Health and Wellbeing Board

29 November 2018

Evaluation of County Durham & Darlington's Fire and Rescue Service Safe and Wellbeing Visits

Report of Amanda Healy, Director of Public Health, Durham County Council

Purpose of the Report

1 To provide the Health and Wellbeing Board with the results of the co-produced evaluation study of the Safe and Wellbeing Visits (SWV) delivered by County Durham and Darlington Fire and Rescue Service (CDDFRS) and recommendations for future consideration.

Background

2 The Fire and Rescue Service (FRS) has always had a prevention role with regards to fire safety. Historically this has focused on preventing fires in domestic and workplace settings. Testament to the success of this work has been an overall decline in the incidence of fires nationally by 40% in the last decade.[1]

3 This impact has been attributed to a number of factors including:

- FRS is seen as a trusted organisation particularly by the most vulnerable
- FRS has a workforce that has utilised and enhanced its skill and competency base to enable it to act as an advocate for a greater role in the wellness agenda
- Their knowledge and experience on prevention and early intervention which can contribute to reduce demand, is being recognised and sought by others e.g. Marmot,[2] Stevens.[3]

4 Nationally, a number of organisations are now working together to devise a closer collaborative approach to prevention. This has manifested itself in the form of a consensus statement[4], principles of a Safe and Wellbeing visit[5], Working

[1] Mansfield, C. 2015, Fire Works: A collaborative way forward for the Fire and Rescue Service, New Local Government Network.

[2] https://www.wmfs.net/content/marmot-partnership-award, accessed 8/2/16, 15.15

[3] http://www.independent.co.uk/news/uk/home-news/firefighters-to-ease-pressure-on-nhs-by-conducting-health-checks-in-peoples-homes-10498305.html, accessed 8/2/16, 15.20

[4] Public Health England, NHS England, Local Government Association, Age UK, CFOA, 2015, Consensus statement on improving health and wellbeing.

[5] PHE,NHSE,LGA,AgeUK,CFOA,2015, Principles for a 'Safe and Well' visit by a Fire and Rescue Service'

Together[6], pilot winter pressures project results[7] and latterly a Standard Evaluation Framework for Safe and Wellbeing visits[8]

5 Locally, during 2014/15 CDDFRS have addressed the prevention agenda both strategically and operationally. Two papers were presented to the Health and Wellbeing Board, the first[9] identified national cost impacts of fire and associated issues to the National Health Service (NHS) and went on to highlight a range of activities undertaken by the local service to address them. The second, a presentation to the Community Wellbeing Partnership[10] provided an updated strategic case for collaboration.

6 Operationally, a Safe and Wellbeing Visit (SWV) 'offer' was developed by the service, which linked to fire fatalities across the CDDFRS area. This consisted of:

(a) What the SWV would look like e.g. focused on brief intervention
(b) Identifying local health and fire need
(c) Identifying partners who would commit to engaging by agreeing to compile a series of brief intervention questions, offering training and development for the FRS, providing any additional resources and having an understanding that the intervention could potentially increase demand
(d) Aligning internal systems and processes to the demands of the respective partners
(e) Designing and producing materials for the visits as well as training materials
(f) Maintaining two way communication channels internally with management and frontline staff and between the FRS and the array of partners.

7 Public Health worked with CDDFRS to:

(a) Produce a contextual framework document. This includes the national and local policy context, a rationale for the identified health issues, an overview of CDDFRS systems and processes to provide partner assurance that they provide a level of robustness comparable to their own, an intervention approach focused on the evidence base for brief interventions and an options statement on potential means of evaluation
(b) Facilitate Making Every Contact Count (MECC) to establish a foundation onto which topic specific health issue training can be supplemented
(c) Provide oversight and scrutiny of information content on health topics
(d) Provide advice and guidance on monitoring and evaluation, and provide options for parties to work collaboratively with a university or other body to conduct an evaluation of the project.

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[6] NHSE, PHE,CFOA, LGA, 2016 Working Together - how health, social care and fire and rescue services can increase their reach, scale and impact through joint working

[7] PHE, 2016, Evaluation of the impact of Fire and Rescue Service interventions in reducing the risk of harm to vulnerable groups of people from winter-related illnesses

[8] Safe and wellbeing standard evaluation framework, in development with Public Health England.

[9] CDDFRS, 2014, How CDDFRS activities could support the work of the Health and Wellbeing Board

[10] CDDFRS, 21/7/2015, Collaboration opportunities for health and fire.

8 The co-produced evaluation report is one of a suite of reports commissioned from Teesside University by Durham County Council. This current report sought to explore the implementation of SWVs. Part of this involved identification of beneficiaries, raising the issue with them and making a referral to a specialist service as necessary. To undertake this effectively organisational systems and processes need to be in place and 'fit for purpose'. So looking at ICT systems, data collection processes, training and organisational development are important enablers to ensure staff understand and are committed to the prevention concept. Finally, how all of this is communicated internally within the FRS, to partners as active change agents, to other stakeholders such as the NHS and Local Authorities and County Durham residents. For the latter, in particular, understanding the evolving role of FRS, how they can assist on a wide range of lifestyle and other issues and identifying any impacts from exposure to SWVs are important.

Aims and objectives

9 The primary aim of this study was to evaluate the implementation of SWVs by CDDFRS. In order to achieve this aim, the following objectives were set:

- To explore the implementation of the SWVs into the fire service daily practice;
- To explore with the fire service and partner organisations their understanding of the process for SWVs and what impacted on their role;
- To assess the referral pathways to see how many clients are referred to partner organisations, how many of the health areas they are being referred for, whether or not these referrals are appropriate, and if relevant health areas are covered by SWVs;
- To gain feedback from beneficiaries of SWVs to assess impact;
- To gain feedback from beneficiaries about how appropriate they feel it is for CDDFRS to ask them about health issues.

Evaluation methodology

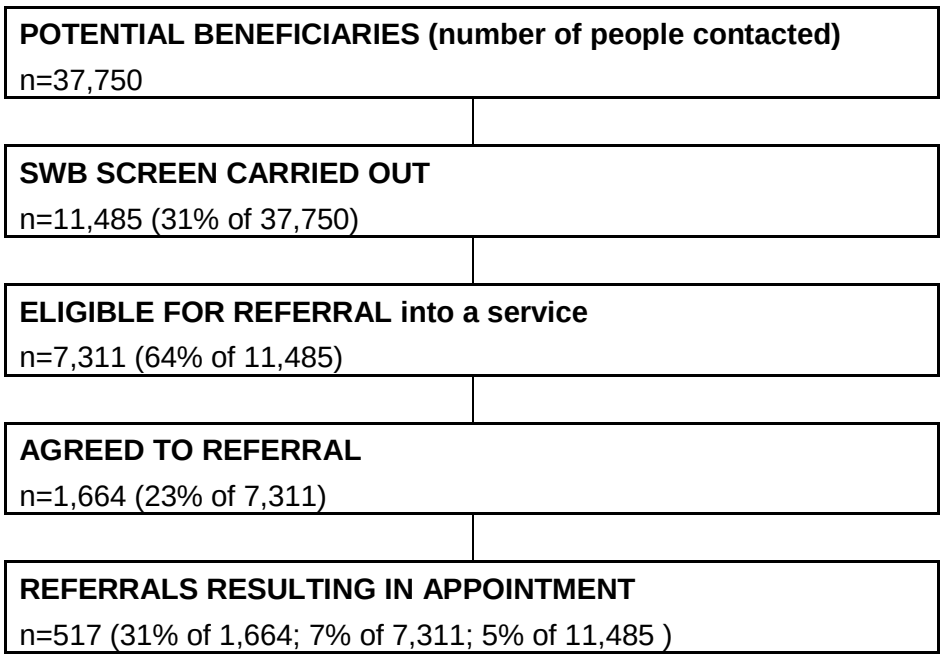
10 The study was a process evaluation and implementation study of the existing SWVs delivered by CDDFRS. The study utilised a mixed methods approach which included using qualitative data collected through focus groups with delivery staff, community risk management staff and partners and interviews with beneficiaries as well as researcher observations of an SWV; and secondary analysis of quantitative data collected by CDDFRS as part of the SWV service.

Summary of findings

Quantitative results

11 In total, 37,750 beneficiaries have engaged with the service over a two-year period. 17,654 in Year One (16th February 2016 – 31st January 2017), and 20,096 for Year two (1st February 2017 – 31st January 2018. Figure 2 shows the number of potential beneficiaries who have moved through the SWV system since February 2016.

Figure 2: Flowchart of numbers through the system



[1] A beneficiary was eligible for referral if they met the necessary criteria on one of the health sections

Table 2: Throughput of numbers based on health topics

	Total	Smoking	Slips, trips & falls	Alcohol	Dementia	Warm homes (Year 1)	Warm Homes & MMB	Loneliness & Isolation
Potential beneficiaries	37,750	37,750	37,750	37,750	37,750	17,654	20,096	37,750
Number screened	11,485	11,485	11,485	11,485	11,485	5,743[a]	5,743[a]	11,485
Number eligible	7,311	2,337	893	43	410	2,629	106	893
(% of screened)	64%	20%	8%	0%	4%	46%	2%	8%
Agreed to referral	1,664	164	511	17	248	214	19	491
(% of eligible)	23%	7%	57%	40%	60%	8%	18%	55%
N. referrals engagement with provider	517	14	13	2	242	64[b]	15	167
(% of who agreed)	31%	9%	3%	12%	98%	30%	79%	34%

[a] guestimate based on whole number for two years. [b]39 to Warm Up North, 25 to Central

12 There was variation within the different topic areas. The highest eligible screening rate being winter warmth (46%) and smoking (20%). However, of those that were eligible for referral who engaged with an appointment the highest was with dementia (98%), Warm Homes & MMB - Year 2 (79%), and loneliness and isolation (34%), with all others being 30% or lower.

13 Discrepancies between the data from the fire service and the partners was found relating to smoking (CDDCFRS n=164; partners n=41) and loneliness and isolation (CDDFRS n=491; partners n=402), dementia (CDDCFRS n=248, partners n=191). This cannot not be resolved so the CDDCFRS data has been used.

Qualitative results

14 CDDFRS managers, CDDFRS crew members, partners and beneficiaries were all invited to participate in focus groups.

Data collection method	*No participants*	*Male*	*Female*	*Mean length of focus group/ interview*	*Range (minutes)*
Delivery staff (crews and CROs)	38[1]	35	3	1 hour 31 minutes	70-112
Partners	6	3	3	38.6 minutes	23-60
Beneficiaries	10	5	5	11.2 minutes	7-17
Community Risk Management Team	3[1]	3	0	46.5 minutes	43-50
Total	**56**	**45**	**11**		

[1] One participant took part in two focus groups, as their job role covered both areas

15 Qualitative analysis of the focus groups and interviews allowed a number of key themes to emerge from the data:

Community Risk Management Team

16 Six major themes emerged from the analysis of the interview and focus group:

- The SWV training process;
- Understanding and Delivery of the SWV;
- Positive outcomes of the SWV service;
- Understanding of the high-risk SWV targeting system;
- Communication within CDDFRS and externally;
- Suggestions and current work to improve the SWV service.

17 Members of the Community risk management team discussed the training that had already been delivered, and how it could be revisited and refined in the future. Findings supported those from delivery staff and partners around building confidence and competency in understanding and then delivering the SWV. Positive outcomes were seen in both the homes of beneficiaries and from feedback from partners, with an additional beneficial impact of improved internal partnerships as a result of introducing SWVs. The high-risk targeted approach to SWV delivery was evident, however, this needs to be communicated throughout CDDFRS. In addition, suggestions were given as to how the service could work better. These included improved face-to-face training for staff, revising what data was recorded in the SWV, reinvigorating the partner meetings, and reducing the target of SWVs with a system that placed the emphasis on increasing the quality of SWVs, i.e. a higher number of referrals.

Partners

18 Eight major themes emerged from the analysis of the interviews with partners (County Durham & Darlington NHS Foundation Trust, Age UK County Durham, Alzheimer's Society and North East Dementia Action Alliance, Solutions4Health, and DCC Housing Services) who had been involved with helping to set up the SWV service: *Awareness and Understanding of the Safe and Wellbeing Concept; Development of the SWV; Delivery of the SWV; Positive impact of the service; Internal and external communication of SWV; Barriers to successful delivery; Position of CDDFRS to deliver the service; and Refinement of Safe and Wellbeing visits.* Partners felt that the FRS were the right organisation to deliver such a service, and were seeing positive outcomes with clients as a result. They were happy with the improved relationships and partnerships that had developed because of the introduction of SWVs, as well as the refinements made to the SWV form throughout the duration of the service to date. Some suggestions were given as to how the service could be improved in the future, such as ensuring the service employed a targeted approach, considering the number of health outcomes that were covered in the SWV, and increasing the amount of training delivered to staff.

Delivery Staff

19 Seven major themes emerged from the analysis of the focus groups: *Awareness and Understanding of the Safe and Wellbeing Concept; Training of staff; Delivery of the SWV; The content of the SWV form; Perceptions and experiences of staff members; Internal and external communication of SWV; and Refinement of Safe and Wellbeing visits.* Delivery staff highlighted a number of positive outcomes from the SWV and were also able to identify the barriers to beneficiaries engaging with CDDFRS, which included the sensitive nature of some of the questions asked. In addition, they were able to provide some suggestions as to how the service could work better for both the staff delivering SWVs, the beneficiaries taking up the service, and also the partners engaged with the service. These included having further training for staff members, especially those who had the skill set to deliver SWVs well, improving the communication of

SWVs to the public to help raise awareness, and CDDFRS reviewing the quality of the referrals versus the number of referrals.

Beneficiaries

20 Five major themes emerged from the interviews with beneficiaries of the service relating to: *Delivery of a Safe and Wellbeing Visit; Content of a Safe and Wellbeing Visit; Public perception of a Safe and Wellbeing Visit; Barriers to engaging with the service; and the Positive health impact of the service.* The key message from the vast majority of beneficiaries was that they felt comfortable during the SWV, with positive engagement with staff, and a belief that the FRS was in a good position to deliver the service. However, some changes to how the SWVs are delivered were suggested to help improve the service. These included a more concerted effort to link the SWV health questions to fire risks, and to make it clear to beneficiaries what would happen in the home, so that the preconceived idea of damage or a mess being created could be addressed.

Summary of findings and recommendations

21 To help reflect on the primary aim of this study, '*to evaluate the implementation of SWVs by CDDFRS'*, the following section highlights some key findings:

- **Objective 1: To explore the implementation of the SWVs into the fire service daily practice;**

22 As in other studies, the involvement of a 'champion' to facilitate the acceptance of such work is important (14). Staff felt that this work could fit into their daily practice but that there is a lot of paperwork and that changes need to be made to ensure it is easier to implement. There are challenges with ICT systems and data collection processes that need to be explored further.

23 It appears that there are some issues around what the staff think the intervention should consist of. Brief advice should happen within about 5 minutes and can be done whilst doing something else, e.g. fitting a fire alarm. More training may be required to ensure that this is happening.

24 In addition, the high-risk profiling that is carried out by the CRM team, to ensure that SWVs are carried out in areas with vulnerable residents, is not fully understood by the delivery teams carrying out the SWVs. Therefore further work is required to ensure this targeted approach is communicated across CDDFRS.

- **Objective two: To explore with the fire service and partner organisations what their understanding of the SWV process was, and what impacted on their role;**

25 Although, in the main, the fire service delivery staff, CRM team and partner organisations felt that delivering SWVs was an important thing to happen they felt that the training could be improved. Delivery staff and the CRM team also

felt that there should be less emphasis on targets and some consideration of how this impacted on other work that is essential to carry out.

- **Objective three: To assess the referral pathways to see how many clients are referred to partner organisations, how many of the health areas they are being referred for, whether or not these referrals are appropriate, and if relevant health areas are covered by SWVs;**

26 The evaluation showed that that around a third (31%) of potential beneficiaries were screened (n=11,485), i.e. the residents who agreed to take part in the full SWV. Of these 11,485, 64% were eligible for referral (n=7,311), i.e. met the necessary criteria. Of these 7,311, 23% (n=1,664) agreed to be referred to partner services. Of these 1,664, 31% resulted in an appointment with a partner service (n=517). There were differences across the different health outcomes. With the highest eligible screening rate highest for winter warmth (46%) and smoking (20%). However, of those that were eligible for referral who engaged the highest was with dementia (98%) and Warm Homes & MMB – Year 2 (79%) and loneliness and isolation (34%). With all others being 30% or lower.

27 Discrepancies between the data from the fire service and the partners was found relating to smoking (CDDCFRS n=164; partners n=41), loneliness and isolation (CDDFRS n=491; partners n=402), and dementia (CDDCFRS n=248, partners n=191).

- **Objective four: To gain feedback from beneficiaries of SWVs to assess impact**

28 Most beneficiaries felt that the interaction over the SWVs was of use especially around issues relating to slips trips and falls, and loneliness and isolation in particular. Beneficiaries had a positive experience with CDDFRS.

- **Objective five: To gain feedback from beneficiaries about how appropriate they feel it is for CDDFRS to ask them about health issues.**

29 In general, beneficiaries felt supported to be asked the questions within the SWV, however some were unclear as to why they were being asked health related questions, which indicates that more work is needed to ensure that the service is advertised more effectively both in standard and social media.

30 Following the evaluation the following recommendations have been developed:

(a) It is recommended that Public Health and CDDFRS make note of the findings as outlined in this report

(b) It is recommended that consideration should be given to reducing the number of health issues covered within the SWV, based on the referral data findings and low numbers of eligible people/referrals for some sections.

(c) It is recommended that further work is carried out to integrate the fire safety elements of the visit with the health issues, so that the link between health and fire risk is apparent to both the delivery staff and the beneficiaries.

(d) It is recommended that the high-risk targeted approach utilised by CDDFRS is communicated to all levels of staff in an appropriate manner, to improve the understanding of how the SWV service targets those who are most at risk and are vulnerable.

(e) It is recommended that the skill set of the current workforce be utilised, to ensure that the quality and consistency of the SWV delivery can be of a high standard.

(f) It is recommended that an online MECC training session is added to the training programme with ideas of how to give advice to those that score positive for each of the sections, as well as the current training packages being updated.

(g) It is recommended that changes should be made to the leaflet given to beneficiaries with contact phone number/email of services for each of the components which would act as brief advice (see figure 12 for suggestion of where this could be placed).

(h) It is recommended that data collection and IT systems need to be streamlined and made easier for staff and partners, as well as a robust online form which does not allow for data to be missing when being transferred from CDDFRS to partners and vice versa.

(i) It is recommended that the differences in relation to numbers of referrals is investigated further, with priority given to the quality of referrals processed and not the number of SWVs carried out per year.

(j) It is recommended that a regular feedback system is developed between the partners, CROs and crews.

(k) It is recommended that a short and concise communication strategy is considered which includes all media (including social media).

Next steps

31 CDDFRS and Public Health have met and discussed recommendations and an action plan will be produced to implement the recommendations.

Recommendations

32 Members of the Health and Wellbeing Board are requested to:

(a) Note the content of the report.

(b) Consider and comment on the report's findings and recommendations.

(c) Receive an action plan update in six months from Fire and Rescue Service.

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Appendix 1: Implications

Finance: the evaluation was paid for by PH and the Safe and Wellbeing Visits are incorporated as part of standard ways of working in CDDFRS

Staffing: All relevant staff were included in the evaluation

Risk: No implications

Equality and Diversity / Public Sector Equality Duty: The purpose of the safe and wellbeing visits is to reach people who may not be engaged with mainstream services and offer advice and support

Accommodation: No implications

Crime and Disorder: Fear of crime may be picked up during the safe and wellbeing visits and if so appropriate advice and signposting would be followed

Human Rights: No implications

Consultation: The evaluation was a mixed methods study and incorporated qualitative focus groups and interviews with beneficiaries and key stakeholders

Procurement: No implications

Disability Issues: No implications

Legal Implications: This plan complies with the Council's legal obligations under the Health and Social Care Act 2012, giving Local Authorities responsibility for improving the health of their local populations.

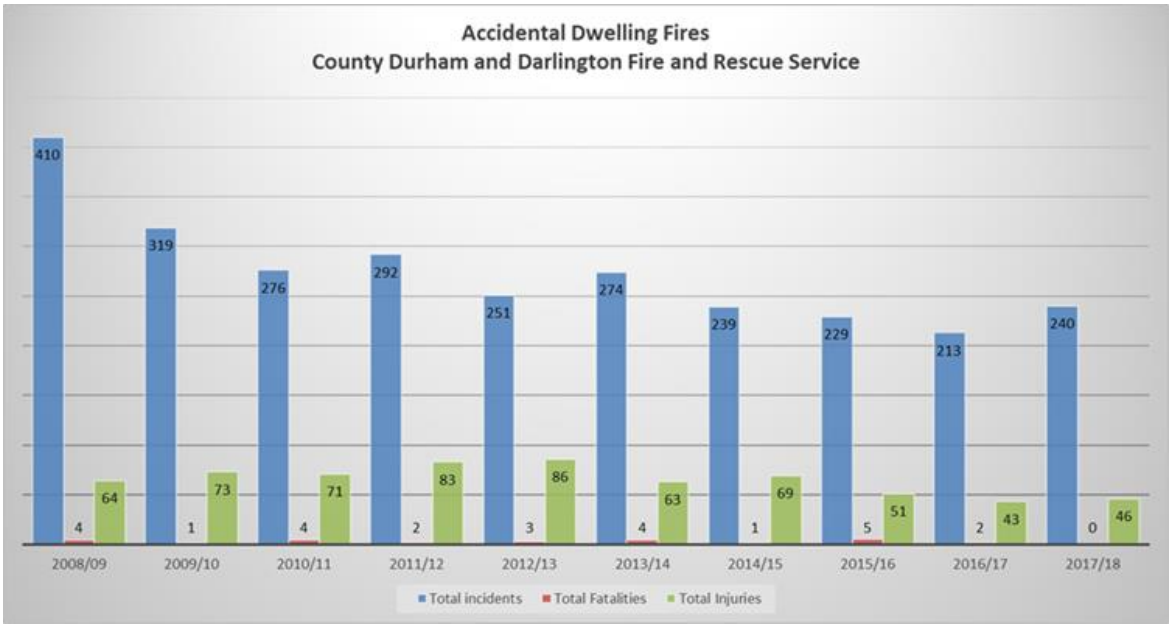
Appendix 2 – Teesside University evaluation report

1. Introduction

Over the last 10 years there has been a dramatic fall nationally in the number of accidental dwelling fires (ADFs) causing injury and death. The total number of fire fatalities in England in the six months from April to September 2012 was 124, 29 (19%) less than in the same period of 2011. This is 33 per cent fewer than the 184 fire fatalities ten years previous (in April to September 2002) (1).

Locally, ADFs have also reduced over the last 10 years. Figure 1 shows that the number of ADFs in County Durham and Darlington were 410 in 2008/09. Since Home Fire Safety Visits and Safe and Wellbeing visits (SWVs) have been introduced, there has been a reduction, with the number now sitting at 240. In 2009, the rolling average number of ADFs month on month was 27. The figure for 2018 is 19.

Figure 1 ADFs in County Durham and Darlington between 2008 and 2018



Nationally, the Fire and Rescue Service (FRS) have always had a prevention role. This has focussed on preventing fires through a series of interventions including media engagement, school based programmes, community demonstration of chip pan fires or smoking, locally tailored leaflets and posters complimenting either national awareness days or devised for local events. The service has also been carrying out Home Fire Safety Checks (HFSC) in people's homes for over a decade. The coverage and scale of these activities is variable across the country. The Fire and Rescue Services Act, 2004 (2) clarifies the duties and powers of the service. These include:

- fighting fires
- protecting people and property from fires
- rescuing people from road traffic incident
- dealing with other specific emergencies, such as flooding or terrorist attack and
- doing other things to respond to the particular needs of their communities and the risks they face

Being able to effectively target vulnerable groups as well as meeting the needs of the whole population is a key challenge in any prevention agenda. As Mansfield states, 'The prevention work carried out by the FRS is bolstered and enabled by its reputation as a trusted organisation; and this is especially true for vulnerable groups. At least 39% of HFSC were targeted at older people and at least 16% were targeted at those with a disability' (3). The natural extension is for the FRS's knowledge, skills and experience in this targeted work to be used even more effectively in a collaborative partnership with the NHS and Social Care on the wellbeing agenda.

On the basis that FRS are effective (4) at targeting interventions at the most vulnerable residents who may be more at risk from fire as well as a range of health conditions, the Local Government Association (LGA), Chief Fire Officers Association (CFOA), NHS England and Public Health England (PHE) produced a consensus statement on health and wellbeing (4). This describes their intent 'to work together to encourage joint strategies for intelligence and early intervention and prevention; ensuring people with complex needs get the personalised, integrated care and support they need to live full lives, sustain their independence for longer and in so doing so reduce preventable hospital admissions and avoidable winter pressures/deaths' (4). Furthermore they have developed principles for Safe and Wellbeing visits (SWV's) that aim to identify and address risk factors that impact on health and wellbeing.

In addition, the LGA and CFOA has developed a health strategy focused on ensuring FRS are regarded as a 'key asset for the health service' (5). Making every contact count (MECC) is an evidence based intervention that has been defined as:

> *'an approach to behaviour change that uses the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing' (6)*

The case for MECC has been made in a number of strategic documents including Healthy Lives, Healthy People (7), the NHS Futures Forum (8), the Wanless reports (9) and NICE guidelines (10, 11).

NICE (10) reinforces the role of prevention delivered through strong multi-sector partnerships. Delivery is envisaged by mobilising the potential of these workforces utilising MECC at scale as well as attaching outcomes to the roles. In addition, their guidance highlights the evidence behind the 'very brief intervention'. This can last between 30 seconds to two-three minutes, is based on the 3 As'- Ask, Advise, Assist, and can include one or more of giving individuals information or directing them where to go for further help, raising awareness of risks and providing encouragement and support for change.

1.1 Safe and Wellbeing visits

The reduction in accidental dwelling fires is largely due to the prevention work carried out by the Fire Service. The underlying premise of the Safe and Wellbeing visit is that County Durham and Darlington Fire and Rescue Service (CDDFRS) and other Fire Services nationwide are well-placed to build on this success to date, and have an opportunity to build on the solid foundations created by the previous home fire safety checks.

The CFOA Health Strategy describes a SWV as:

> '*a person centred home visit to identify and reduce risk to the occupier or occupiers, which expands upon a Home Fire Safety Check to include advice and interventions that address other risks that will further reduce fire risk, but will also help to improve health and wellbeing. Safe and Well maximises the opportunity to promote improved health outcomes and reduce harm, as part of the hundreds of thousands of visits Fire and Rescue Services are already undertaking.*' (4, page 7)

Locally, CDDFRS have developed the SWV to be carried by both Operational and non-Operational staff (Community Risk Officers [CROs]). The visit expands on the scope of previous home safety checks by focussing on health as well as fire.

The SWV was piloted between mid-February until the end of June 2016, and was extended and mainstreamed into CDDFRS core work. This ran alongside a national project developed in partnership with Public Health England, Greater Manchester Fire and Rescue Service, Staffordshire FRS and Gloucestershire FRS. This centred on the impact of the SWV on 'winter pressures' in the areas of social isolation, smoking, alcohol use, dementia, falls and flu inoculations. These link well to core health issues identified in the Joint Strategic Needs Assessment (JSNA) and Health and Well Being Strategy for County Durham and Darlington (12), notably Cardio Vascular Disease (smoking and alcohol), Mental health (dementia and social isolation) and Excess Winter Deaths/ Cold related ill health (slips, trips falls, flu immunisation). A whole population approach was utilised, although this was complemented by a targeted approach for some health issues

such as falls for those aged 65 and over. CDDFRS has now begun to embed its wider SWV service.

The SWV template covers a wide range of issues, which for the purpose of this report, include:

- A number of questions on each health topic
- Referral pathways
- Information of fire safety/safer homes
- Data protection compliance

In addition to the previous work carried out in the national evaluation, Public Health England have extended this pilot to work with other fire services. Locally, the Overview and Scrutiny Committee for Safer and Stronger Communities at DCC released a report in March 2017, of the work carried out so far by CDDFRS in delivering the SWV service.

1.2 Aims and objectives

The primary aim of this study was to evaluate the implementation of SWVs by CDDFRS. In order to achieve this aim the following objectives were set:

- To explore the implementation of the SWVs into the fire service daily practice;
- To explore with the fire service and partner organisations their understanding of the process for SWVs and what impacted on their role;
- To assess the referral pathways to see how many clients are referred to partner organisations, how many of the health areas they are being referred for, whether or not these referrals are appropriate, and if relevant health areas are covered by SWVs;
- To gain feedback from beneficiaries of SWVs to assess impact;
- To gain feedback from beneficiaries about how appropriate they feel it is for CDDFRS to ask them about health issues.

2 Methods

2.1 Study Design

The current study was a process evaluation and implementation study of the existing SWVs delivered by CDDFRS. The study utilised a mixed methods approach. The mixed methods approach can lead to conflicting data (13), but these discrepancies can allow an interrogation of the dataset more fully. This increases study robustness, and may lead to a different conclusion to one that may have come from only one data collection method. This included using qualitative data collected through focus groups with delivery staff, community risk management staff and partners and interviews with beneficiaries as well as researcher observations of an SWV; and secondary analysis of quantitative data collected by CDDFRS as part of the SWV service.

2.2 Ethical Approval:

Ethical approval from the School of Health and Social Care Ethics Committee at Teesside University was granted in July 2017**.** Following on from this, approval was then sought from Durham County Council through their Research and Guidance process (RAG).

2.3 Referral data – (Secondary analysis of quantitative data)

CDDFRS collect data as part of the SWV service. Secondary analysis of this data looked at how many clients are referred to partner organisations and how many of the health areas they are being referred to. Data was sent as a de-identified data dump. It told us what services are receiving the most referrals from SWVs, and highlighted those were work may need to be done in the future to increase referrals. It also told us how many referrals were being converted into appointments with the actual services. As part of the analysis of referral data, the time period from the start of the pilot on February 16th 2016 through to January 31st 2018 has been examined.

2.3.1 Analysis

Descriptive statistics are presented on:

- How many residents are referred to partner organisations by CDDFRS
- How many of the health areas they are being referred to
- What services are receiving the most referrals from SWVs
- How many referrals are being converted into appointments with the actual services

2.4 Community Risk Management Team Focus group and Interview (qualitative)

2.4.1 Recruitment

Inclusion Criteria

- A member of the Community Risk Management Team (CRM team)
- Aged 18 years or over

Recruitment Strategy

Participants for the focus group and interview were recruited from staff that are involved with overseeing the SWV service. Participants were approached by their line managers who acted as gatekeepers for this aspect of the evaluation. The researcher then worked with the gatekeeper to organise when and where the focus group would take place.

2.4.2 Data Collection

The aims of the focus group and interview were to gain some in-depth feedback about the SWV service. A topic guide was prepared in advance and covered a range of issues giving staff an opportunity to give their perspective on the implementation of SWVs,

including the training of staff, barriers and facilitators to delivery, their understanding of the targeted process and their perceptions of delivery staff experiences.

2.4.3 Analysis

The focus group and interview with CRM staff were audio recorded to aid in transcription. Once the transcript was transcribed verbatim the data was analysed using applied thematic analysis (13). Research staff from Teesside University worked in collaboration with public health staff from Durham County Council in the identification and coding of themes. For the purpose of this research an inductive approach to coding was adopted as we were looking for feedback on an existing service. We did not code the transcript in line with existing theories (13).

2.5 Partner Interviews (qualitative)

2.5.1 Recruitment

Inclusion Criteria

- Partners involved with designing and implementing the training for SWVs and who received subsequent referrals; Wellbeing for Life, County Durham & Darlington NHS Foundation Trust (Slips, trips and falls); Age UK County Durham (Loneliness and isolation); Alzheimer's Society and North East Dementia Action Alliance (Dementia); Solutions4Health (smoking); Lifeline (Alcohol); and DCC Housing Services (winter warmth).
- Aged 18 years or over

Recruitment Strategy

Participants for the interviews were recruited from the partners who are engaged with the SWV service. Participants were contacted by a key member of staff at CDDFRS. Participants who wished to take part in the interviews contacted the research team using the contact details on the information sheet and invitation letter, so that they could arrange when and where the interview took place.

2.5.2 Data collection

The aim of the interviews was to gain some in-depth feedback about the SWV service from partner organisations who were involved in developing the SWVs and the referral pathways, designing and delivering the training to delivery staff, and who received referrals from SWVs. A topic guide was prepared in advance and covered a range of topics including what their input was to the design training and implementation of the SWVs, what impact the SWVs has had on their capacity, whether or not they are receiving appropriate referrals from SWVs, what was the communication strategy for SWVs and was this appropriate?

2.5.3 Analysis

The focus groups with partners were audio recorded to aid in transcription. Once the transcripts were transcribed verbatim the data was analysed using applied thematic analysis (13). Research staff from Teesside University worked in collaboration with public health staff from Durham County Council in the identification and coding of themes. For the purpose of this research an inductive approach to coding was adopted as we were looking for feedback on an existing service. We did not code the transcripts in line with existing theories (13).

2.6 Delivery staff focus groups (qualitative data)

2.6.1 Recruitment

Inclusion Criteria

- Member of SWV delivery staff in County Durham[11] (Crew members and Community Risk Officers [CROs])
- Aged 18 years or over

Recruitment Strategy

Participants for the focus groups were recruited from the staff that are engaged with the intervention and are trained to deliver the SWV's. This included crew members (focus group one - five) and the CROs (focus group six). Participants were approached by their line managers who acted as gatekeepers for this aspect of the evaluation. The researcher then worked with the crew managers to organise when and where the focus group would take place.

2.6.2 Data Collection

The aims of the focus groups were to gain some in-depth feedback about the SWV service. A topic guide was prepared in advance and covered a range of issues giving delivery staff an opportunity to give their perspective on the implementation of SWVs and any barriers and facilitators, what their understanding was of the process and the theory behind making every contact count, and whether they had had sufficient training and support to confidently carry out SWVs within the community.

2.6.3 Analysis

The focus groups with delivery staff (crew and community risk officers) were audio recorded to aid in transcription. Once the transcript was transcribed verbatim the data was analysed using applied thematic analysis (13). Research staff from Teesside University worked in collaboration with public health staff from Durham County Council in the identification and coding of themes. For the purpose of this research an inductive approach to coding was adopted as we were looking for feedback on an existing service. We did not code the transcript in line with existing theories (13).

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[11] This evaluation will only be evaluating data that covers County Durham

2.7 Beneficiary Interviews (qualitative)

2.7.1 Recruitment

Inclusion Criteria

- Beneficiary of the Safe and Wellbeing Visits service
- Aged 18 years or over
- Engaged in the Safe and Wellbeing Visits service between November 2017 and March 2018

Recruitment Strategy

Participants were recruited from the residents who engaged with the SWV service in County Durham between October 2017 and March 2018, and were a convenience sample. Initial contact with all participants was made by the delivery staff, who acted as gatekeepers. The research team then contacted them to arrange a suitable date and time for interview, either over the telephone, or in the participants home. Consent to take part in an interview was taken on the day of the interview.

2.7.2 Data collection

The aim of the beneficiary interviews was to gain in-depth feedback from residents who received a SWV and were referred onto partner agencies. An interview schedule was prepared in advance and consisted of a number of open ended questions, covering a range of topics including how did they become aware of SWV (i.e. self-referral or targeted by CDDFRS); where they signposted to any service; if so which, and whether or not this referral had had any impact on their lives; how they felt about CDDFRS asking health related questions; where the health questions relevant to them or were there important health questions which were not asked.

2.7.3 Analysis

The interviews with beneficiaries were audio recorded to aid in transcription. Once the transcripts had been transcribed verbatim the data was analysed using applied thematic analysis (13). Research staff from Teesside University worked in collaboration with public health staff from Durham County Council in the identification and coding of themes. For the purpose of this research an inductive approach to coding was adopted as we were looking for feedback on an existing service. We did not code the transcripts in line with existing theories (13).

2.8 SWV Observations

The aim of the SWV observations was for the researcher to get an understanding of the process, and to simply watch what happened. Following on from the observations, the researcher wrote down some reflective notes on the process just witnessed. Researcher notes are given in boxes throughout this report.

2.8.1 Data collection

The aim of the researcher observations of the SWVs was to get some insight into how a visit was delivered, the process, how the fire fighters felt talking through the questions and to see how beneficiaries reacted. The researcher went out with two crews on two separate occasions, observed a number of SWVs, and immediately following the visit, made an audio recording of the experience.

2.8.2 Analysis

The researcher audio recorded and wrote up any observations immediately upon leaving the visit. These observations were analysed using applied thematic analysis (13). Research staff from Teesside University worked in collaboration with public health staff from Durham County Council in the identification and coding of themes. For the purpose of this research an inductive approach to coding was adopted as we were looking for feedback on an existing service. We did not code the transcript in line with existing theories (13).

2.9 Participant Characteristics - Qualitative data

Five stations covering a geographical spread of County Durham, and including whole-time and retained fire fighters were invited to take part in a focus group. In addition, the CROs were also invited to attend a focus group. Thirty-eight agreed to participate. All partners who were involved in developing and setting up the SWV service to be rolled out within County Durham were invited to take part in a focus group or an interview. Of the six partners representing the health questions in the SWV form, four agreed to be interviewed. Any beneficiary who had engaged with an SWV between October 2017 and March 2018 within County Durham was eligible to take part in an interview, and was asked by the fire fighters delivering the SWVs during this time period if they would like to be interviewed as part of the evaluation. The characteristics of participants can be seen in more detail in Table 1.

3 Quantitative Results

Table 1: Interview numbers

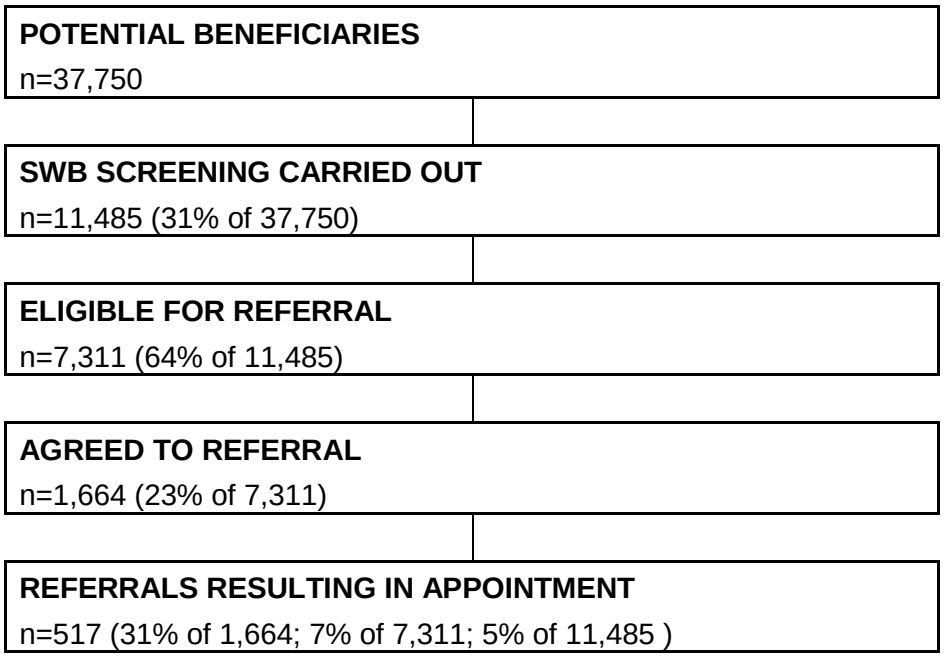
Data collection method	*No participants*	*Male*	*Female*	*Mean length of focus group/ interview*	*Range (minutes)*
Delivery staff (crews and CROs)	38[1]	35	3	1 hour 31 minutes	70-112
Partners	6	3	3	38.6 minutes	23-60
Beneficiaries	10	5	5	11.2 minutes	7-17
Community Risk Management Team	3[1]	3	0	46.5 minutes	43-50
Total	**56**	**45**	**11**		

[1] One participant took part in two focus groups, as their job role covered both areas

3.1 Referral Data

In total, 37,750 beneficiaries have engaged with the service over a two-year period. 17,654 in Year One (16th February 2016 – 31st January 2017), and 20,096 for Year two (1st February 2017 – 31st January 2018. Figure 2 shows the number of potential beneficiaries who have moved through the SWV system since February 2016.

Figure 2: Flowchart of numbers through the system



[1] A beneficiary was eligible for referral if they met the necessary criteria on one of the health sections

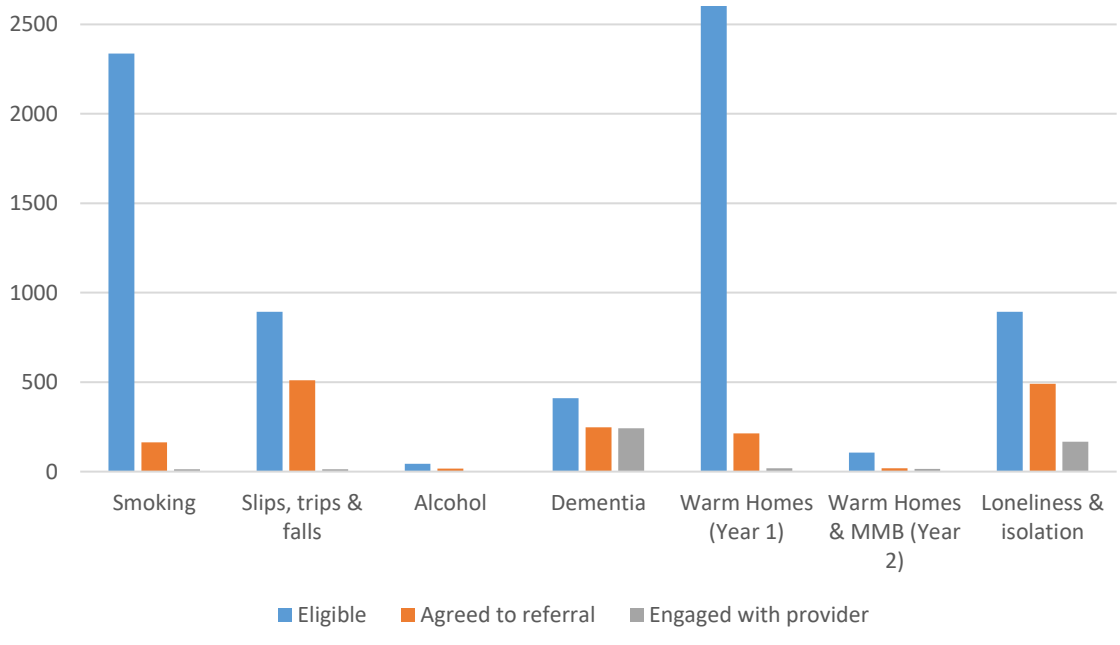
Table 2: Throughput of numbers through the system

	Smoking	Slips, trips & falls	Alcohol	Dementia	Warm homes (Year 1)	Warm Homes & MMB (Year 2)	Loneliness & Isolation	TOTALS
N. potential beneficiaries	37,750	37,750	37,750	37,750	17,654	20,096	37,750	
N. screened	11,485	11,485	11,485	11,485	5,743[a]	5,743[a]	11,485	
N. eligible (% of screened)	2,337 (20%)	893 (8%)	43 (0.4%)	410 (4%)	2,629 (46%)	106 (2%)	893 (8%)	7,311
N. agreed to referral (% of eligible)	164 (7%)	511 (57%)	17 (40%)	248 (60%)	214 (8%)	19 (18%)	491 (55%)	1,664
N. referrals engagement with provider (% of who agreed)	14 (9%)	13 (3%)	2 (12%)	242 (98%)	64[b] (30%)	15 (79%)	167 (34%)	517

[a] *guestimate based on whole number for two years.* [b] *39 to Warm Up North, 25 to Central Heating fund.*

Nb: Warm Homes was only year 1 and then Managing Money Better (MMB) was added to Warm Homes in year 2

Figure 3: Numbers eligible, agreed to referral and engaged with the provider



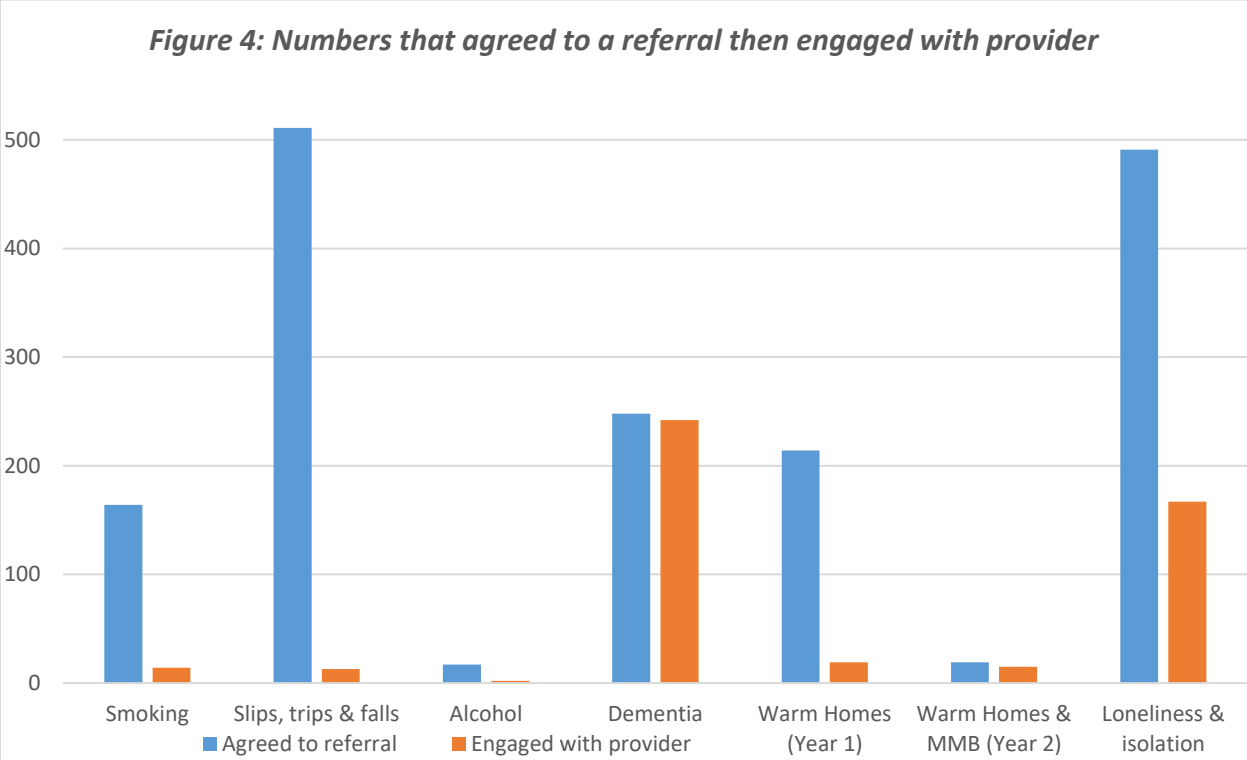


Table 3: Referrals by year (CDDFRS data)

SWV health outcome	**Beneficiaries referred year 1**	**Beneficiaries referred year 2**	**Total**
Smoking	111	53	164
Slips, trips & falls	343	168	511
Alcohol	14	3	17
Dementia	187	61	248
Warm Homes (year 1)	212	2	214
Warm Homes & MMB (year 2)	X	19	19
Loneliness & isolation			491
Total			**1,664**

In total, 1664 referrals have been made to partners over the two-year time period. There is, however, discrepancies between the data from the fire service and the partners and this needs to be investigated relating to smoking (CDDCFRS n=164; partners n=41) loneliness and isolation (CDDFRS n=491; partners n=402), and dementia (CDDCFRS n=248, partners n=191).

3.2 CDDFRS and the targeted approach to SWVs

The high risk area methodology used by CDDFRS, something which is utilised for SWVs, has been in operation since 2007 and was introduced following a spate of fatalities in ADFs. It was also introduced to replace some of the outputs from the Fire Services Emergency Cover (FSEC) toolkit which were used to identify areas of high risk, as the FSEC toolkit was coming to the end of its support.

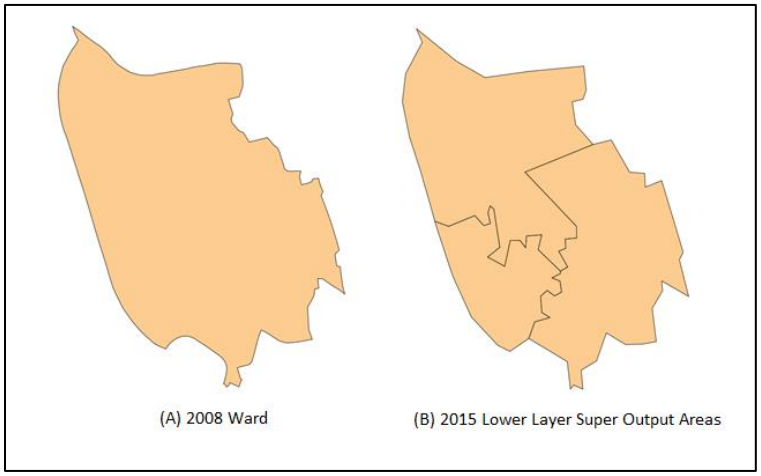
The tool aggregated a range of datasets at 2008 ward level in order for areas of potential and probable risk to be identified geographically. The top 30% high risk areas were identified to target prevention activities used by the service e.g. SWVs. The datasets used within the methodology were identified as significant risk factors of ADFs and associated fatalities and injuries. Population and housing stock data was also incorporated to normalise the data so that wards of varying size could be compared.

3.2.1 2018 Update

For 2018, the methodology has been significantly updated. The update has occurred due to several factors;

1. The new high risk areas have been calculated using Lower Level Super Output Areas (LOSAs). The main reason for this change was because the 2008 wards which were previously used are no longer in existence in Durham. Electoral divisions were introduced and these geographic areas are significantly larger than wards (approximately 3 wards per electoral division). As these new areas are too large to deliver targeted resource delivery, LSOAs have been utilised as these allow more precise targeting of resources. Figure 4 shows how LSOAs are contained within wards;

Figure 4 Example of the containment of LSOAs within 2008 Wards



2. Census data – the previous high risks areas utilised census data from 2001 to both normalise incident data and to provide data for additional risk factors e.g.

lone households, people with limiting long term illnesses. New census data from 2011 is available at LSOA level and therefore by using the LSOA geography, census data from 2011 could be incorporated which would provide more accuracy in the scoring methodology. 2011 census data is not available at the old 2008 ward level.

3. Deprivation – As the LSOA geography has been used in the new high risk area model, deprivation data from the 2015 Index of Multiple Deprivation (IMD) has been added to the methodology. Deprivation is a significant risk factor associated with dwelling fires and associated fatalities and injuries.

3.2.2 How does the scoring methodology work?

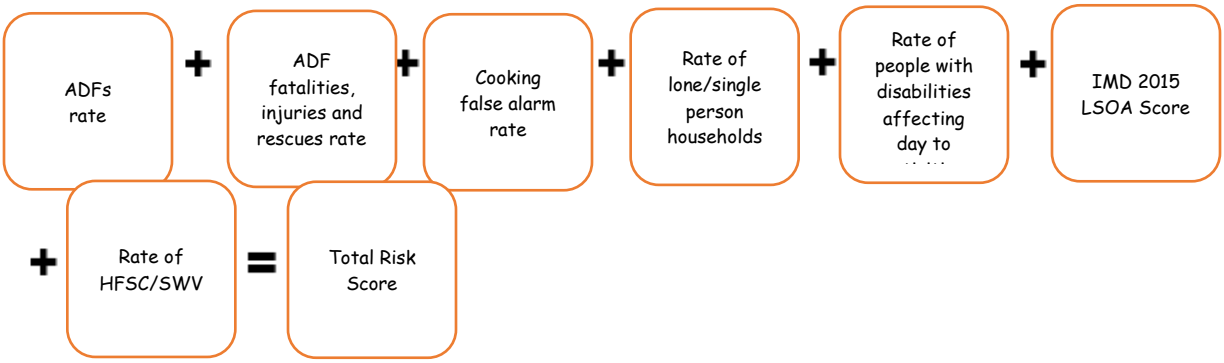
In order to identify areas of potential and probable risk a number of risk factors are used. These are;

1. Rate of ADFs over the most recent 5 year period (per population for LSOA)
2. Rate of fatalities, injuries and rescues from ADFs over the most recent 5 year period (per population for LSOA)
3. Rate of cooking related false alarms in dwelling over the most recent 5 year period (per population for LSOA)
4. Rate of single person/lone households (census 2011) (per number of dwellings for LSOA)
5. Number of people with disabilities affecting day to activities (census 2011) (per population for LSOA)
6. LSOA deprivation score (IMD 2015)
7. Rate of home fire safety checks/safe and wellbeing checks over the most recent 10 year period (per number of dwellings for LSOA)

The census and IMD data is already available at LSOA level and so the incident and home fire safety check/safe and wellbeing check data must be aggregated to LSOA level. This is then normalised as LSOAs having varying geographic and population sizes. Incidents are normalised with population data from the 2011 census. Home fire safety check/safe and wellbeing check data is normalised using 2011 census household numbers.

Each of the 7 risk factors are then indexed – this gives them a score between 1 and 100 depending upon how they compare with other LSOAs. A score closer to 100 is worse. Each risk factor is then multiplied by a weighting. This allows risk factors with more significance to add more weight to the overall risk scoring. Previous incident activity is allocated a greater weight. The 7 risk factors are represented in Figure 5.

Figure 5 The 7 risk factors used by CDDFRS



The total risk score is then indexed, so that it fits between a range of 0 and 100, 0 being the lowest risk and 100 being the highest risk. The LSOAs are then split into 10 equal sized bands depending upon the indexed risk score, as seen in Figure 6:

Figure 6 LSOA Risk score bands

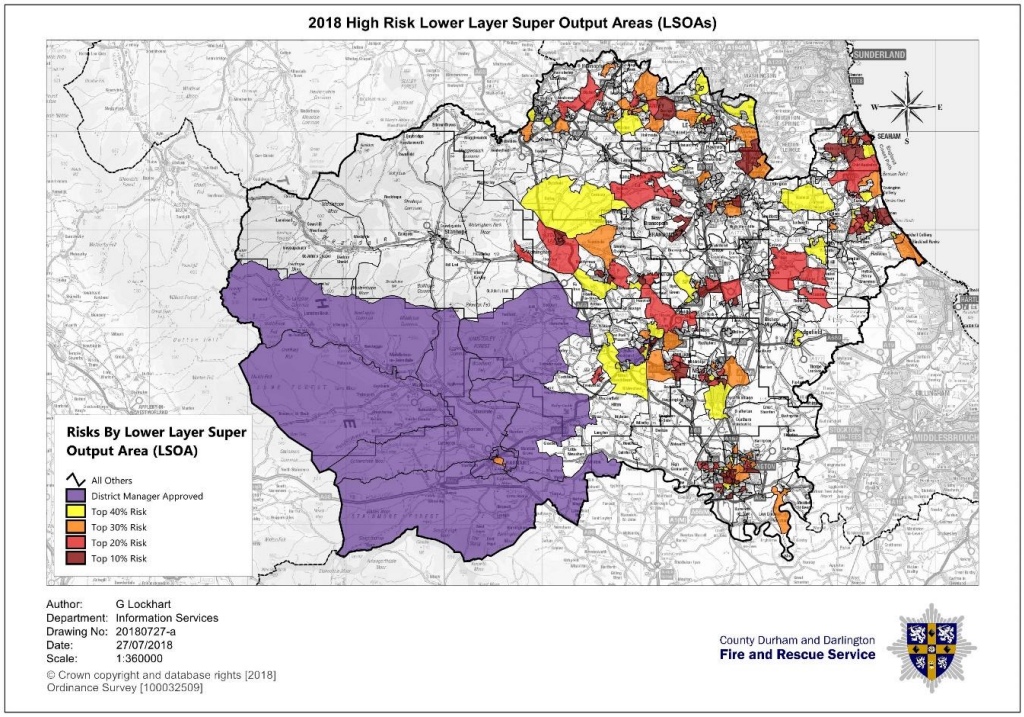
	Risk Score Band	Area in KM^2	Number of LSOAs	% of Service Area	Cumulative % of Service Area
Lowest Risk	0-10	415.0	38	17.1%	100.0%
	10-20	377.0	39	15.5%	82.9%
	20-30	513.6	39	21.1%	67.4%
	30-40	344.7	39	14.2%	46.2%
	40-50	299.4	39	12.3%	32.1%
	50-60	161.7	39	6.7%	19.7%
	60-70	113.7	39	4.7%	13.1%
	70-80	70.5	39	2.9%	8.4%
	80-90	98.7	38	4.1%	5.5%
Highest Risk	90-100	34.7	40	1.4%	1.4%
	Grand Total	**2429.1**	**389**	**100.0%**	**100.0%**

The targeted risk areas are now the 40% highest risk areas. This is a change from the previous 30% - this is because the LSOAs are smaller and cover less geographic area than wards.

As a result of targeting the top 40%, 13.1% of the service area will be covered. This equates to 317.6km^2. In additional to the calculated high risk LSOAs, there is the option to add additional LSOAs – these are areas that if delivery staff believe, using their local knowledge of incident activity and demographics, should also be targeted as they represent a risk.

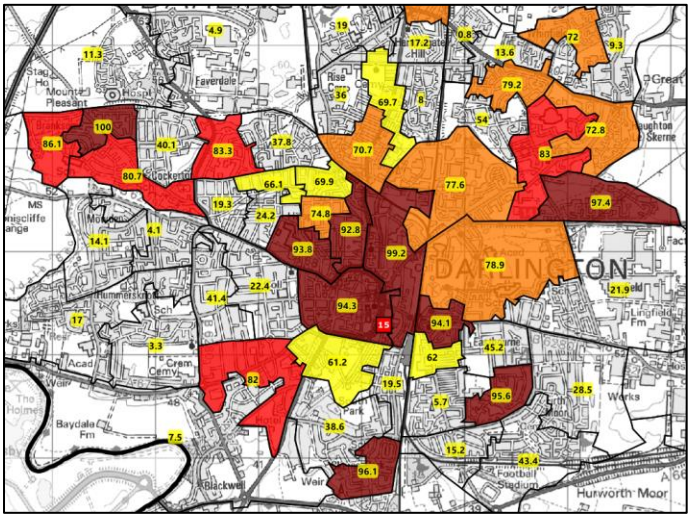
The image below shows the geographic spread of the 40% highest risk LSOAs as well as the district added areas (purple LSOAs).

Figure 7 40% highest risk LSOAs



As you zoom in the percentile scores are displayed, as shown in Figure 8. The closer to 100 the greater the risk:

Figure 8 The zoom option for pinpointing high risk areas



An area can be selected by clicking on it with a ‘show more’ feature, which allows more information to be displayed about the LSOA in question. Such information includes how many injuries, fatalities and rescues; number of dwellings; number of lone households;

number of dwellings with a disabled resident as well as other useful details about an area.

3.3.3 2018 High Risk Dwellings

High risk dwellings is a brand new concept that has been introduced for the first time in April 2018. The concept aims to enrich and help target safe and wellbeing visits to properties which may be of higher risk therefore improving the efficiency and effectiveness of SWVs in terms of delivery to those who need them most. Whereas high risk areas have been in general use for a number of years, the concept of high risk dwellings also re-enforces the fact that properties can be high risk and be located outside of a high risk area as well as inside one.

Where the high-risk area methodology examines and assesses data about an area (LSOAs), high risk dwellings utilises internal and external data about each dwelling. Six risk factors have been used to produce an overall risk score for each dwelling;

1. Is the occupier(s) in the Exeter data set (over 65 and registered with a GP)?
2. Is the property in a high-risk mosaic group?
3. Has the property received a safe and wellbeing visit (SWV) or a former home fire safety check (HFSC)?
4. Is the anticipated response time more than 8 minutes?
5. Has the property had a previous incident (primary fire or false alarm)?
6. Has the property had more than one previous incident (primary fire or false alarm)?

The six risk factors are calculated for each dwelling within the service operational area which consists of approximately 290,000 dwellings. Combining the risk factors is designed to stratify the data rather than use the datasets in isolation. For each risk factor that applies to a property, a single point is awarded. The maximum points achieved is six which is the highest risk score possible. Once the scores have been calculated some further criteria are also applied to filter the data. These are;

1. The risk score must be high, very high or ultra high AND any of the following;
   a) The dwelling must not have had a previous SWV/HFSC OR
   b) The dwelling has had a previous SWV/HFSC but has since had an incident OR
   c) The dwelling has received a SWV/HFSC but it was more than 3 years ago.

Table 4 displays the number of dwellings which fall into each risk category. It also displays the total number which meet the additional filtering criteria and are the ones which are subsequently targeted.

Table 4 Number of dwellings in each risk score category in County Durham and Darlington

Risk Score	Risk Description	Total Dwellings	Dwellings Which Meet Filtered Criteria	% of Dwellings Which Meet Filtered Criteria
0	Ultra Low Risk	17,096	-	-
1	Very Low Risk	98,607	-	-
2	Low Risk	116,784	-	-
3	Medium Risk	47,405	-	-
4	High Risk	6,937	6,713	2.3%
5	Very High Risk	302	269	0.1%
6	Ultra High Risk	16	16	0.0%
	Grand Total	**287,147**	**6,998**	**2.4%**

Data accurate at 27 September 2018

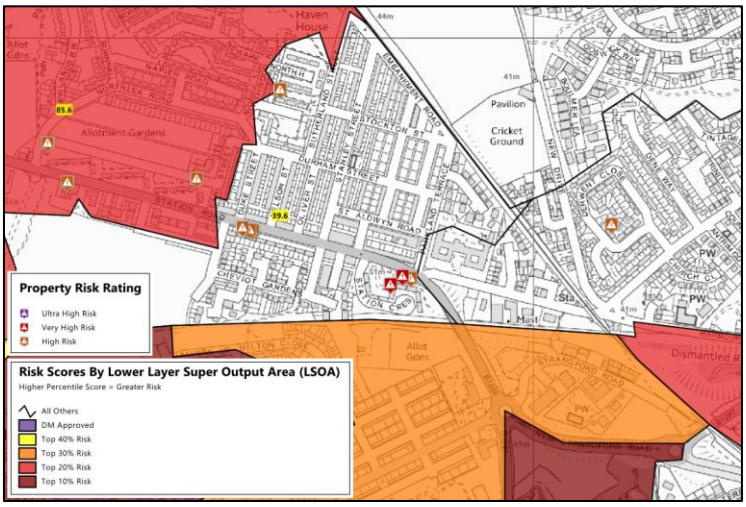
The calculation for the high-risk dwellings is automatically run each and every day. This ensures that if any dwellings receive SWVs or experience an emergency incident in that time they are scored appropriately. So in essence dwellings may be removed from the dataset or new ones may be added.

3.3.4 Access to the data

The high-risk dwelling dataset is accessible from within the services CadCorp Web Map Layers geographical information system. Delivery staff can turn on the dataset to display the high-risk dwellings data. This can be used in conjunction with other overlays such as the high risk LSOAs.

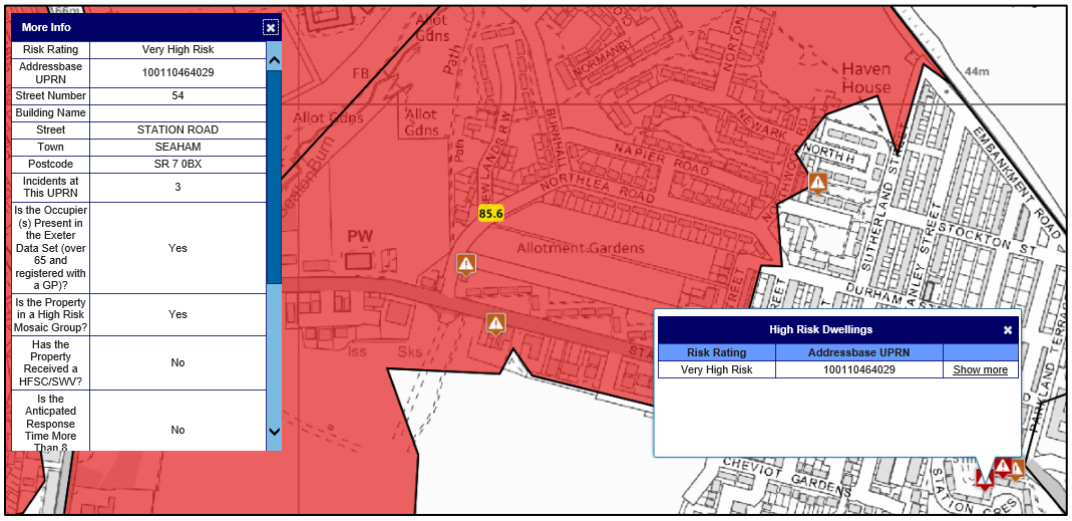
Figure 9 shows a screen grab of an area in County Durham with a high risk profile.

Figure 9 Screen grab of high-risk dwelling data



Delivery staff can also select a dwelling point and obtain additional data regarding that dwelling. The additional data contains the full address, the six scoring risk factors and any previous incidents or SWV/HFSC, as shown in Figure 10.

Figure 10 Additional data for high-risk dwellings



Delivery staff also have the option of drawing or creating a polygon around a selected area of the map. They are then provided with a list of high-risk dwellings which can be downloaded to excel and taken with crews when they head out to deliver SWVs.

3.3 Training of CDDFRS staff to deliver SWVs

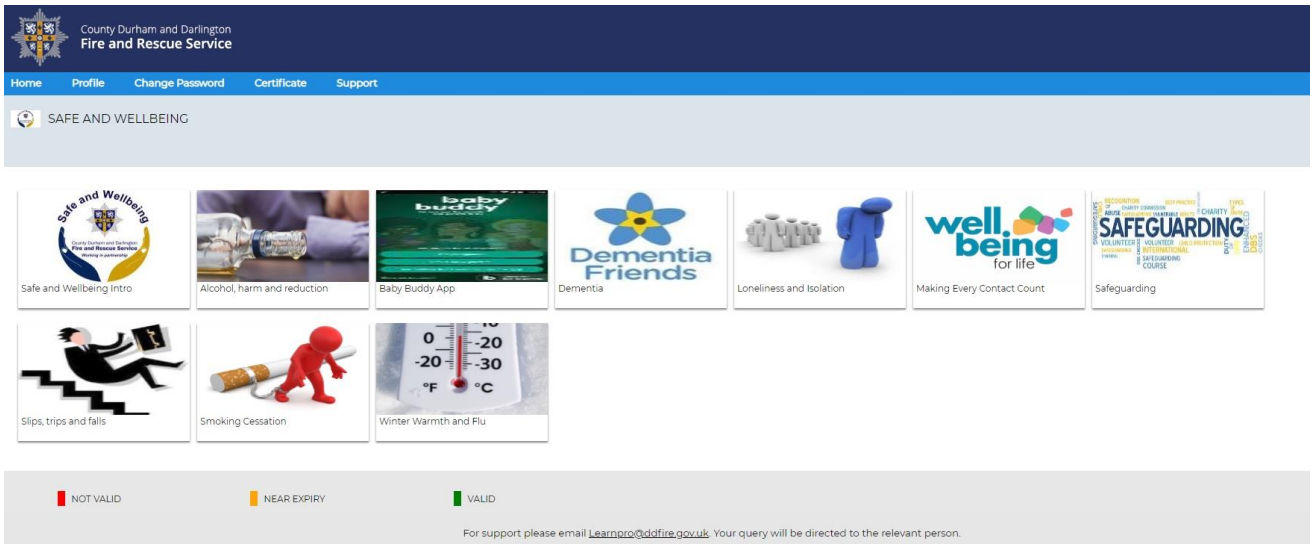
As part of the roll-out of SWVs in 2016, a number of training packages were put in place. Wellbeing for Life delivered MECC training in early 2016 to CDDFRS. This covered three hours of face to face training with staff members. There is no data available which provides a record of which staff this was delivered to.

Each partner involved with SWVs was asked to provide a training package for CDDFRS staff, which could be accessed using LearnPro (Figure 11). These training packages cover all six health questions on the SWV form: slips, trips and falls; alcohol; dementia; smoking; loneliness and isolation; and winter warm. Each section varies in the quality of the information provided and the time taken to work through the information (30-60 minutes). Only one out of the six providers includes a short test at the end of the training package (10 questions).

Delivery staff are alerted to complete their competency with each training package every six months, either by sighting amber or red on their training page, or by a watch manager noticing the six month period is due to expire and requesting completion by the staff member. At present, competency is recorded by delivery staff ticking a box to say they have read a training package.

CDDFRS are due to start a new round of face to face training starting in December 2018, with six members of staff delivering over a six month period, to compliment the online training packages. There is also work scheduled with partners to refresh the online training packages.

Figure 11 Screen grab from CDDFRS SWV online training



4 Qualitative Results

4.1 Focus group and interview with members of the Community Risk Management Team

Six major themes emerged from the analysis of the focus group and interview: *The SWV training process; Understanding and Delivery of the SWV; Positive outcomes of the SWV service; Understanding of the high-risk SWV targeting system; Communication within CDDFRS and externally; and Suggestions and current work to improve the SWV service.*

4.1.1 The SWV training process

There was an understanding from the CRM team that various elements of training had taken place prior to and during the early stages of the SWV roll out in February 2016, with a mix of face-to-face and online training:

> *"The training was a couple of years ago now, it was MECC training, face to face for everybody. Dementia friends was face to face, and the rest was online via LearnPro". p6*

With regards to being able to quantify this with a number from day one, it was believed that there was no data on record, but that the systems will currently show which staff members are up to date with the online training packages that are available at present:

> *"Technically, staff should always be up to date with training, as it links with CPD payments and is a requirement of the role". p55*

> *"There's no individual records for MECC training or other training, as Learnpro don't keep it for that long…..we can check who is in date now, but not from the beginning". p6*

The importance of the training was highlighted by the CRM team. With the SWV service still in its infancy, it was agreed that the training would form the basis of ensuring a standard SWV experience was delivered across the county:

> *"We need to have assurance of what expectations we have here are being matched on the stations. You can't expect people to pick that document up without some formal training that is recorded. It gives us assurance for standardisation as well. There needs to be key messages and key approaches that are consistent". p55*

Although the next roll out of training was discussed as being imminent, there were concerns about training purely being online, even though there was the acknowledgement that to train the whole workforce was a huge undertaking. It was suggested that face-to-face training would be the most appropriate, with online training to support this:

> *"I don't think the online training (by itself) is effective at all. That's not just for safe and wellbeing, that's a problem we have across the service. It's just the logistics of face to face…it's a phenomenal task". p6*

It was also highlighted that the system to check delivery staff competence was not as robust as it should be, with five out of the six health outcome training packages requiring only a tick in a box to confirm understanding. This links in with other findings from the delivery staff focus groups, with participants feeling that there wasn't appropriate training in place. It was felt that although training had taken place in 2016, and that online training should have been utilised every six months, it was now the right time to revisit the training provided to staff:

> *"The training needs to be revisited and started from scratch, as it's been 2/3 years. We need new packages from all the partners". p6*

4.1.2 Understanding and Delivery of the SWV

A couple of issues that were raised by partners and delivery staff were also highlighted by the CRM team, including the challenge to improve crew members understanding and purpose of the SWV, as well as building confidence and competency to incorporate some of the sensitive questions into the SWV conversation:

> *"…I think that initial fear has gone. We asked for some feedback from (place) crews, and they said 'it's just part of the job now'. But the lack of understanding of why we do the SWV is still a problem. The actual visits…some of them don't like asking questions…around alcohol mainly. But most seem happy to do it".p6*

In addition, the CRM team aligned with findings from the delivery staff and partner focus groups that the way an SWV was delivered and the approach of the staff member was vital to how it was received by beneficiaries:

> *"One of the things that we are aware of is that CROs have a different approach to engagement. We could ask some people if they engaged with the health questions, and they'll say yes or no. We ask others, and they say 'well I didn't get asked any, cos they've been entered into the conversation if you like. …..It's the conversation and the way it's been put through. The likes of our CROs are consistently hitting 60% plus for engagement. It forms part of the conversation, rather than 'have you, did you, would you, are you. They (the beneficiaries) don't see it as a questionnaire".p55*

There was a suggestion that some delivery staff were more confident and capable to deliver an SWV, and actually, if this was determining who actually delivered the talks, it might act as a in-built mechanism to keep the quality of SWVs consistent:

"I think on station, you have such a blend. One or two don't like doing it, but that's spot on. Some don't like doing school visits, it's just those who feel more comfortable to step up and lead on it will, take on the lions share. That's actually one way of protecting the quality". p55

4.1.3 Positive outcomes of the SWV service

CRM participants discussed various positives that arose from the SWV service, but identified that they often did not come into direct contact very often with beneficiaries after a visit, but would see the benefits by other means:

"We very rarely get to speak to the service users. Sometimes if we get turned out to incidences, we kinda see some of the benefits, when they start talking about the fire crews and they've done this that and the other for us. Interestingly enough last week we had a system activate in a carbon home premise, and that had been arranged and sorted out by (name) the day before that person set fire to their home…..so we see the benefits like that". p55

"(Organisation) will say 'oh were you aware that we had a small fire….it was to a carpet that had been treated so it didn't spread', or 'we've been in this property and the bedding has scorch marks on so we need a new one', so we know that it's been effective, and all of those interventions have come because of a SWV visit. So we see it, but we don't necessarily get to hear it (from the beneficiaries)". p56

Another positive outcome from the introduction of SWVs was the improvement in the working relationships between crew members and CROs. SWV has provided a mechanism for this relationship to develop, with opportunities to work together and share expertise.

"Internally, with the CROs, their relationship building can be really useful, and I think their interpretation of their role grows because of that. We're hoping that rather than just having 1 or 2 with certain skills in areas, we will see that standardise across the team". p55

"I think for the crews, one of the benefits is the level of engagement they get at a local level, and the amount of feedback that they get from CROs is probably good. That's building and can only get better. I think that is a big plus of SWVs. It's almost a shared misery isn't it…I'm having problems with this, how did you get over it? How can you help me?". p6

4.1.4 Understanding of the high-risk SWV targeting system

The current system that uses various datasets to produce the high-risk ward data was described by CRM participants:

> *"About 18 months ago, actually, not even that long ago, they started identifying the high risk wards, where a lot of the work was targeted at, and each watch on the station would be allocated high risk wards. We are now looking at the super low output areas, and that's going to be even more targeted down to streets or even individual houses. That's in development at the minute". p56*

This development and improvement with how CDDFRS have been utilising the data that is available, then using it to try and reach out to those who are most vulnerable specifically for County Durham, was evident:

> *"We sit differently to the national picture, where they predominantly target elderly and mental health. (name) work is showing ours (those dying in dwelling fires) isn't the elderly or those with mental health issues, it's middle aged to older gentleman, living on their own, with an alcohol reliance and an element of social isolation. Those are the people who are dying in house fires and are one group we are trying to reach". p55*

4.1.5 Communication within CDDFRS and externally

The development of the high-risk targeted system is understood by the CRM team, and evidenced in section 3.2. However, this understanding of the targeted approach was not evident in later delivery staff findings, and this lack of delivery staff understanding was supported by CRM members discussion:

> *I: Is there an awareness amongst the crews, in your opinion, of that work that goes on with the targeting systems?"*
>
> *P6: No, not really. Perhaps the switched on watch managers, but I think most fire fighters wouldn't be aware of that.*
>
> *P55: And again, some of the education that's going to be rolled out, that will get covered".*

The communication of the SWVs to the public was identified as an on-going task for CDDFRS to contend with, , linking in with later findings from partners and delivery staff:

> *"It'll always need further work. There are still people who don't know we fit smoke alarms, and that's been going for like 25 years. It needs to be a continuous thing". p56*

The lack of a feedback loop to the crews following on from a referral was also mentioned by CRM participants, with a specific plea to partners involved to provide a higher number of case studies to close the feedback loop. This is to ensure that crews get to see the positive stories that are a result of their ability to engage with the public and support beneficiaries to see a referral partner:

> *"That is what the crews are lacking at the minute, they don't necessarily get some of the fantastic results that are coming from their initial visits". p56*

> *"We need the partners to take more of an active part…especially with case studies. Need more interaction".p6*

4.1.6 Suggestions and current work to improve the SWV service.

There were mixed views about the current target of delivering 18,000 SWVs a year, with some participants feeling this was an acceptable number:

> *"When you look at the figures, we're actually over 19,000. It demonstrates that people are doing all they can".p55*

> *"When we were part of the EMR pilot, we had some watches delivering that and also hitting their SWV targets. This surely highlights that there is capacity amongst stations to hit the targets they've been given?"p56*

However, there was a feeling from some participants that the target meant that although the quantity of visits was ok, the quality of SWVs sometimes suffered as a result:

> *"The targets definitely don't help the quality of the safe and wellbeing visits. Every time we sit down with them (the crews), it's always problems with the targets. Comes down to trust though? If we reduce the target dramatically, is their trust for the visits to take place and will we see a huge increase in quality? That would be perfect." p6*

> *"I think personally, as long as we have a target, we will always struggle with targeting, if you like, because at the end of the day 18,000 is the headline figure. As long as we can't waiver from that, then the amount of time and effort and resource that will go into identifying the most vulnerable will probably be the bit that suffers. That's no to say that we're missing the mark mind, I just think we would struggle to prove we're not missing the mark".p55*

A suggestion was provided to try and improve the quality of the SWV, by providing more flexibility to delivery staff, and asking for a higher percentage of referrals. This would then potentially improve the quality of the visits that are taking place:

"I think with a hard and fast figure with no wiggle room, we're going to struggle. Can we not say, this is the target- but we recognise certain parts of the process can take longer, therefore if we get a referral rate over 30%, we have to acknowledge that's taken more time to conduct a visit. So for every 10%, we'll give you a reduction of whatever, because that's going to be time taken up improving the quality". p55

The introduction of bringing CROs into the watches one day a week was an example of work that has already started in an effort to improve the SWV service, and to use the CROs as best practice. CROs currently don't have a SWV target to hit:

"The CROs will work on a district one day a week, so they can get to know their crews…..the crews then have a contact. It's a sounding board for them. This is where we've been, this is what we've saw. How would you interpret that? They are a resource for the crews." p6

"That's why we've looked at using them (the CROs) for establishing the tool for best practice. Because if not them, then who? Nobody has a greater insight into what we should be achieving with them (the SWVS) that the CROs. They are our experts, even though they may conduct fewer SWVs than delivery staff. Goes back to quality over quantity. They don't have targets".p55

However, it was highlighted that for any reduction in the target to work, the delivery staff would need to show their commitment to get on board, as this would require trust to make sure that additional time given was used to improve the quality of each visit that took place:

"I think a substantial reduction (in targets) would make a difference. A 1000 wouldn't, as we have so many watches, it would work out a few a month. It would need to be a substantial cut. I think it would be good, but that trust has got to be there that they will spend longer in the houses".p6

Work that is currently planned to help improve the SWV service includes a new roll out of training from December onwards:

"From December, we are going to roll some training out, 5 or 6 staff, 6 months. Will cover other areas too such as safeguarding, but Safe and wellbeing such as the reasons why we're doing it, who the partners are, give out some case studies. To try and educate the staff as to why we do it, and hopefully they can see the value in it". p56

A change to what data is recorded was also suggested as a much needed improvement, to ensure that any refusals were recorded, and therefore productivity levels were evident regardless of the number of SWVs carried out:

> *"It's ok running the data for where we need to be, but if we can't get a foot in the door, then it's very difficult for crews. We can only go back to the same door so many times…..we need to be recording those where we don't have an answer or get a refusal. Is that knock and refusal being recorded? No, it's not. So that needs to be addressed, to show we are trying our best to engage with those vulnerable individuals".p55*

> *"They could go out for a full afternoon and completed one SWV, but might have knocked at 30 doors that day, so they need to demonstrate that they've have all these non-answers".p6*

Additional actions were identified with relation to partners and looking at what their service was providing, as well as reinvigorating the quarterly partner meetings:

> *"(Partner) send a pack out, which they (the beneficiaries) have to reply to. To me that doesn't work. With (partner), the change with (partner), they've just disappeared off the face of the earth. I don't know who to speak to….We aren't sure what some of the partner offers are, as they change so often. These issues need to be ironed out".p6*

> *"One of the problems is getting all the partners together. Have had to cancel the last couple of meetings….attendance has just trickled away".p6*

The need to identify items on the SWV that were not fit for purpose anymore and removed from the form was seen as critical.

> *P6: Not had any use for the flu vaccination question. Not since day one. No one requests that information. No partner has ever asked for it*

> *P55: The whole form is due an overhaul. We are undermining the intervention if we are ultimately asking a dead-end question. It's not going to go anywhere*

In contrast, some discussion was had around the need to protect the SWV service, as it was gaining momentum, but to be open to other partnerships, and how the SWV could help those in need:

> *"We've got be careful it doesn't become a victim of it's own success, as it is so well talked about…..for example, I had a phone call asking for something to go on the form about animal cruelty. I get it, and we'd love to be able to help everybody, but we can't. On the flip side, I've had a*

meeting with someone about young carers, she's asked if we can ask on question 'is there a young carer in the home? Would they like to be referred to this team? I really think we should do that, as that is an area we could do some good in. The question is, do we have the capacity, can we fit it on the form? Does the format work?" p55

4.2 Interviews with Partners

Eight major themes emerged from the analysis of the interviews: *Awareness and Understanding of the Safe and Wellbeing Concept; Development of the SWV; Delivery of the SWV; Positive impact of the service; Internal and external communication of SWV; Barriers to successful delivery; Position of CDDFRS to deliver the service; and refinement of Safe and Wellbeing visits.*

4.2.1 – Awareness and Understanding of the Safe and Wellbeing Concept

The partners who had been involved with developing the SWV service had a good awareness and understanding of what the SWV entailed, and were able to give a good description of the offer:

"My understanding is….that contact will make an assessment of an individual's readiness to change. If they are showing signs of readiness to change, then there will be a referral to a particular specialist service. So, say if someone shows that they are interested and motivated to want to stop smoking, then a referral would be made to the specialist stop-smoking service. If they're not ready and motivated, then the Fire & Rescue Service personnel may just leave some information with them, so that maybe at some stage in the future they might make that change into motivation". p39

"....it is a visit the fire service were doing anyway....the fire service go and check the house over, they make sure they have got smoke alarms fitted and check for risks and things like that. In this case what's been added in are some health-related questions around smoking, winter warmth, slips, trips and falls and alcohol". p42

4.2.2 – Development of the SWV

A number of partners were involved in the development of the SWV, and to help drive the service forward, a strategic document was developed to steer the work as well as regular steering groups. This was found to be important:

"I was quite keen to have almost that strategic overview of what they were trying to achieve from undertaking this. So, that's why I suggested to them about developing a framework document and to their credit,

they agreed that ……I suppose the Fire & Rescue Service's perception of prevention is maybe quite different from mine, so it was bringing together those, I wouldn't say they were opposing views but certainly there was some tensions that had to be worked through. The document, I feel, was very complete, in the sense that given what I've just said, I think we had a fairly robust document there and it enabled us to reflect on it as we went through the process, so there's a lot of good that came out of that". p39

In addition, partnership working was evident, as partners were involved in writing and developing the questions for the SWV form:

NC: So did you actually have any input into how the safe and wellbeing form was developed?

P44: Yes, I've wrote the questions for (service).....I took advice from other people (service users), our office workers, as to what those questions should be.

"Initially the development came through our chief exec, development worker and one manager. So although I wasn't involved in the initial development, I was on the team from our perspective that were going to be involved in helping this to be delivered".p41

4.2.3 Delivery of the SWV

The importance of agencies working together in times of austerity was seen as a positive output of the work:

"One of the other things I think that has, and this might sound a little bit backwards, austerity has actually helped, because a lot of people now will actually look for help from other people. Whereas before, we had more money, and we had more resources, and we were trying to do all this, whereas now, we have less money, less resources, so we get to a point now if we can't solve that problem, who can. So, it has helped a little with that. It would be nice to have more money, but it is what it is. So, I think people in all groups, in all organisations, look for help now".p40

"…..and then you can get what agencies involved, you know, that might not have been involved. So, we link in with the housing services now, and social services, a social worker, mental health workers, district nurses". p43

However, partners felt that although initially they had been involved in writing the questions, with hindsight, it would have been helpful for delivery staff to have been involved in the decision making about how and what questions to ask:

> *"From a user point of view, I think it is vital to have the crews feeding into that because obviously, we have seen only six questions per partner and they're very simple because we are the deliverers of those questions, so it is simple for us. I think that it's really important for the crews to feed into that question, "how do they feel in the property when they are delivering these questions? Is that fine for them?", that's great but do they think it's too many? Is it too difficult? That's where it's really important to get their feedback…… It's okay for me, as a provider, to say, "oh, my couple of questions are easy, aren't they?" but in terms of my six and then there's their own fire safety inspection on top of that, are they happy to do that? If they are, that's fine but I think it's really vital to understand, from their perspective, how is it affecting their delivery? Their core service is the Fire Safety Visit, isn't it?"p40*

During the early stages of implementing SWVs, there were some issues with referral data from the crews coming through to all the partners. Sometimes the data would be wrong on the form, such as phone number, or there would be missing data:

> *"Originally, what used to happen was, obviously I don't know if this is the same for other partners, but the crew would obviously tick the relevant box, then that would be sent to ourselves, just on a spreadsheet, these are the people with the contact details and we would phone them back, to follow up on their enquiry. In the beginning there was wrong telephone numbers of the people phoned, so obviously it had to go through a few changes……so there was quite a few teething problems at the beginning".p44*

These earlier 'teething problems' have improved with time, with better data provided. There were also occasions were partners felt that the referral that had been made shouldn't have been made in the first place, as beneficiaries either had no recollection of such a visit, or confirmed that they had had an SWV, but did not want to be referred to an organisation for support:

> *"In the beginning, what was happening was we were getting referrals and when the team were phoning the people back, they had no recollection of, "hi, we're phoning you back because the Fire Service have asked us to phone you up", they say, "no, why?". That's just*

obviously people forget, even if you phone them back very quickly, "no", "well [beneficiary name] are on the form. Would you like some information about what we can offer?", "not really". There were quite a few referrals that we followed up on that didn't actually ... either that person didn't remember but that's just life, people have busy lives or they weren't interested in the schemes we were asked to phone them about…… There was quite a few like that, which is why we went through changes to try and refine it down to the people who actually needed our assistance and support".p40

Partners discussed the actual length of each SWV, whether it was too long, and whether the number of topics covered in the health section of the questionnaire was too long. Although, it was mentioned on a number of occasions that the forms had been revised to help reduce the amount of data collected:

"There is a range of health issues in the Safe & Wellbeing visit and I suppose one of the issues, from our perspective, is whether there are too many issues there for the visit and whether the visit should be focused on the generic concept of wellbeing, rather than going down a specific route". p39

"The questionnaire, the part that we link to, we have reduced dramatically so there isn't as many questions and is basically just straight to the point, erm, and that has made a huge difference". p41

There was also discussion around how engaging with those who are the most vulnerable sometimes required those lengthier visits, and that this in turn may have had an impact on staff capacity:

"..the amount of time it would take for the crew to do these when they're in somebody's home, are they time-restricted? Obviously, you're dealing with a vulnerable household, it's not very quick, you have to sit down, work through their case, that could take an hour, does the crew have the time to spend an hour per visit, so there's a barrier". p43

The difference in the lengths of SWVs was also picked up as part of the researcher observations:

The timings and length of the talks were very different, and it just depended on the types of people the crews were talking to; their age, their background, what commitments they had, we had some people who needed to head out to pick children up from school. Around about that 3, 3.15pm period. I would say they ranged from 15 to 30 minutes. NC observation

A common theme from the interviews with partners was the strong feelings about the sensitive nature of questions. There was a sense of appreciation that the fire service and the crews on the front line were doing a wonderful job because they were having to deal with such vulnerable people and ask difficult questions within topic areas that were very new to them; something some of the partners had experience of and knew how difficult it was. There was also an understanding that by asking these sensitive questions, the fire fighters were then put into uncomfortable situations:

> *"I think so, because when this first came out I actually went up and covered a shift. I went and did one of these when it initially came out. I think I'm reasonable at communicating, so I tried to phrase the way I wanted it to go across. But I think it will definitely have an impact, because if you're sitting reading it, because some of the questions, when you read them, you, sort of, think, would I really want that asked to me, and straight to my face. And around alcohol, you know, a lot of people, wow, straight away". p41*

> *"When the crews started to do these visits, some of them were reporting back that there were quite a lot of issues arising during the course of the visit, around social isolation with dementia and they were reporting back that they felt maybe it was difficult for them to deal with these issues". p43*

4.2.4 Positive impact of the service

The quality of partnership working between the fire service and the partners who were interviewed was seen as a highlight of the implementation of the SWV service:

> *"….when the guys are out there doing their Safe & Wellbeing visits, they are obviously picking up on elements they see in the person's property which we won't see with the phone call and they'll cascade that out to such a two-way referral process. It's coming from partners to Safe & Wellbeing, it's coming from Safe & Wellbeing to partners". p42*

> *"It's brought partners together, it's obviously delivering services in a different way. The ethos of one point of contact in the access of several services, that's the ethos and it makes a lot of sense, doesn't it…….it's got to be a joined up mechanism because we all have limited access to people in their homes, so if we can use any portal mechanism it makes a lot of sense". p44*

Some partners reported that they had seen an improvement in the quality of life of beneficiaries because of the SWV service:

> *"..I was aware through the steering group that there were other services like the Alzheimer's and the smoking service, where they captured some of the impact on the beneficiary, so the beneficiary commenting on the fact that the Alzheimer's Disease Society[12] had worked with them or their partner and the impact that that had made on their life quality". p39*

> *"We have had a few positive outcomes where people have been awarded benefits because of the original referral from the fire service….for instance we have had a few people who have been awarded disability benefits so the like of attendance allowance erm, which would make them about £80 better off". p42*

4.2.4 – Internal and external communication of SWV

An area that partners felt had been very positive was the improvement in communication between all of the partners, and how the steering group for the SWV service provided an opportunity to develop the SWV and the process, as issues could be raised:

> *"……...communication, I felt, has been good. There was the steering group was established and the membership of that was pretty good in the first six to nine months, I would say. Following that, I think the membership has started to tail off a bit. Otherwise, I believe communication relationships have been good". p39*

> *"It's more of a case in feedback in the meetings…of any issues we have come across and they then feed it back to the lads who are actually doing the job".p41*

There was also the view that the SWV service was also aligned to allow strategic reporting to higher bodies, to ensure that the service could be monitored and be held accountable, but also to make sure that it was communicated to those partners and organisations in the region who needed to be kept in the loop with what was being delivered:

> *"Strategically, we've reported it back up through what was the Community Wellbeing Partnership, so they had update reports that went*

[12] Alzheimer's Society

up to the Health & Wellbeing Partnership. Overview and Scrutiny got involved and clearly, are still involved in it and then it was also reported back through the Altogether Safer Partnership as well. So, I think all of that is part of the communication process around the Safe & Well Visits". p39

4.2.5 – Barriers to successful delivery

Some partners commented that after the SWV service commenced, there was a high volume of referrals coming through, which had an impact on workloads. However, as the service was embedded and fire fighters started to improve the quality of referrals, the numbers dropped significantly. This has allowed the current rate of SWV referrals to be managed within usual partner workloads:

NC: How time-consuming was it? What workload did that make ...?
P43: It generated several days' worth of work.
NC: Is that per week or per month?
P43: Per month but we were in a small service, so obviously even a couple of days work like that is quite time-consuming.

"When it's the normal process that's fine but if you're phoning somebody and they say, "I'm not interested", it's taken me a couple of calls to get through there or the phone doesn't work or whatever, it has an influence on resources, which is why we went back and said, "maybe we need to do some refining on the process". p42

This finding from the qualitative data is supported from the referral data which shows that in the first year of delivering the SWV service, the number of referrals was much higher than in year two.

There was discussion around the training of the fire fighters, and what had taken place. There were mixed views, with some believing that some online training had taken place, but not aware of any face to face training, with reasons to explain why this hadn't occurred:

"There was talk of us providing training, but that hasn't really got off the ground as such ...one of the issues is because of our resources. This is because our organisation is so inundated at the moment it's finding the resources to go and do training to somebody else". p42

"Having said it was a steep learning curve, I do think they put a lot of training in place to cover that….. I wouldn't call it training, I would call it

briefing sessions and information. I think training implies it's quite in-depth and lengthy and this type of thing. It was more a briefing session, a taster as to, "this is what this service is" but giving people enough information without overloading them with lots and lots of information".p40

"My understanding was that the training involved two core elements. One was around the Making Every Contact Count theoretical approach to behaviour change. That was a three-hour session, delivered by the Wellbeing for Life Consortia, the Public Health Commission and my understanding, again, was that all of the crews, now I think there's something like 3000[13] Fire & Rescue Service personnel across Durham and Darlington, maybe not the Darlington crews but certainly the County Durham, received this training".p39

4.2.6 – *Position of CDDFRS to deliver the service*

All partners were unequivocal in their belief about how the public viewed the fire service:

"….the credibility of the Fire Service is a big element to get people into these schemes". p44

"The thing is that this was a totally new intervention when the Fire & Rescue Service picked up on it back in December 2015……..You have to give them some credit, Fire & Rescue Service County Durham and Darlington, for actually supporting this as an organisation. What we have now is that they have embedded it as part of their normal day to day activities and that's quite an achievement, I think and should be given due recognition because that's a very short time span in which the management of that service have seen the benefits of this and have committed the service to doing it. I think that's really good and indeed, is a good example of Making Every Contact Count that maybe other employers could be thinking about". p39

As other studies have found, for work like this to be successful you need a champion on site as well as knowledge about how important this work is and this was highlighted:

"A lot of that was due to the individual who was leading it, who was very focussed and very driven by it……he was driven and he had his dates

[13] The number of staff at present within CDDFRS is currently 300+, not 3000

and he was going to do it, come rain or shine. All credit to him and the service that they did it". p44

" I think for me, obviously, some of the tangibles of what I previously mentioned about embedding it within their organisations, almost as a model employer that others could learn from, they've presented the Public Health England Making Every Contact Count Conference. They've also presented at a Fuse event that Durham County Council held around fuel poverty and cold-related ill health and they may well have presented at other events". p39

The potential of the fire service being a key partner, able to lead on other health related issues was seen as a possibility by some partners:

"….the Fire & Rescue, I believe, would like to explore whether they could be commissioned from the NHS to deliver this type of service. I think that's potentially one of their strengths.....if they want to make a case to the Clinical Commissioning Groups". p40

It was also observed that the fire fighters who were out delivering SWVs were providing a number of different services for the community members they were engaging with. This highlights the potential capacity they have to support other services:

(Talking about family who had a fire in their home) It was lovely to see (name) take on another kind of role, giving the family information about the red cross. He was constantly on the phone to headquarters to see what they could do to help the family in this situation, which is obviously quite a distressing situation. And that just showed another side to the fire service. So the local authority are struggling to help at that point, so the fire service have come on board and are supporting in that way. NC observation

It was acknowledged that training on how to deal with vulnerable individuals was a key challenge with some worried about getting accurate data:

"Clearly, the implications for their staff was key but also, because they're visiting vulnerable people, I think it's about how they get that message across and what they were trying to do but it's not specifically fire-related and that's quite a different take on their role and function and how you get that message out to people, particularly the more vulnerable individuals, I think is the key challenge". p39

"Another barrier is the knowledge needed to fill this form in completely. Each of the schemes are very detailed and specific but if the person doesn't have the knowledge or the background or have forgotten about it, are they able to fill in all those questions and all those detailed items accurately? "p40

4.2.7 – Refinement of Safe and Wellbeing visits

The SWV has been through a number of changes since the beginning of the pilot in February 2016, and is currently on version six. These changes have come as a result of feedback from partners but also from CROs and fire fighters. The on-going revisions to the form suggest that the fire service are amenable to change in the journey towards a more effective and efficient SWV service:

> "Some of the iterations of the forms then changed. I think the number of questions maybe reduced, to be more specific, rather than generic and general. Maybe because in the beginning they were generic and general, that was generating people maybe who we couldn't assist…..I've noticed the referrals have reduced quite significantly". p41

The mechanism for delivering SWVs was not only different across crews, but also there was a different referral mechanism for some partners. One referral mechanism relied on contact details being handed to the beneficiary in addition to the fire service referral. This may have impacted on understanding of how referrals were processed and actioned, if a partner was receiving a referral from the fire service, but then waiting for contact from a beneficiary:

"Basically, what was happening before was the fire crew would fill in the sheet and then they'd send us it that way but we decided eventually that we would give the person a letter from Durham County Council. The fire crew, if they thought that, "yes, we're going down the street here, yes, they need some supportive assistance", we would give them a letter which said, "these are the services provided by Durham County Council. If you are interested, phone Durham County Council directly". p40

NC: Okay, so there's now no system where the information gets sent to you as a referral?

P43: There is that still as well but it's supported by the letter. Because when we were phoning people, they couldn't sometimes remember about how we were going to phone them, so the crews asked, "are you

interested in these schemes? Yes, you are? Well, I'll just leave you a little letter there" and then they still send it to us as well

There was certainly evidence of a targeted approach through some of the observations of the research team (NC), in particular, the targeted nature of delivering SWVs following on from a fire incident, demonstrated below:

> *Rather than cold calling, the crew were doing a hot strike, so they were heading to the area where a fire had been (that morning) so that while it was fresh in people's memories in the area, they might be able to engage with people, and talk about the importance of fire safety. NC observation*

Despite the fact that the CDDFRS work is highly targeted (see section 3.2), there was still some confusion from partners as to whether the work was targeted or not:

"….if you want to actually supply certain services from certain partners to certain demographics, you have to target. You can't just do that by driving into an area where you think you can generate lots of referrals". p40

"Well, I thought it was targeted. They use various systems to determine how they target but I suppose my point is that the data we have seen back from them doesn't do a breakdown of how many people they've seen in that lower super output area, so that might be quite useful to try and unpick". p39

This highlights the need for further work to take place to communicate the targeting strategies that CDDFRS employ to all partners involved in the SWV service.

4.3 Focus groups with Delivery Staff

Seven major themes emerged from the analysis of the focus groups: *Awareness and Understanding of the Safe and Wellbeing Concept; Training of staff; Delivery of the SWV; The content of the SWV form; Perceptions and experiences of staff members; Internal and external communication of SWV; and Refinement of Safe and Wellbeing visits.*

4.3.1 Awareness and understanding of the Safe and Wellbeing concept

Crew members and CROs understood that the SWV intervention had a purpose to support those whose health behaviours might be detrimental to their health and wellbeing, and importantly, link in with preventing behaviours which have the potential to increase a fire risk:

"….but in addition to that I would say erm, in a way we are trying to erm, maybe identify or highlight issues where the person may not realise that they've got an issue. So not just offering service to them but, someone's actions, what they are doing, or their habits or the way they are living their life may be detrimental to their own health, or may be dangerous, or they may have Alzheimer's, something like that. And we can, we can spot that and then we can signpost them to sort of health, or additional sort of organisations that can provide assistance to them".p19

"I think the safe and wellbeing…you sort of treat, or give them the same advice, if you thought something was wrong. You highlighted to them maybe they were overloading their sockets, and stuff like that….but with being on the wellbeing, you do tailor it a bit more as well, and it gives you more of an option to help that person, I think. You know, if they say they're lonely and isolated you can refer them. If they are smoking, there's that mechanism to help them stop. If they want though. It very much leaves it to them. It's their choice".p1

However, a few fire fighters believed that the SWV was an intervention to fit a smoke alarm, as that was what had been delivered previously:

"Well essentially erm and importantly to me, I think, as a fire service, we fit smoke alarms". p37

"On a safe and well-being visit the most important thing that we do is fit a smoke alarm, because that is what we started out doing, before we did this".p12

There was the suggestion that the understanding of what an SWV is amongst members of the public was not common, with more people knowing that there is a smoke alarm fitting service, but not a service that enquires about their health:

"Some get it though, depends how you do it but some do get what you are doing. Some get that you've got to ask the questions. It's not, if you show them the icons you know at the bottom of the different agencies they understand that it is not the fire brigade that is asking them it is these agencies and they are quite happy to say yeah son I know how it works, yeah ask, fire away".p22

"A bit of both because it is surprising how many people, we have been doing it for I don't know what ten years, longer. See the difference between the smoke alarms and safe and well-being. People know we do smoke alarms don't they? People sort of expect that now. Nobody I have spoken to has got the new forms, the green forms, I've got to explain what it is all about. I don't think the general public know a great deal about anything we do, other than if they ring 999 we'll turn up". p33

4.3.2 Training of staff

Some staff talked about having some training in delivering the SWV, which was a variety of face to face and online, with mixed results:

"...the chances are maybe one or two of them had the skill set to start with, and the rest of them are just picking it up. So the crew work very well together, because they've learnt off each other. It's like, kind of, peer learning almost".p17

"It's pretty informal really.... I just watched (name) with a tablet, and then, you know, I'd be giving a talk, and (name) would be watching to make sure it was alright".p4

P11: Remember that video we watched? The young couple? A young lad and lass delivering one?
P12: I heard about it, but I never saw it.

"There wasn't much, nobody physically came down here and said blah de blah de blah. It was all online it was all e-mails and there was some online erm tutorials that you had to go through covering six areas I think it was, or domains…….Smoking cessation all of these sort of things, and it was all online. To be honest you were just going through it as quick as you can to get next, next, tick the thing off". p26

Despite the corporate approach to training, not all staff could recall the nature of this training and were keen to have some training delivered to them in the future:

"We haven't had the proper training for it. We haven't had any training for it".p30

"I think a lot of the stuff has been handed down, you know, and we don't know whether we're doing it right or wrong. I wouldn't know where to look on SharePoint. If that information is there, I wouldn't know where to look for it".p34

"The part I'm sort of complaining about is the fact that I haven't had the training to deal with that (beneficiary getting upset). I've spoken to somebody who's actually a social worker and they do get training to actually talk to people who've had bereavements and things like that". p9

Staff mentioned that with the correct training in place, they would feel in a much better position to be able to go out and deliver SWVs:

"So that maybe they could feel they've got the confidence in you, they could give you the training so that you know what you're talking about". p32

4.3.3 Delivery of the SWV

It was evident across all of the focus groups with delivery staff that the fire service has employees from all backgrounds, with a variety of skill sets. Not all staff perceive communication skills as common place across the service…

"There is people in the job and one thing you have to understand about the fire brigade is that it attracts people from all kinds of walks of life and all different skill sets. Now I know guys who wouldn't, great in the fireground, great when they are hands on they wouldn't do eh school talks, they wouldn't do safe and well-being things.… because they weren't very comfortable talking to other people and you can't… I don't think you can change that just because you are in the fire service, you know you could get someone in tomorrow they are not very comfortable sitting talking to strangers and I don't think the fire brigade can change that so that person isn't, that person will never sit down and ask somebody questions, do you know what I mean?"p14

This perceived difference in skills, mainly conversational skills meant that some staff delivering SWVs could happily talk to the public. It was suggested that staff who struggled with conversing with the public took up other roles within the SWV service.

"I haven't done, I haven't had a great deal to do with it because my previous station we had just certain people would do the safe and well-beings and certain people didn't. So I really haven't had a great deal to do with it. Eh I have had a little bit of input and I've asked a few people questions eh but haven't had a great deal to do with it sadly".p20

> *“Here we, everybody takes part in every facet of it, you know everyone erm delivers them, books them, records them and does some sort of holistic, everyone here can do every part of it”.p2*

It was felt that the ability to have a conversation with someone with appropriate terminology was crucial to completing a successful SWV:

> *“It is the way you put it over though, you’ve got to ‘Do you mind if I ask you some questions’. Some of them are personal questions but I think it has got to be worded”.p28*

> *“I would say I have got a couple of questions, if there are any that you don’t want to answer feel free. And that is down to the individual doing the, that is doing the visit”.p11*

> *“The volume of questions, yes, because wasn't it about three pages that you would go through the first time round. So, yes, that has gone now but you're still going off a script instead of actually conversing with the person. That would be so much better, I mean we've already said you can glean more information that way and I've complained about not having the training like everything. But, when it comes down even though we all joined for a specific reason, not one person would ever say no to doing it, we take it on board and we try to do our best. I just would like us to have better training that's all”.p38*

The idea of how to approach the discussion was different for different people:

> *“Funny cause I don’t say, this is a different way of approaching it, I don’t go oh well this is your home fire safety check now I am going to ask you some, I just oh right is it okay if I ask you a few questions, you know don’t answer then if you don’t want to and I do it as a oner anyway. They don’t know that they’ve taken part in it in a way”. p6*

> *“I do the whole home fire safety check and get that boxed off and everything and then say do you mind if I ask you some questions about your lifestyle from our partner agencies”.p21*

There was a common suggestion that some staff were not keen to deliver SWVs as they had been in the fire authority for a long time, with a career desire to be more operational. Younger staff potentially had a different outlook.

"If you are a recruitment company looking to recruit 100 people to undertake Safe and wellbeing visits, we wouldn't pass the application form stage let alone the interview because we are career fire fighters who have been doing the job 15, 20 years and we're not experts in any way".p31

".....if you went right the way to apprentices who would come out with us now and they would think this is the right thing to do".p10

What was noted during observations was that fire fighters seemed to create their own roles within the SWVs, to utilise the different skill sets within the crews. Staff were empowered to ensure that the process was efficient and responsive:

Always needed to have one of the crew on the pump to listen out for a call, and the rest out doing a visit had their radios on so they could dash back if an emergency came through. They would try to have two in the house at any one time; one fitting the smoke alarm, and the other doing the safe and wellbeing talk. NC observation

This variance in delivery was a common theme throughout the interviews and the researcher observations, with fire fighters delivering their talks in a number of ways. Although this is to be expected, as individuals have their own delivery style that can work for them, some guidance on particular areas or issues that need to be discussed might help to provide some consistency in delivery:

"I think it depends how proficient you are, some lads can go in and rattle through it, some lads just take their time and kind of work through it meticulously, but it was taking half an hour per visit". p6

The way the questions were asked differed, and that is probably something to take away and build upon for ensuring there is some consistency across the service with how the talks are delivered. What I thought was a better way to ask some of the questions was, erm, one of the fire fighters asked a lady 'I hope you don't mind me asking, but are you over 65?' and it was almost like it was apologetic as some people might find that question offensive. It worked on that occasion as the fire fighter had really good people skills. However, I can see how <u>there is the potential</u> for that to offend someone. Whereas another fire fighter asked 'is there anyone in this household who is over 65?' which might be a better way to actually ask all of the questions, you know, 'is there anyone in the household who likes to have a drink?', 'is there anyone in the household who smokes?', 'is there anyone in the household who suffers from dementia?' So that way, you're not actually directing it at the person you're talking to, you're asking about the household in general. NC observation

The content of the SWV form was discussed in great deal across all focus groups with delivery staff. It was apparent that a number of the fire fighters delivering the SWVs felt uncomfortable when asking beneficiaries, the health questions:

> *"…..initially my conversation when moving onto the safe and well part of it, home fire safety visit was 'I want to apologise for some of these questions' even before I had started……Some of them are around loneliness and isolation, I think are quite hard because I think you've had crying. I have seen people in tears over those questions".p15*

> *"The concept of going into someone's home isn't alien to us at all, it was just this awkward add-on thing that we try to fuddle our way through to try and make sense of these awkward pauses where you try to read what the next question is".p25*

Some of the health topics were viewed as being more difficult to ask, such as the questions on dementia, and loneliness and isolation:

> *"I got really nastily shouted at by this elderly guy because I asked him about dementia. 'That is not the question you ask a man in his 70s, how dare you!' p13*

> *"Some of them questions around loneliness and social isolation, I think are quite hard because I think you've had crying (points to other participant). I've had someone nearly in tears on me, but, recently had just lost their partner…….they might not have seen nobody all week and then they start pouring their heart out to you, and you are just sat there twiddling your thumbs thinking well what do I say?" p7*

This was certainly a theme that was picked up during the observations of SWVs and how uncomfortable the atmosphere could become due to the sensitive nature of the questions:

> *When I was with the fire fighters and thinking about the questions on the paper, I did actually start to feel a little bit of uncomfortableness myself. I mean, sitting in the office talking about it, you know there are people who are really vulnerable and would benefit from a referral from one of the six questions. But actually, when you're in somebody's home, and they've invited you in, to then ask them 'how much do you drink?' or 'do you have dementia?', I can see that that is definitely a bit more tricky and certainly does make you feel uncomfortable. NC observation*

In addition, the SWV form that the delivery staff complete does not seem as useable as it could be. With some age groups, particularly young people, some of the questions do not feel relevant to ask:

> *"Again but to move onto that safe and well-being visit, the side of it from the home fire safety check you have to ask their permission. And that is one of the things on the questionnaire that we fill in; you know if they don't want to answer them questions they don't want to. Like I say, most like young people just want a smoke alarm putting up and that is it". p29*

> *"And the vast majority of the questions they don't reply anyway. There is only the questions about smoking and alcohol that you would expect somebody who is maybes in their 20s….. dementia and them falling over. They're not going to have Age UK in their home".p35*

4.3.5 Perceptions and experiences of staff members

Staff felt that their status in society was beneficial in the public having trust in them as well as the use of incentives:

> *"I think the actual organisation we're in, as well, the fire service, has got a fantastic reputation….it's not just the uniform side of it, because if a police officer was there, they might not trust as much……so we'll go in and do the safe and wellbeing visit in a property, and somebody could potentially, or has in the past, said stuff to people, which has highlighted problems".p16*

> *"A load of times we erm we do a lot of door knocking so we are quite fortunate because people let us into their houses but very rarely you get knocked back".p23*

> *"The word free isn't it, as soon as you mention the word free, cause you can see them looking at you, as you are talking away trying to get in as soon as they hear the word free they'll go ah right, yes come in". p12*

Researcher observations also highlighted the trust shown from the public to the fire service, and the relative ease with which fire fighters were able to engage with people:

> *I think in nearly every situation, people accepted the fire service coming in and getting a new smoke alarm fitted. Although there was one house where the alarm was hard wired, so that one didn't need to be changed. NC observation*

The fire fighters have a ‘can do’ attitude, putting them into a strong position to deliver a service such as SWV:

> *“I would say, I mean it is what it is frankly, right I don’t think many find them a joy to do, safe and well being visits and if they do then (inaudible 13:50). But I come in, I do it and I get on with it so. And eh we’ve referred loads of people and if any of those have been helped then good”. p20*

There were comments that the SWV has created a mechanism to deliver something that was already being carried out by the fire service:

> *“Of the referrals that we’ve made 90% of those are people who’ve like contacted our headquarters and said we need someone to go around here my mum’s living on her own now can you pop round and see them. But if you remember the days when before the SWVs you would go in to a house and it would happen quite a few times, you’d go in and there would be a little old lady by herself and you would think that woman needs help but there wasn’t really a mechanism. I’d tell whoever was in charge and they would maybe e-mail our fire safety team and they might go out and see them and that was it really. And we needed something better than that in place which this is; it’s just a little bit too much”.p30*

What was felt across all the focus groups was that there was an understanding of the rationale for the SWV intervention and the role of the fire service in delivering, but the view of actually delivering the SWV on the ground was mixed:

> *“I think, I think if I was to summarise personally I think there is some value to be had in the safe and well visit I mean I can see the rationale behind doing it. I understand that if you are speaking to people and gleaning information from them and giving referrals it can only be a positive you know there are, there will be in this county mow that if we hadn’t been around would not be here now and it has got to be better to prevent it than to sort of deal with it later on. So I can understand that, the logistics of how it is done and the mechanics of how it is done maybe could be better but I understand that there is a need for it in some way, shape, or form”.p24*

One of the beliefs evident across the focus groups was of the importance of SWVs to provide an opportunity to reach out to the most vulnerable people in society:

"I think most of the referrals that we've made are good and vulnerable people needed it, so I think parts of it (the SWV form) are needed. Like I say, parts of it". p19

"…this fella just broke down, when we got to the alcohol questions, and asked him how often he was having a drink, and he said, well, whenever I'm depressed. And I said, how often is that, and he said three, four times a day, and he just broke down and couldn't carry on".p27

In addition to the importance of reaching out and having a positive impact on beneficiaries, there was a belief that they were the correct individuals to do this sort of work:

"I must have referred I don't know 50 people if not more, and some good will come of that. You know if it's going out and giving them erm flame retardant bedding or pyjamas or helping them with stuff fitting a sprinkler system in their home or you know like, all of this stuff will have happened I've no doubt some good will have come of this, you know. Age UK may have visited and put some hand rails up for someone you know…..Some good will have come of it".p15

"We're a very good vehicle for it because they see us as a fire brigade service and they still like us at the minute, most of them, you turn up, you're giving them something free. If somebody just turned up, like a BT salesman turns up on your door, you'd just basically say go. Because we're there, we turn up in our truck, they like us, they let us in the house and we can do this. If you just went there with the sole intention of asking the questionnaire, you wouldn't get in".p26

Crews spoke about the driver behind the target setting for the SWV service, and how it linked in with national level targets:

"It is a national level the targets, that's what we are going for, they look at our service compared to another service what is a similar size family group, aside from (place and place) how many are we doing per 1,000 per head of population. Oh we are doing 50, well….we want to beat, we want to get above them. it is just our target to be better, be the best, do you know what I am on about?"p35

However, for some, it did feel like they had to provide the numbers coming through which meant that the targets were stressful and they have to hit them every month and this meant that the work took precedence over other things:

> *"However, the only thing, it is what it is like I said. The only issue I have is that, this is all, and, make no bones about it. This is all numbers driven, it's all targets that's all it is". p14*

> *"See I think the operational training should be our main focus, but I don't think there should be a target because it will become like this, oh I've not done 10 hours oh god oh I'm going to have to make that up or we're going to have to do this, or we're going to have to get out and do an extra two hours and we've got to do that by the end of the month".p33*

During the observations, it was possible to see the difference in numbers of visits during similar two hour sessions:

Think they managedto do 15 in the space of the two hours we were out, but this was at a time when there was a hot strike, there were a lot of people out in the street, having a look to see what was going on with the fire. So I do wonder whether they would have been able to get 15 just with the regular cold calling. NC observation

Today, the crew managed to get six visits completed. Quite a few doors knocked where people weren't at home. I think the different visits have shown me that there can be a real variation in what is possible to get accomplished. This must put considerable pressure on staff if they do a few days where they are struggling to visit people due to factors outside of their control. NC observation

They felt that the targets had an effect on the quality of what they were doing, therefore other things like prevention work suffered because of this:

> *"I think it is a very important thing that we do, for certain people massively but I think the fact that we have such a high target but yet there is no target or recognition on how many vulnerable people are er, passed on or referred, they don't care. So they are not actually bothered by how effective our visits are and who is being helped by it they are just bothered about how many we do". P19*

“I was sat at (name) one and there was a big fire at a recycling dump and we had been there three or four days putting the fire out all of the watch was there and they were congratulated from like the district manager for doing this fire, well done lads however, however you have fallen behind on your smoke alarm fitting this month, can you make come concerted efforts so that we are not behind at the end of the month. What?”p38

Furthermore, the pressures of having to reach these targets were starting to affect staff mental health:

“I’m a watch manager so I’m in charge of achieving these targets, it’s my responsibility. Towards the end of the month, the last two weeks, I am so anxious on my days off, I'm thinking about it when I shouldn’t, so I have this mental health impact on me and it's suddenly who do I speak to that about? I'm a watch manager, I should be able to deal with it, I'm a big, strong lad, I've been doing it for years, you can deliver it. But, actually, I'm so anxious on my days off, I'm thinking (swear word), I've got to go back to work, I've got to do this on Monday, I've got to catch up". P17

“I’m thinking, I don’t think people realise that as well but because I’m in charge I’m directly responsible…..know it is and I am the one who sets our work now for the week, the month and that definitely factors into everything that we do. I know that these have got to be done”.p36

Staff agreed that one of the barriers to engaging with the beneficiaries was the reluctance to give data to a third party, with some mentioning that they felt like they were interrogating beneficiaries, and were worried that they might be coming across as judgemental when asking them the health questions:

“Picture it yourself if someone came to your door and said I just want to ask you a few questions and they are nice and smiley you know maybes even a fire fighter, yeah I, then as soon as they mentioned I’ve got a few questions to ask on behalf of these agencies and you know straight away you are thinking ah Christ tell me what is coming here now I’m going to get all my details passed around. Happens day in day out doesn’t it? And I think this whole third party thing scares a lot of people”. p20

“Sometimes it can feel quite patronising some of them because you are talking to a lot of the time it is elderly people you know, older people,

and some of their living experience you feel a bit patronizing asking them these questions and they look at you and they are thinking look son why do you want to know? I've agreed to let you in to fit a smoke alarm, why you doing all of this for, kind of thing, and you get them sort of confused. Why are the fire brigade doing that for?"p13

Finally, some staff reported that there was the occasional negative interaction with members of the public whilst carrying out SWVs. This potentially comes from the public not understanding or being aware of the SWV service:

"I've had abuse sitting outside, sitting parked up erm when we were fitting smoke alarms there is a lad doing the talks er driver who is sitting in the fire engine, we got back eh sat in the truck waiting for the lad to finish his talks, this was a while ago before safe and well-beings came in but it didn't really matter, still the same scenario and a guy came out of his house and he said I've been watching this fire engine it has been parked up here for the last hour and there is 1,2,3, four blokes on it now sitting doing nothing, is this what I am paying my taxes for?"p29

4.3.6 Internal and external communication of SWV

Fire fighters spoke of feeling an improvement with communication from senior management within the fire service. Something which was felt was lacking before:

"….. to be fair (name) started a comms briefing if you are aware of that? Yeah, so and things like that I think are excellent for communication because you do get to hear it from the horse's mouth there is no Chinese whispers there is no hum and ha there is no reading an e-mail in the wrong way because it is worded slightly strangely or whatever, so I think stuff like that is really good. So I would say that the communication is a lot better than it used to be. Erm especially from the people that are higher up that you don't see all of the time".p31

However, staff felt that there was a lack of internal feedback to crews on what was happening following on from a referral. This was something that the crews believed was important to help close the loop, and was also mentioned by the CRM team:

"I've referred quite a few people for different things; I've never had any feedback at all for any single referral". p8

"I think, (name) said it all, nobody ever says that old fella that lives by himself well done there you've done a great job you've really helped him

we've referred him to that, this and the other, we've helped him and we've given him… I've never heard that in my life but I've heard your 20 short this month". p22

"It would be great to get regular feedback on what happens with the referrals. I don't mean in depth detail, but just something short and sweet to let us know if there has been a positive outcome. Not all cases are worrying, but in some, you do think about it after the visit has ended, and wonder whether you've made a difference".p14

There was an appreciation of this from the CROs, who were aware of the frustration of the lack of feedback, and were trying to come up with ways to improve this:

""We can't get the feedback, once it goes to partner agencies, because of data protection. So we've asked if they could send anonymous case studies back, so that we can publish them. We do have the odd one". p3

"We've had some good ones (case studies). We are working on it…..you know, on SharePoint, there's a little section for feedback…it's on there now as a test". p6

"Even if I could get an email to (watch) at (place) to say, the referral you've made regarding that address, just to let you know, I've made some enquiries, social services are involved. Thanks for your referral….that could be a start". p5

It was also seen as important that there was external press and social media activity about the safe and wellbeing visits happening in the county. However this seemed to not be taking place regularly at a strategic level, with staff taking it on themselves to tweet

" …say we had it online, in the paper, in the free paper a weekly add there, think the money that would save, just a weekly add saying look this is what we do, if you want us give us a shout all you need to do is click, or ring, it's all free and we'll come and do it. That way you are going to places where they want you, you have been referred, go and do better". p30

"That's interesting facts coming out of that (place) fire, that photograph at the fire.....embedded in the tweet was a link to advice for free Safe and Wellbeing visits. This particular tweet had more likes than any other

tweet that the service has done in the last two years so it's up there and when you look at the tweet activity, 9,168 people have seen that tweet but that link that I embedded inside, only 68 people clicked on that link to see it and if you did click on the link, it takes you to the brigade's Safe and Wellbeing page and how to request it and all the information. So, 68 people out of 9,100 people".p33

The research team observed fire fighters uploading pictures to social media to warn the public about the importance of smoke alarms. There are fire fighters within CDDFRS who are active members of social media platforms, and are capable of using technology. This capacity, with themes of improving the promotion of SWV throughout the qualitative data collection, suggests that CDDFRS could look at developing a communication strategy purely around their SWV service.

(Name) had taken me up to look at some of the damage from a fire. They took a photograph of the blackened smoke alarm and actually used that to tweet, as the fire service has a twitter account. To kind of say, 'if it wasn't for this (the alarm) things could have been a lot worse'. NC observation

4.3.7 Refinement of Safe and Wellbeing visits

The ability to link the questions in the SWV to the general work of the fire service and their usual observational skills around vulnerability was important:

"I sometimes tell people every time I have had a fire it has either been smoking or alcohol or combination of both. Every single one, that tends to grab people's attention".p18

"Yeah that's an important, cause quite often we do go into, properties it's just normal people, normal house, nice clean tidy and sometimes, wrongly or rightly you do assume that none of these questions are going to apply to these people you know. Like I said wrongly or rightly because you don't know what somebody could be a closet alcoholic. But eh, you can, do get a feel for people straight away and feel silly asking them about eh certain questions when it is blatantly obvious. Well smoking you walk into the house and you can't smell anything but once you've started your questions, it comes to smoking, does anyone smoke. It's embarrassing".p27

It was also important that the staff made the most of opportunities. For example, after a fire incident, using the 'hot strike':

"….it shocks some people (visiting a house as part of a hot strike[14])….. some people will go oh yeah, well you'd better come in. It just pricks people's memory, doesn't it, when something close to home happens and it's the shock factor, isn't it?"p29

The interviewees felt passionate working with beneficiaries and wanted to be better at it:

" But, that's all right if you want to stay where we are with it, but if you're obviously striving to get better at something you've always got to look at how much better you can get".p26

"You know, we are individuals. There is people who care there....some of the crew went home worrying.....did you manage to get in? We just want to make a difference". p17

However they agreed that more needed to be done to make the SWVs easier for all concerned:

"I think yeah, it just if we can't, I don't know how, I haven't got the answers but I think if we could act on referrals and then go, say we got a referral through, go through do the referral and then (inaudible 69:06) do an enhanced, give them just a better standard you know, more holistic sort of from start to finish, a proper job with a referral. Even if you only got, I know this sounds like I am trying to get out of work, but even if you only had two, or three, or four referrals a week, right okay we got a referral lets sort his out, let's get this done let's go there, let's see what we can do, let's make a difference how can we help". p15

There were also suggestions about how the SWV in its current form could be slightly tweaked to yield better results, and be seen in a more positive light from those delivering:

"I think the (health) section could be used as a prompt….two or three questions, and then if they start to disclose, a box underneath for additional information rather than all the questions, as it's a bit long winded".pP3

At the moment, there are still some issues with missing data on the referrals coming through to partners:

[14] A 'hot strike' is when a crew visits an area to carry out SWVs which has just experienced a fire

"But yeah, but some of the, some of them is an issue that I get all the time, I get a report back with someone saying right you've done these home fire safety, I refer to them as home fire safety checks I mean SWV right, done these home fire safety checks but these three have not had a house number inputted or this one hasn't had a street name, or this one hasn't had a postcode and we can't sort of finish the process off until we get those details. To my mind we should, the software shouldn't allow you to progress until it is in". p10

"There is certain information that you put on the computer that you have to put through in order, that you have to input in order for it to be generated as a form. And people know that and if you do go to these houses and you get the bare minimum information just to fill that form out, to send it off complete".p32

If the online form that needs to be completed as part of the SWV allows the form to be submitted without all data, then it creates an opportunity for a referral to not be successful. This might be an area that the fire service could look into, to ensure that when the online form is completed, it cannot be submitted until all essential data has been inputted.

4.4 Interviews with beneficiaries

Five major themes emerged from the analysis of interviews with beneficiaries relating to: *Delivery of a Safe and Wellbeing Visit; Content of a Safe and Wellbeing Visit; Public perception of a Safe and Wellbeing Visit; Barriers to engaging with the service; and the Positive health impact of the service.*

4.4.2 – Delivery of a Safe and Wellbeing Visit

The interaction with crews was seen as a very positive experience by beneficiaries, with particular praise given to the communication skills of the fire fighters who had delivered the SWV talk:

"To be quite honest I felt comfortable cos they were so easy to talk to…….I've never sat down with someone to answer questions like that….and how they would talk to me, it was just like how a normal person would talk to you. They didn't come in with big words. They said, do you understand what we are talking about? And I said, yes I do". p45

"Everything they told me….I mean my daughter was here, she even said, that's brilliant how they explained things to you mam, because sometimes you could forget, but they went through it with you". P49

This was something that was also picked up throughout the SWV observations:

> *And just the manner in which (name) was speaking to the family was really lovely. The interaction, you could see the family were, you could see that they genuinely felt there was care and consideration there from the fire service about their wellbeing. You know, they had four children. They were of school age, so they needed somewhere to be able to feed them and clothe them, and make sure they could get some sleep because they were at school. Those were the immediate concerns of the family and the fire service did a great job at dealing with them. NC observation*

Some beneficiaries talked about how the fire fighters had already picked up cues on their health habits without the need to ask any questions. The quotes below highlight the ability of fire fighters to use their observational skills to pick up on potential health issues amongst beneficiaries:

> *"They didn't need to ask me if I smoked, as I was stood at the door smoking when they came up (laughter), but I told them I never smoke inside you know?". p52*

> *"I actually move around with a walking stick, so I knew that the fire officer might already have a sense that I had mobility problems. It is nice to think they are worried about me, and if I have accidents because of my body getting weaker". p46*

4.4.2. – Content of a Safe and Wellbeing Visit

When asked about what the fire fighters talked about, and what questions were asked, it was evident that fire fighters felt very comfortable talking about fire safety and the use of smoke alarms. This isn't surprising, as fire fighters have been delivering home safety checks for a number of years now:

> *"About the candles….did I leave anything unattended. Going about, talking about the alarms. It was all about the safety. I knew exactly what they meant about the safety of the house". p54*

> *"I remember him asking me about whether I used a chip pan or not. I love home- made chips, but I don't have one of those old fashioned chip pans, I've got the air fryer now. It's not the same mind, but I understand it's safer. When we lived at (place), (name) down the street had a fire in her kitchen because of a chip pan. It caused a lot of damage. It's just not worth it". p50*

Some beneficiaries talked about how the safe and wellbeing questions had been linked to fire risk, such as smoking and drinking, which then creates a better understanding of why health questions are being asked by the fire service:

> *"They asked me if I smoked or drinked and I said no, because if you fall asleep and things like that, they said there had been accidents with things like that, and I said no, I don't do anything like that".p47*

Although not all beneficiaries were able to make the link between fire risk and health, which was suggested from the lack of data from the interviews to demonstrate this, and was also picked up within the observations:

> *An elderly gentleman who had issues with his breathing, he said outright 'I'm not going to give up smoking. I'm at this age, and this is where I'm at'. It was quite funny because the fire fighter said to him 'if you stop smoking you'd be able to walk to the end of the street rather than get a taxi, and he replied 'If I was able to get to the end of the street without a taxi then I would attempt to give up smoking', so almost not really putting the fitness and the smoking together. NC observation*

A couple of the beneficiaries spoke about the information that was left with them at the end of the SWV, which is noted by CDDFRS as best practice, as well as adhering to data protection laws. However, it wasn't clear as to whether the information had been utilised:

> *"Aah yes, I remember that sheet. I do have it somewhere in the kitchen. The one with the safety advice and phone numbers. I know it's there somewhere, in case I do need to look at something. I probably should find that actually". p48*

> *"I thought that was really good (leaving the information sheet). Cos sometimes you forget about things. Especially when you have people in your house making a bit of noise fitting the alarm on the landing. And I was trying to keep my eye on the clock cos I needed to leave by 3.10pm to collect the kids. So that was good to know I had that as a reminder about stuff".p45*

It was noted by a few beneficiaries that once the SWV was finished, the opportunity to engage with the fire service wasn't over. Additional information was left with them, including contact telephone numbers in case the beneficiary had any questions, providing an exit route for themselves, and information to provide to friends or family if they wanted to receive an SWV:

"They even said if I have any problems to contact the fire station….he said just get in touch".p51

"I took the form from him, as I knew that (name) would want to get her smoke alarms checked and fitted. So I was able to give them the sheet so they could call up themselves". p53

It was also seen through SWV observations, that fire fighters were also able to refer to other organisations and schemes that weren't a direct link to the referral partners, highlighting that some fire fighters had a solid knowledge base to be able to support beneficiaries:

(name) actually ended up engaging really well with this gentleman and said he would out some information from the (place), which wasn't anything to do with smoking cessation, but was to do with helping those with breathing difficulties. That was great to see that additional knowledge from the fire fighter, and for (name) to be like 'I'm not referring you to any smoking cessation, but this organisation might still be able to give you some support, is it ok if they give you a phone call. He was really good at supporting that individual and providing much needed support for them. NC observation

4.4.3 – Public perception of a Safe and Wellbeing Visit

The views of the beneficiaries towards the fire fighters was very positive, with many complimentary anecdotes, and a sense of a job well done by the fire service:

"They were just so good the two men. They were absolutely brilliant". p47

"They told me exactly what it was about. Walked around the house. I can't really say anything bad about the service, cos they were just so good, they were amazing".p54

"It was actually really lovely. It's not often you get people coming around and wanting to help you out. And for free as well! It was good to be able to get some advice and was nice to talk to someone for a bit. They were probably sick of me yapping on to them, but they were very polite, they didn't show it". p45

The praise for the fire fighters from the beneficiaries was so much so that they wanted the research team to pass on their thanks for the experience they had with their SWV.

This also strengthens the suggestion that the SWV can have an impact on a person's wellbeing and highlighted the positive experience:

> *"…and will you thank the brigade for me?" p52*

> *"It would be great if you could let (name of fire station) know that I'm really appreciative of what they did when they came into my home. It really has made me think about fire proofing the house. And after all the horrible stuff in the news with the tower….it just really has had an impact on how safe I feel".p49*

Interestingly, they also spoke to their friends in the community about the SWV's, or mentioned previous discussion in their local community:

> *"I told them (neighbours), I said they put them in, ask you the questions and there's no mess". p48*

> *"We've all been told in our community about the SWVs".p51*

However, it was obvious that not all beneficiaries understood the meaning of the visit or could recall the issues that were discussed at the SWV:

> *"Well I don't see the relevance of how much I drank actually to tell you the truth". p54*

> *"If I didn't want to answer them, I wouldn't have answered them you know what I mean? There was no rude questions you know, offensive. To be honest, I can't even remember them asking me how much I had to drink". p46*

One area that stood out throughout the interviews with beneficiaries was that they had strong memories of the fire safety element of the safe and wellbeing visit, and also the fitting of the smoke alarms. However, there was not as much recall of the health questions that had been asked:

> *R: " Were you referred to any of the health services?*
> *P53: "They showed me a list of things, but I haven't done anything about it yet. You know. But I've got the carbon dioxide[15] thing anyway"*

[15] The item mentioned by the beneficiary was a carbon monoxide detector

"I was very pleased that they fitted the fire alarm and they did an efficient job".p54

I noted throughout my (NC) time observing the crews during a number of safe and wellbeing visits, there was an obvious split in the talk (see box below), with the fire safety/ smoke alarm element coming first, and then the safe and wellbeing questions. the majority of fire fighters observed appeared comfortable delivering the fire safety part of the talk, and less so with the health questions:

People would definitely engage with the discussion around fire safety, and you could see that that was definitely what the fire fighters felt most comfortable with, that fire safety element and talking through those issues. Because obviously, that's been their bread and butter for however many years. There was definitely more of an uncomfortableness around the safe and wellbeing questions. NC observation

4.4.4 – Barriers to engaging with the service

One suggestion from beneficiaries as to why the fire service struggled to gain entry into some homes was the uncertainty as to what would take place as part of the visit. There seemed to be a worry about damage or mess that fitting a smoke alarm would cause:

"There's a few I would say don't know about the SWV. I think they went to the houses and there were one or two didn't want them, because they didn't want them to you know, make a mess. And I told them, I said they don't make a mess. They just didn't want them coming in on the carpets". p50

This barrier was also picked up during researcher observations, with an initial reluctance to allow the fire fighters too far into the house:

Although you could see that sometimes there was some hesitancy to let the fire fighters go beyond the hallway, probably for reasons such as feeling like their house was a mess. But to be honest, the fire fighters don't really want to go too far into the house to begin with, whilst they were trying to build up that rapport. NC observation

4.4.5 – The positive health impact of the service

Interestingly, beneficiaries did see the benefit of the SWV and said they felt it had improved their wellbeing by taken part:

"I was just talking to my daughter on Monday, and I said….learn to look after yourself and how to react, it does make you feel better. You can understand if there's anything, really not right". p49

“I don’t know if I can put my finger on it, I have a bit more hope I guess. Maybe I am going to get to meet some people, not be stuck here all the time. Even just having someone to talk to, helps me, as I do get quite lonely now that (name) is gone”. p46

“I have a lot of issues pet, I’m getting on. But do ya know what, I have a bit more peace of mind cos of seeing the boys. I feel safer. They can come round any time they like”.p50

5. Strengths and limitations of the evaluation

This evaluation has benefitted from a number of strengths which have allowed a robust evaluation to take place over the past two years. Longitudinal research has a number of strengths, as it can potentially provide richer information by allowing the analysis of duration (16). Two years of data allows the opportunity to view patterns or changes over time (17). There is also the possibility to build up a bigger picture over a prolonged period of time.

As part of this relationship building, trust is more likely to be established so that during focus groups and interviews, rich data can be gathered. The possibility of developing research based on longitudinal data also builds a bridge between ‘quantitative’ and ‘qualitative’ research traditions and enables re-shaping of the concepts of qualitative and quantitative (18).

CDDFRS were also able to provide an anonymised data dump of a huge dataset that is collected routinely by delivery staff, and inputted by the CRM team. This allowed the research team to focus on the collection of qualitative data, with the knowledge that quantitative data would be available to produce a mixed methods evaluation.

Another strength of this research was the element of collaboration and co-production. Emerging evidence shows the importance of this, to try and move away from the notion of research coming from an ‘Ivory Tower’ (19). As a researcher, there is benefit to having the opportunity to work alongside delivery staff, get to know people to collaborate with, as well as for delivery staff to see what the research team are doing.

A potential limitation of the research was the sample size of participants. 40 participants took part in the qualitative evaluation from CDDFRS, but with over 300 members of staff, this data provides a snapshot of experiences, and may not capture the full breadth of the SWV service. Convenience sampling was also used to recruit participants (20), as it was the most convenient method to enable participation. This is due to the nature of the fire service, and the difficulty in randomly selecting crew members from different districts, stations and watches.

Finally, this evaluation only explores the quantitative data and qualitative experiences of staff, partners and beneficiaries in County Durham. This piece of research is specific to County Durham, and has the potential to lack generalisability to other regions in the country.

6. Conclusions

In summary, the results of the evaluation highlight that the SWV service has been well received by beneficiaries, partners, and the CRM team, in addition to some of the delivery staff. There is a good understanding of what the SWV service is trying to achieve, and an appreciation of the hard work and time that CDDFRS has invested. The main cause for concern is addressing training needs, communicating the high-risk targeted strategy utilised by CDDFRS to all staff, and prioritising good quality referrals. By addressing these issues, the SWV service can continue to develop and be refined. This will ensure that a high-quality service can be delivered across County Durham, which can add value to current health services and offers.

The results from the focus group and interview with members of the CRM team indicated that training had been delivered to staff, but the process of ensuring that training was producing competent staff to deliver SWVs was not in place. The building of competency and confidence was seen as crucial to allow a consistent delivery mechanism. In addition, the qualitative findings and the section describing the current high-risk targeted approach showcased the work that CDDFRS are putting in to working with the most vulnerable and at-risk groups in County Durham. The work that now needs to happen is for this system to be communicated and cascaded throughout the service, in an understandable and user-friendly format. Positive outcomes were seen in both the homes of beneficiaries and from feedback from partners, with an additional beneficial impact of improved internal partnerships between CROs and crew members. Finally, a number of suggestions from CRM participants were put forward to help the service develop and improve. These included revised face-to-face training for staff, revisiting what data was recorded in the SWV, reinvigorating the partner meetings, and reducing the target of SWVs with a system that could balance higher referral percentages/ improved quality of an SWV with a lower number of SWVs due to the increase in time spent on each visit.

The results of the partner interviews indicated that participants felt there was a need for a service such as the SWV, and that there was huge benefit to having such a service ran by CDDFRS. Some issues were noted around the quality of referrals and the training of fire fighters across the different health outcomes. It was however, agreed that these issues had continued to improve from the outset of the service in February 2016 due to the partnership working from all stakeholders involved, and because of the will and intent of CDDFRS to continually improve.

The findings from the focus groups with delivery staff highlighted that there was a good understanding of why the SWV had been introduced, but there was a mixture of staff who felt they did or did not have the correct and appropriate skill set to deliver the service in its current format. One of the areas that CDDFRS may wish to explore is ensuring that the health outcomes on the form are of purpose (i.e. are being used) and that staff feel comfortable with the knowledge and skills required to talk to beneficiaries about their health. In addition, delivery staff felt that to provide a higher quality service, a move towards Key Performance Indicators (KPIs) that reflect on the successful outcomes of a referral, rather than a pre-determined number of visits every year would help to improve the service.

The results of the focus groups with beneficiaries highlighted that the interactions with the fire service had been very positive, and in some instances, potential improvements in wellbeing were noticed through feelings of being safe and listened to. A potential barrier to the fire service engaging with people were the preconceived ideas of how the SWV would negatively impact the home, such as the SWV causing mess and disruption. This could be addressed with further work on advertising and communication of the SWV to the public. It was also noted that further work is needed on communicating exactly what the SWV service is, to ensure that it is not just seen as a home fire safety check.

In summary, the SWV service has the potential to make a real difference within local communities, especially to the lives of the most vulnerable in County Durham. This evaluation, alongside the earlier work of the Overview and Scrutiny Committee, and the current evaluation with Public Health England, can hopefully feed into addressing the issues that have been raised in this report from beneficiaries, partners, the CRM team and delivery staff.

To help reflect on the primary aim of this study, '*to evaluate the implementation of SWVs by CDDFRS'*, there are a number of key bullet points exploring each objective:

- **To explore the implementation of the SWVs into the fire service daily practice;**

As in other studies, the involvement of a 'champion' to facilitate the acceptance of such work is important (14). Staff felt that this work could fit into their daily practice but that there is a lot of paperwork and that changes need to be made to ensure it is easier to implement. There are challenges with ICT systems and data collection processes that need to be explored further.

It appears that there are some issues around what the staff think the intervention should consist of. Brief advice should happen within about 5 minutes and can be

done whilst doing something else, e.g. fitting a fire alarm. More training may be required to ensure that is happening.

In addition, the high-risk profiling that is carried out by the CRM team, to ensure that SWVs are carried out in areas with vulnerable residents, is not fully understood by the delivery teams carrying out the SWVs. Therefore further work is required to ensure this targeted approach is communicated across CDDFRS.

- **To explore with the fire service and partner organisations what their understanding of the SWV process was, and what impacted on their role;**

Although, in the main, the fire service delivery staff, CRM team and partner organisations felt that delivering SWVs was an important thing to happen they felt that the training could be improved. Delivery staff and the CRM team also felt that there should be less emphasis on targets and some consideration of how this impacted on other work that is essential to carry out.

- **To assess the referral pathways to see how many clients are referred to partner organisations, how many of the health areas they are being referred for, whether or not these referrals are appropriate, and if relevant health areas are covered by SWVs;**

The evaluation showed that that around a third (31%) of potential beneficiaries were screened (n=11,485), i.e. the residents who agreed to take part in the full SWV. Of these 11,485, 64% were eligible for referral (n=7,311), i.e. met the necessary criteria. Of these 7,311, 23% (n=1,664) agreed to be referred to partner services. Of these 1,664, 31% resulted in an appointment with a partner service (n=517). There were differences across the different health outcomes. With the highest eligible screening rate highest for winter warmth (46%) and smoking (20%). However, of those that were eligible for referral who engaged the highest was with dementia (98%) and Warm Homes & MMB – Year 2 (79%) and loneliness and isolation (34%). With all others being 30% or lower.

Discrepancies between the data from the fire service and the partners was found relating to smoking (CDDCFRS n=164; partners n=41), loneliness and isolation (CDDFRS n=491; partners n=402), and dementia (CDDCFRS n=248, partners n=191).

- **To gain feedback from beneficiaries of SWVs to assess impact**;

Most beneficiaries felt that the interaction over the SWVs was of use especially around issues relating to slips trips and falls, and loneliness and isolation in particular. Beneficiaries had a positive experience with CDDFRS.

- **To gain feedback from beneficiaries about how appropriate they feel it is for CDDFRS to ask them about health issues.**

In general, beneficiaries felt supported to be asked the questions within the SWV, however some were unclear as to why they were being asked health related questions, which indicates that more work is needed to ensure that the service is advertised more effectively both in standard and social media.

7 Recommendations

- It is recommended that Public Health SMT and CDDFRS make note of the findings outlined in this report.
- It is recommended that consideration should be given to reducing the number of health issues covered within the SWV, based on the referral data findings and low numbers of eligible people/referrals for some sections.
- It is recommended that further work is carried out to integrate the fire safety elements of the visit with the health issues, so that the link between health and fire risk is apparent to both the delivery staff and the beneficiaries.
- It is recommended that the high-risk targeted approach utilised by CDDFRS is communicated to all levels of staff in an appropriate manner, to improve the understanding of how the SWV service targets those who are most at risk and are vulnerable.
- It is recommended that the skill set of the current workforce be utilised, to ensure that the quality and consistency of the SWV delivery can be of a high standard.
- It is recommended that an online MECC training session is added to the training programme with ideas of how to give advice to those that score positive for each of the sections, as well as the current training packages being updated.
- It is recommended that changes should be made to the leaflet given to beneficiaries with contact phone number/email of services for each of the components which would act as brief advice (see figure 12 for suggestion of where this could be placed).
- It is recommended that data collection and IT systems need to be streamlined and made easier for staff and partners, as well as a robust online form which does not allow for data to be missing when being transferred from CDDFRS to partners and vice versa.
- It is recommended that the differences in relation to numbers of referrals is investigated further, with priority given to the quality of referrals processed and not the number of SWVs carried out per year.
- It is recommended that a regular feedback system is developed between the partners, CROs and crews.

- It is recommended that a short and concise communication strategy is developed which includes all media (including social media).

Figure 12: useful contact information

Useful Contacts

Organisation	When should I contact them	Contact details:
Trading Standards	Consumer advice and concerns about illegal sales activity or fake goods.	Tel: 0345 404 0506
Alzheimer's Society	If you would like free advice about Alzheimer's or dementia.	Tel: 0191 298 3989
Citizens Advice	If you want free advice about managing money and fuel bills.	County Durham: 03444 111 444 Darlington: 01325 256 999
Social Care and Health	If you have hearing impairment or loss and require advice about specialist smoke alarms.	Tel: County Durham: 03000 267 979 Tel: Darlington: 01325 346 200
Register my appliance	Free information about product safety repairs or recalls.	Email: www.registermyappliance.org.uk
Electrical safety first	Free information and advice about electrical safety in the home, including electrical product safety recalls.	Email: www.electricalsafetyfirst.org.uk
Carers Support	Free advice service, including funding for a carer break, grants and how to find your way through the maze of services for you and the person you care for.	County Durham: 0300 005 1213 Darlington: 0300 030 1215

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