Agenda Item 6

Lincolnshire COUNTY COUNCIL
Working for a better future

Policy and Scrutiny

Open Report on behalf of Nick Borrill, Chief Fire Officer	
Report to:	**Public Protection and Communities Scrutiny Committee**
Date:	**19 September 2017**
Subject:	**Change of Service Delivery Strategy and Transition from Home Safety Checks to Safe and Well Visits**

Summary:

Having delivered Home Fire Safety Checks for in excess of 15 years and fitted many thousands of smoke alarms in people's homes, the number of serious dwelling fires has fallen whilst the rate of ownership of working smoke alarms has risen to an all time high. Despite these trends people continue to lose their lives to fire. This and the national drive promoting fire and rescue services as a health asset has brought about a change in service delivery strategy, focusing our resources on the most vulnerable and developing the popular 'Home Safety Check' into a more holistic 'Safe and Well Visit'. The range of issues tackled has expanded over the years from a pure fire safety check into a broader home safety check. Whilst fire safety remains hugely important, it seems that now is the time to broaden the check once again to incorporate a wider range of issues, recognising the effectiveness of the fire service's preventative work.

This paper seeks to inform committee members of the key changes to our Home Safety Check service delivery strategy and provide an understanding of the new Safe and Well Check that is currently being piloted.

Actions Required:

The Public Protection and Communities Scrutiny Committee are invited to consider the change in service delivery strategy and transition from Home Safety Checks to Safe and Well Visits and offer feedback as appropriate.

1. Background

1.1 Change in Strategy

Lincolnshire Fire and Rescue's Prevention Strategy, as set out in the IRMP Baseline Document[1], commits the Service to deliver targeted Home Safety Checks and work with partners to signpost the residents of Lincolnshire to the most appropriate services for their needs.

[1] https://www.lincolnshire.gov.uk/lincolnshire-fire-and-rescue/about-us/service-planning/irmp-baseline-document/130350.article

Over recent years the Service has delivered against this strategy predominantly through Home Safety Checks in targeted areas within the community which have been identified using a range of data sources including local demographics and delivered by both Community Safety Checks. The checks have been aimed primarily at reducing the impact of domestic dwelling fires and increasing smoke detector ownership.

The English Housing Survey 2014-15[2] found that 93% of surveyed homes now had smoke alarms fitted and since then new legislation[3] has made installation of smoke alarms mandatory in all private sector rented property which has increased ownership even further. Clearly through a range of initiatives both national and local, smoke alarm ownership is becoming the norm and evidence suggests that the need to provide smoke alarms is becoming secondary to a range of health and wellbeing related issues.

Working in partnership, the Service has, over the years, worked hard to establish referral pathways with a broad range of community services, the success of this partnership working has led to increasing numbers of referrals, to the point that almost all of the home Safety Checks completed are now through referrals. It became clear from these referrals that we were reaching the more vulnerable members of our communities and that many of the people we visited had needs far greater than those that we had traditionally encountered. We found that our community safety staff, known as Advocates, needed to establish new pathways with partners to help resolve the issues identified and increasingly needed new skills. Recognising the increasing volume and the great value of this work, the Service took the step of reviewing its approach to delivering Home Safety Checks.

The resultant new approach takes into consideration the level of risk presented in each case, ensuring those at highest risk are treated as a priority. By allocating a risk score we are able to prioritise our resources. There are three factors that influence the level of risk and thereby the priority, these are:

- Likelihood – the probability of having a fire
- Severity – the risk factors of the individual based on lifestyle
- Outcome – the interventions required to reduce the risk

A risk matrix is then used to allocate and prioritise visits to the most vulnerable as follows:

- Critical Risk – within 5 days by CFS Advocate
- High risk – within 10 days by CFS Advocate
- Medium Risk – within 30 days by fire crews
- Low risk – DIY Pack

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/539096/Smoke_Alarms_in_English_Homes_Full_Report.pdf
[3] Energy Act 2013: Section 150. http://www.legislation.gov.uk/ukpga/2013/32/contents

The Home Safety Checks are then delivered by appropriately skilled staff, we use our fire crews to deliver the medium risk visits which generally require little in the way of additional support or specialist equipment and our advocates to deliver the high and critical risk visits which tend to be more complex, usually involve a degree of partnership working and often require one or more return visits. For the low risk cases we direct the householder to a do it yourself pack available either from the Service website or where through the post where internet is not a medium that the householder is comfortable with.

This new approach is now established and we are finding more of our Advocate time being spent supporting those at highest risk. With many of the issues identified being broader than the traditional fire or home safety matters and requiring multi agency support, it is now considered appropriate to progress to the next stage. So we have taken the decision to develop the 'Home Safety Check' into a 'Safe and Well Visit' in line with the nationally supported direction.

1.2 The National Position

NHS Sustainability and Transformation Plans released in August 2015 set out a Five Year Forward View in which Fire and Rescue Services (FRS) nationally are identified as a health asset. Working together with Public Health England, the National Fire Chief's Council (NFCC), the Local Government Association and Age UK established a new working relationship aimed at improving the quality of life for people who would benefit from brief health and wellbeing interventions in their own homes, and better co-ordinated public services.

The Strategic Health Group and NFCC continue to promote 'Fire as a Health Asset' to the Government, including the devolved administrations, the NHS, social care departments and third sector organisations.

1.3 Chief Fire Officers Association (CFOA) Health Strategy 2015-19

This strategy (Appendix A) sets out how CFOA, now the NFCC, are leading the drive to provide greater collaboration between fire and health services to produce better health outcomes for the communities they serve. Such collaboration will support a number of wider priorities and issues for both the fire and rescue service and our health partners.

As part of their work NFCC have developed guidance to assist fire & rescue services to develop their highly successful 'Home Safety Check' initiatives into more holistic 'Safe and Well Visits'.

Between October 2015 and March 2016, three fire and rescue services took part in a pilot which intended to measure the impact of their interventions on reducing the risk of winter-related ill health in vulnerable people. The pilot aimed to address the health risks of falls, social isolation, cold homes and flu during the winter months.

The evaluation demonstrates the value of fire and rescue service engagement with this work. A summary of the evaluation follows:

- Of over 6000 homes visited, more than half of these resulted in the identification of households with people at risk of a fall, social isolation or a cold home
- Approx. 3500 of these visits resulted in a referral to other services
- Advice and/or home adaptations were provided to over 5000 households
- It is estimated that the pilot resulted in the avoidance of 147 visits to accident and emergency
- 80 new falls assessments for those at risk of a fall were completed
- A return of £7 in social benefits for every £1 additional investment was achieved
- People receiving a visit found it valuable and felt it had a positive outcome on their health and wellbeing
- The pilot strengthened local partnerships and complemented the work of health, social care and voluntary sector organisations.

1.4 The Safe and Well Visit in Lincolnshire

We looked to identify opportunities within Lincolnshire, and commenced discussions with partners across the county. A number of opportunities were identified that could improve community health and wellbeing outcomes, particularly to the more vulnerable people of our community, enhance existing prevention and response activities, add value and potentially reduce costs to partner organisations.

Working on the model used for the pilot referred to in 1.3 and with support from partners we developed a 'Safe and Well Visit' aligned to Lincolnshire's needs.

The visit is aimed at the more vulnerable residents and offers fire safety, housing, practical lifestyle and general wellbeing advice. It also includes a falls assessment and given the significant rise in cooking related fires, offers specific advice on cooking safety.

We have now commenced the transition from 'Home Safety Check' to 'Safe and Well Visit' with a local seven week pilot which started on the 14th August 2017. A review will take place at the end of the pilot with a view to a full roll out to all ten Community Fire Safety Advocates and our nine Wholetime Duty System fire crews by November 2017.

2. Conclusion

Lincolnshire Fire and Rescue aim to offer a greater contribution to the health, safety and welfare of the communities of Lincolnshire through concentrating its resources on delivery of a Safe and Well Visit to the most vulnerable whilst continuing to provide good service to those most able to help themselves.

3. Consultation

a) Have Risks and Impact Analysis been carried out?

Yes

b) Risks and Impact Analysis

This is available within Fire and Rescue's Community Fire Safety department

4. Appendices

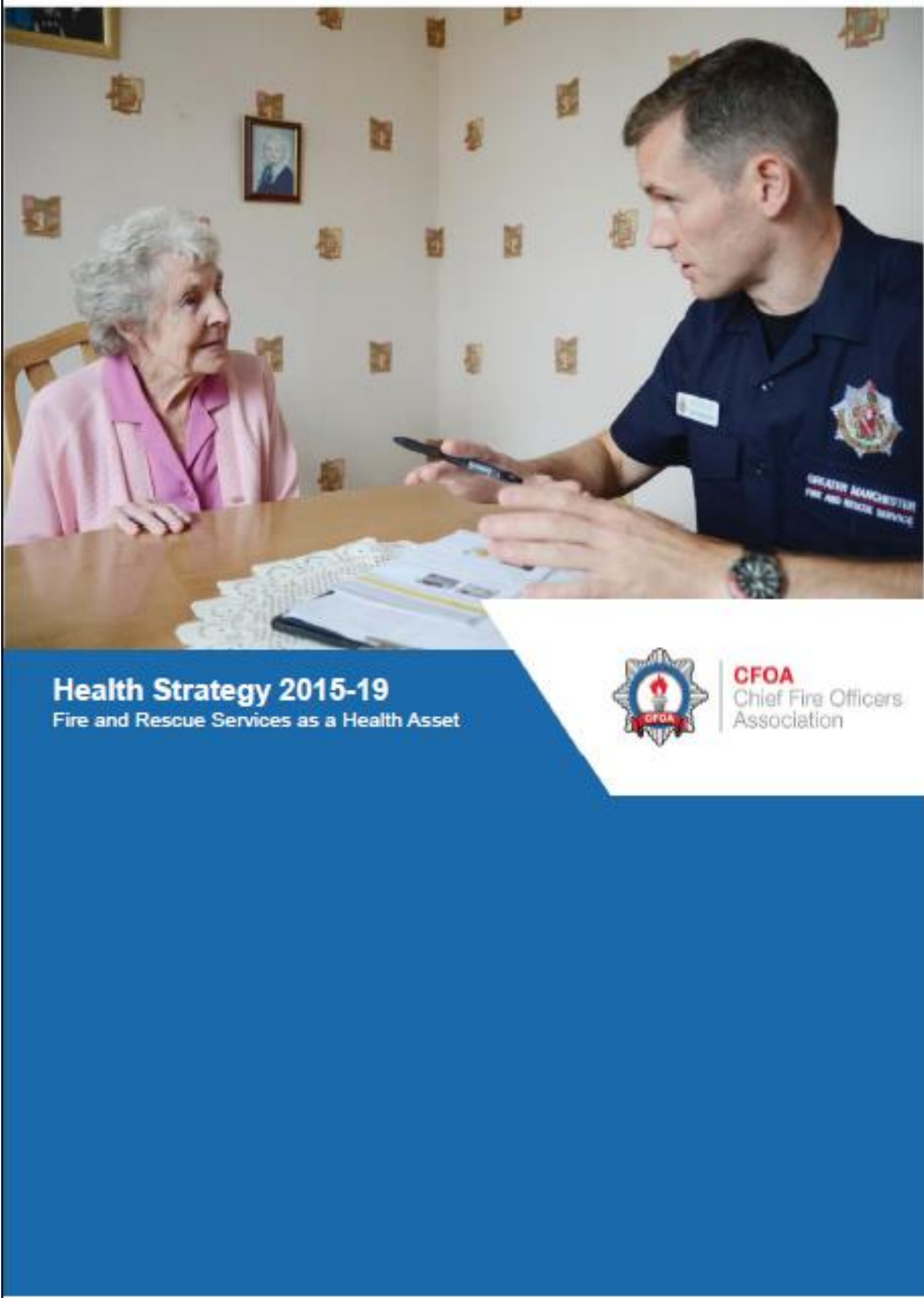
These are listed below and attached at the back of the report	
Appendix A	Health Strategy 2015 – 2019: Fire and Rescue Services as a Health Asset

4. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon York, who can be contacted on 01522 555130 or Simon.york@lincoln.fire-uk.org.

Appendix A



Fire as a Health Asset

I was so impressed with the work of the fire services! I realised that the agendas of preventing ill-health and preventing fires were closely linked: fires and ill-health occur in the more deprived areas, to people at the bottom of the socio-economic gradient, to those in poor quality housing, and to those whose circumstances have lead them to take up unhealthy lifestyles. The fire services do what every stakeholder involved in reducing health inequalities should do: engage directly with the community, work to provide them with the opportunities they need to live a healthy life and focus on prevention.

- Professor Sir Michael Marmot
Fair Society, Healthy Lives – Strategic Review of Health Inequalities in England Post 2010
Published 2010

Firefighters have been fantastically successful in moving from a responsive to an interventionist service. Instead of the fire and rescue service being residualised, its remit must be expanded to offer different types of interventions – including in preventative health and social care. By working with local councils and health and wellbeing boards, local fire services can be really effective partners in improving the overall health of their neighbourhood.

- Dr Claire Mansfield
Head of Research, New Local Government Association
Author of Fire Works: A Collaborative Way Forward for the Fire and Rescue Service
July 2015

Introduction

The first question many people will ask is why should fire be seen as a health asset at all? It is an important question, but I believe it has an obvious answer.

The NHS, public health and social care are facing the same challenge the FRS did over a decade ago; demand outstripping resource and capacity to respond. However, they recognise the success the FRS has had in reducing demand through investment in prevention activity, and are now looking to colleagues in the fire sector to help them replicate this.

We know that a great many of the causes of poor health outcomes are the same as those that determine risk from fire. Frailty, poor mental health, obesity, smoking, alcohol and substance abuse – amongst other things – place major stress on health services and represent some of the key factors involved in fatal fires. We therefore have a fantastic opportunity to work together for mutual benefit.

The hundreds of thousands of targeted home fire safety checks that fire and rescue services currently undertake nationally are a unique and powerful opportunity to influence the lives and health outcomes of vulnerable people. The hugely positive and trusted fire and rescue service brand gives fire service staff a way across the threshold and a means to engage with some of the hardest to reach in our communities.

Ambulance services are under particular pressure, with enormous growth in demand and increasing expectations. Fire and rescue services have the capability to support and assist our blue light colleagues through co-responding, first responding and similar schemes, helping to free up highly skilled paramedics and technicians to deal with other more complex issues.

'The overall aim of this strategy is to ensure fire and rescue services are regarded as a key health asset.'

The benefits of this approach will clearly be mutual; by helping health services to tackle these issues we will also address some of our own risks and priorities. The costs associated with poor health outcomes even in the short term are in the billions. Of course there is also an opportunity to access the significant resources the NHS controls to support our efforts in relation to risk reduction.

This strategy is intended to outline how CFOA will establish a unified offer to health against a number of priorities. It will be championed by the Strategic Health Group, which is comprised of representatives from across all of CFOA's directorates.

It recognises that any approach will need to take account of local capabilities, relationships, risks and needs. Communication between all those involved will be vital to determine what is wanted by health services and what fire and rescue services are in a position to deliver. While there cannot be a one size fits all model, this strategy and multiple case studies show that good practice can often be adapted and changed to fit local needs.

To return to where I began, the question is not why should the fire and rescue service be involved in health, but why has it not been more involved before now? I am sure that within the next ten years fire and rescue services will come to be recognised as a key asset for the health service. I am confident that together we can build safer and healthier communities.

Peter O'Reilly
CFOA Strategic Health Lead

Supporting CFOA's Priorities

How does this strategy fit with our wider priorities?

This strategy sets out how CFOA is going to support a drive to provide greater collaboration between fire and health services to produce better health outcomes for the communities we serve. Such collaboration will support a number of wider priorities and issues for both the fire and rescue service and our health partners. Some of these are listed below.

It aims to fulfil the intent set out in the **consensus statement** signed by CFOA, NHS England, Age UK, Public Health England and the LGA in October 2015, although it goes further than even this.

CFOA's Strategic Direction document 'Making the difference needed' has as one of its key priorities to build '**Safer, healthier and more resilient communities**'. This strategy and our wider relationship with the health service will be one of the most important ways of achieving this. Similarly, 'Making the difference needed' recognises the need to advocate for the wider implementation of co-responding schemes and the need to drive reform and service integration, both of which are key elements of this strategy.

The **NHS's Five Years Forward View** places great importance on 'getting serious about prevention' and it has been recognised that fire and rescue services have been trailblazers in this regard in the past two decades. Equally, the Forward View recognises the need to explore new models of health care, work with new partners and back innovation. We believe that we have the experience and capacity to help the NHS to achieve these aims.

Both health and fire services have recognised the importance of '**making every contact count**' by improving the outcomes that citizens receive, reducing duplication and ensuring that maximum benefit is gleaned from all contact with public services. The communities we serve deserve the best value for money and quality of services they can – who provides it and how it is provided should be secondary considerations.

The **NLGN report Fire Works** recognised the potential role fire could play in health and recommended that it be developed further and recognised as an important part of the fire services work.

Not only does greater collaboration improve services for those at the receiving end, it has the capacity to save our services time, money and resources. At a time when all public services are facing squeezed budgets and pressure to innovate and collaborate, a closer working relationship between health and fire has **the potential to save millions of pounds and many lives**. It will be important to find means to measure and evaluate the success of the work, especially when some outcomes will involve something not happening.

PHE, the Royal Society for Public Health and others have recognised that there is a need for investment and recognition of the '**wider public health workforce**' – those outside of the health and care profession who have a role in providing public health interventions. We believe fire and rescue services are a key part of that wider workforce, and one that punches well above its weight. This is something already being recognised widely by our colleagues in public health.

Our Priorities

Our priorities

Aim: To ensure that fire and rescue services are regarded as a health asset

Priorities:

1. Build relationships with national, regional and local health and social care partners, government departments and the third sector to encourage closer collaboration and data and information sharing between fire and health and clearly communicate the benefits of these relationships

2. Develop the design principles for and encourage the uptake of "Safe and Well" visits and the effective use of all fire and rescue service resources, building on the Home Safety Check and informed by existing good practice and ongoing evaluation

3. Explore and develop other areas where fire services can improve health outcomes, by drawing on best practice, utilising new technology and investing in upstream prevention activity.

4. Develop the skills and training requirements necessary to allow the fire service workforce to effectively support improved health outcomes

5. Agree guidance for commissioners, health service providers and fire and rescue services to facilitate commissioning opportunities

6. Work with Ambulance Trusts, Association of Ambulance Chief executives (AACE) and other partners to complement the professional expertise delivered by paramedics at medical emergencies

7. Work with all health partners to improve the fire safety of the health and care premises where vulnerable people are at risk, and reduce numbers of avoidable incidents that impact on the availability of Fire and Rescue Service resources

In each case, we will seek to use the experience and expertise gained in the pursuit of these priorities to improve the wider work and operations of the fire and rescue service in all areas of our work.

Priority One

Build relationships with national, regional and local health and social care partners, government departments and the third sector to encourage closer collaboration and data and information sharing between fire and health and clearly communicate the benefits of these relationships

CFOA wants the fire and rescue service to be recognised by public health colleagues and the government as a key health asset. This will require us to build trusting relationships with partners and promote the capabilities of fire and rescue services and the mutual benefits such collaboration will bring. The overall aim of this should be to facilitate conversations between individual fire and rescue services, health and social care commissioners and providers at a local level so that schemes can be introduced. It is also vital that we operate in a way that is aligned and mutually beneficial, helping health colleagues to achieve their aims – such as those outlined in the NHS five year forward plan – and ensuring that fire and rescue services are able to achieve theirs.

Many people in government, other public services and the population at large are not aware of the wider role fire and rescue services already play in prevention, protection and community safety. For some, the service is still predominently associated with emergency response, designed to tackle a narrow range of emergencies. While this remains a critical part of what the FRS does, we have long known that we save as many if not more lives by preventing incidents from happening. Clear communication of the reasons and benefits behind fire and health collaboration, such as the shared risks and opportunities presented by Safe and Well Checks and other prevention activities, will be important if we are to receive support from colleagues and the communities to whom we want to deliver.

Information and data possessed by public services represents a powerful means of improving services and reducing harm. Health colleagues have information on illness, frailty, prescriptions and much more that can be used to identify those in need and coupled with fire and rescue service data and mapping tools to create a rich picture of those most at risk. We already know that in many instances public bodies are aware of individuals or families who are at risk but partner agencies remain unaware, often because of a perception that data and information cannot or should not be shared. We should challenge this view and work towards a position where the assumption is always in favour of sharing relevant data unless there is a good reason not to do so. Of course it is important to have in place security and confidentiality guidelines to ensure that the public can have confidence in how data is shared, who it is shared with and how it will be used.

When we are successful…

- Fire and Health services will collaborate across a number of agendas and to deliver against these will share resources, personnel, equipment and budgets.
- Government departments will have a joined up approach that enables the realisation of the benefits of providing greater integration between fire and health.
- The potential of fire as a health asset will be reflected in a broader focused National Framework
- Fire and rescue services will have access to a wide range of timely, relevant data in useable formats, which can be used to risk stratify and to prioritise and target health and wellbeing interventions, as well as other prevention activity.
- At a local level, fire and rescue services will be regarded as a key health asset and will be a key member of local Health & Well-being boards.

How might we measure this?

- Feedback from Clinical Commissioning Groups (CCGs) and fire and rescue services about their experience and interactions.
- Reductions in fires and negative health outcomes, such as excess winter deaths, amongst those targeted using health data.

Priority Two

Develop the design principles for and encourage the uptake of "Safe and Well" visits and the effective use of all fire and rescue service resources, building on the Home Safety Check and informed by existing good practice and ongoing evaluation.

A Safe and Well visit will be a person centred home visit to identify and reduce risk to the occupier or occupiers, which expands upon a Home 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 hundereds of thousands of visits Fire and Rescue Services are already undertaking.

The range of risks addressed will be tailored to meet local needs and capacity. Services will identify a multitude of risks, delivering advice and brief interventions and acting as the point of contact to reduce risks. These will target our most vulnerable people, from the frail and elderly, those with mental health issues to those with substance dependencies. Interventions could be equally broad, from undertaking the Gait Test for frailty, to administering vaccines, to fitting safety equipment or the early identification of long term conditions. Where appropriate, issues will be referred to specialists for further advice and support. These visits will assist in reducing pressures and demands for partners, identify more of the people in greatest need and deliver better outcomes for the communities we serve. To support these aims we should consider the effective use of all Fire and Rescue Service resources including stations, vehicles, equipment and staff.

Public services and health in particular are, quite rightly, strongly evidence based. There is a recognition that the evidence from the fire and rescue service's own success is a good starting point for this work, but there is much that fire and rescue services will do in support of health and social care partners that has a limited evident base; it will therefore be important to ensure that new initiatives and approaches are evidence led and linked to health outcomes frameworks so that it is clearly recognised and valued by health partners.

When we are successful…

- At a local level fire and rescue services will be working with local health partners to deliver thousands of Safe and Well visits, building on the success of Home Safety Checks.
- The most vulnerable in our communities will be receiving a joined up service, providing quick and effective early realistic assessment of need to improve their health and wellbeing and keep them safer in their homes.
- Health partners will be under reduced pressure and see improved outcomes for their patients

How might we measure this?

- Reduction in the demand or reduction in the growth in demand for accident and emergency, health and social care etc.
- Associated cost savings for health services – e.g. reduced frequent callers to GP surgeries (see Dorset SAIL project)
- Reduction in demand for other Emergency Services (fire, police, ambulance, responses from telecare etc.)
- Impact on outcomes from PH or NHS outcomes framework

Priority Three

Explore and develop other areas where fire services can improve health outcomes, by drawing on best practice, utilising new technology and investing in upstream prevention activity.

Fire and rescue services have a range of other interventions beyond a safe and well visits that they can make to improve health outcomes, from working with people and organisations to improve fitness to promoting key life savings skills and technology. The unique and trusted brand of the fire and rescue service enables us to engage with and motivate often hard to reach groups, and this can be exploited to improve the health and wellbeing of people young and old. As we have been able to do in terms of community resilience, fire and rescue services can act to empower communities to become more self-reliant and improve their own health, safety and wellbeing by providing advice, guidance, education and support to prevent susceptibility to risk before it occurs. Our experience in reducing fires and other emergencies through improved fire prevention and protection has proven to us that upstream activity which produces improved outcomes in the medium or long term are most effective.

New technologies, such as telecare services or fire suppression systems, play a positive role in supporting vulnerable people to remain independent in their own homes by connecting them directly to help and limiting or controlling fires when they occur. There is clear evidence that the use of telecare monitored fire detection systems, where fitted correctly, can be effective in the rapid detection of fire and mobilisation of fire crews and can therefore play an important role in achieving a range of benefits for both vulnerable individuals and the community in general.

Sharing good practice is one of the core roles of CFOA as the professional voice of the fire and rescue service. There is a wealth of existing guidance, information and good practice produced by both the health service and fire and rescue services which would be of use around health and fire matters. Sharing this guidance will allow services to integrate it into their thinking and strategic planning and include it within their interventions. Learning from others is also a vital way to improve services and avoid the mistakes of the past. Of course in all these areas we recognise that local differences mean that no one model will fit all areas.

When we are successful…

- Fire and Rescue Services will be seen as being key partners for Public health teams, CCGs and NHS Trusts for health, wellbeing and fitness promotion
- Fire and rescue services and health and social care partners will be able to utilise technologies such as telecare or mobile suppression systems to reduce the risk of death and injury from fire and other emergencies
- Fire and rescue services will have access to a comprehensive portfolio of good practice regarding fire, health and wellbeing collaboration and best practice from within the fire and rescue service will become common practice

How might we measure this?

- Direct feedback from PHE, NHS Trusts and CCGs – evaluation, monitoring outcome frameworks, positive referrals leading to change
- Conduct qualitative evaluations of fire service prevention activity both for the NHS Trusts and for FRSs before and after the arrangements are put into effect

Priority Four

Develop the skills and training requirements necessary to allow the fire service workforce to effectively support improved health outcomes

Firefighters and fire service staff are highly skilled and fulfil a range of roles. Over the past decades they have taken on a great many new tasks which have required them to be highly adaptable and open to new roles and responsibilities. Many of their existing skills, such as trauma care, risk assessments or community safety interventions, coupled with a problem solving culture and a strong ethic of public service, are relevant to our efforts to support the health and wellbeing agenda. There is clearly an opportunity to add to these skills with other basic health interventions.

Of course, there are an enormous number of complex issues in health and it will not be appropriate for fire and rescue service staff to try to tackle all of the problems. In many instances their role will be to identify risks and signpost to appropriately qualified health and social care colleagues, or non-statutory services. Nonetheless, if fire and rescue service staff are to become a health asset, a trusted partner and the eyes and ears of our health and social care colleagues, it will be vital to provide them with the appropriate skills and know how they will need to identify health risks, hold difficult conversations with vulnerable people and build the relationships with partners necessary to effectively signpost these issues.

When we are successful...

- A robust safeguarding process for firefighters and fire service staff working with vulnerable people will be in place.
- At a local level fire and rescue services in collaboration with health will be providing the necessary training and development to their staff to enable them to undertake a wider health role in a confident manner
- The public will be assured that health and wellbeing interventions are undertaken by professional and appropriately skilled people appropriate to their local risks and needs

How might we measure this?

- Independent verification of the health and wellbeing interventions being undertaken by fire service staff
- Level of satisfaction from firefighters and fire and rescue service staff undertaking health and wellbeing interventions
- Measure householders assessment of improved health and wellbeing
- MECC training and Marmot objectives combined with knowledge of importance of wider determinants of health

Priority Five

Create guidance for commissioners, health service providers and fire and rescue services to facilitate commissioning opportunities

Clincal Commissioning Groups CCGs, Local Authority Public Health departments, Social Services and health service providers will play a key role in any collaboration between health and fire, so they must be well informed and have confidence in the approach. Being clear with commissioners on why they should engage, what is possible (and not possible) and who is best to contact will be one means of doing this, together with examples of where fire and rescue services have already delivered successfully against the health and wellbeing agenda. Setting out the range of possibilities and potential at a national level will lead to the important conversations at a local level that lead to improved outcomes for the public. It will also be important to remember that the possibilities may be more limited in some areas than other, due to political, economic or operational factors.

Commissioning is not the same as procurement, although the two terms are sometimes incorrectly used interchangably. Ensuring senior managers have a proper understanding of what commissioning is and how it works, as well as the necessary skills to take part in the commissioning process will be vital.

Although not all commissioining involves payment, it will also be important to consider and explore how work carried out by fire and rescue services on behalf of health might be funded. In some instances this work will incur little or no additional cost and the benefits will clearly be mutual. However, there may be occasions where a proper commissioning process with attached funding would be appropriate. This is already the case in some places around co-responding, first responding, or some other elements of community safety.

When we are successful…

- Health and Clinical Commissioners and health service providers will be fully aware of the benefits that can be achieved by engaging with fire and rescue services as a health provider
- Fire and rescue services will be fully aware of the commissioning opportunities with health and will have ready-made 'packages or tenders'
- Fire and rescue services will be widely commissioned by CCGs and other partners to undertake health interventions

How might we measure this?

- Direct feedback from fire and rescue services and CCGs on their understanding of the process and opportunities
- Through delivering against agreed objectives and outcome measures

Priority Six

Work with Ambulance Trusts, Association of Ambulance Chief Executives (AACE) and other partners to complement the professional expertise delivered by paramedics at medical emergencies

Ambulance services, unlike the fire and rescue service, are facing rapidly increasing demand for their services. In 2014/15 for example, they saw an increase of 9.3% or 265,952 category A calls that required an emergency response. Fire and rescue services in some areas are already providing assistance to ambulance colleagues for certain types of emergency and non-emergency calls, either working with paramedics to assist them at the scene of an incident, or freeing them up to tackle more pressing or complex incidents. While recognising that different areas face specific demands, risks and needs, there is clearly scope to extend this across the UK.

The vast majority of firefighters receive basic medical training to varying standards including trauma technicians. Many have the skills and resources necessary to provide an effective first or co responding service, or other intervention service. There is significant scope to develop these skills further through the development of single service or joint training approaches. Some services are even expanding into conveyancing in more isolated rural areas. Fundamentally, our services should be citizen focused and organisational boundaries or funding routes should not prevent us from providing the best possible service to someone in need.

Usually the first people at a scene of a cardiac arrest or similar medical emergency are members of the public. Fire and rescue services, have the capacity to extend the knowledge of lifesaving skills such as CPR and the availability of lifesaving technologies such as Automatic External Defibrillators (AED) through our enforcement and inspection roles with businesses or as part of our education programmes with children.

When we are successful…

- At a local level, every fire and rescue service will be able to work with their local ambulance service to provide a first or co-responding or other emergency and non-emergency medical response services appropriate to their local risks and needs
- There will be an increase in the availability of publicly available defibrillators and wider dissemination of vital first aid skills
- A member of the public suffering a cardiac arrest or other serious medical emergency will receive the fastest and most appropriate emergency response regardless of who provides it

How might we measure this?

- The number of Category A medical emergencies answered/lives saved
- Reduction/slow in growth of calls/responses made by ambulance colleagues
- Number of AED machines purchased/installed in community settings.

* http://www.hscic.gov.uk/catalogue/PUB17722

Priority Seven

Work with all health partners to improve the fire safety of the health and care premises where vulnerable people are at risk and reduce numbers of avoidable incidents that impact on the availability of Fire and Rescue Service resources

The NHS and other health partners have a strong record around fire safety, thanks to a clear recognition of the special risks associated with hospitals, care homes and other buildings where vulnerable people receive care. Amendments to the legislation governing Primary Authority Schemes (PAS) have brought the Regulatory Reform (Fire Safety) Order 2005 within their scope. The potential now exists for fire and rescue services to engage positively with those responsible for NHS and other health and care related premises to support and continue to improve fire safety and risk management and expland the use of fire safety technology such as suppression, through PAS. Of course, any improvements to the standard of fire safety on health and care premises will have the benefit of not only reducing false alarms but also reducing the risk of real fires and the associated dangers they pose to patients and staff as well as the negative effects caused by downtime dealing with alarms or incidents.

Hospitals are often responsible for the largest number of Unwanted Fire Signals or Automatic Fire Alarm activations received by fire and rescue services It is possible, through alarm management processes to make significant reductions in unwanted calls from hospital sites. London Fire Brigade, which receives thousands of unwanted fire signals from hospitals across the capital, have had success in this area with a number of hospital Trusts, not least St Mary's Hospital in Westminster, where AFA calls reduced from more than 100 in 2009/10 and 2010/11 to only two in 2011/12 .

When we are successful…

- Hospitals, care homes, sheltered housing and other health and care premises will be much safer in the event of fire and better able to manage their responsibilities under fire safety legislation
- There will be a reduction in the number of false alarms which disrupt the provision and delivery of health services and waste fire and rescue service time and resources
- Health and care staff will be more confident in their knowledge of fire safety

How might we measure this?

- Reduction in fire incidents from health buildings
- Reduction in false alarms from health buildings

* http://www.london-fire.gov.uk/Documents/Sup06-Management-of-Calls-to-Automated-Fire-Alarms.pdf

Involving You

This strategy has been developed by fire and rescue services, for fire and rescue services.

The content of this strategy and in particular the priorities identified have been created by the CFOA Strategic Health Group, informed by our conversations with other CFOA colleagues and with health partners through the Fire-Health project group. We have sought to draw on a wide range of examples and experience from the fire and rescue service in forming the document.

However, the discussion has to continue, and this document will need to remain "live" and open to adaptation and change. Please visit the Fire as a Health Asset pages on the CFOA website to see the ongoing work of the Strategic Health Group and further detail on our performance against this strategy.

Your input, evidence and feedback are always welcome. Please contact either Peter O'Reilly at oreillyp@manchesterfire.gov.uk or Geoff Harris at harrisg@manchesterfire.gov.uk if you have any comments or questions.

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