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Safe and Well Standard Evaluation Framework Pilot Report

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Prepared by:

Ellie Houlston, Public Health Leadership Fellow, Public Health England

Ged Devereux, Public Health Practitioner, Greater Manchester Fire and Rescue Service

Lyndsey Bell, Strategic Risk Analyst, Greater Manchester Fire and Rescue Service

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Version 2	**Amendments Ged Devereux**

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Pete Wilson, West Midlands Fire Service

Emma Dean, Greater Manchester Fire and Rescue Service

Data and Learning, (formerly Outcomes and Metrics) Work stream members

West Midlands Fire Service

Greater Manchester Fire and Rescue Service

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Abbreviations

FRS	Fire and Rescue Service
CFOA	Chief Fire Officers Association
LGA	Local Government Association
NHSE	NHS England
PHE	Public Health England
HSC	Home Safety Check
SEF	Standard Evaluation Framework
SWV	Safe and Well Visit
NFCC	National Fire Chiefs Council
NFHP	National Fire Health Project Group
HMIC	Her Majesty's Inspectorate of Constabulary
UPRN	Unique Property Reference Number

To be read in conjunction with:

Design Principles for SWV

SWV SEF Tool

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Executive Summary

This report examines the feasibility of introducing a Standard Evaluation Framework (SEF) approach to gathering evidence of the impact and effectiveness of Safe and Well Visits (SWV) delivered by Fire and Rescue Services (FRS) in England.

The pilot was designed and developed on behalf of the Chief Fire Officers Association (CFOA) (and latterly the National Fire Chiefs Council, (NFCC)) with support from NHS England (NHSE) and Public Health England (PHE).

The purpose of the pilot was to test a new approach to standardising, gathering and aggregating evidence of effectiveness for SWV delivered by FRS in England, against a background of diverse approaches and localised service offers.

The pilot set out to answer the following three questions:

1. Does the SEF tool support individual FRS to produce meaningful evaluations of SWV impact?

2. How challenging is it for diverse FRS with different delivery approaches and IT systems to adopt a standardised, core dataset?

3. Can data from individual FRS be collated and aggregated using existing systems and resources?

The pilot aims and objectives were as follows:

Aim: *To test the feasibility of introducing a Standard Evaluation Framework approach for Safe and Well visits in England to support individual FRS evaluations and provide standardised data for the purposes of aggregation.*

Objectives:

1. To test the Safe and Well Standard Evaluation Framework tool with a small number of representative FRS in England.

2. To build evaluation capacity and skills within pilot FRS.

3. To test a system for the collation and aggregation of pilot FRS Safe and Well data.

4. To encourage and support multi-agency partnerships for the delivery and evaluation of SWV

5. To identify and address issues with the draft Safe and Well Standard Evaluation Framework tool.

6. To make recommendations about the feasibility of rolling the Standard Evaluation Framework approach out across England.

Six English FRS agreed to participate in the pilot, which ran from April 2017 to January 2018. They were Cambridgeshire, Oxfordshire, West Midlands, Lancashire, Cleveland and Tyne and Wear.

The pilot FRSs were required to produce their own SWV evaluation reports using the SEF tool. They were also required to collect a core dataset (as set out in the SEF) and submit data at the mid and endpoints of the pilot.

Each FRS attended three workshops and hosted a site visit with their mentor. Feedback at each stage of the pilot was used to shape the remaining stages of the process.

Data was returned to a central repository via an excel spreadsheet. Greater Manchester FRS provided analyst time to collate and interpret the returns.

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Key learning from the pilot is as follows:

Recommendations are split into overarching, strategic recommendations and technical recommendations relating to the Standard Evaluation Framework and practical application.

Overarching recommendations:

It is recommended that the NFCC:

1. **Endorse a shift away from a property focus towards a person centred approach and increased multi-agency working, consider if, in the medium to longer term, new person-centred IT systems will be needed to meet future service requirements.** *This may necessitate further piloting with individual FRS to trial a shift from a property to person-centred data recording systems.*

2. **Takes action to support FRS to be more open and transparent in sharing learning experiences (such as the development of SWV) including the sharing of what has not worked as well as what has.**

3. **Considers ways to build evaluation skills and capacity in FRS in the UK through identification of appropriate training and developing skills and relationships with academic partners.**

4. **Considers steps to encourage and support FRS to improve data quality, encourage standardisation and develop standardised terminology.** *This includes, but is not limited to encouraging electronic data collection and finding ways to improve data completeness and accuracy.*

5. **Addresses the definition of Safe and Well visits, clarifies that this approach is aligned to the Firefighter role map and makes the distinction between Safe and Well visits and the historical approach to Home Safety Checks through its National Standards Framework.**

6. **Develops a core standard and methodology for addressing fire risk including how to quantify it and what actions to take as part of a home visit to complement local approaches.**

7. **Recognises that Safe and Well represents a cultural shift for FRS and that ongoing work is required to support behavioural change for operational staff and support staff.**

8. **Considers how to address the need for a Unique Identification system for person level data and appraises the potential options including possible use of NHS numbers and other alternatives.**

9. **Considers developing quality assurance guidance to encourage consistency and a culture of continuous improvement in relation to HSCs and SWV.**

10. **Considers the options and resource implications relating to the creation of an NFCC held data repository for Safe and Well.**

11. **Subject to the enactment of recommendations 4-6 the SEF tool should be adopted, rolled out and made available to all FRS in the UK.**

12. **Supports FRS to collect referral feedback as part of locally agreed and recognised safe and well offers, to aid multi-agency working and enable evaluation of effectiveness and cost effectiveness.**

The next set of recommendations are technical recommendations relating to the SEF document and data repository.

It is recommended that:

13. **The pick lists on the data collection tool are expanded and clarified in line with the lessons learned during the pilot.**

14. **The SEF tool is added to, to ensure FRS capture the background to, and developmental learning from, their Safe and Well programmes.**

15. **The specific age criteria are removed so that the SEF can be applied to a broader range of at risk adults.**

16. **Face to face training is undertaken with all staff undertaking Safe and Well visits.**

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1. Background and Context

For the past decade FRS in the UK have had a statutory duty to prevent fires. Considerable effort has been focused on reducing fire risk and preventing avoidable harms across the life course.

In October 2015 CFOA, NHSE, the Local Government Association (LGA), PHE and Age UK produced a joint consensus statement setting out their intention to collaborate and strengthen efforts to tackle a range of shared risks.

The risk factors for fire are closely aligned to the risk factors for increased vulnerability to poor health. They include:

- Age
- Living alone
- Falls
- Frailty
- Living in a cold home.

Specifically, the joint consensus statement focuses on ways in which FRS in England can target people aged 65+ to reduce fire risks, identify people at increased risk of falls, frailty, cold homes and hospitalisation with the aims of improving safety and quality of life and thereby reducing winter pressures on the NHS. The main vehicle for this change is the enhancement of the traditional FRS Home Safety Check (HSC) into a SWV to include assessment for these risk factors.

Many FRS have already moved to, or are considering moving towards, an expanded HSC. The NFCC has produced a document setting out the Design Principles for the new SWV. Whilst SWV build on existing good practice, they nevertheless represent a change to the traditional FRS delivery model. Understanding the impacts, costs and benefits of this new service model is a vital, but significant, challenge and evaluating effectiveness is essential. The implementation of SWV raises questions both locally and nationally such as:

1. Is the delivery of SWV an appropriate and effective use of FRS resources?
2. How effective are FRS at targeting those at greatest risk?
3. Does a SWV from the FRS improve the safety and wellbeing of the beneficiary?
4. Which SWV delivery models work best?
5. Will SWV reduce demand on health and social care and wider public services?

These questions were originally posed by the National Fire Health Project (NFHP) group which was responsible for taking forward the intentions within the consensus statement. They are particularly challenging to answer given the nature of FRS in England.

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1.1 A brief overview of the development of SWV

There are 42 FRS in England and three in the devolved administrations (Wales, Scotland and Northern Ireland). Each is autonomous and able to decide how best to deliver services in its local area(s).

There are different FRS governance models in place across the country. For example, some FRS are embedded within local authorities, some are autonomous but cover a single unitary authority area and some cover several local authority areas.

Each FRS has taken the SWV agenda forward in its own way. There is a broad spectrum, from those who have not undertaken SWV at all, to those who have developed models which have built up their credibility and capability to the point where they have taken on commissioned contracts from NHS and Local Authority partners.

There is also a broad spectrum in relation to the content of SWV, from a core offer of fire, falls, fuel poverty and smoking through to FRS that work with partners to offer services and brief interventions that cover a range of issues including (but not limited to) visual impairment, dementia, social isolation, bowel cancer screening and flu.

The way in which SWV are delivered also varies, with some FRS using crews, others using only community safety staff and some a mixture of both. Visits are recorded in different ways, with some areas using paper based systems and others using electronic tablets. There are also different computer software packages including the CFRMIS system, Customer Relationship Management software and a small number designing their own, bespoke systems.

Prevention has been a core part of the FRS agenda for over a decade and is a role that has contributed to a significant reduction in fire deaths and serious injuries over that time. Nevertheless the move to SWV, which involves tackling a broader range of risks relating to fire has been welcomed enthusiastically by some and received with caution by others. Hearts and minds play a significant part in the success, or otherwise of SWV introduction, and underlying considerations relating to organisational culture and enthusiasm for this agenda add another layer of complexity to the picture.

It is against this backdrop that the challenge of answering the NFHPs questions was set. In addition, during the initial roll out of SWV, responsibility for FRS moved from the Department of Communities and Local Government into the Home Office and the intention to re-introduce an inspection regime for FRS in line with Her Majesty's Inspectorate of Constabulary (HMIC) was announced.

1.2 Developing an Evidence Base

The challenge of gathering evidence to demonstrate whether or not SWV are an effective and efficient use of FRS resources across a broad range of organisational approaches with no standardised data collection or collation systems in place cannot be overestimated. Indeed there is no systematic approach to assessing the effectiveness of long-established HSCs to use as a basis to build on.

An initial SWV pilot and evaluation commissioned by CFOA and PHE took place during the winter of 2015-16. The report (Hindle et al, 2016) made a number of recommendations, including the following:

- **Data sharing:** Improved data sharing agreements between FRS and partners will help in targeting vulnerable populations. It will also help the FRS to better assess its role and impact on health and wellbeing outcomes and health inequalities.
- **Data collection:** Standardised data collection and monitoring practices would improve data collection systems and ensure that the data being collected is comparable across the country.
- **Governance:** A multi-partner steering group should oversee the establishment of the Safe and Well visit within local areas. This should be carried out as part of a wider system approach to address health improvement and reduce demand on public sector services operating in the home setting. It will also improve the alignment of the FRS with other services, and vice versa.

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It was recognised by the NFHP group that further evaluation and data would be needed to answer the questions posed, building on the learning from the initial pilot.

A multi-agency task and finish group called the Outcomes and Metrics group was established to explore the options for evaluation and evidence gathering. Membership included several FRS, PHE, NHS England (chair), LGA and Age UK.

There were a number of constraints to consider when looking at possible options:

1. There was no available budget

2. There was limited staff resource

3. Evaluation skills in FRS were variable

4. There was no obvious co-ordinating body

It was recognised by the group that given the constraints and context in which SWV were being delivered a pragmatic approach would be needed. However, it was also recognised that to achieve an approach which allowed a collective picture to be painted, opportunities for standardisation would need to be identified.

One potential way to achieve this was to take a Standard Evaluation Framework (SEF) approach originally developed in the NHS by Roberts, Cavill & Rutter (2009) to evaluate obesity interventions. The group agreed to explore whether a SEF could be developed for use with FRS in England.

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Chapter 2: The Standard Evaluation Framework Tool

Developing a Standard Evaluation Framework for SWV was a significant challenge. It required the O+M steering group to agree an unambiguous definition of a SWV, something that did not exist at the time.

Following consultation with partners the group agreed that a SWV differed from a traditional HSC in terms of additional health related elements and the provision of brief advice. A 'core' SWV was deemed to contain the following elements as a minimum:

- Fire Risk
- Cold Homes
- Smoking
- Falls Risk

A minimum essential dataset was therefore developed based on these elements, with a longer list of optional data items to use based on the content of individual FRS SWV content. See figure 1 below for example.

Figure 1: Example of Essential and Optional lists from SEF dataset

	Part three: Demographics of individual beneficiaries	Essential	Source
3.1	Date of Birth		FRS
3.2	Gender		FRS
3.3	Ethnicity		FRS
3.4	Disability status		FRS

	Part three: Demographics of individual beneficiaries	Optional	Source
3.1	Caring responsibilities		FRS
3.2	Wellbeing Measure		FRS
3.3	Measure of social isolation		FRS

Technical guidance was provided for each data item to ensure consistency of collection. Where possible recommended data definitions were taken from nationally validated tools or agreed standards, such as those used by the Office for National Statistics.

To keep the data list manageable, it was agreed to focus the SEF on SWV to older people (aged 65+). This was in line with the National Consensus Statement between CFOA, NHSE and partners and the availability of Exeter data, enabling FRS to specifically target this age group. There was however a recognition that the SEF approach could be adapted in future to encompass a broader SWV definition.

The SEF also provided general guidance on how to plan evaluations, the different types of evaluation and when to use them. The advice given was pragmatic and recognised the different stages FRS are at when it comes to evaluation.

Demonstrating longer term impact and outcomes, whilst desired by commissioners, remains a significant challenge. Recognising that for any high level indicator, it is difficult to attribute any one activity to a change, a pragmatic approach was agreed.

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The SEF advocated the use of three data streams:

1. Process data: Routine data, to include number of visits to target group; number of referrals made etc

2. Qualitative data: Stakeholder consultation, participant views, FRS staff perspectives

3. Quantitative/Outcome data:

A four stage analysis was agreed:

i. **Scope:** Estimated populations at risk e.g. number at risk of falls, social isolation etc

ii. **Reach:** Numbers of people who connect with the service (contacts)

iii. **Impact:** At individual level - numbers who change something, or something is changed for them as a result of a Safe and Well Check

iv. **Outcome:** Actual changes in outcome data e.g. reductions in avoidable admissions

It is recognised that demonstrating impact on outcomes will be extremely challenging, but constructing a picture which demonstrates a logical progression, e.g. evidence of reach and impact will be useful in making a case.

It was recognised during the development of the SEF that there was a trade-off between academic rigour and practicality. As FRS skills and confidence in conducting evaluations grows the SEF can be adapted and strengthened.

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Chapter 3: Pilot Methodology

During the development of the SEF tool it was recognised that introducing a new approach to evaluation would need to be tested. It was therefore agreed to pilot the SEF with a small number of FRS before deciding whether to roll it out more widely.

The purpose of the pilot was to test out the feasibility of the approach and identify potential issues and challenges to introducing the SEF across England and it set out to answer the following three questions:

1. Does the SEF tool support individual FRS to produce meaningful evaluations of SWV impact?

2. How challenging is it for diverse FRS with different delivery approaches and IT systems to adopt a standardised, core dataset?

3. Can data from individual FRS be collated and aggregated using existing systems and resources?

3.1. Aim and Objectives

The following pilot aim and objectives were agreed:

Aim: *To test the feasibility of introducing a Standard Evaluation Framework approach for Safe and Well visits in England to support individual FRS evaluations and provide standardised data for the purposes of aggregation.*

Objectives:

1. To test the Safe and Well Standard Evaluation Framework tool with a small number of representative FRS in England.

2. To build evaluation capacity and skills within pilot FRS.

3. To test a system for the collation and aggregation of pilot FRS Safe and Well data.

4. To encourage and support multi-agency partnerships for the delivery and evaluation of SWV

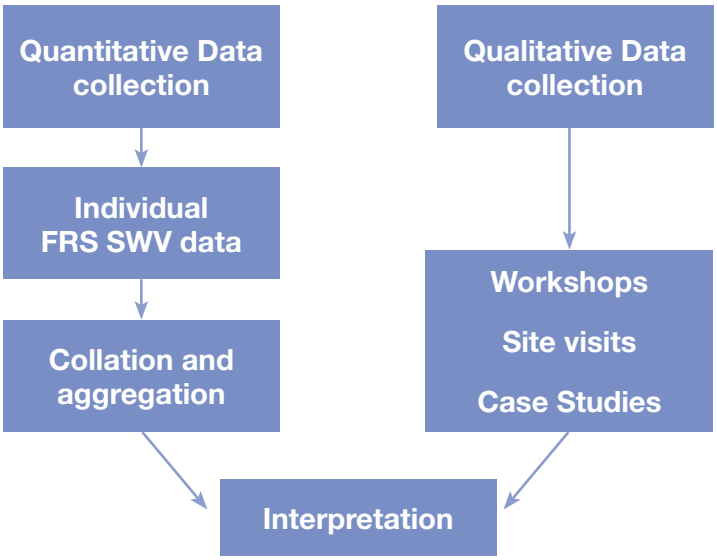
5. To identify and address issues with the draft Safe and Well Standard Evaluation Framework tool.

6. To make recommendations about the feasibility of rolling the Standard Evaluation Framework approach out across England.

3.2 Mixed Methods

The pilot involved a mixed methods approach (see figure 2).

Figure 2: Mixed Methods approach to the SEF Pilot



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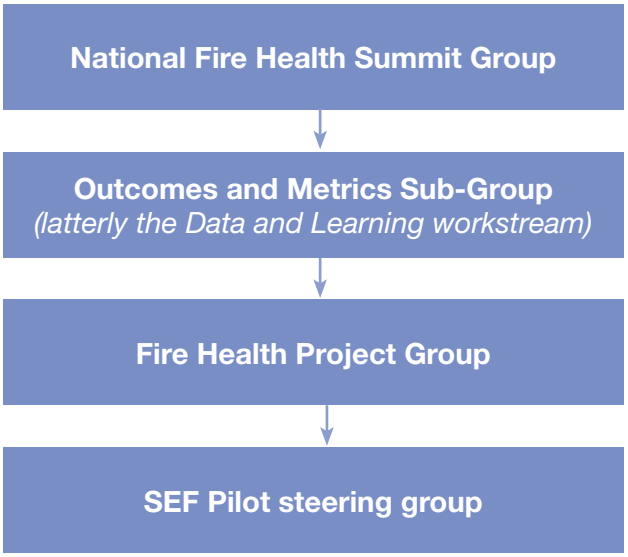
A mixture of quantitative and qualitative data was collected during the pilot, collated and interpreted both at key stages during the pilot and at the end of the process and conclusions were drawn.

3.3 Governance

The governance for the pilot was as follows:



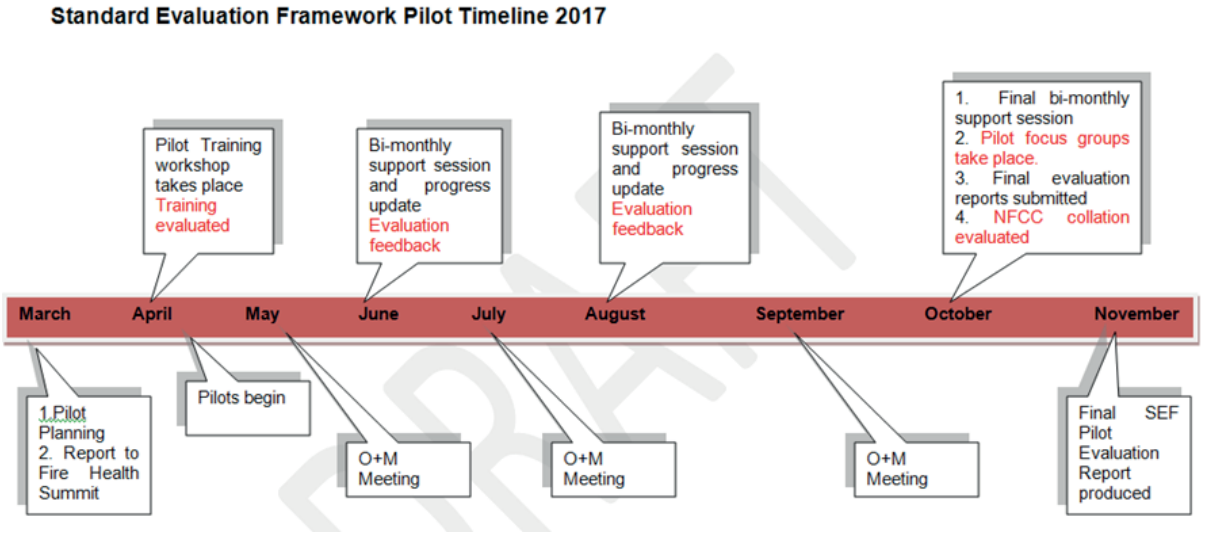
The National Fire Health Summit Group tasked the Fire Health Project Group with addressing the questions of effectiveness and cost effectiveness relating to SWV. The Outcomes and Metrics (O+M) sub-group was originally established to find ways of addressing this challenge. Over time the O+M group took on a wider remit. Once the SEF approach was agreed a smaller O+M sub-group was established to steer the project. This group initially had representation from NHSE, PHE, Royal Society for Public Health and West Midlands Fire Service and reported into the wider O+M group.

Over time the membership of this group changed, as WMFS became one of the pilot FRS thereby creating a conflict of interest. The wider O+M group also morphed into the 'Data and Learning' group and it was this group that oversaw the final stages of the project.

3.4 Timeline

An initial timeline was agreed for the pilot, with a planning stage, implementation stage and concluding stage, taking a total of 9 months. The implementation phase where FRS utilised the SEF to gather data from their own SWV was initially planned to run from April to September 2017. There were three workshops planned to take place at the beginning, middle and end of the pilot and one round of FRS site visits.

Figure 3: Initial Timeline for the Standard Evaluation Framework Pilot



For various reasons, including specific feedback from participating FRS, the timescale was adjusted slightly and whilst the implementation phase remained a 6 month period, there was slight variation in when each FRS began and ended that phase. The final concluding stage was lengthened slightly to take account of previously unforeseen challenges such as resource changes resulting from staff sickness, Grenfell implications, reduced capacity in the pilot steering group etc. The final workshop took place in January 2018 and the final report was produced in March 2018.

3.5 Pilot FRS Selection

Initially it was intended to select three FRS to take part in the pilot. The National Fire Health Summit Group requested that pilot FRS should be representative of the diversity within the sector in terms of governance, scale and delivery approaches.

An initial invitation for participants circulated via CFOA communities elicited over 20 responses (see Appendix 1). The steering group therefore agreed a set of criteria and a process with a multi-agency scoring panel to select pilot FRS. It was also agreed that given the level of interest, expanding the pilot group to 6 FRS would provide a more robust test bed for the SEF tool.

Table 1: SEF Pilot FRS Selection Criteria

Criteria	Rationale
Is the FRS carrying out SWV currently?	The SEF is designed to evaluate SWV and therefore it was essential that any participating FRS had or would have a SWV programme underway for the full 6 month period of the pilot implementation phase.
When did the FRS start its SWV delivery?	To get the breadth of experience in the pilot there was an intention to identify those at different stages of the SWV journey
Does the FRS SWV include all 4 core elements identified in the SEF?	The SEF sets out 4 core elements of a SWV- Fire risk, smoking, cold homes and falls risk. To participate in the pilot an FRS had to demonstrate that all 4 elements were part of its SWV
What is the governance model of the FRS?	Implementing a standardised approach to data collection and evaluation would pose different challenges to different FRS depending on governance models. A range of governance models was sought with a minimum of one of each of the following to be included: Unitary, County Council, Metropolitan and Combined.
What staffing model is used to deliver SWV?	As part of the pilot it was important to test the SEF with different delivery models e.g. those that use community safety staff, crews and/or retained staff to deliver SWV
Is there evidence of senior buy-in for participation in the pilot?	Senior buy-in from each individual FRS was determined to be an essential criteria. Each FRS was asked to demonstrate that they had support to participate from senior officers.
Is there evidence of partner involvement in the SWV?	One of the objectives for the pilot was to 'encourage and support multi-agency partnerships' and it was therefore vital that FRS could demonstrate partner involvement in their SWV programmes

3.5 Pilot process

The pilot process is set out in Figure 3. There were a series of three workshops, one at the beginning, one in the middle and one at the end of the pilot.

Each participating FRS was allocated a mentor to contact for advice and to answer queries for the duration of the pilot. The mentors also conducted site visits to each of their FRSs following the initial workshop.

The participating FRS were required to produce their own evaluation reports as part of the pilot. They were also expected to collect the data set out in the SEF 'essential data set'. Two data returns were scheduled, one at 3 months and one at the end of the implementation phase of the pilot. GMFRS offered to act as the repository for data for the duration of the pilot. They also provided analyst time to support the collation and interpretation of the data.

3.6 Communication

To facilitate communication between pilot FRSs a closed CFOA Communities Group was established and participants were encouraged to share information and experiences online.

Each participating FRS was also allocated a mentor to support them during the pilot whom they could contact at any point for support and advice. There were two mentors who each supported three FRS.

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4. Participating Fire and Rescue Services

Six FRS were chosen to participate in the Safe and Well SEF Pilot. Steps were taken to ensure there was a spread in terms of geography, governance and approach.

Cambridgeshire FRS	
Governance Model	Combined Fire Authority
SWV Start Date	August 2016, with full roll out from November 2016
Staff delivering SWV	Whole time crews and community safety staff
Further Information	Cambridgeshire FRS was the smallest FRS participating in the pilot and as such had limited resources. They demonstrated a commitment to the SWV agenda and partnership working during the application process, having mainstreamed SWV and worked with the local drug and alcohol action team to train all whole time staff in alcohol awareness.

Cleveland Fire Brigade	
Governance Model	Unitary
SWV Start Date	October 2016
Staff delivering SWV	Community safety staff
Further Information	Cleveland has developed its own IT system to capture SWV data. Also demonstrated strong partnership arrangements, holding regular meetings with partners co-designing the visit and receiving funding for equipment associated with the visit. Provide a commissioned winter warmth service.

Lancashire FRS	
Governance Model	Combined Fire Authority
SWV Start Date	December 2016
Staff delivering SWV	Community Safety Staff and whole time crews
Further Information	Lancashire FRS have rolled Safe and Well out across stations as part of a pilot coinciding with the SEF pilot.

Oxfordshire FRS	
Governance Model	County Council
SWV Start Date	June 2016
Staff delivering SWV	Community Safety Staff and whole time crews
Further Information	Provided face to face SWV training for staff. Chief Fire Officer also has responsibility for Trading Standards. Have access to social care datasets as part of council. Early stage of SWV delivery.

Tyne and Wear FRS	
Governance Model	Metropolitan
SWV Start Date	August 2016
Staff delivering SWV	Community Safety Staff
Further Information	Strong partnership with local public health team in Newcastle. SWV only within one area (Newcastle). Falls prevention focus. Modular training supported by public health.

West Midlands Fire Service	
Governance Model	Metropolitan
SWV Start Date	November 2015
Staff delivering SWV	Crews and Community Safety Staff
Further Information	The largest FRS in the pilot and with the longest established SWV model.

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5. Pilot Activities

The SEF pilot took place between April 2017 and January 2018. Prior to the official start of the pilot there was a planning phase which was undertaken by the O+M Group and the project steering group. The outline stages are set out in the project timeline in Figure 3. This section of the report sets out the collective activities of the pilot in chronological order. For the duration of the pilot each FRS was conducting its own SWV programme and collecting data on a routine basis.

5.1 Initial workshop

An initial workshop took place on 5th April 2017, hosted by Greater Manchester FRS, bringing together all six pilot FRSs and their delivery partners. The aim of the workshop was to set out the pilot process, expectations of participants and the support available. Whilst planning the workshop and talking to FRS colleagues it became clear that some general evaluation training would also be welcome so this was built into the programme. The agenda for the day can be seen in Appendix 1.

The morning session consisted of an introduction and rationale for the pilot given by members of the O+M group and a spokesperson from the Home Office Fire and Rescue Analysis Programme. This was followed by some basic training on evaluation provided by PHE staff.

The afternoon focused on the SEF tool and took participants through its content and how to use it. Each FRS was introduced to their mentor and asked to arrange site visits.

Overall the workshop was well received. The following comments are from the workshop evaluation. We asked:

What was useful about the day?

> "Very good with a good introduction to the SEF and some clarity on what the NFCC/PHE will offer in support going forwards."

> "All the discussions and points raised by other FRS were useful."

> "The evaluation tool can be applied to other fire service data analysis."

What will you take away from the day?

> "Loads of great ideas about how we can participate."

> "Good info about where to find data."

> "The types of evaluation and the best practice in order to succeed."

What more can we do to support you?

> *"A question and answer facility."*

> *"More work to bridge the gap between terminology between PHE, FRS, NHSE and others."*

> Although overall the comments were positive, there were some that helped to shape the next phase of the pilot e.g:

> *"The time would have been better to share what we are all doing and learn from each other's work."*

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"It would have been useful to know what other SWV interventions actually do."

"Ask us what we are doing. Listen to us and build around our work."

"Some of the terminology was difficult to understand."

As a result of comments from the first workshop, a second, mid-pilot workshop was designed to give maximum opportunities for sharing experiences and networking.

5.2 Site visits

Each pilot FRS was allocated a mentor. Site visits were arranged in May and June 2017. Each visit took half a day, followed a structured approach and involved a round table discussion with key FRS staff and their local delivery partners. It also provided an opportunity to demonstrate IT systems, talk through challenges and give an overview of progress to date.

An individualised data collection tool (Excel spreadsheet) had also been designed to collate data from each FRS and this was shared at the visit.

5.3 Mid-term workshop

A second workshop was added to the pilot schedule and took place on 3rd October 2017 at West Midlands Fire Service. In response to requests from the FRS it was focused around hearing from each FRS about their experiences to date and maximising opportunities for discussion and networking.

Each FRS was given a simple format to follow, which included talking about what went well, challenges and next steps.

Prior to the workshop there were some concerns raised about sharing challenges and 'things that had not gone well' with other FRS. To overcome this a standard set of questions was used, the workshop organisers created a 'safe, confidential space' for sharing, and any elements that could be used to compare performance were avoided.

GMFRS gave individual feedback to each FRS regarding their first data returns. Further details about the data return process can be found in section 6 of this report. Key issues that were raised during the workshop included the following:

- Achieving a consistent level of standardisation remains challenging given the significant local variation in service delivery.
- A central data collection point will be needed and capacity required to clean data so that it can be aggregated for national purposes.
- Household vs individual data was discussed at length. This is a challenge in terms of where risk sits (e.g. with person or property) and how data is recorded e.g. are current IT systems fit for purpose?
- Pre-population of SWV forms with basic data would be a big help to FRS delivery staff.
- There needs to be a balance between data collection requirements and the quality of the visit itself.
- There was a lot of discussion about quality assurance and how FRS might be more effective at assessing the quality of SWV.
- Needs to be leadership over the core role of Firefighters, recognising that tackling a broader range of risks relating to fire is part of the role.
- Negotiating referral pathways with partners can be extremely time consuming.

Overall the workshop was positively evaluated, particularly the focus on shared learning, with the following comments received:

"Real value in the individual FRS presenting their respective positions."

"Day was good. Brought up a number of good points and issues – reassurance that others are having the same issues and that this may influence national thought process."

"Really valuable hearing the experiences of the other 5 FRS in the pilot – some excellent learning points."

"Very beneficial day, particularly listening to the experiences of the other services."

"Interesting to hear what other FRS are doing – lots of ideas that could be implemented locally."

Despite the initial concerns around sharing challenges and giving an honest appraisal in front of colleagues from other FRS, this turned out to be the most valuable element of the day for the attending participants.

Further requests from the workshop included a focused session on quality assurance for safe and well, further guidance on consent, discussions on the implications of the new General Data Protection Regulations and sharing examples of what worked well in training.

5.4 End of pilot workshop

The final workshop was held on 11th January 2018 in Newcastle-Upon-Tyne and focused around feedback from the participating FRSs and consultation on the draft recommendations from the pilot.

The feedback from the participants has shaped the recommendations included in this report.

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6: Data Collation

6.1 Rationale for the approach

FRS have been conducting HSCs and more recently SWV for a number of years. However, the topics and questions covered during the visits are determined by each FRS, and as a result, the visits are implemented in varying ways.

Consequently, there is no single national system to collect/store the information and no standard format in which FRS are required to submit data obtained from the visits. The only current requirement is to return the total number of HSCs carried out by each FRS, along with the number of HSCs carried out with the elderly (65+) and the disabled.

The aim of the SEF is to support FRS across England to evaluate SWV effectively. In order to do this, the SEF needed to assess and test the feasibility for the FRS involved in the pilot to collect, record and submit standardised data, which could then be aggregated and analysed at a pilot level.

As Microsoft Excel is an accessible product that can be utilised to both store and interrogate data, it was deemed to be an appropriate tool for the purposes of the SEF.

Each participating FRS was required to make two data returns, one half way through the pilot (3 months) and one at the end (6 months).

6.2 SWV SEF Template – Spreadsheet Development

6.2.1 Initial Template

Prior to the pilot, a spreadsheet template was produced for each FRS to record information gathered during the SWV. The template was a prescribed format in order to facilitate the collation of all six pilot FRS data and contained a cover sheet, guidance notes, a data sheet and set of pick lists.

- Cover Notes – the cover notes introduced the template as a tool to record all the 'essential' data listed in the SEF paper. It set the expectation that each FRS would be required to undertake a degree of data cleansing in order to transform the raw collected data into the required format. It also provided some 'Do's and Don'ts' with regards to the data submission.

- Guidance Notes – The guidance notes provided further information about the 'essential' data, including a brief explanation as to what data should be collected/returned, and in what format. It also provided a reference number to the corresponding section in the SEF paper, if further details regarding the submission were required.

- Data Sheet – This was a blank template containing 38 data columns under six thematic topics - as per the 'essential' criteria in the SEF paper;
    - Intervention Details
    - Demographics of Individual Beneficiaries
    - Beneficiaries Identified at Risk
    - Fire Risk Addressed
    - Number of Referrals
    - Number of Follow up Interventions

  The spreadsheet also contained pre-populated dropdowns for the relevant columns (based on the 'Pick lists' tab).

- Pick lists – This tab provided a list of the required responses for each column heading. The pick list options were based on those listed in the SEF paper. The pick lists were provided to assist with individual data entries, but data could also be copied and pasted into the template in bulk.

The templates were tailored to each FRS and sent out at the start of the pilot. Five of the six pilot FRSs utilised the template to collect data between June/July 2017. Data collected during this time was submitted as an initial data return at the end of July 2017.

6.2.2 Amended Template

Following the initial data return and subsequent analysis of the data contained within each FRS spreadsheet, the templates were amended slightly.

Amendments were made to some headings, as feedback, and the data, suggested some ambiguity. The headings were amended accordingly and more clarity was provided regarding the required data. For example, within the 'Beneficiaries Identified at Risk' thematic topic, the original heading stated 'Smoking'. This was changed to 'Does anyone in the household smoke?'

A review of the pick lists was also required for some questions, as the data returns indicated that some options hadn't been considered or provided. For example, within the 'Demographics Of Individual Beneficiaries' thematic group, the 'Housing Tenure' pick list provided options for 'Social Rented' and 'Private Rented', but didn't have an option for just 'Rented' if it was unknown/ undisclosed if the property was privately or socially rented. 'Rented' was included as an additional option.

A 'Feedback' tab was also added to the amended template. This tab was specific to each FRS and detailed the work required to collate the initial data return into the required formats. This feedback was provided to assist each FRS to undertake data collation in-house, to reduce the time spent collating the data for the second extract.

The amended templates (including details of changes to the templates) were sent to each FRS at the end of October. The amended templates were to be utilised for the second data return at the start of December 2017.

6.3 Technical Lessons Learned

A number of lessons have been learned through the development of the standard data capture template and also through the subsequent analysis of the returns;

6.3.1 Data Design

The templates for data collection were initially produced based on the headings and pick list options in the SEF paper. However, as described, the initial data return indicated that not all response options were considered (or included) from the outset. An attempt to rectify this was via an amended template for the second data return.

However, the second data return identified further issues concerning inconsistencies within the pick list formats, including capitalisation and hyphens in some (but not all) of the lists. Whilst seemingly trivial, it would have made it easier for the pilot FRSs to submit their returns if this has been consistent within the pick lists from the start of the pilot, particularly when submitting records in bulk.

An issue with regards to 'blank' records and the procedure to follow in the event of incomplete records was identified during the second extract. Issues arose with the collation of blank records as the reason the records were incomplete was ambiguous. It wasn't known if;

- the FRS didn't collect this information
- the question wasn't asked during that particular visit
- the occupier declined to disclose the information
- the question wasn't relevant to the occupier

A number of assumptions therefore had to be made. Indeed, data scanning enabled the identification of questions that weren't collected by the FRS as there were multiple 'blank' records for all SWV from that individual FRS. It was assumed that if the occupant didn't wish to discuss that particular question during the SWV then 'Prefer not to say' or 'Not Disclosed' would have been selected (although these options weren't available in all the pick lists). The remaining 'blank' records were then amended to 'NULL'.

Furthermore, the guidance notes weren't explicit regarding how to record blank records. As a result a number of variations were received with some FRSs leaving the fields blank, whilst others entered 'blank' or 'NULL'. This increased the time spent collating the data, which could have been avoided through improved data design.

As a result, the 'Cover Notes' and/or 'Guidance Notes' should have been more explicit regarding what action to take with regards to blank records. For example, more specific guidance should have stated; for all fields where the data isn't currently collected by the FRS, state 'Not Collected', if the occupier didn't wish to disclose state 'Prefer not to say' or 'Not Disclosed', if not relevant to the occupant state 'Not Applicable' and if the question wasn't asked state 'NULL'.

6.3.2 Household v Individual Data Collection

Five of the six FRSs involved in the pilot submitted a single record per visit and provided information at a household level. For these household records, data gathered within the 'Demographics of Individual Beneficiaries' thematic group largely concerned the main occupant, whilst information collected in the 'Beneficiaries Identified at Risk' thematic group related to any occupant within the household.

One remaining FRS collected individual records for all occupants living in the household in order to support the person centred approach of the SWV, and also to facilitate the tracking of onward referrals. Feedback from this FRS was that the mixture of household and individual data was confusing, particularly in relation to the way in which delivery staff collected the data. As a result, this FRS provided records for all the individual occupants that received a SWV rather than aggregating the records to a household level.

Although the majority of FRSs involved in the pilot collected SWV data at a household level and didn't have any issues with this combination of individual and household level data within the return, the potentially confusing combination did translate into the analysis of the returns, as SWV statistics switch between households and occupants.

Aggregating the individual level data to be analysed with the household data also proved time consuming, as it had to be analysed separately and then combined with the other returns.

The issue of household versus individual data collection remains outstanding following the SEF pilot, and features within the Recommendations.

6.3.3 Data Collation

Due to the current lack of standard data collection (or data format) at a regional or national level, each FRS has developed local systems to capture SWV data to suit organisational requirements. Indeed, a review of the returns identified there is little consistency even for information such as 'Ethnicity', as each FRS utilises a different format.

As part of the SEF, each FRS was asked to collate their source data into the required format utilising the standard pick list options, prior to submitting the return. This was with the intention that the six returns could just be 'dumped' into one master file, and subsequently analysed.

Although the pilot FRSs were asked to 'transform' their local data into standardised data that met the SEF requirements, the majority of returns did not adhere to the required format. That's not to suggest the FRSs didn't attempt to 'transform' their data, but were unable to do so due to system constraints, lack of resources, time constraints or employee absence.

As a result, the initial data returns for each FRS had to be cleansed individually prior to collation. This was a manual and time consuming process as 32 of the 38 data fields required a standardised format.

Cleansing of the initial data extract varied somewhat across the FRSs, from less than 30 minutes up to a full day. Following the initial extract, each FRS was provided with feedback to assist with future in-house data collation. This was with a view to reduce the time spent collating the data for the second extract. However, in some instances, the time spent collating the feedback (and also seeking clarification regarding the data), took longer than making the manual adjustments.

The initial feedback was utilised by some FRSs; some issues remained in the second extract, whilst some new issues arose. Newly emerging issues largely concerned inconsistencies with capitalisation and hyphens (as detailed earlier), and also the presence of trailing spaces. There were also a number of instances where required responses such as 'Yes' and 'No', were returned as abbreviated 'Y' and 'N' (albeit inconsistently amongst the FRSs).

As a result, the data cleansing remained a manual process for the second data extract, and cleansing still had to be completed for each FRS individually prior to collation. It therefore wasn't any quicker to complete.

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Data submitted as part of the pilot has helped to illustrate the current differences in recording practices and highlighted the need for a standardised return, if there is an appetite to analyse the effectiveness of SWV at an aggregated level. This is not without challenge, as FRSs have designed existing systems around their individual data collection and it won't be easy to find one solution that applies to all, particularly as each FRS records their data in different formats. This is also likely to require ICT support.

6.3.4 Data Transfer

The FRSs involved in the pilot were requested not to provide any personally identifiable information in the returns, which they followed.

The FRSs submitted their returns via email as an attachment, with some FRSs choosing to password protect the files.

Due to the size of some the returns, the data was blocked by the receiving FRSs firewall. Furthermore, one FRS utilised '7 Zip' to compress their data return. This required the installation of software and the intervention of ICT to enable the receiving FRS to open the data.

Based on the above, a secure portal for each FRS to upload their data might have been a better way in which to submit the returns.

Feasibility of the Approach

Based on the lessons learnt from the pilot, it is possible to improve the data collection template and the standardised options to facilitate a more consistent return. However, of the 11 data returns (two returns were submitted by each of the five FRSs and one remaining FRS submitted one return during the pilot), only one return didn't require any manual adjustments.

As described, collation of the returns was a manual task; often the time taken to seek clarification regarding data consistency and to explain how to 'transform' the data into the required format, exceeded the time taken to make the adjustments. Nonetheless, collation of the data remained a time consuming process when dealing with 11 returns from six FRSs, let alone the 45 FRSs in the UK.

Indeed, the process to collate each FRS return was as follows:

1. Identify records where the visit was refused, attempted or doorstep engagement and sense check data.
    α. The majority of data fields should be 'Not Applicable'.

2. Identify data fields that aren't collected by the FRS (this field will be 'blank' or 'NULL' for all visit records submitted by the FRS) and ensure 'Not Collected' has been entered for these returns.
    α. Adjust any 'blank' or 'NULL' records to 'Not Collected'.

3. Identify data fields that have been left 'blank'.
    α. Adjust these records to 'NULL'.

4. Check each of the 32 data fields that utilise a pick list option are an exact formatting match with the required pick list options.
    α. Utilise copy/paste/remove duplicates, 'Exact', 'VLOOKUP' and 'IF' functions in Excel to ensure each FRS return uses exactly the same pick list options for analysis purposes.

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5. Remove any outstanding trailing spaces using ‘Find and Replace’ or ‘TRIM’ function.

6. Seek clarification regarding data inconsistencies and/or data assumptions, if required.

7. Record any required manual adjustments into the FRS feedback template.

8. Copy and paste values into MASTER spreadsheet, ready for analysis.

In addition to the aforementioned issues with collating / standardising the returns, not all FRSs involved in the pilot collected all the ‘essential’ data. A number of FRSs are using HSC legacy systems to record and store SWV data, and are not currently able to collect (or extract) all the ‘essential’ information. A couple of FRSs re-designed their data collection during the pilot, but no one FRS was able to provide data for all the ‘essential’ fields. Indeed, none of the pilot FRSs were able to return information pertaining to follow up activities.

Table 2 illustrates the fields returned by the pilot FRSs;

- Data in the fields in blue was collected
- Data for the fields in grey was not collected
- FRS A was unable to submit an initial return

Table 2: Data fields completed by pilot FRS

Theme	Column Heading	FRS A		FRS B		FRS C		FRS D		FRS E		FRS F	
		1st Return	2nd Return	1st Return	2nd Return	1st Return	2nd Return	1st Return	2nd Return	1st Return	2nd Return	1st Return	2nd Return
Intervention Details	FRS												
	S&W Visit ID												
	Month-Year of Visit												
	S&W Visit Status												
	Identified as a Target Address?												
	Station												
	Watch												
	Postcode												
Demographics Of Individual Beneficiaries	Ward												
	Housing Tenure												
	Living Status												
	Age Band												
	Gender												
	Ethnicity												
	Disabled? (Y/N)												
	Hearing Impaired? (Y/N)												
	Mobility Issues? (Y/N)												
	Smoking Status												
Beneficiaries Identified At Risk	Fire Risk Identified During Visit? (Y/N)												
	Number of Occupants in Household												
	Falls Risk Assessment Undertaken? (Y/N)												
	Number of People Receiving Falls Risk Assessment												
	Any Smokers in the Household? (Y/N)												
	Number of Smokers in Household												
	Risk of Cold Homes Identified? (Y/N)												
Fire Risk Interventions	Working Smoke Alarm Present? (Y/N)												
	Number of Smoke Alarms Fitted												
	Number of Hard of Hearing Alarms Fitted												
	Fire Retardant Bedding/Throws Provided? (Y/N)												
	Fire Safety Advice Given During the Visit? (Y/N)												
Number of Referrals	Number of People Referred for Fire Risk												
	Number of People Referred for Falls												
	Number of People Referred for Smoking												
	Household Referred for Cold Homes? (Y/N)												
Number of Follow-Ups	Number of Fire Risk Follow Ups												
	Number of Falls Follow Ups												
	Number of Smoking Follow Ups												
	Number of Cold Homes Follow Ups												

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7. Headline Statistics from Pilot

Five of the six FRSs involved in the pilot submitted a single record per visit and provided information at a household level. In these instances, the demographic data largely concentrates around the main occupant, whilst the 'beneficiaries identified at risk' related to all household occupants. This is with the exception of one FRS which has moved to holding individual records for all occupants living in the household. This FRS has chosen to collect individual records in order to support the person centred approach of the SWV, and to facilitate the tracking of onward referrals / follow up activities. Multiple records for occupants living in the same household have been incorporated accordingly into the subsequent analysis of the returns.

7.1 Intervention Details

SWV Targeting / Visit Status

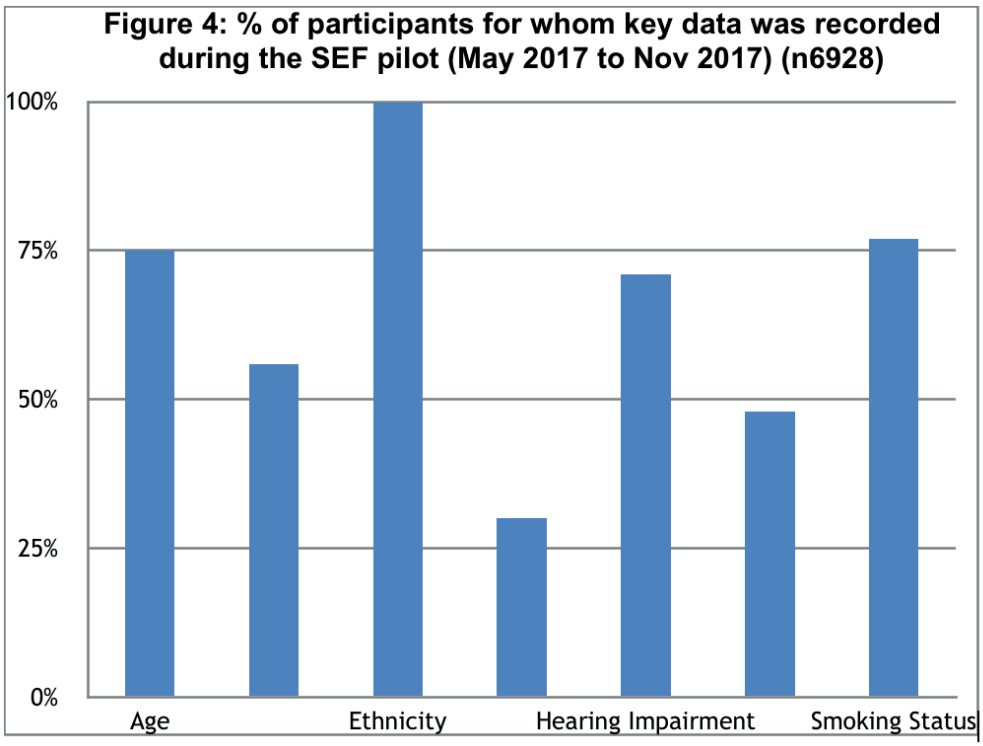
- Between **May 2017 and November 2017**, the six FRSs involved in the Standard Evaluation Framework pilot attempted to undertake a total of **9,868 SWV in households with residents aged 65 and over.**

- Of the **9,868 households, 90% (8,879) were identified as target addresses** by the pilot FRSs. This targeting is based on the respective FRS methodology to identify people representing an increased risk of fire.

- Of the total **9,868 attempted visits, 70% (6,902) were successfully completed.** However, two of the four FRSs didn't provide returns for attempted/refused visits.

- Of the **6,902 successfully completed visits, 68% (6,010) were within households that were identified as a target** by the FRSs. This suggests occupants 65 and over are receptive to SWV.

Subsequent analysis pertains to data collected during the SWV that were successfully completed in 6,902 households with 6,928 occupants (incorporating the individual records submitted by one FRS). Figure 4. shows the data completeness across the demographic data items included within the SEF Pilot requirements. It shows that there is further work to do to ensure consistent recording of key demographic data. The exception is ethnicity which was asked for by all pilot FRS. However, 24% of records within the returns recorded ethnicity as 'not disclosed' or blank.



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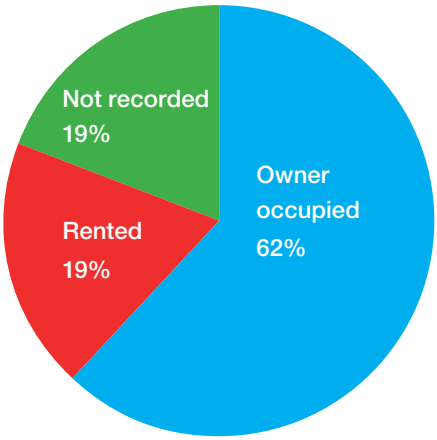
7.2 Demographics of Individual Beneficiaries

7.2.1 Housing Tenure

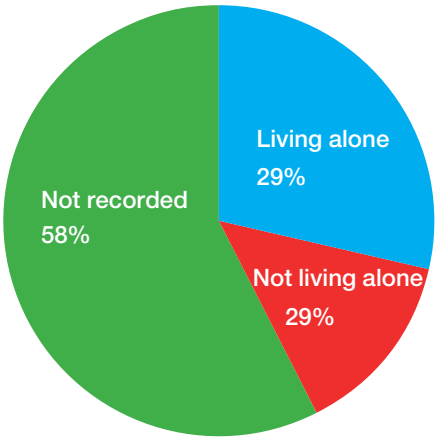
Figure 5: Housing tenure of successfully completed SEF Pilot SWV from May 2017 to Nov 2017 (n6902)



Although the SEF document and data collection template required a breakdown by private and socially rented properties, this level of detail isn't consistently recorded by the pilot FRSs, and therefore a breakdown by type of rented property is unavailable.

7.2.2 Living Status

Figure 6: Living status of successfully completed SEF Pilot SWV from May 2017 to Nov 2017 (n6902)



Data pertaining to living status was collected by three of the six pilot FRSs, and is available for 42% (2,923) of the completed SWV records. People living alone are an important risk group for FRS.

7.2.3 Age Band

The majority of the FRSs involved in the pilot were in a position to provide the age of the respondent within the required five-year age bands. This is with the exception of one FRS that advised all visits were completed with people aged 65 and over.

The **age band was provided for 75% of occupants (5,176),** of which **the majority (65% or 3,369 occupants) were aged 75 and over**.

This is a further indication of the need to address person vs household level data. A number of the demographics here relate to protected characteristics, which should be routinely collected, but often aren't.

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Also, some FRS take the view that advancing age equals increasing risk (and consequently target older residents) but this is not always the case.

7.2.4 Gender

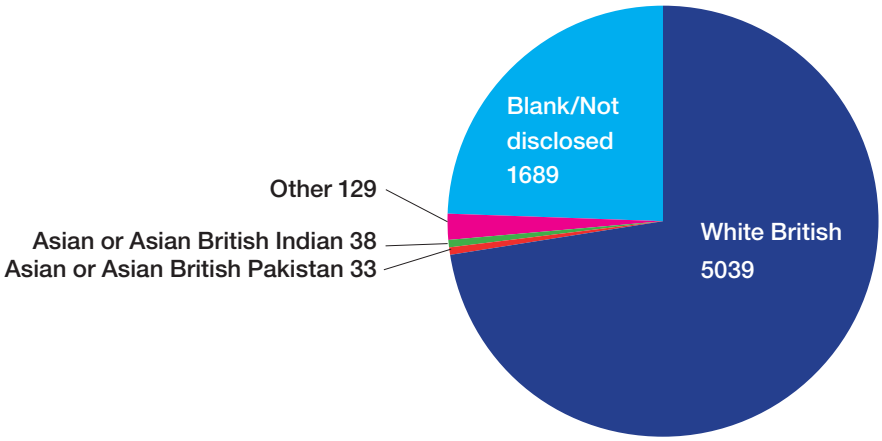
Four of the six pilot FRSs consistently recorded the occupants' gender, one FRS commenced collecting this information during the pilot, whilst the remaining FRS was unable to provide this information.

Data regarding the occupants' **gender was recorded for 56% (3,861) of occupants**.

Of these 3,861 occupants, **64% (2,478) were female and the remaining 36% (1,383) were male**. Females receiving SWV in the pilot areas are over-represented when compared the proportion of females aged 65 and over (55%) in the UK as a whole.

7.2.5 Ethnicity

Figure 7: Ethnicity participants in the SEF Pilot SWV from May 2017 to Nov 2017 (n6902)



All FRS involved in the pilot record ethnicity. However 24% (1,689) of records were blank or 'not disclosed'. When compared with the UK, ethnic minorities receiving a SWV during the pilot are under-represented when compared with white British occupants.

7.2.6 Disability

Four of the six pilot FRSs recorded the occupants' disability, one FRS commenced collecting this information during the pilot, whilst the remaining FRS does not collect this information. The question relating to the occupants **disability status was completed for 30% (2,098) of occupants.**

Of the 2,098 whose disability status was completed, **61% (1,289) were not disabled, 28% were disabled (580) and 11% (229) preferred not to say**.

7.2.7 Hearing Impairment

All FRSs recorded the occupants' hearing status, one of which commenced collecting this information during the pilot. The **hearing status was recorded for 71% (4,912)** of occupants.

Of the **4,912 occupants, 88% (4,345) did not have any hearing impairments, 8% (381) did have a hearing impairment and the remaining 4% (186) preferred not to say.**

7.2.8 Mobility Issues

All but one FRS recorded information regarding the occupants' mobility. The question regarding **mobility issues was completed with 48% (3,337) of occupants**.

Of the 3,337 occupants that answered the question about their mobility, **51% (1,697) did have an issue with their mobility,** 44% (1,453) did not have any mobility issues and the remaining 6% (186) preferred not to say. This characteristic is particularly relevant to fire risk and ability to escape in the event of a fire.

7.2.9 Smoking Status

Data pertaining to the smoking status was collected by five of the six pilot FRSs, and is **available for 77% (5,331) of occupants**. Of the 5,331 occupants whose smoking status was collected, **86% (4,601) were non-smokers and the remaining 14% (730) were smokers**.

Although the SEF document and data collection template required a breakdown of smoking by tobacco and e-cigarettes, this level of detail was only recorded by one FRS, and therefore a breakdown by smoking type is unavailable.

7.3 Beneficiaries Identified at Risk

7.3.1 Fire Risk

Information regarding fire risk was recorded by all six FRS for the majority of households. Fire risks were identified during two thirds of the SWV undertaken by the pilot FRS equivalent to **67% or 4,612 households.**

When cross referenced with the 6,010 households that were identified as a target by the FRSs fire risks were identified in 68% (4,057) of households. Overall, this suggests targeting by the respective FRSs is helpful in directing services to people who represent a risk of fire. However, at a service level, the returns indicate some FRS are better at targeting than others. Each FRS has its own targeting methodology and it would be helpful to evaluate the different methods to determine which are most effective, and what can be learned from the different approaches.

7.3.2 Number of Occupants

Four of the six pilot FRSs consistently recorded the number of occupants, one FRS commenced collecting this information during the pilot, whilst one remaining FRS was unable to provide this information.

The **number of occupants was recorded for 48% (3,302) of households**.

Although not directly comparable with the 'living status' (as only three FRSs returned this information), data pertaining to the number of occupants confirmed that the majority of households visited during the pilot contained single occupants (equivalent to 86% or 2,833 households). For the 14% (469) of households with multiple occupants, the maximum number in any one household was nine occupants. However, it was most common for households to have two occupants, equivalent to 90% (423) households.

Living alone and overcrowding are both fire risks and therefore it would be helpful to ensure greater consistency of recording when it comes to home occupancy.

7.3.3 Falls Risk Assessments / Number of Occupants Receiving Falls Assessments

Five of the six FRSs returned information regarding falls risk assessments, equivalent to records for 87% (6,031) of households. Of the 6,031 households, **at least one occupant received a falls risk assessment during 55% (3,296) of visits.**

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Of the 3,296 households;

- Just one occupant received a falls risk assessment during the majority of visits (98% equivalent to 3,225 households / occupants).
- There were 65 households where more than one occupant received a falls risk assessment. Of these households, falls risks assessments were most frequently undertaken with two occupants (48% of occasions or 31 visits).
- There were six households where a falls risk assessment was undertaken but no-one in the household received a falls risk assessment. All six records were submitted by the same FRS, and this is therefore assumed to be a recording error.

7.3.4 Smoker in Household

Four of the six pilot FRSs consistently recorded if there were any smokers within the household, one FRS commenced collecting this information during the pilot, whilst one remaining FRS was unable to provide this information. **Information regarding any smokers within the household was recorded for 77% (5,305) of households** visited during the pilot.

Of the 5,305 households, 10% (543) were smoking households. The remaining 90% (4,762) were non-smoking households.

As a sense check, data pertaining to smokers within the household was cross-referenced with the smoking status (from the 'Demographics of Individual Beneficiaries' section). This illustrated an inconsistency for 5% (256) of the 'non-smoking' households as they have a 'current smoker'. This inconsistent data was evident for just one FRS.

The number of smokers within the household was collected by four of the six FRSs, and the question was completed during 37% (2,532) of visits. Of the 2,532 households where this information was completed, 7% (170) had one or more smokers.

Of the 170 households with one or more smoker, the majority of households had just one smoker (91% or 155), followed by two smokers (6% or 11 households). This data has been cross-referenced with the smoking households, and the data has been consistently captured by the respective FRSs.

7.3.5 Cold Homes

Five of the six pilot FRSs recorded risks associated with cold homes, equivalent to records for 85% (5,892) of households. Of the 5,892 households, **44% (2,570) were identified as being at risk from cold homes.**

7.4 Fire Risk Interventions

7.4.1 Working Smoke Alarm Present

All six FRS recorded the presence of a working smoke alarm, with only six incomplete returns. Of the 6,896 households where smoke alarm information was recorded, 56% (3,878) had a working smoke alarm and the remaining **44% (3,018) didn't have a working smoke alarm.**

7.4.2 Number of Smoke Alarms Fitted

Information regarding the number of smoke alarms fitted is available for 6,895 households. Of the 6,895 households, 56% (3,878) didn't have any smoke alarms fitted during the SWV. Of the households that had at least one smoke alarm fitted (3,017), the majority required one or two alarms, equivalent to 53% (1,600) and 42% (1,257) of households respectively.

When cross referenced with data pertaining to the presence of a working smoke alarm, **of the 3,878 households that didn't**

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have a working smoke alarm, 41% (1,579) also didn't have a smoke alarm fitted during the visit.

7.4.3 Number of Hard of Hearing Alarms Fitted

Information regarding hard of hearing alarms was only recorded by two of the six pilot FRS, and was completed for 12% (812) of households. Of the 812 households, just 1% (12) had a hard of hearing alarm fitted.

7.4.4 Fire Retardant Bedding

Information regarding fire retardant bedding was only recorded by two of the six pilot FRSs, and was completed for 42% (2,917) of households. Of the 2,917 households, just 2% (48) received fire retardant bedding.

7.4.4 Fire Safety Advice Given

Information regarding fire safety advice was recorded for all 6,902 households, and all households that received a visit were issued fire safety advice.

7.5 Number of Referrals

7.5.1 Number of People Referred for Fire Risk

Information regarding fire risk referrals was recorded by four of the six FRSs, and was collected for 37% (2,563) of occupants. Of the 2,563 occupants where the fire risk referral information was completed, less than 1% (0.6% or 15 occupants) required a fire risk referral. Given that all households received fire safety advice, this suggests the brief interventions delivered by FRS staff are sufficient (in the majority of cases) to address fire risks.

7.5.2 Number of People Referred for Falls

Five of the six pilot FRSs recorded information pertaining to falls referrals, and referral information was completed for 5,432 occupants. Of the 5,432 occupants, 2% (103) received a falls referral.

When compared with the 3,296 households where at least one occupant received a falls risk assessment, information pertaining to falls referrals was completed for 3,152 households (equivalent to 3,162 occupants).

Of the 3,152 households, 3% (87) contained at least one occupant for whom an onward falls referral was made, equivalent to referrals for 88 occupants (3% of occupants). The remaining 15 occupants who received a falls referral, did not received a falls risk assessment.

7.5.3 Number of People Referred for Smoking

Referrals for smoking were recorded by four of the six pilot FRSs, and the question regarding smoking referrals was completed for 57% (3,953) of occupants. Of the 3,953 occupants, less than 1% (0.3% or 13) received a smoking referral.

When compared with the 730 smokers (from the 'Demographics of Individual Beneficiaries' section), just 2% (13) of occupants received an onward referral to help address issues associated with their smoking.

7.5.4 Household Referred for Cold Homes

Four of the six pilot FRSs recorded information in relation to cold homes referrals. Information regarding referrals for cold homes was collected for 57% (3,927) of households. Of these, just 1% (27) required a referral due to cold homes/fuel poverty.

All 27 households that received a cold homes referral were identified as being at risk from cold homes / fuel poverty. This is equivalent to 1% of the 2,570 households that were identified as being at risk from cold homes.

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7.5.5 Number of Follow up Interventions

Information pertaining to the follow up interventions undertaken following the SWV was not provided by any of the FRSs involved in the pilot.

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8. Lessons Learned

There have been a number of learning points from the pilot, some of which relate to the core purpose of the pilot and some of which have wider implications.

8.1 Safe and Well Roll Out

It is clear from the pilot that developing and rolling out Safe and Well visits has been a significant undertaking in every FRS, involving a range of activities including (but not limited to):

- Leadership
- Staff training
- Adapting data and IT systems
- Building new partnerships

Significant numbers of frontline staff have been trained in tackling a broader range of risks relating to fire and in having opportunistic conversations with the public based on Making Every Contact Count (MECC) principles. Training has often been delivered in partnership with public health and/or NHS colleagues.

SWV are new for FRS and a significant effort has gone into staff engagement to demonstrate the value of this work in relation to the core firefighter role. Whilst it is acknowledged that there is more to do on this, the progress made should not be underestimated.

8.2 Fire Risk Methodology

The model proposed in the SEF to demonstrate impact on outcomes requires an initial assessment of population level risk for each of the elements of the SWV. Whilst it was reasonably straightforward to model population level risk for individual elements such as falls, cold homes and smoking at local area level using nationally available data, it was not straightforward to do this for fire risk. Many areas offer a universal HSC service (although increasingly FRS are moving towards a targeted approach) and in universalism it is assumed that the whole population is at risk. Clearly that risk is not equally spread and each FRS therefore uses its own methodologies to determine local fire risk, often based on small numbers of fire deaths and serious injuries. A clear ask from the pilot FRSs is that a national methodology to determine population fire risk would be welcomed.

8.3 Quality Assurance

One of the challenges when developing the original SEF was to provide an unambiguous definition of a SWV. To demonstrate whether or not an intervention is effective it is necessary to define it. The basis for this definition should have been the definition of a HSC, with the added SWV elements. However, there is currently no nationally agreed definition or standard for a HSC.

Determining quality and effectiveness begins with a clear definition and standard for the service being delivered, against which it can be measured. Participating FRS have grappled with the issue of what constitutes a good quality, effective visit and whilst anecdotally it appears that there is a lot of good and excellent practice on the ground, demonstrating it and maintaining it will continue to be challenging in the absence of clear definitions and National Quality Standards.

8.4 Partnerships

At the beginning of the pilot FRSs were at various stages with their partnerships from well-established to early stages. Feedback during the pilot has demonstrated that SWV have acted as a catalyst to bring key partner agencies together. These relationships have been built around a shared agenda.

SWV require referral partnerships to be established with agencies that FRS may not have worked with directly in the past. Creating these pathways has been time consuming and, at times, frustrating, but the achievements have been significant.

FRS have succeeded in bringing neighbouring local authorities and clinical commissioning groups together across geographical boundaries to agree common pathways into services. Given the complexity of services for conditions such as falls (with different tiers and referral criteria) this is an impressive achievement which others could learn from.

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8.5 Shared learning

Initially participating FRS were reluctant to share experiences and learning from what had 'not gone well' with each other. This was not something that had originally been anticipated as an issue and may, in part, have been a reflection of the 'healthy competitiveness' that exists between FRS. By creating a confidential non-competitive environment FRS were able to share with each other and the feedback was that this was particularly valuable and not always part of the 'FRS way'.

Creating an environment where organisations are able to learn from their own mistakes and those of others, and share experiences with those who may well be grappling with the same issues as them is something that is particularly important when working on complex, multi-faceted initiatives such as SWV.

8.6 Data and IT

An issue that arose throughout the pilot was related to the way data has been historically collected by FRS. Most IT systems and HSC recording is undertaken at *Household* level, with Unique Property Reference Number (UPRN) as the identifier. By contrast, SWV are about the *person* and onward referrals are made on an individual basis. In homes with multiple occupancy this caused a particular issue e.g. if more than one household member required a referral there was often no facility to record multiple occupant details. This also means that only one data item is recorded per visit, which runs the risk of significantly underestimating the reach and impact of FRS who often work with far more individuals than they are able to record.

This poses a strategic question for FRS in the future: Should community safety services remain household based or should they move to a person-centred approach? Some FRS have already invested in Customer Relationship Management software which allows them to record individual information.

This also raises the wider issue of the evidence base for risk e.g. to what extent is fire risk related to property and to what extent is it related to personal risk behaviours? If the balance tips towards personal risk behaviours should FRS nationally consider moving towards person-centred home safety risk management systems?

One of the striking features of the pilot is that not one of the participating FRS succeeded in extracting output/outcome data from referral partners. There is a significant push to demonstrate effectiveness in relation to SWV but there is no HSC effectiveness model to build on and it is extremely challenging to track outputs and outcomes resulting from referrals. Arguably those outcomes are the outcomes associated with the referral partner not the FRS, so at what point do we deem SWV to have been effective? Are there better ways to demonstrate effectiveness than chasing outcome data from referral partners, who during the pilot have, rightly, pointed out that no other referrers request this information and therefore they do not have systems set up to deliver it. Would it be helpful to focus on building links with academic partners and considering different methodologies?

With regards to the feasibility of continuing the approach, the pilot has helped to illustrate that the spreadsheet template did not work effectively in practice as the respective FRS legacy systems were designed prior to the SEF pilot, and therefore don't return the data in the required format. Given the variation in systems, and the mix of household vs individual level data it would be difficult to find a 'one size fits all' solution at present.

The spreadsheet template was a useful tool with functionality that allowed an external FRS to retrospectively collate the data, but it remained a manual and time consuming process to retro-fit the returns into a standardised format. It would therefore require a significant amount of manual adjustment, either by each FRS prior to submission or a host (e.g. the Home Office or the NFCC) to collate the returns from the 45 UK FRSs, into one standardised dataset.

In order to standardise the process, the first step should be to create a standard set of questions to ask during an SWV, with appropriate responses. In much the same way that IRS works, this standard data should be collated centrally in a nationally approved system, but allowing individual FRSs to utilise whichever local system they want. This gives them the flexibility to record additional information to satisfy their own local SWV requirements, which may have been developed with partners.

9. Conclusions and Recommendations

The pilot met its objectives to test the feasibility of introducing a Standard Evaluation approach to collating evidence of effectiveness for SWV at a national level.

The pilot has demonstrated the significant effort that goes into rolling out a programme of SWV within an FRS. There have been important wider benefits across a range of areas including an upskilled workforce, a range of new partnerships and an enhanced reputation for FRS locally. All areas described new partnerships with health partners and others that had developed as a result of SWV and the real value they had added. Training and skills development have been major elements of all SWV programmes with large numbers of staff trained. Developing safe and well visits has enhanced the reputation of FRS with their partners and in local communities

There has been real progress in how pilot FRS target the most vulnerable developing new approaches using Exeter and other datasets and working with public health/local authority colleagues.

The SEF approach improved confidence and skills in evaluation in the pilot FRS (see case studies, Appendix 3). There have been improvements across the board in data collection, storage and general information governance as a result of SWV development. However, data quality and consistency remains a challenge.

The expectation that FRS can demonstrate effectiveness through obtaining output and outcome data from referral partners has proved extremely challenging and may not be feasible as part of ongoing performance monitoring.

The Excel mechanism did not work particularly well as a method of collating data, and alternative solutions should be sought, subject to further consideration of the varied IT systems currently being used by FRS nationally.

The pilot has highlighted a number of further questions and research needs.

- Cost Benefit Analysis/Effectiveness is very difficult to measure robustly, not one FRS managed to get follow up data from referrals
- There is still a need for standardisation across FRS as to what constitutes a SWV.
- There are still too many inconsistencies in SWV across FRS.
- Should the NFCC be looking at HSC and SWV protocols nationally.

Recommendations are split into overarching, strategic recommendations and technical recommendations relating to the Standard Evaluation Framework and practical application.

Overarching recommendations:

It is recommended that the NFCC:

1. **Endorse a shift away from a property focus towards a person centred approach and increased multi-agency working, consider if, in the medium to longer term, new person-centred IT systems will be needed to meet future service requirements.** *This may necessitate further piloting with individual FRS to trial a shift from a property to person-centred data recording systems.*

2. **Takes action to support FRS to be more open and transparent in sharing learning experiences (such as the development of SWV) including the sharing of what has not worked as well as what has.**

3. **Considers ways to build evaluation skills and capacity in FRS in the UK through identification of appropriate training and developing skills and relationships with academic partners.**

4. **Considers steps to encourage and support FRS to improve data quality, encourage standardisation and develop standardised terminology.** *This includes, but is not limited to encouraging electronic data collection and finding ways to improve data completeness and accuracy.*

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5. **Addresses the definition of Safe and Well visits, clarifies that this approach is aligned to the Firefighter role map and makes the distinction between Safe and Well visits and the historical approach to Home Safety Checks through its National Standards Framework.**

6. **Develops a core standard and methodology for addressing fire risk including how to quantify it and what actions to take as part of a home visit to complement local approaches.**

7. **Recognises that Safe and Well represents a cultural shift for FRS and that ongoing work is required to support behavioural change for operational staff and support staff.**

8. **Considers how to address the need for a Unique Identification system for person level data and appraise the potential options including possible use of NHS numbers and other alternatives.**

9. **Considers developing quality assurance guidance to encourage consistency and a culture of continuous improvement in relation to HSCs and SWV.**

10. **Considers the options and resource implications relating to the creation of an NFCC held data repository for Safe and Well.**

11. **Subject to the enactment of recommendations 4-6 the SEF tool should be adopted, rolled out and made available to all FRS in the UK.**

12. **Supports FRS to collect referral feedback as part of locally agreed and recognised safe and well offers, to aid multi-agency working and enable evaluation of effectiveness and cost effectiveness.**

The next set of recommendations are technical recommendations relating to the SEF document and data repository.

It is recommended that:

13. **The pick lists on the data collection tool are expanded and clarified in line with the lessons learned during the pilot.**

14. **The SEF tool is added to, to ensure FRS capture the background to, and developmental learning from, their Safe and Well programmes.**

15. **The specific age criteria are removed so that the SEF can be applied to a broader range of at risk adults.**

16. **Face to face training is undertaken with all staff undertaking Safe and Well Visits**

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Design Principles for Safe and Well

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Appendix 1: Invitation to apply to take part in the pilot

Invitation to participate in a pilot to test a new approach to evaluating Safe and Well visits

We are looking for a small number of FRS in England to test out a new approach to evaluating Safe and Well visits. To participate you will need to already be delivering a programme of Safe and Well visits. This pilot is about testing a consistent approach to evaluation across FRS in England.

As a participant in this pilot you will receive:

- Training in Evaluation
- Training in how to use the CFOA Standard Evaluation Framework guide
- Ongoing support for the duration of the pilot
- Support to generate an evaluation of your own Safe and Well visit programme

To take part in the pilot your organisation will need to commit to the following:

- To nominate someone within your organisation to lead on the evaluation pilot and to act as a single point of contact
- To involve your Safe and Well local partners including health and social care in the evaluation
- To release people to attend the evaluation training in April
- To commit staff time to complete the evaluation

A key purpose of evaluation is to identify where improvements can be made and to make recommendations for the future. To take part in the evaluation you do not need to worry about having all the answers ready, or data collection systems sorted. The pilot will support you to identify how to develop your service and systems and where improvements can be made for the future.

If you are interested in finding out more or would like to participate please contact ellie.houlston@nhs.net or ged.devereux@phe.gov.uk by **Wednesday 15th February 2017**

If you have previously expressed an interest in taking part in the pilot could you please confirm that you are still interested by contacting either Ged or Ellie by the closing date.

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Appendix 2:

AGENDA Standard Evaluation Framework Training Meeting 09.30 Wednesday 5th April 2017 Greater Manchester Fire & Rescue Service Training and Development Centre, Cassidy Close, Manchester, M4 5HU		
Time	**Title**	**Lead**
09.30	Welcome and Introduction to the day	Geoff Harris, Assistant Chief Fire Officer
09.40	Overview of Safe and Well	Ged Devereux, Public Health England/ GMFRS
09.50	Public Health England	Matt Hennessy
10.20	Setting the Scene	Anna Richardson, Home Office
10.50	Coffee break	
11.00	Evaluation – what is it? Why is it important Types of Evaluation Outputs vs Outcomes Evaluation case study examples	 Ellie Houlston
12.30	Lunch	
13.30	What is the SEF? • Why standardise? What questions do we want to answer? • Aims and objectives Benchmarking – Where are we starting from? • Poppi and Pansi • JSNA • Fire risk at population level – risk stratification	Ged Devereux Ged Devereux Ellie Houlston
14.45	Coffee break	
15.00	Data collection • Systems • Definitions • Data quality assurance (completeness, consistency etc) Timeframes/volume of visits – sample size? Ongoing support	Ellie Houlston Ged Devereux
16.15	Q&A and next steps	
16.30	Close	

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