were equally split between 2 (Good) and 3 (Outstanding), with 38% of respondents falling into the Outstanding category. One agency reported that they were 1 (Requires Improvement).

All respondents in the `What's Working Well?' category reported experienced and qualified colleagues with good management structures in place.

Vacancies were also raised in this question, under the `What are you Worried About?' section; with 16% of respondents raising this issue. Training concerns were also raised, albeit a smaller number.

Updated accountability protocols were required under `What Needs to Happen?', along with reviews of work and capacity. AFRS stated that they were working with the National Fire Chief Council to formalise consistent training and identifying requirements for Fire Service professionals. Another agency highlighted a review of their attendance at partnership meetings, in order to ascertain whether they could attend more.

Q6. Does your organisation have a designated practitioner (or, for health commissioning and health provider organisations/agencies, designated and named practitioners) for child safeguarding, whose role is to support other practitioners in their organisations and agencies to recognise the needs of children, including protection from possible abuse or neglect?

43% of respondents stated that they were either 2 (Good) or 3 (Outstanding) for this category. However, 3 agencies reported that they were 1 (Requires Improvement), and 1 agency reported 0

(Inadequate). Clear structures in place, with accountable members of staff in place were routinely sighted as the reason why agencies had scored 2 or 3.

Within the `What are we Worried About?' section, again, vacancies and capacity were raised as a concern. The changes to LPS and the impact that this will bring to 16-18 yr olds, alongside existing pressures, was raised as an area for concern. Additionally, contextual safeguarding concerns and the remit of children's safeguarding expanding, alongside increases in patient numbers was also raised.

64.8% of respondents stated that the above role had an explicit job description.

Q8. Are they given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively?

67.5% of respondents to this question stated yes; but some stated that this needed further analysis to understand the true picture. A&S Police stated that it can be difficult to achieve protected time for training due to the demands placed on the business. In addition, other respondents stated that some posts have additional responsibilities and are not in a designated role.

Question for ASSSP – Potential Recommendation: Should all agencies undertake analysis to see whether effective supervision and training is available to all relevant roles across the partnership?

Organisational Culture

Q9. How do you know you have a culture of listening to children and young people, within your organisation? This should incorporate taking account of their wishes and feelings, both in individual decisions and in the development of services.

70% of respondents stated that they were 2 (Good) for this question, with 10% stating that they were 1 (Inadequate). Shadow Boards, Youth Councils, Young Persons Participation Forums and Children in Care Councils were all sighted as being good practice in this area. Apps, such as the Mind of My Own, were also in development, and were good to see as innovative mechanisms in which to ensure that we are listening to children. Hospital Trusts also outlined creative ways, such as magazines and newsletters which enabled children and young people to have a view on services. Statement of Commitments and Exit Interviews were highlighted as ways in which 1625 engaged with young people using their services. Police have recently undertaken training with PC's and PCSO's into the impact of forced entries into addresses has on children and young people; enabling mitigation of negative impact and how to consider communication needs so as not to cause additional trauma. Additional scrutiny into Stop and Search powers has also been recently introduced, the results of which will be taken to the Constabulary Management Board and PCC Panels.

However, there are still opportunities to improve, as highlighted in the `What are you Worried About?' section; opportunities to strengthen engagement with children during the child protection conference process were raised, as were ensuring that we are listening to *all* children and young people's voices, especially those with SEND or children Missing from Education.

Within the `What Needs to Happen?' section, co-production was one method suggested for improving the way in which we listen, and investing in young people's champions as a dedicated resource to capture views. Another suggestion was that we concentrate on inter-agency reviews for understanding how children and young people feel about their safeguarding experiences.

Question for ASSSP – Potential Recommendation: Could there be regional development of an app, such as `Mind of My Own', in order for a consistent manner of gathering views of children and young

people? This would need to complement other forums or opportunities for engagement, rather than replace.

Q10. Working Together 2018 requires that each organisation creates a culture of safety, quality and protection within the services provided. Can you tell us how you have implemented this within your own organisation?

81% of organisations rated themselves as either 2 (Good) or 3 (Outstanding), which 2 agencies reporting 0 (Inadequate) and a further 2 reporting (Requires Improvement).

Strong and visible leadership has been sighted as an example of outstanding culture, alongside other measures such as scrutiny around supervision, exit interviews for staff, and clear use of Whistleblowing policies, or Freedom to Speak Guardians. Compliance of delivery is monitored at appropriate governance levels across differing organisations, and agencies responsible for commissioning ensure that safeguarding standards are included within all contracts which is then collated and reviewed quarterly.

However, within the `What are you Worried About?' section, some agencies reflected their view that their workforce is not as culturally diverse as the communities that they are based in/serve, although there is mitigating work in progress to address this. Sustainability of the IRIS service within GP surgeries was another concern, due to successful integration causing high demand on services. Another comment was based in the differing geographical footprints across that of all of our partners, with competing demands and priorities potentially causing conflict, as well as duplication of effort. Thresholds into services was also seen as another area for concern, which could cause `*defensiveness and excuses*' and affect partnership relationships. One concern raised related to the serious youth violence funded work – stating `*maintaining staff confidence when risks escalate is a current priority'*.

Under the `What Needs to Happen?' section, additional work was suggested to strengthen partnership working so that information sharing can be more effective. There was a request to further explore the lead professional role, and embed this within local safeguarding partnerships. Additional training was also suggested. Strong and visible leadership was advocated, with workloads being addressed in order for senior staff to be more available to their teams.

Question for ASSSP – Potential Recommendation: Further scrutiny and assurance work to be completed in order to understand and mitigate risks in this area.

Q11. Within your organisation, how do you ensure that your staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children?

53% of respondents reported 2 (Good), and 37% reported 2 (Outstanding) for this question, with one respondent stating 0 (Inadequate), with a further two stating 1 (Requires Improvement).

Safer Recruitment practices and mandatory safeguarding training are sighted as having a positive impact on staff competencies, along with using a robust appraisal and supervision process. In addition, visible policies and clear guidance being available to all staff is necessary, within a clear communications framework. Previous S.11 walkabouts have identified that safeguarding training has become embedded within the workforce with all staff understanding their obligations.

Within the `What are you Worried About?' section, several agencies were concerned about the completion rates of Level 1 training across their entire organisation; whilst this training may not be mandatory, it was seen as best practice given that Safeguarding is Everyone's Business. Organisational change and service transformation work is seen to impede the stability of the safeguarding service,

with mergers and changes in personnel seen to affect the confidence of colleagues and partners within operational delivery. One agency stated that all their staff are trained to Level 1 only, with no opportunities for further development. Monitoring took place to ensure that all staff received their training, but no quality assurance was described, in order to understand whether staff transferred the learning into daily practice.

Question for ASSSP – Potential Recommendation: Quality assurance to take place of existing training provision, assess competencies and ensure that learning is embedded within organisations.

Q12. How does your organisation create an environment where staff feel able to raise competency concerns?

Whistleblowing policies and appraisal processes were the most mentioned way in which to raise competency concerns, which are effective alongside a compassionate leadership approach. Robust reporting mechanisms where significant safeguarding incidents have occurred is already in place, but the culture must be appropriate for reviews to be seen as learning opportunities as opposed to adopting a `blame culture'. Only 10% of responses included a response to the LADO/DOFA, and only one response mentioned the use of escalation policies, with the same organisation (1625ip) also mentioned the use of SWCPP if concerned.

Question for ASSSP – Potential Recommendation: Additional communication across the partnership is required in relation to LADO/DOFA, Escalation Policies and SWCPP.

Learning and Development

Q13. How does your organisation ensure that learning or recommendations from reviews are embedded into practice?

66% of respondents reported that they were 2 (Good) at embedding learning, with a further 21% reporting that they were 3 (Outstanding).

Practice briefings and quality assurance sessions were reported under `What's Working Well?', alongside monitoring of learning through the statutory review groups. Briefings, supervision and training sessions were also mentioned as other effective mechanisms for ensuring learning is embedded. The learning briefs from the Safeguarding Partnerships are seen as very useful.

Timeliness of the completion of reviews is seen as a complicating factor under `What are you Worried About?', as the timespan can affect the learning transfer, and the distance between operational activity and the partnership arrangements can have an effect on learning opportunities.

Immersive learning and/or virtual reality learning is seen as an innovative way in which to share learning, and opportunities to promote this should come from strategic leadership, and is highlighted under the `What Needs to Happen?' section. Another suggestion is that patient/service-user stories should be seen as standing agenda items at relevant safeguarding meetings in order to share learning – although these have to be completed sensitively so as not to be seen as sensationalist, and re-traumatising the patient/service-user. Shared learning across partnership boards and the region would be useful, in order to avoid duplication, and reduce pressure on operational managers attending review meetings.

Q14. What are your organisation's arrangements for ensuring appropriate supervision and support for staff?

57% of respondents felt that their organisation's arrangements were 2 (Good), with a further 37% stating that their arrangements were 3 (Outstanding).

Robust arrangements for supervision were highlighted alongside safer recruitment techniques and appropriate training opportunities.

Some of the challenges outlined in `What are you Worried About?' include capacity to undertake effective supervision, the lack of available and appropriate rooms in which to hold supervision sessions, and any longer term evaluation into the effectiveness in improving confidence and ability for staff. Differing shift patterns between managers and operational staff do not always provide sufficient opportunities for face to face supervision to take place. Equally, there is no one consistent supervision method that could be used across all agencies, which would support any measurement of effectiveness.

A stronger supervision method for volunteers was noted to be required under `What Needs to Happen?', as was additional support for those staff working in remote geographical locations. There was a request to scope additional supervision methods for providing supervision across all staff groups, to include group supervision, reflective learning and peer supervision.

Question for ASSSP – Potential Recommendation: Consider regional supervision assurance activity across all the core agencies (e.g. Health, Education, Social Care, Early Help and Police), to understand who has access, effectiveness and value.

Q15. How does your organisation ensure safeguarding training is offered and completed by all appropriate and relevant staff?

57% of respondents stated that they were 2 (Good), with a further 38% rating themselves as 3 (Outstanding). Many organisations state that they monitor compliance for safeguarding training, although the take up of this can be as low as approximately 50%.

Capacity to attend training is sighted as one of the main areas in `What are you Worried About?', with the ability to monitor compliance another.

Q16. How does your organisation ensure that all practitioners have regular reviews of their own practice to ensure that they have knowledge, skills and expertise that improve over time and how this informs their continuous professional development?

54% of respondents felt that they were 2 (Good) in this area, with a further 26% responding as 3 (Outstanding). Comments centred on supervision and regular, effective, appraisals. Visits from Inspectorates, as well as previous S.11 audits have all provided opportunities for regular reviews of knowledge, skills and expertise.

Within the `What are you Worried About?' section, one respondent stated that the `*increasing complexity of safeguarding issues with which we work means that some staff feel under-confident at times, which means that management support is then a priority.*' This is a recurring theme throughout all questions; the context of the safeguarding environment is becoming more demanding – both in terms of numbers but also complexity.

Given that appraisals featured highly in the method used by most organisations to evaluate own practice, the completion rate of appraisals was low for some agencies – this could mean that in some areas, practice review could only occur once a year.

Question for ASSSP – Potential Recommendation: How do we provide our workforce with the requisite knowledge and experience given the ever-increasing complexities of safeguarding? In addition, what other methods are there for undertaking practice reviews, other than annual appraisals?

Q17. What content concerning the safeguarding and promotion of the welfare of children is included within your organisation's mandatory staff induction? This should include familiarisation of child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare.

50% of respondents felt that they were 2 (Good), with a further 46% rating themselves as 3 (Outstanding). All agencies reported that promotion of safeguarding responsibilities is included within new staff induction policies with mandatory online training being required to be completed within a set time period and in most cases, to be signed off by their line managers.

Maintaining compliance across large organisations was one area which was highlighted in the `What are you Worried About?' section, and given the need for efficiency, the move to e-learning was highlighted as not as effective as face to face learning.

Managing Allegations and Resolving Professional Differences

Q18. Do you have clear whistleblowing procedures, which reflect the principles in Sir Robert Francis' Freedom to Speak Up Review and are suitably referenced in staff training and codes of conduct, alongside a culture which enables issues about safeguarding and promoting the welfare of children to be addressed?

62% of respondents felt that they were 2 (Good), with a further 35% reporting as 3 (Outstanding). Whistleblowing policies are in place in all organisations, and some areas have Speak Up Guardians in place. Processes were stated to be well known, accessible and advertised. As before, one agency sighted LADO/DOFA arrangements and the use of the Escalation Policy.

Police colleagues have highlighted an area for development; volunteers, such as those in the Citizens in Policing Teams, are not covered under whistleblowing policies in the same way that employees are. A draft policy statement has been drafted and is currently with the Head of HR for review to ensure that there is parity.

Under the `What needs to Happen?' section, it was felt that an audit of whistleblowing activity would be useful, along with a communications brief to all partners to remind colleagues of the existence of the policy.

Question for ASSSP – Potential Recommendation: Audit/Assurance activity of whistleblowing activity to take place to understand usage of policy.

Question for ASSSP – Potential Recommendation: Communications brief to all partners to remind them of existence of whistleblowing policies.

Q19. Does your organisation/agency have clear Resolving Professional Differences/Escalation policies for staff to follow when their child safeguarding concerns are not being addressed within their own organisation or by other agencies?

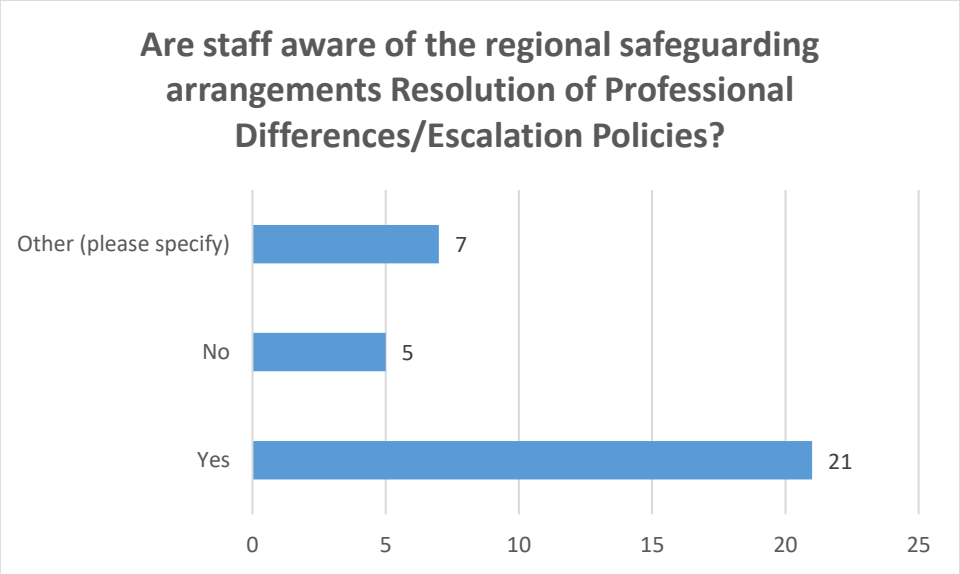
50% of respondents felt that their organisation was 2 (Good) in this area, with 31% stating that their agency rated 3 (Outstanding). However, 3 agencies felt that they were 0 (Inadequate) in this area.

Agencies reported good usage of the Escalation Policy, in line with recommended pathways. In addition, there was evidence of the SWCPP and safeguarding partner's websites being visited, specifically around Escalation procedures. They are seen as a professional way in which to raise concerns about a child, rather than heighten any sense of `*professional wrangling'.*

Under the `What are you Worried About?' section, the timeliness and effectiveness of escalation can be seen as a blocker to progress. In addition, recording of the use of the Escalation policy remains patchy, with no evidence of formal monitoring taking place. It is also reported that there is a tendency for escalations to be highlighted at a senior level, whilst still being discussed at an operational level therefore duplicating involvement. There is also a recognition that we `*need to retain the right balance in advocating for children and recognising the challenges in our partner agencies to respond positively to such advocacy'.*

Question for ASSSP – Potential Recommendation: There is a lack of clarity about what level of escalation is reported to the partnership, in order to highlight volume and themes. In line with the findings from Q20 below, it is recommended that communications are refreshed in relation to these policies, with clear guidance issued, with audit/assurance activity taking place a short while later to ensure that it has been understood – repeated within 12 months to check whether this has been embedded.

Q20. Are staff aware of the regional safeguarding arrangements Resolution of Professional Differences/Escalation Policies?



One comment states that staff are aware `*but are confused by it'.* Whilst data shows that the overwhelming number of respondents are aware of the policies, previous S.11 audits identified that staff are not clear about the Resolution of Professional Differences/Escalation policy. The policy is due to be refreshed in South Gloucestershire.

Question for ASSSP – Potential Recommendation: See recommendation for Q19 above.

Safer Recruitment

Q21. Does your organisation follow safe recruitment practices and ongoing safe working practices for individuals whom the organisation or agency permit to work regularly with children, including policies on when to obtain a Disclosure Barring Service or criminal record check?

56% of respondents reported that they were 3 (Outstanding) in this area, with a further 36% reporting that they were 2 (Good). The vast majority of organisations describe themselves as having clear and robust safer recruitment practices in place and in some areas, annual `dip tests' taking place to provide assurance.

Within the `What are we Worried About?' section, AFRS have detailed that they are working towards all operational crews being DBS checked. Given that they are likely to have unsupervised contact with vulnerable members of the community, I believe that this should be as standard, and welcome this revised approach. One particular challenge can be the time it takes to get DBS checks completed and another is the lack of automatic refreshed checks every three years.

Information Sharing

Q22. Does your organisation have arrangements which set out clearly the processes for sharing information with other practitioners and with safeguarding partners?

60% of respondents reported that they were 2 (Good) in this area, with a further 36% responding as 3 (Outstanding). Information sharing is included in the majority of all agency's safeguarding training with guidance available on partnership websites. Information Governance processes exist where appropriate, with necessary oversight and clear guidelines in place.

Comments within the `What we are Worried About?' section note that there are still some staff who are anxious about sharing information and that guidance could be more accessible and explicit. There are still some areas in which consent to share remains an issue. YOT also highlighted that as they are privy to police information, in some cases this has not been shared with children's social care, and this can present them with a challenge.

Summary of Findings and Recommendations

Reviewing the self-audits submitted to the S.11 audit, there are a number of learning points/questions for the ASSSP identified and some recommendations to consider:

Question	Finding/Recommendation
8	Should all agencies undertake analysis to see whether effective supervision and training is available to all relevant roles across the partnership?
9	Could there be regional development of an app, such as `Mind of My Own', in order for a consistent manner of gathering views of children and young people? This would need to complement other forums or opportunities for engagement, rather than replace.
10	How do we assure ourselves of ongoing activity relating to increasing diversity within our workforce? Assurance to take place into the sustainability of the IRIS service within GP surgeries – successful integration has caused a high demand on services. Streamlining of differing geographic footprints across partners; how do we reduce duplication of effort and increase efficiency? Assurance to take place of thresholds into services – perhaps feeding into existing activity that has already taken place?
11	Quality assurance to take place of existing training provision, assess competencies and ensure that learning is embedded within organisations.
12	Additional communication across the partnership is required in relation to LADO/DOFA, Escalation Policies and SWCPP.
14	Consider regional supervision assurance activity across all the core agencies (e.g. Health, Education, Social Care, Early Help and Police), to understand who has access, effectiveness and value.
16	How do we provide our workforce with the requisite knowledge and experience given the ever-increasing complexities of safeguarding? In addition, what other methods are there for undertaking practice reviews, other than annual appraisals?
18	Audit/Assurance activity of whistleblowing activity to take place to understand usage of policy.
18	Communications brief to all partners to remind them of existence of whistleblowing policies.
19	There is a lack of clarity about what level of escalation is reported to the partnership, in order to highlight volume and themes. In line with the findings from Q20, it is recommended that communications are refreshed in relation to these policies, with clear guidance issued, with audit/assurance activity taking place a short while later to ensure that it has been understood – repeated within 12 months to check whether this has been embedded.

S.11 Learning Points and Additional Considerations

- The initial plan was for the four Local Authority areas to work together to produce one combined audit response for 2019/2020, with separate appendices for each place-based area. However, due to the outbreak of Covid-19, the logistics for working together to produce this report were significantly impacted. As a result, each place based area has completed the report independently, and submitted their responses to

their partnership Executive. However, it is anticipated that for 2020/2021, we will revert to a collaborative approach; ensuring that activity driven from the S.11 audit is streamlined and aligned to partnership priorities.

- It was a deliberate decision to simplify the questions used for this year's survey, as we aligned ourselves to a more streamlined process, incorporating Somerset, for 2020/2021. In addition, the use of survey monkey was problematic for respondents to complete their S.11 submissions. Therefore, the question set for 2020/2021 will be more comprehensive, and as a result, alternative methods for collating this information will be explored in time for the 2020/2021 self-assessment.
- Data capture for 2020/2021 will incorporate other methods to accompany the S.11 self-assessment, such as walkabouts and peer-support models.

Victoria Caple

Independent Scrutiny Coordinator

Avon & Somerset Strategic Safeguarding Partnership

June 2020

Appendix One

Organisations who responded to the self-audit and scores for questions:

Key:

Grade	Score	Colour
Inadequate	0	Red
Requires Improvement	1	Orange
Good	2	Green
Outstanding	3	Blue

Bristol Local Authority									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Avon & Wiltshire Partnership Trust									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Bath & North East Somerset Carer's Centre									
4	5	N/A	N/A	N/A	9	N/A	11	12 -	13
14	15	16	17	18	N/A	20 – No	21	22	-

BNSSG CCG (Bristol)									
4	5	6	7 – Yes	8 – No	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

BNNSG CCG (BNSSG)									
4	5	6	7 – Yes	8 – No	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Oxford Health NHS Foundation Trust									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Royal United Hospitals Bath NHS Foundation Trust									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Bath & North East Somerset CCG									
4	5	6	7 – Yes	8 – No	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Bristol Community Health									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Avon Fire & Rescue									
4	5	6	7 – No	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Public Health – South Gloucestershire LA									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 – No	21	22	-

1625 Independent People									
4	5	6	7 – No	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Avon & Somerset Constabulary									
4	5	6	7 – Yes	8 – No	9	10	11	12 -	13
14	15	16	17	18	19	20 – No	21	22	-

Weston Area Health Trust									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

BGSW CRC									
4	5	6	7 – No	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 – No	21	22	-

University Hospitals Bristol NHS Foundation Trust									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

North Bristol NHS Trust									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Curo Homes									
4	5	6	7 – No	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Barnardos									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Virgin Care Services Ltd									
4	5	6	7 – Yes	8 – No	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

National Probation Service									
4	5	6	7 – No	8 – No	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

North Somerset Community Partnership									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Sirona Care & Health									
4	5	6	7 – Yes	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-

Avon Fire & Rescue Services									
4	5	6	7 – Yes	8 – No	9	10	11	12 -	13
14	15	16	17	18	19	20 – No	21	22	-

South Gloucestershire Youth Offending Team									
4	5	6	7 – No	8 – Yes	9	10	11	12 -	13
14	15	16	17	18	19	20 - Yes	21	22	-