



Public Health  
England

Protecting and improving the nation's health

# **Evaluation of the impact of Fire and Rescue Service interventions in reducing the risk of harm to vulnerable groups of people from winter-related illnesses**

## About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

Public Health England  
Wellington House  
133-155 Waterloo Road  
London SE1 8UG  
Tel: 020 7654 8000  
[www.gov.uk/phe](http://www.gov.uk/phe)  
Twitter: @PHE\_uk  
Facebook: [www.facebook.com/PublicHealthEngland](https://www.facebook.com/PublicHealthEngland)

Prepared by:

Linda Hindle, Lead Allied Health Professional and National Engagement Lead for Police, Fire and Ambulance services based on an evaluation carried out by ICF Consulting Services Ltd. This pilot and evaluation has been overseen by an advisory group including:

Geoff Harris, Greater Manchester Fire and Rescue Service  
Angie Bone, Public Health England  
Debbie Stark, Public Health England  
Gill Leng, Public Health England  
Joanne Harcombe, Public Health England  
Helen Carter, Public Health England  
Lily Makurah, Public Health England  
Melanie.Sirotkin, Public Health England  
Nuzhat.Ali, Lead Older Adults, PHE  
Raymond Jankowski, Public Health England  
Carl Petrokofsky, Specialist in Public Health, PHE  
Daniel MacIntyre, Public Health England  
Brian Moss, Staffordshire Fire and Rescue Service  
Dez Stoddart, Staffordshire Fire and Rescue Service  
John Beard, Gloucestershire Fire and Rescue Service  
James Russell, Staffordshire Fire and Rescue Service  
Rob Barber, Staffordshire Fire and Rescue Service  
Glynn Luznyj, Staffordshire Fire and Rescue Service

James Bywater, Staffordshire Fire and Rescue Service  
Sally Waldron, Gloucestershire Fire and Rescue Service  
Evan Morris, Chief Fire Officers' Association  
Katie Walkin, NHS England  
Ellie Houlston, NHS England  
Josephine Johnson, NHS England  
David Bramley, NHS England  
Kirsty Gaskell-Sinclair, Age UK  
Reuben Balfour, ICF International  
Shane Beadle, ICF International  
James Kearney, ICF International  
Eleanor Breen, ICF International

And with advice from Louise Upton and Lewis Ahlquist, Home Office and Shaun Donaghy, Public Health England. Geoff Harris, Fire Rescue Service

For queries relating to this document, please contact: Linda Hindle, Lead Allied Health Professional and National Engagement Lead for Police and Fire Services, Public Health England, [linda.hindle@phe.gov.uk](mailto:linda.hindle@phe.gov.uk)

© Crown copyright 2016

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v3.0. To view this licence, visit [OGI](https://www.nationalarchives.gov.uk/ogl/) or email [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk). Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Published: November 2016

PHE publications gateway number: 2016-478

# Contents

About Public Health England	2
Foreword	5
Executive summary	7
Introduction	13
Evaluation methodology	16
Pilot activities	17
Results of the evaluation	21
Outcomes and impacts	36
Limitations of the evaluation	41
Conclusions and recommendations	42

# Foreword

**Professor Kevin Fenton, Director of Health and Wellbeing, Public Health England**

Over the last year, the Fire as a Health Asset consensus statement published by NHS England, Public Health England, the Chief Fire Officers' Association and Age UK has led to increased collaboration between fire and rescue services and the health and social care system across England.

Fire and rescue services have been working in a preventative role for a long time now and their interventions have contributed to a significant decrease in the number of people who die in fires. It was an obvious expansion of this preventative role to focus on the wider health and wellbeing of the vulnerable people that fire and rescue services come into contact with. Following the publication of the consensus statement, more than half of all fire and rescue services have converted their home safety checks into Safe and Well visits.

This evaluation explores the impact of broadening the Safe and Well visit to include a focus on risk factors for winter-related illnesses. Most excess winter deaths and illnesses are caused by respiratory and cardiovascular problems during relatively moderate outdoor winter temperatures of 4 to 8°C. The risk of death and illness increases as the temperature falls further, yet much of this is preventable. It is therefore important to use the skills and contacts of a range of partners to identify those at risk and provide support to reduce risks. Fire and rescue services are paramount to this.

This pilot focused on the four main contributors to winter-related illness including the prevention of falls, the prevention of cold homes, the prevention of social isolation and ensuring eligible people receive the flu immunisation. The pilot has provided insight into the practical issues associated with implementing interventions across fire and rescue services and their partners, which will be helpful to other areas embarking on this approach. It is clear that partnerships have matured during the lifetime of the pilots and there is much potential for further collaborative working and data sharing.

Clearly, the impacts of an intervention such as this continue over the longer term. The indications from these pilots are that there is a positive outcome in terms of social benefits as well as identification and referral of those at increased risk of falls, social isolation and cold homes. The cost of the intervention is also minimal compared to the cost of the outcomes it aims to prevent.

I hope this report will be of value to fire and rescue services, sustainability and transformation plan boards, health and wellbeing boards, local authorities and clinical commissioning groups. It is also welcomed by national fire, as a health asset collaboration partner. I would like to thank the Chief Fire Officers' Association, Staffordshire, Gloucestershire and Greater Manchester Fire and Rescue Services and members of the advisory group for their contribution to these pilots.

## Peter O'Reilly, Strategic Health Lead, Chief Fire Officers' Association

On behalf of the Chief Fire Officers' Association and Staffordshire, Gloucestershire and Greater Manchester Fire and Rescues Services, I welcome the publication of this evaluation report. The report describes how local partners working with fire and rescue services can reduce fire risks using combined approaches to prevention and early intervention. Where the underlying causes of those fire risks relate to wider health and wellbeing issues, fire and rescue service staff can support people to remain independent in their own homes and reduce pressure on health and social care services.

The pilot has demonstrated how collaboration between local partners can be strengthened to improve how we target interventions towards those most at risk and those that create demand. It builds on our understanding of the links between the underlying causes of demand for fire and rescue services and health and social care partners; and sets out recommendations for how collaboration between fire, health and social care can be improved.

The practical issues that the pilot raises will help fire and rescue services to develop their own approaches to Safe and Well visits. Working with local partners we are better placed to address local risks and needs. More than 80% of England's fire and rescue services are developing similar approaches to tackling the underlying causes of fire risks. The recommendations contained in this report will provide a blueprint for further collaboration to improve outcomes for some of our most vulnerable communities.

The alignment of fire and rescue services with other partners to support health improvement and reduce demand on public services operating in the home setting is an encouraging element of the report. This person-centred approach should be built upon to strengthen prevention and early intervention to reduce fire risk and support wellbeing.

The maturing approach to fire risk reduction that this pilot highlights supports the realisation among fire and rescue services that a single visit to a home solely to consider generic fire risk is also an opportunity to address the underlying causes of fire risk that are also wider health and wellbeing issues.

This report demonstrates the value of collaboration to deliver benefits for fire and rescue services and health and social care partners. More importantly, this work demonstrates how we can work smarter and learn together to improve outcomes for the most vulnerable people in our communities.

## Executive summary

This report examines the impact of fire and rescue service (FRS) interventions to reduce the risk of winter-related ill health in vulnerable groups of people between October 2015 and March 2016. Excess winter deaths and winter-related health risks are an important issue for public health as colder weather conditions are associated with increased risks of illness and injury, particularly among older people.

The pilot was commissioned by Public Health England (PHE) and the Chief Fire Officers' Association (CFOA) with the support of NHS England to reduce the risk of harm to vulnerable groups of people from winter-related ill health. This pilot incorporated recommendations made by NICE in its quality standard for preventing excess winter deaths caused by cold homes<sup>1</sup> and PHE's Cold Weather Plan for England.<sup>2</sup>

The pilot aimed to address the health risks of people vulnerable to falls, social isolation, cold homes and flu during the winter months.

The main objectives of the pilot were to:

1. Build capacity within pilot areas to deliver Safe and Well<sup>3</sup> visits which systematically focus on a broader range of health issues, including issues relating to winter-related ill-health (including falls, social isolation, cold homes and flu).
2. Identify households vulnerable to falls, social isolation, cold homes and flu within pilot areas.
3. Provide targeted interventions to reduce the risk of falls, social isolation, cold homes and flu which may lead to a reduction in the pressures on public services in local areas (for example, A&E admissions to hospital, fire service call-outs, demands for GP and social care services).
4. Build and strengthen relationships between the FRS and local service partners, including development of referral pathways into other forms of help and support within the community.
5. Reduce the risk of excess winter deaths.
6. Demonstrate the value of the FRS in supporting partners to improve health and wellbeing and reduce demand on health and social care services.

---

<sup>1</sup> <https://www.nice.org.uk/guidance/qs117>

<sup>2</sup> <https://www.gov.uk/government/publications/cold-weather-plan-cwp-for-england>

<sup>3</sup> The concept of the Safe and Well visit broadens the scope of home fire safety checks to identify and act on a wider range of risks to help and support people's good health and wellbeing.

### This evaluation considered three questions:

- I. How have the specific interventions being considered in the three pilot areas had an impact on winter pressures?
- II. What was the impact of the interventions on the individuals who received a home visit?
- III. What was the return on investment of the intervention?

### Summary of main findings

The pilot aimed to increase capacity within local FRS areas to deliver home visits to focus on a broader range of issues relating to health and wellbeing, to support the Safe and Well initiative. Brief interventions focused on prevention of falls, cold homes and social isolation as well as signposting to flu immunisation were incorporated into the visit.

Overall the pilot achieved four of the six objectives:

1. Build capacity within pilot areas to deliver Safe and Well visits which systematically focus on a broader range of health issues, including issues relating to winter-related ill-health (including falls, social isolation, cold homes and flu).

A total of 1,200 staff received training to deliver the intervention. Staff reported improved skills and knowledge in relation to falls prevention, cold homes, flu vaccinations and social isolation. Face-to-face training was more effective than webinars at achieving this.

2. Identify households vulnerable to falls, social isolation, cold homes and flu within pilot areas.

A total of 6,304 visits were conducted. Of these, 4,917 (78%) households included at least one person over 65 years old, 1,800 (29%) households included someone with a long-term condition and 1,619 (26%) reported someone living with a disability.

3. Provide targeted interventions to reduce the risk of falls, social isolation, cold homes and flu which may lead to a reduction in the pressures on public services in local areas (for example, A&E admissions to hospital, fire service call-outs, demands for GP and social care services).

A total of 3,296 (52%) people received advice to prevent a fall and 1,378 (22%) were referred for a falls assessment. Similarly, 3,296 (52%) people received advice to prevent cold homes and 406 (6%) were directly referred or signposted to further support. A total of 462 (7%) people were identified as at risk of social isolation and offered advice or referral. The majority had already received their flu immunisation. Beneficiaries trusted FRS to provide Safe and Well visits



4. Build and strengthen relationships between the FRS and local service partners, including development of referral pathways into other forms of help and support within the community.

Nearly all partner organisations indicated that the pilot had led to improved communication and relationships between themselves and the FRS and they intended to further develop joint working in the future. Most partner organisations reported that the pilot had led to an increase in referrals and demand for their services. Referrals were considered appropriate, supporting the aims of partner organisations to deliver services to people in need. Partners indicated that a longer lead in time to the start of the pilot would have allowed better joint planning around data sharing and referral pathways.

Implementation was more effective when developed on a smaller scale and gradually increased.

5. Reduce the risk of excess winter deaths.
6. Demonstrate the value of the FRS in supporting partners to improve health and wellbeing and reduce demand on health and social care services.

The pilot was not able to report on objectives 5 and 6 within the timeframe because a detailed breakdown of the use of NHS services has not yet been released. This report is therefore presented as an interim report; further analysis of the data will be commissioned by CFOA in 2017/18.

Although it has not been possible to assess return on investment, this report does outline the additional cost of delivering the intervention and compares this value to the cost of the outcomes the intervention seeks to avoid. It also highlights the perceived value of the interventions by beneficiaries and partners.

The additional time required to add the winter pressures components to the Safe and Well visit was estimated to be 30 minutes per visit.

The additional cost was £13 per visit on an ongoing basis.

To break even, every 1,000 visits would need to prevent 65 A&E attendances or 8.4 emergency admissions or 3 mid to high risk falls.

## Some lessons from the implementation of the pilot

The pilot demonstrated some degree of transferability across three different models of delivery within the FRS. However, there is an indication that implementation is more effective on a smaller scale, across a single area, compared to large scale implementation across a metropolitan area, with a diverse population. Both Staffordshire and Gloucestershire delivered the pilot incrementally over a smaller geographical area than Greater Manchester and reported fewer challenges and problems in delivering the home visits. The benefits of this approach were that they could learn from problems as they went along and alter parts of the pilot without too much disruption.

Using data about local populations to identify and target vulnerable households takes considerable time and resource. Involving local partners and agencies, with their specialist knowledge of vulnerable people within local areas, would be beneficial.

Existing experience and capacity to deliver home visits, combined with an established referral pathway, enabled pilot areas to hit the ground running. Staffordshire had already been delivering a similar pilot to the Winter Pressures Pilot (under the SAfER pilot) and was able to draw on this experience and local networks. It is likely that this helped the FRS to exceed its target number of home visits and reduced the chances of setbacks and delays. In addition, having sufficient time to plan and prepare for delivery was important to the smooth implementation of the pilot.

Face-to-face training was the preferred method of delivery by staff. Feedback from the staff e-survey and interviews with frontline staff indicate that staff who received face-to-face training were more confident in their ability to deliver home visits and had a better understanding of the winter pressures components and their purpose.

Engaging with partners from the planning stages of the pilot was also important. The majority of partners and FRS reported that they felt the pilot would have benefited from greater collaboration at the beginning, potentially through a pilot area steering group, to better establish data sharing mechanisms between the FRS and partners to support the referral pathways, but also support the FRS in reaching the right people.

The pilot was more effective at identifying and addressing households vulnerable to some issues compared to others. Analysis of data on flu vaccinations, together with evidence from qualitative interviews with beneficiaries, suggests that the pilot had little impact on vaccination rates across all three pilot areas. This is largely because recipients of a home visit reported receiving their flu vaccine from local health services at the beginning of winter.

Systems of data collection to support the monitoring of the pilot and information shared with referral pathways could be improved. All three pilot areas had different mechanisms for collecting and presenting data. This affected the comparability of the pilots and the type

of information shared through the referral pathways. A standardised approach would be useful in improving the data collection process.

There is data being collected by national and local health and social care partners that could support the measurement of the pilot's outcomes and impacts. However, accessing this data is challenging as it is not being collated in a systematic way. Efforts should be made by the pilot areas, the advisory group, partners and the wider health and social care system to improve mechanisms for data sharing and quality assurance.

## Recommendations

1. **Sufficient preparation time:** This is required in the lead up to delivering the home visits before winter begins to allow adequate time to train staff to deliver the home visit, develop and test data collection methods, work with partner organisations to support the pilot, develop and test formal referral pathways, establish local provision of services to avoid duplication, and draw on local knowledge from partners to identify target households.
2. **Targeting:** FRS covering areas of high deprivation should re-evaluate their target groups. Households in areas of high deprivation may experience vulnerability and support needs at an earlier stage in the life course compared to areas of lower deprivation.
3. **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.
4. **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.
5. **Training:** Face-to-face training is preferable because it gives trainees adequate opportunity to ask questions about what they are being asked to deliver. Training should reflect the cultural and organisational changes being placed on staff with respect to the delivery of the activities included in the Winter Pressures Pilot, as well as the whole Safe and Well visit. In particular, training should focus on equipping staff with the skills to approach difficult and personal topics (for example, income benefits, loneliness, mental health).
6. **Delivery:** Incremental roll-out of interventions allows for any problems to be overcome and appropriate improvements and alterations to be made to the approach without too much disruption to the service.

7. **Engagement:** A range of approaches to engaging households in a home visit will be needed. Combining proactive approaches, such as canvassing individual streets and areas through knocking on doors and offering home visits through telephone calls and local promotions, with reactive approaches, such as responding to referrals and requests from individual households or other organisations for a home visit, will increase rates of home visits.
8. **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.
9. **Content of the home visit:** A review of the four issues covered in the home visit should be undertaken to ensure visits focus on the areas where they can have the largest impact. The evaluation found that the home visits were more effective in addressing falls, cold homes and social isolation than flu vaccinations.
10. **Commissioning:** Local commissioners should ensure that there is adequate funding to support organisations that provide referrals pathways to beneficiaries and the wider health and social care infrastructure. This will improve the value of the Safe and Well visit (including the winter pressures component) and ensure that it is sustainable in the future.
11. **Longer-term evaluation:** Data collected in this pilot can be used with emerging national and local data to improve understanding of the longer-term impact and return on investment.
12. **Next steps:** PHE and FRS should complete the estimation of the pilot's SROI using data that will be available in 2017/18.

# Introduction

This report examines the Winter Pressures Pilot commissioned by Public Health England (PHE) and the Chief Fire Officers' Association (CFOA) to reduce the risk of winter-related ill health in vulnerable groups of people between October 2015 and March 2016.

## Context and rationale

### Fire and rescue services have extensive experience of home interventions and prevention

Over the past decade, the Fire and Rescue Service (FRS) has contributed to the improved health and safety of people in their homes by reducing fire risks and hazards through Home Safety Checks (HSCs). Much of this work has focused on prevention and contributed to a large decrease in the number of fire incidents and fire-related injuries and deaths.<sup>4</sup>

In April 2015, a Fire and Health summit was held to explore the added value of the FRS in improving public health. An important proposal from the summit was to replace the 670,000 HSCs conducted by the FRS each year with a new type of home visit called a Safe and Well visit. This has a broader scope than the HSC, identifying and acting on a wider range of risks in order to improve people's health and wellbeing.

The Safe and Well visit has the potential to help the most vulnerable and reduce pressure on public services.

A partnership between the CFOA, PHE, NHS England, the Local Government Association (LGA) and Age UK took forward the concept of the Safe and Well visit under the Fire as a Health Asset programme.<sup>5</sup> Fire and rescue services across the country adopted the Safe and Well visit during 2015 and 2016, replacing the HSC. At the same time, PHE and CFOA agreed to explore the impact of Safe and Well visits on winter-related illnesses.

Excess winter deaths and winter-related health risks are an important issue for public health as colder weather conditions are associated with increased risks of illness and injury, particularly among older people.<sup>6</sup> These risks not only have implications for individuals, such as negative health outcomes, but also affect public services, which often experience surges in demand during periods of cold weather.<sup>7</sup>

---

<sup>4</sup> DCLG (2015) Fire and Fire Safety 2013-14. English Housing Survey.

<sup>5</sup> <https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/fire-asset/>

<sup>6</sup> PHE (2015) Cold Weather Plan for England. Protecting health and reducing harm from cold weather.

<sup>7</sup> NHS England (2014) Understanding Winter Pressures in Accident and Emergency departments.

However, there was little evidence linking the activities of the FRS to reducing winter-related health risks and pressures on public services. Therefore, PHE and CFOA agreed to develop a pilot to explore and evidence how the FRS might use the Safe and Well visit to reduce the impact of winter-related health risks.

## Overview of the Winter Pressures Pilot

The pilot aimed to address the health risks of people vulnerable to falls, social isolation, cold homes and flu during the winter months (November to March). By doing so, it aimed to reduce the pressures on public services and the number of winter related illnesses. The main objectives were to:

- build capacity within pilot areas to deliver Safe and Well visits which systematically focus on a broader range of health issues, including issues relating to winter-related ill-health (including falls, social isolation, cold homes and flu)
- identify households vulnerable to falls, social isolation, cold homes and flu within pilot areas
- provide targeted interventions to reduce the risk of falls, social isolation, cold homes and flu which may lead to a reduction in the pressures on public services in local areas (for example, A&E admissions to hospital, fire service callouts, demands for GP and social care services)
- reduce the risk of excess winter deaths
- build and strengthen relationships between the FRS and local service partners, including development of referral pathways into other forms of help and support within the community
- demonstrate the value of the FRS in supporting partners to improve health and wellbeing and reduce demand on health and social care services

Three FRS were selected by CFOA to take part in the pilot during the winter of 2015/16. These were Greater Manchester FRS (Greater Manchester) representing a metropolitan authority; Staffordshire FRS (Staffordshire) a combined authority, and Gloucestershire FRS (Gloucestershire) a unitary authority. They were chosen on the basis of readiness and capacity to undertake the pilot as well as representing the three FRS delivery models.

An advisory group was established to oversee the pilot that included experts from PHE, NHS England and Age UK and operational leads from each FRS.

The pilot consisted of four common elements:

**Defining the intervention and training staff to deliver it consistently.** A training pack was developed by the advisory group for pilot areas. It covered the steps necessary to identify and take appropriate action against falls, cold homes, flu and social isolation.

**Identification and engagement of beneficiaries.** The pilot aimed to deliver a total of 10,000 home visits. Targets were set based on the proportion of the total annual HSCs they would expect to deliver during the pilot period, adjusting for lead-in time and incremental implementation of the pilot. Pilot areas were tasked with identifying vulnerable households within their local populations and targeting these households for a home visit. All areas used NHS Exeter data alongside locally available data sources such as Mosaic and fire incident data, with additional data overlaid where available. All areas targeted people aged over 65, particularly those living alone. Potential beneficiaries were engaged by either letter, door to door canvassing by FRS or referrals from partner organisations.

**Delivery of the intervention including assessment, initial intervention, signposting or referral and data collection.** FRS staff conducted home visits to carry out an assessment of households in terms of their risks to falls, cold homes, social isolation and flu, as well as accidental fires, and take appropriate action in response to the assessment. The following data was collected: occupant name, age, ethnicity, dwelling type, risks identified during home visit, information and guidance provided, actions taken and referrals made.

**Development of partnerships and referral pathways.** FRS staff worked closely with existing or new partners to ensure referral routes for individuals identified as needing specialist or ongoing support.

## Focus of the evaluation

This study aimed to evaluate the winter pressures pilot over its lifetime and answer three main research questions:

- 1) How have the specific interventions being considered in the three pilot areas had an impact on winter pressures?
- 2) What was the impact of the interventions on the individuals who received a home visit?
- 3) What was the return on investment of the intervention?

## Evaluation methodology

A full version of the evaluation methodology is available in the technical annex to this report. The main stages of the methodology were:

- an inception stage, in which preparatory information and data was collected and analysed in order to develop a project work plan and the research tools for the evaluation
- a formative stage, in which information and data was collected on the progress of the pilot, its initial activities and expected outcomes and impacts
- a summative stage, in which evidence was collected on the progress of the pilot towards achievement of its outcomes and impacts which contributed to an analysis of the pilot's return on investment and the production of this summary report

As a consequence, this report draws on the following sources of information and data collected during the evaluation in order to establish the pilot's inputs, outputs, outcomes and impacts:

- interviews with operational leads and delivery staff: 22 (eight face-to-face and 14 telephone) interviews were conducted with staff involved in managing the pilot from each pilot area at three intervals during the evaluation
- interviews with frontline staff: 22 (face-to-face) interviews were conducted with frontline staff, including firefighters, community service advocates and watch managers, who carried out the visits
- interviews with staff working for partner organisations: 18 telephone interviews were conducted with partner organisations working with each of the pilot areas
- interviews with beneficiaries: 60 telephone interviews were conducted (20 in each pilot area) with households who had received a home visit as part of the pilot
- responses to an e-survey of frontline staff: 173 frontline staff (equal to a response rate of 14%) from the pilot areas reported their experience of the winter pressures pilot, including the training, delivery of home visits, referral pathways and the data collection process
- analysis of management information (MI) supplied by pilot areas: data on fire call-outs within each pilot area, the data collected during the home visits, the referrals made, and the costs of the pilot inputs were provided by each pilot area
- analysis of national data sets: data was collected on the number of A&E episodes and emergency admissions taken from the NHS England A&E Attendances and Emergency Admissions data series, and data on flu vaccination rates taken from PHE seasonal flu vaccine uptake data

Ethical approval was discussed by the advisory group, who agreed that the work was a service evaluation rather than testing a new approach and therefore did not require ethical approval. FRS were already doing Safe and Well visits and incorporating many of the



interventions being evaluated. This pilot standardised the intervention to support the evaluation.

## Pilot activities

This section examines the activities carried out during the pilot starting with the preparatory activities and moving on to the delivery of the pilot. The execution of these activities differed between pilot areas to reflect local circumstances. A summary of the main activities and details of the specific differences are included in Table 1.

**Table 1: Differences in execution of the pilots between the 3 FRS pilot areas**

Pilot element	What the pilot areas did?		
	GREATER MANCHESTER	STAFFORDSHIRE	GLOUCESTERSHIRE
<p><b>Training:</b> A training pack was developed by the advisory group for the pilot areas. It covered the steps necessary to identify and take appropriate action against falls, cold homes, flu and social isolation.</p> <p>In total ,1,239 FRS staff were trained.</p>	<p>In total 959 staff were trained.</p> <p>The pilot area delivered training to all fire crews within the service (including community safety advocates (CSAs), firefighters and watch managers), representing a whole-scale system change, covering all 10 boroughs in Greater Manchester.</p> <p>Training was delivered through a combination of face-to-face presentations and webinars, with most of the training being delivered through webinars. The training was delivered by the Greater Manchester training team.</p>	<p>In total 127 staff were trained.</p> <p>The pilot area delivered training to fire crews and the prevention team (including whole time and retained duty system staff) operating in six areas in Staffordshire (East Staffordshire, South Staffordshire, Stafford, Moorlands, Stoke-On-Trent and Tamworth).</p> <p>Training was delivered through face-to-face presentations by one of the pilot operational leads. Fire crews operating in the six areas involved in the pilot were trained incrementally, to allow for review of training delivery and to incorporate potential improvements before increasing the scale of delivery.</p>	<p>In total 153 staff were trained.</p> <p>The pilot area delivered training to CSAs and whole time firefighters across the whole of the service.</p> <p>Training was delivered through face-to-face presentations by the Gloucestershire training team. Training was first delivered to CSAs and then to firefighters.</p>

Pilot element	What the pilot areas did?		
	GREATER MANCHESTER	STAFFORDSHIRE	GLOUCESTERSHIRE
<p><b>Identification, engagement and targeting:</b></p> <p>Pilot areas were tasked with identifying vulnerable households within their local populations and targeting these households for a home visit.</p>	<p>To identify potential households who are vulnerable to winter-related health risks to take part in the pilot, the FRS used Exeter data<sup>8</sup> to produce a list of 350,000 households (including information on addresses) who may be vulnerable to winter-related illnesses or death.</p> <p>Using the Mosaic Tool,<sup>9</sup> to produce a breakdown of households categorised into five-year age groups, they selected 6,500 households characterised by female homeowner households aged 85 and over and living alone; who they believed were at greatest risk of winter-related illness to engage in the pilot.</p> <p>Households were invited to participate in the pilot by letter sent to their address. A smaller number of households were also referred to the pilot by partner organisations.</p>	<p>To identify potential households who are vulnerable to winter-related health risks to take part in the pilot, the FRS used a combination of data sources, including data on fatal fire characteristics<sup>10</sup> and fire incident data<sup>11</sup> combined with data on the local population using the Mosaic Tool).</p> <p>They combined this data with Exeter data to identify the addresses of households who may be vulnerable to winter-related illness or death among people aged 65 and over.</p> <p>Households were invited to participate in the pilot by letter sent to their address, followed up a week later by canvassing and door knocking in the areas identified. In some cases the home visit was conducted on the spot, while others were booked for a specific time.</p>	<p>To identify potential households who are vulnerable to winter-related health risks to take part in the pilot, the FRS used information and local knowledge from partner organisations to identify vulnerable people aged 65 and over living in the area.</p> <p>They promoted the pilot locally through their partners (including the local Clinical Commissioning Group (CCG), flu clinics and GP surgeries) to generate referrals to the FRS for a home visit.</p> <p>Home visits were set up in response to referrals and those invited to participate in the pilot.</p>

<sup>8</sup> The Exeter data contains year of birth, address and postcode. It was supplied to the English FRS from the Health and Social Care Information Centre in September 2015. This required a full governance and Information Sharing Agreement between the English FRSs and NHS England.

<sup>9</sup> Mosaic Public Sector is a comprehensive tool which helps to identify people in need of support within a local population.

<sup>10</sup> Fatal fire characteristics are drawn from analysis of Accidental Fatal Fire characteristics over a two year period to identify common characteristics among households that experience an incident.

<sup>11</sup> Incident data, in terms of severity and frequency, uses the Mosaic tool to identify groups with a history of having had accidental dwelling fires, the severity of those fires and whether the fires resulted in a fatality.

Pilot element	What the pilot areas did?		
	GREATER MANCHESTER	STAFFORDSHIRE	GLOUCESTERSHIRE
<p><b>Scale:</b> The pilot aimed to deliver a total of 10,000 home visits.</p> <p>Targets were set based on the proportion of the total annual HSCs they would expect to deliver during the pilot, adjusting for lead-in time and incremental implementation of the pilot.</p>	<p>Greater Manchester serves a population of 2.5 million. It set a target of 6,000 home visits across Greater Manchester.</p>	<p>Staffordshire serves a population of 1 million. It set a target of 2,000 home visits across six areas (in East Staffordshire, South Staffordshire, Stafford, Moorlands, Stoke-On-Trent and Tamworth).</p>	<p>Gloucestershire serves a population of 860,000. It set a target of 2,000 home visits across Gloucestershire.</p>
<p><b>Data collection:</b> The pilot areas developed new methods of data collection, broadening the scope of the data collected from HSCs to include the new information from the Winter Pressures visit and the referral pathways.</p>	<p>Greater Manchester developed a data collection form which was 23 pages long. Most data was collected via paper format, with some being collected digitally, using tablets.</p> <p>They collected data on the following:</p> <ul style="list-style-type: none"> <li>• occupant (name(s) of occupant(s), DOB, sex, ethnicity, employment status)</li> <li>• household (dwelling type, heating system)</li> <li>• health and wellbeing (physical health issues, mental health issues, disabilities, health behaviours (such as smoking, alcohol))</li> <li>• risks identified during home visit (fire safety, flu, cold home, falls, social isolation)</li> <li>• information and guidance provided (on</li> </ul>	<p>Staffordshire developed a digital data collection form using tablets.</p> <p>They collected data on the following:</p> <ul style="list-style-type: none"> <li>• occupant (name(s) of occupant(s) age (by group), ethnicity)</li> <li>• household (dwelling type)</li> <li>• risks identified during home visit (fire safety, cold home, falls, social isolation)</li> <li>• information and guidance provided (on fire safety, falls, cold homes, flu, social isolation)</li> <li>• actions taken (on fire safety, cold homes)</li> <li>• referrals made</li> </ul> <p>A spreadsheet on SharePoint was used to store data, managed by the Staffordshire central</p>	<p>The data collection form was eight pages in length. Most data was collected on paper with some being collected digitally, using tablets.</p> <p>They collected data on the following:</p> <ul style="list-style-type: none"> <li>• occupant (name(s) of occupant(s), age (by group), ethnicity)</li> <li>• household (dwelling type)</li> <li>• health and wellbeing (physical health issues, mental health issues, disabilities, health behaviours (such as smoking, alcohol))</li> <li>• risks identified during home visit (fire safety, flu, cold home, falls, social isolation)</li> <li>• information and guidance provided (on fire safety, falls)</li> </ul>

Pilot element	What the pilot areas did?		
	GREATER MANCHESTER	STAFFORDSHIRE	GLOUCESTERSHIRE
	<p>fire safety, falls, cold homes)</p> <ul style="list-style-type: none"> <li>actions taken (on fire safety, falls, cold homes, flu, social isolation)</li> <li>referrals made</li> </ul> <p>A new data storage system was implemented at the same time as the pilot. This was managed by the Greater Manchester central prevention team.</p>	<p>prevention and protection team.</p> <p>They also developed a data sharing process with Age UK in which Age UK provided feedback on actions taken during the referral pathway. This was stored on the same spreadsheet on SharePoint.</p>	<ul style="list-style-type: none"> <li>actions taken (on fire safety, falls, cold homes, flu, social isolation)</li> <li>referrals made</li> </ul> <p>A new data storage system was implemented at the same time as the pilot. This was managed by the Gloucestershire central prevention and protection team.</p>
<p><b>Home visits:</b></p> <p>Pilot areas conducted home visits to carry out an assessment of households in terms of their risks to falls, cold homes, social isolation and flu, as well as accidental fires, and take appropriate action in response to the assessment.</p>	<p>The pilot area conducted home visits assessing the risk of a household to the following:</p> <ul style="list-style-type: none"> <li>falls (using the Get up and Go test)</li> <li>cold homes (including the provision of thermometers)</li> <li>social isolation</li> <li>flu</li> <li>accidental fire</li> </ul> <p>The pilot area also provided information, advice and guidance (IAG) to households on falls prevention, keeping warm during winter, fire safety and contact details of local organisations to support vulnerable older people and people experiencing social isolation. It also conducted direct actions during the home visit to address falls, cold homes and fire safety hazards.</p>	<p>The pilot area conducted home visits assessing the risk of a household to the following:</p> <ul style="list-style-type: none"> <li>falls (using the Get up and Go test and Falls Risk Assessment Tool (FRAT) test)</li> <li>cold homes (including the provision of thermometers)</li> <li>social Isolation</li> <li>flu</li> <li>accidental fire</li> </ul> <p>The pilot area also provided IAG to households on falls prevention, flu, fire safety and keeping warm during winter. It also conducted direct actions during the home visit to address cold homes and fire safety hazards.</p>	<p>The pilot area conducted home visits assessing the risk of a household to the following:</p> <ul style="list-style-type: none"> <li>falls (using Get up and go test and FRAT test)</li> <li>cold homes</li> <li>social isolation</li> <li>flu</li> <li>accidental fire</li> </ul> <p>The pilot are also provided IAG to households on fire safety. It also conducted direct actions during the home visit to address falls and fire safety hazards.</p>

Pilot element	What the pilot areas did?		
	GREATER MANCHESTER	STAFFORDSHIRE	GLOUCESTERSHIRE
<b>Referrals:</b> Referrals were made (where appropriate) after conducting a home visit to local organisations and agencies in order to provide further help and support to households.	<p>The pilot area used a wide range of organisations and agencies to accept referrals (including local Age UK organisations, Adult Social Care Services, NHS Falls Services, winter warmth agencies, housing associations and the voluntary sector).</p> <p>The organisations varied across the whole pilot area. For example, in Manchester the FRS worked with three partner organisations: Age UK, a local Home Heat helpline and a winter warmth organisation; in Salford the FRS worked with five partner organisations: local adult services, local council winter warmth office, Age UK, Salford Helping Hands and a local housing association).</p>	<p>The pilot area used its existing partnership and referral pathway with Age UK (Age UK Staffordshire North, Age UK Burton, Age UK Stafford and District and Age UK Staffordshire South) to support the pilot and provide a single referral point. This relationship was developed through a previous pilot called Sustained Action for Evidencing Reduction of Risk (SAfER) pilot.<sup>12</sup></p> <p>Age UK supported Staffordshire as a one-stop-shop referral pathway in which they would receive a referral, conduct an initial assessment of need, and either support internal support or refer on to another organisation.</p>	<p>The pilot area used its existing partnerships and relationships with a range of local organisations and agencies to accept referrals (including, Age UK Gloucestershire, Adult Social Care (Gloucestershire County Council), NHS Gloucestershire CCG, the local NHS falls prevention service, Warm and well Gloucestershire and Gloucestershire Community Trust).</p>

## Results of the evaluation

A summary of the key findings is presented in Table 2 followed by further descriptive analysis drawing on the interviews of FRS staff, beneficiaries and partners, the e-survey, and the pilot areas MI.

<sup>12</sup> The SAfER pilot is a collaboration between Staffordshire FRS and Age UK. It aims to reduce preventable hospital admissions and avoidable winter deaths through delivering home visits to vulnerable people aged over 65 and putting them in contact with preventative services. The pilot began in August 2015 and was initially rolled out in the areas of South Staffordshire and Stoke-on-Trent. At the meeting to discuss the scoping report in November, it was agreed that ICF would evaluate the data from both the Winter Pressures and SAfER pilot on the wishes of Staffordshire FRS and PHE. For more detail see: <http://ageactionalliance.org/wordpress/wp-content/uploads/2015/04/Sustained-Action-for-Evidencing-Risk-Joint-Communication-V7-4.pdf>.

**Table 2: Summary of the main findings**

	<b>Achievements</b>	<b>Challenges</b>
Overall	All three pilot areas implemented the pilot visits and tested the process envisaged building and expanding on previous work to develop HSCs.	Speed of setting up the pilots was slower than anticipated with need to develop training, a process for targeting, data collection system and working with new referral organisations. Urgency did not help to develop partner relationships especially new referral pathways and data sharing.
Preparation	Staff earmarked for undertaking the visits were trained and prepared as well as being supported to undertake the additional components.	Considerable proportions of staff trained did not feel prepared. Webinars were not appropriate to explain the wider purpose of the visit and the additional activities needed. Some staff who were trained did not undertake home visits.
	Established data systems to collect information from visits and introduced tablets to collect it electronically.  Used new systems to identify and target households (two pilot areas) which were felt to be helpful in targeting.	In one pilot area the data forms were too long and paper based. Data collected varied between the pilot areas.  All pilot areas to differing degrees used referrals from partners broadly based on target definitions they had set to supplement the Exeter data.
	Established new referral partners and built on existing relationships with partners.  Engaged with many households identified/targeted for home visit; little resistance to FRS staff undertaking the visit; fire/home safety clearly a selling point.	Little time to engage partners in identification processes or to develop data sharing arrangements. A small amount of duplicated/ unnecessary home visits occurred.  Needed personal visits soon after letters to engage many households targeted.
	Visited some households in need of the winter pressures components and provided information, advice and guidance (IAG), actions to mitigate	Additional time required for winter pressures components. Some households not evidently 'vulnerable' (in terms of age, disability, health condition);
Delivery		

	<b>Achievements</b>	<b>Challenges</b>
	such risks as well as referrals.	relatively small proportions in need of help in relation to falls, social isolation and cold homes. Advice on flu vaccination not needed.
	Data collected for use by FRS, partners and evaluators; households visited generally agreeable to provide information and for it to be shared.  Many referrals made to other organisations to provide further IAG and practical help especially about falls prevention and keeping warm. Referral partners generally felt referrals to be appropriate and additional to their targeting of services. In one area, single referral partners acted as effective channels for referral to a range of other agencies.	Paper based systems increased costs of delivery and led to missing data. Referral partners were not always given information they needed. Evaluators not provided with consistent information or sufficient information for the assessment of value for money.  Some partners had to collect information from households again. Information on outcomes from referral not available for evaluation. Pressure on partner capacity in some instances.
Outcomes	Benefits to many households from visits and referrals relating to winter pressures components evident.	Difficulties in capturing all of the benefits from data collected; some will emerge in future.
	FRS staff have skills and experience to do winter pressures components of visit competently.	Some staff would benefit from further training and support.
	Partners generally supportive of winter pressures components and that targeting complemented their own work.	
	Estimate of benefits needed to cover programme costs	Estimation of SROI limited by data collected and data available at point of reporting.

## Training

A key aim of the pilot was to build capacity within pilot areas to address winter-related health risks systematically.

### The pilot managers felt the training was appropriate to staff needs

Operational leads and delivery staff were asked about their views of the training. In their general view, the contents of the training package equipped frontline staff with the appropriate skills and knowledge to undertake the home visits. They also felt that the training built on the experience of some small-scale work they had conducted locally on issues relating to falls and cold homes.

Staff in Staffordshire and Gloucestershire said they had encountered capacity issues in trying to deliver the training through face-to-face presentations as they did not have enough personnel to deliver the training at the scale required. Therefore, they adopted a staggered approach, whereby local fire crews were trained one at a time. This increased the length of time it took to train staff, but Staffordshire in particular felt that there were benefits to this method as they were able to improve the training and respond to feedback from fire crews as they went along.

The number of staff trained by Greater Manchester was significantly larger than both Staffordshire and Gloucestershire. Greater Manchester operational leads felt that the development of the webinar enabled them to efficiently train a much larger number of frontline staff.

### Face-to-face training was consistently reported as most effective

Frontline staff that were trained as part of the pilot had mixed views about the training. Feedback from the e-survey and face-to-face interviews with frontline staff revealed the following:

- Around two-thirds of survey respondents from Staffordshire and Gloucestershire reported that they felt the training sufficiently prepared them to conduct all aspects of the home visits, including assessing risks, providing information, advice and guidance (IAG), addressing issues within the home, and making referrals, in relation to falls, cold homes, flu and social isolation.
- Most of the frontline staff interviewed from Staffordshire and Gloucestershire said that on the whole, they felt the training they had received prepared them for delivering the home visits and knew where to go should they require any additional information. A few staff in Gloucestershire believed that they would have benefited from further training sessions to refresh everything they were meant to cover during the visit.



- Around two-thirds of survey respondents from Greater Manchester indicated that the training had not sufficiently prepared them to conduct all aspects of the home visits, including assessing risks, providing IAG, addressing issues within the home, and making referrals, in relation to falls, cold homes, flu and social isolation. Among those interviewed, the community safety advocates (CSAs) were generally more positive about the training and their understanding of the pilot than fire crew staff. They also felt that it fitted in well with their activities and job role. Fire crew staff in Greater Manchester had less understanding of the pilot and why they were being asked to conduct the extended home visit. They felt that the training had not sufficiently prepared them to cover what they were being asked to do during the home visit. Most felt they did not have the confidence to approach some of the issues involved in the pilot (such as questions around social isolation).
- Frontline staff that had face-to-face training were generally more positive than staff who had attended webinars. In Greater Manchester, CSAs received face-to-face training, whilst the fire crews received training via the webinar. Fire crew staff that were interviewed generally found the webinar not very useful and would have liked to have had the opportunity to access face-to-face. Greater Manchester operational leads and key delivery staff reported that, following feedback from crews, they introduced a series of question and answer sessions, specific email and online access to advice and guidance, and a direct line to support frontline staff and address concerns.

### Beneficiaries found staff competent and professional

Nearly all beneficiaries reported those undertaking the visits as professional and competent, with many stressing that staff were "*kind, caring and considerate*" and understanding to their individual situation. Most beneficiaries were also able to recall staff conducting common activities, including:

- checking doors, windows and entrances/exits to the home
- checking electrical equipment, wiring and plugs sockets
- dialogue about personal needs in relation to falls, cold homes, social isolation and flu, as well as fire safety
- installation of handrails, fire alarms, detectors and other adaptations
- the provision of IAG around falls, cold homes, social isolation and flu, as well as fire safety
- dialogue about potential referrals to other organisations for more support

### Identification of target households

The pilot aimed to target households most at risk of winter-related illnesses, which are people living alone over the age of 65. Pilot areas used a combination of local FRS data, Exeter data, Mosaic and data from local partner organisations see Table 1.

## Two pilot areas found analysing local data about at-risk households a challenge

Operational leads and delivery staff from Staffordshire said that the identification process was relatively straightforward, largely because this was work they were already delivering as part of the SAfER pilot using data on fatal fire characteristics, FRS incident data and the Mosaic Tool. Specifically, they felt that the use of Exeter data enabled them to improve their approach to identifying households with people at risk aged 65 and over with greater accuracy.

Operational leads and delivery staff from Gloucestershire and Greater Manchester reported challenges with using data to support the identification process. Staff from Gloucestershire stated that while they were able to make some use of the Exeter data to generate a list of households of at risk people aged 65 and over, they did not have access to other data which enabled them to risk-stratify those households on the list in order to identify a target group of households most in need. In practice, they largely relied on referrals from partner organisations which worked well.

Staff from Greater Manchester reported that while they were able to manipulate the Exeter data using the Mosaic Tool to produce a list of 6,500 addresses of at risk households, this was a very complex and resource intensive task which took longer than they had anticipated, and contributed to delays in getting the pilot fully up and running.

## Partners were not always involved in the identification process

All partner organisations reported that they were approached by the pilot areas and asked whether they wished to take part in the pilot, to which they were happy to be involved. Most partner organisations felt that their participation in the pilot would be an opportunity to strengthen their relationship with the FRS, either improving existing partnerships or presenting the opportunity to develop new relationships.

A few of the partner organisations interviewed believed that the pilot could have benefitted from greater collaboration between the FRS and partner organisations to identify at risk households and to complement activities. For example, in the Greater Manchester pilot area, a partner stated that their organisation (a housing association) delivered home visits to older residents to assess the home environment of residents during the winter months to reduce the risks of experiencing cold homes and address any support needs.

They felt that greater collaboration in the development of the pilot could have:

- enabled the FRS to draw on greater local knowledge about the needs of vulnerable people within local populations with the potential to develop and improve data and information sharing processes between the FRS and partners
- reduced the likelihood of duplication of efforts and services to support vulnerable people between the FRS and other agencies

- increased awareness among local organisations and agencies about the activities of the FRS, and vice versa

### Developing data sharing systems to support the pilot was a challenge for pilot areas

Operational leads and delivery staff from all three pilot areas reported that they were unable to develop agreements to share data between the FRS, partner organisations and other local agencies and services on potential beneficiaries of the visits. They felt that being able to access this information would have helped to identify and target households and build knowledge of local needs.

Greater Manchester and Gloucestershire also reported that the short lead-in time was a barrier to agreeing data sharing processes between the FRS and partner organisations to support the pilot. There was no formal process developed in relation to beneficiary information being shared at the time of the referral and information being shared about the actions of partner organisations once a referral had been made. Based on the existing relationship with its partner organisation, Staffordshire had a data sharing process in place to support the pilot about the type of data each party was going to provide (for example, personal information about beneficiary and their needs and the actions taken by the partner organisation).

### Engaging at risk households in the pilot

#### Personal approaches to at risk households were needed to reach agreement to have a home visit

Operational leads and delivery staff reflected on the approaches used to engage the at risk households they targeted.

- Greater Manchester operational leads and delivery staff said they found engaging beneficiaries by mail challenging because the response was low and it often took a long time for people to respond – this had a negative impact on the number of home visits the pilot area was able to conduct. They felt that their engagement approach would have been better if they had been able to contact beneficiaries by telephone (however, phone numbers were not available), supported by local canvassing by fire crews and volunteers.
- Staffordshire operational leads and delivery staff felt their approach of sending letters first, followed by canvassing and door knocking to be effective. In particular, they believed that canvassing households they had identified within a particular area, covering them street by street, worked well to engage people because they trust and respect the FRS brand. Making sure to follow up letters with a knock on the door a week later helped ensure the beneficiaries were still able to recall the letter offering a home visit.

- Gloucestershire operational leads and delivery staff believed that having referrals from partner organisations worked well because beneficiaries were already aware that they would be receiving a home visit when frontline staff made contact. However, they mentioned that the presence of a fire engine and staff in uniform was an enabling factor.

### Beneficiaries' trust in the FRS aided their participation

Beneficiaries who were interviewed reported various ways in which they had been engaged in the programme. Very few recalled being engaged by mail from the FRS. Around a third reported that the FRS had not engaged them before the visit, and they simply agreed to the visit when the FRS knocked on their door. A similar proportion had been engaged through other services (sheltered housing, health and social care services) while a few had been engaged during public events where they had been approached by the FRS.

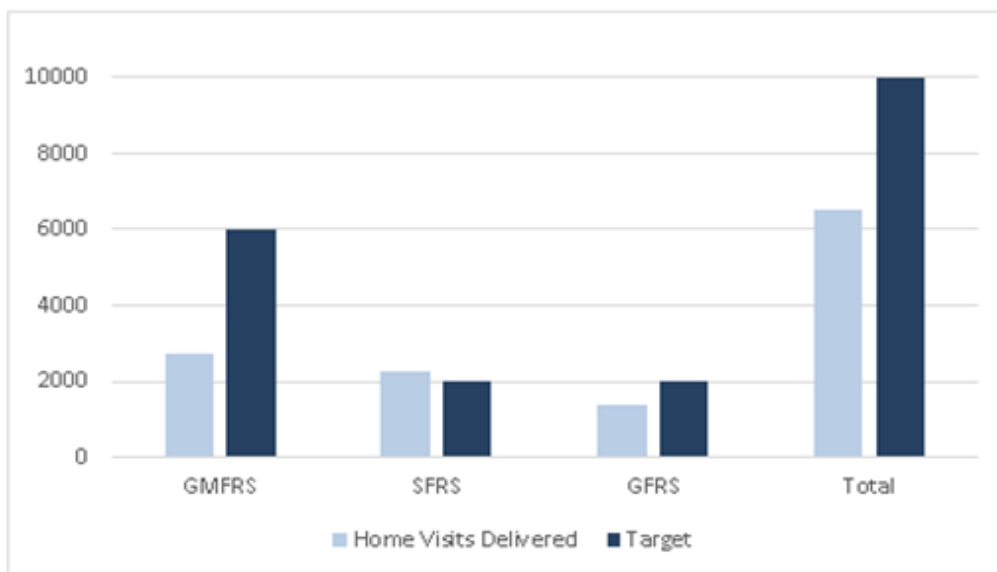
Most of the beneficiaries attached a significant level of trust in the FRS and their staff to provide support through the proposed visit. A few of the beneficiaries said that they would not have been involved in the pilot had it been run by another organisation; *'the fire service you can trust'*. Staff carrying ID or badges reassured them that they were in safe hands.

### Home visits undertaken

#### The pilot underachieved on its target number of home visits

Pilot MI data, in Figure 1, shows the performance of pilot areas against their target number of home visits.

**Figure 1: Number of home visits achieved against target (source: Pilot MI data)**



Overall, the pilot failed to achieve its total target of 10,000 home visits by the end of March, managing around 63% of the target number. However, there was a difference in the performance of pilot areas and the factors that influenced the progress made.

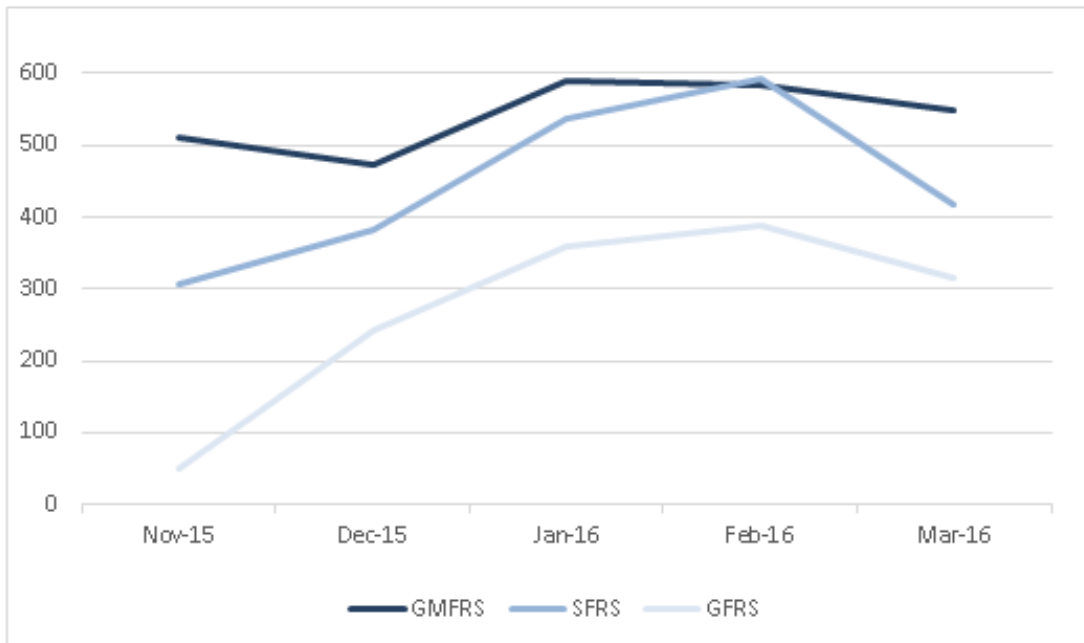
Greater Manchester achieved under half of their target home visits (45%). Operational leads and delivery staff reported challenges in the identification process; once these were resolved there were difficulties in engaging with those identified as being at most risk due to lack of information that identified the householders. They also reported that heavy rainfall and flooding in the North West of England at the end of December 2015 and start of January 2016 diverted resources away from the pilot. This is illustrated in Figure 2, which shows fewer home visits in December compared to other months.

Staffordshire achieved its target of 2,000 home visits, exceeding it by 12%. Operational leads and delivery staff explained that their experience in delivering similar home visits, gained through the SAfER pilot and using existing resources and local partners to support the pilot, helped in getting the pilot off the ground. Around a third of Staffordshire staff who responded to the survey had received training on falls and cold homes prior to the Winter Pressures Pilot.

Gloucestershire managed to achieve around two-thirds of their target home visits (68%) over the course of the pilot. Operational leads and delivery staff reported that challenges in getting the database up and running (in order to capture the information required for the pilot), and limited capacity to train large numbers of staff at one time in order to deliver the home visits, contributed to delaying the full implementation of the pilot by a month. This is illustrated in Figure 2, which shows fewer home visits in the first month compared to other months.

Pilot MI data, in Figure 2, shows the number of home visits delivered each month by the pilot areas over the duration of the pilot.

**Figure 2: Number of home visits delivered per month by each pilot area over duration of pilot (Source: Pilot MI data)**



### Characteristics of households visited

#### At least 78% of home visits were delivered to target households

All (100%) Staffordshire’s home visits were to beneficiaries aged over 65 (63% aged 65-79; 37% aged 80 and over). Nearly two-thirds of home visits were to female beneficiaries. In Gloucestershire, at least 90% of home visits were to beneficiaries aged 65 and over. Nearly two-thirds of home visits were to female beneficiaries. Around one-in-five beneficiaries reported having a long-term health condition, while just under half of beneficiaries reported living with a disability.

In Greater Manchester, at least 55% of home visits were to beneficiaries aged 65 and over, while 28% were to beneficiaries aged under 65 (of which around 46% reported having a long-term health condition and 25% reported a living with a disability). Around two-thirds of all home visits were to female beneficiaries (64%). Some 57% of beneficiaries reported having a long-term health condition and 36% reported living with a disability.

#### Pilot managers acknowledged that the targeting could be improved

Operational leads and delivery staff from Greater Manchester felt that the targeting had been a challenge. By placing a greater reliance on referrals from partners and other organisations, this contributed to visiting households that did not fit the pilot’s target criteria. However, operational leads and delivery staff reported that there was a younger cohort of adults within Greater Manchester who experienced similar risks as those aged 65 and over. Some frontline staff also felt that despite delivering home visits to households aged under

65, they had supported at risk people (such as those experiencing cold homes during the winter).

In Staffordshire, all operational leads and delivery staff felt that the targeting of the pilot had worked well and they had been successful in reaching the right people. On the whole this view was echoed by frontline staff. A few reported visiting households who had already received an HSC a few months prior to the current home visit or turning up to empty properties.

In Gloucestershire, all operational leads and delivery staff said that the pilot had been successful in targeting the households of people 65 and over, but they were also conducting home visits with other at-risk groups (which might include younger households). This was supported by frontline staff.

### Duration of the home visit

All three pilot areas estimated that the additional time for the winter pressures element of the home visit amounted to, on average, an extra 30 minutes.

### Data collection

#### Pilot managers reported that the data collection process was a major challenge

All operational leads and delivery staff from the three pilot areas felt that the data collection was beneficial to the pilot, particularly in recording information about beneficiaries to pass onto referral partners. In Staffordshire, the use of tablets to collect data during home visits was believed by interviewees to increase the efficiency with which information could be collected and stored (through a synchronised database). The tablets also enabled frontline staff to access the internet while undertaking the visit.

However, operational leads reported the following challenges. Staff from Greater Manchester said that the main problem they faced was collecting missing or insufficient data and the length of time it took to input the information collected on paper forms onto a computer was also resource intensive. In response to this problem, operational leads and delivery staff attempted to quality assure data collection forms, but this was resource intensive and viewed as a poor use of staff time. They also took steps to improve training and move to electronic data collection to rectify this problem. Staff from Staffordshire reported that as the number of home visits delivered increased, it became burdensome to input and store the data to support both the evaluation and the referral pathway, because of the volume of data being gathered.

#### Frontline staff also found problems with data collection



Most frontline staff interviewed reported that, overall, nearly all beneficiaries were happy to share information with them. This meant that they did not face difficulties collecting the data they needed to record and carry out their assessments. Staff who had tablets also felt positive about using them to collect data as it made this aspect of the home visit easier and saved staff from having to manually enter data to a database.

However, some frontline staff reported that the method of data collection restricted the amount of qualitative information they could collect. For example, some staff who used paper forms to collect data reported that the boxes for taking notes on actions and support needs were sometimes too small to make detailed notes, requiring them to use additional pieces of paper.

Some staff who used tablets reported the formatting lacked the option to provide detailed notes on specific issues (such as reasons for a falls referral).

### Partners felt there was room for improvement in the data collection process

Overall, partners interviewed were satisfied with the information they received from pilot areas. However, a few reported receiving some referrals with little or no information about the beneficiary and the issue they were supposed to be responding to. To improve this, interviewees stated that they would benefit from receiving a more detailed and specific description of the needs and issues of the beneficiary being referred to their service.

### The home visit and interventions

#### Analysis of MI data indicates that staff conducted activities to reduce risks around falls and cold homes, identified risks, and provided IAG to households

The pilot MI data on risk assessments conducted during the home visits shows:

- over one in ten home visits identified households at risk of experiencing a fall (14% in Greater Manchester, 10% in Gloucestershire and 9% in Staffordshire)
- less than one in ten home visits identified households at risk of cold homes (16% in Greater Manchester, 3% in Gloucestershire and 2% in Staffordshire)
- less than one in ten home visits identified households at risk of social isolation (12% in Greater Manchester, 4% in Gloucestershire and 4% in Staffordshire)

The pilot MI data on the direct actions taken to mitigate against risks in the household shows:

- Gloucestershire conducted the highest proportion of falls preventative actions within households (100% of households), compared to Greater Manchester (14%)
- Staffordshire provided the highest proportion of thermometers to households (98% of households) to help monitor the temperature of the home, compared to Gloucestershire (20%)

The pilot MI data on the IAG provided to households shows:



- Greater Manchester provided IAG on keeping warm during in winter, flu vaccinations, and falls prevention, as well as the contact details for local Age UK organisations and Silverline,<sup>13</sup> to 41% of households. They also provided IAG on social isolation to 18%
- Staffordshire provided IAG on keeping warm during winter, flu vaccinations and falls prevention to 98% of households
- Gloucestershire did not collect data on the provision of IAG to households

Analysis of MI data for all three pilot areas shows that all home visits (100%) carried out under the pilot took actions to improve the fire safety of the home, including the provision of IAG on fire safety. Frontline staff reported conducting activities such as, assessing the house for potential fire risks (electricals, kitchen appliances, heating systems and exits); the installation of smoke detectors, fire alarms, carbon monoxide detectors; and, advising beneficiaries on fire safety.

### The 'Get up and Go' test

As part of the home visit, staff were required to conduct a 'Get up and Go' test to establish whether the occupant was at risk of a fall. Most frontline staff saw the value of using the tool—it was a useful way of establishing whether a person was at risk of a fall and it was often easy to explain to occupants the reasoning behind being asked to conduct the exercise. However, a few staff reported that they found that the test was sometimes unnecessary or impractical. For example, staff reported that they were often able to establish the vulnerability of a person by observing how quickly they answered the front door and watching them move around the house, as well as when they were developing an escape route in case of fire with the beneficiary. In addition, some staff found it impractical to roll out 3 metres of measuring tape, especially in properties which were very small or had limited space.

Beneficiaries were also asked for their views on the test. Most beneficiaries who could recall the test responded positively even if they did not think it was relevant to their current needs.

### Staff reported beneficiaries welcomed the visit and the activities they carried out

Most respondents to the survey indicated that they rarely encountered problems during the home visits in being able to complete their assessment. This was reiterated by frontline staff who were interviewed, who stated that most beneficiaries were willing to provide them with the information they needed and let them look around their homes. Some staff reported that engaging people in conversation about flu vaccinations was relatively simple and they rarely encountered people who had not already been fully informed by the health

---

<sup>13</sup> Silverline is a free confidential helpline providing information, friendship and advice to older people, 24 hours a day, all year round.

service. A few staff across the pilot areas stated that they encountered difficulties with discussing social isolation and cold homes because it required them to ask more personal questions around benefits, income, and loneliness.

### Feedback from beneficiaries confirms the most home visits were conducted as planned

Participants generally described a similar structure of home visit across all three pilot areas. In at least a quarter of cases, they highlighted that the first element of the visit included a detailed explanation of the visit's purpose. Almost all participants reported one or two staff undertaking the assessment. This included assessment of fire safety and in some cases trip hazards. Some felt that the assessment involved answering a large number of questions, although in only one case someone not feel comfortable answering the questions. Once an assessment of their home had been completed, most beneficiaries reported that they were offered IAG by staff.

### The referral pathway

MI data shows that, overall, the home visits generated 3,376 referrals to partner organisations. This is equal to 35% of home visits leading to at least one referral to partner organisations (59% of home visits in Greater Manchester, 17% of home visits in Staffordshire and 15% of home visits in Gloucestershire). The data also shows that the home visits generated 1,526 referrals for further fire safety support during the course of the pilot. This is equal to 24%<sup>14</sup> of home visits leading to referral for further fire safety support (51% of home visits in Greater Manchester and 7% of home visits in Staffordshire). Greater Manchester reported the highest number of total referrals to partner organisations with 2,726, while Staffordshire reported 370 referrals and Gloucestershire reported 280 referrals.

Of the referrals to partner organisations made by Greater Manchester, nearly half (49%) of the total number of referrals were to local falls assessment teams, while referrals were also made to organisations to support people to keep warm during winter (14%), local Age UK organisations (13%), local authorities (13%), and health services (7%).

All of Staffordshire referrals to partner organisations were to Age UK. MI data collected by Staffordshire and information reported by Staffordshire operational leads and key delivery staff as well as Staffordshire partners on the referral pathway, indicates that 155 (42%) of referrals to Age UK led to onward referrals to other organisations. These organisations included local authorities, Citizens Advice Bureau, adult social care services, falls assessment teams and other voluntary sector agencies.

---

<sup>14</sup> This figure is for the proportion of home visits resulting in referrals for further fire safety support by GMFRS and SFRS only. GFRS did not present comparable data on this output.

Gloucestershire reported that over half (58%) of the total number of referrals were made to the local authority and a quarter (25%) of the total number of referrals were to falls assessment teams. There were also referrals made to the Age UK (10%) and organisations to help people to keep warm during winter (6%).

### Pilot managers relied mainly on existing partners to develop effective referral pathways

Operational leads and delivery staff reported differences in experiences with the referral pathways they had in place:

- all staff from Greater Manchester felt that the referral process could have worked better (as they relied on standard referral pathways rather than establishing a formal process with each partner organisation), but was the best solution given the time which they had to be ready to deliver the pilot. They had little expectations on the number of referrals they were likely to make during the pilot
- all staff from Staffordshire believed that the referral pathway with the four Age UK organisations operating in Staffordshire worked well. They did not have any expectations of the number of referrals they were likely to make. Overall, they felt that good communication between the FRS and the four Age UK organisations in Staffordshire supported their co-operative working model and that having a 'one stop shop' referral pathway helped avoid confusion and complexity about which services deliver what to beneficiaries
- all staff from Gloucestershire believed that the referral pathways worked well and the numbers being referred met their expectations. The feedback they had from partners indicated that the referrals being made were appropriate.

### Frontline staff would appreciate more feedback about referrals

Most frontline staff reported that they had little to do with the referral pathway, particularly firefighters. Some staff were concerned about how they could ensure that referrals had addressed people's needs and felt that they should have feedback from the pilot management team about the actions taken by partner organisations once referrals had been made.

### Partner organisations were generally positive about the referral process

In general, partners interviewed felt the needs the pilot was seeking to address were important for the local population and aligned with the objectives of their own organisations. In particular, partners felt it was essential that greater cooperation and collaboration between different services was achieved in order to meet the demands of a growing number of people who require support to live independently. A few interviewees believed that some of the referrals generated as part of the pilot had enabled them to engage with older people before they reached crisis point, supporting work local partners were conducting around prevention. This was seen as huge benefit in preventing the worsening of people's health and wellbeing and supporting people to remain in their homes.

However, some partners reported that the pilot created some challenges for them. Some interviewees reported insufficient information on those who were referred to their organisation. Often, the information provided to partners consisted of sufficient personal information but lacked detail on the particular issue which needed to be addressed requiring a repeat assessment of needs. A few partners also indicated that the pilot had resulted in a significant increase in demand for their services. While they were happy to support the pilot and would do all that they could to meet this demand, the lack of additional investment to support the increased demand generated by the pilot placed some strain on existing resources and there were concerns about their ability to meet this demand in the future.

### Most people felt referrals were appropriate

Around two-thirds of people interviewed reported receiving information for them to contact another agency or were informed that they should expect to hear from another organisation to address a particular issue. They reported that they had either been followed up with the other agency or were contacted by another organisation.

All of those who received a referral reported that this was appropriate and done with their consent. A small number of people reported refusing a suggested referral. This was largely because they did not feel it was necessary or because they believed they were already accessing the necessary support to manage their needs.

### Outcomes and impacts

There is evidence to indicate that the pilot has led to some positive outcomes and impacts in addition to the fire safety aspects of the Safe and Well visit.

#### Outcomes for beneficiaries

#### The pilot led to improved awareness and support around risk of falls as well as cold homes and social isolation

There is evidence that the pilot resulted in short-term outcomes for beneficiaries as a result of the home visit. This includes increased awareness by vulnerable people of some of the risks they may face during the winter period. MI data shows that over a third of households received IAG on the risks around falls and social isolation during the home visits and a quarter of beneficiaries recalled that the home visit had improved their awareness of these risks. Around one in ten beneficiaries reported improvements in awareness of the risk of falls, stating that the home visits identified and addressed hazards and informed them of how to reduce the risk of falling when on the move. Most frontline staff interviews also reported issues around mobility to be the main winter-related risk they identified and addressed. Nearly one in ten beneficiaries also reported receiving a thermometer to help monitor the temperature in their home and information about keeping warm during winter.

The pilot also facilitated beneficiaries in receiving support from other services. MI data shows that 3,376 referrals were made to partner organisations as a result of the pilot in order to provide support to beneficiaries. Over a third of beneficiaries reported that they recalled being referred or provided with contact details for further support at the time of the home visit from partner organisations, including Age UK, local authorities and falls assessment teams. There is some evidence that the support received from other services resulted in outcomes for beneficiaries in the medium term. Nearly a fifth of beneficiaries reported (at the time of the interview) that they had been contacted and assessed by partner organisations as a result of the home visit to address their support needs, including needs around falls (for example, falls assessment teams, physiotherapist) and social isolation (for example, local befriending service). One in ten beneficiaries reported improvements to the home environment to support their mobility needs and reduce the risk of falls, such as the installation of hand rails and other home adaptations. As one beneficiary described:

*“I have exercises, a seat in the shower, and also I have got a toilet frame so can I can lean when I get up which has helped a lot...as a result of visit from the physio...We couldn't believe it was all the fire service that [initiated] it”.*

A few beneficiaries also reported that they had received support to reduce their social isolation and were now receiving visits or talking to people over the phone on a regular basis. Around three-quarters of beneficiaries stated that they received their support with flu vaccinations from health services and received their vaccination prior to the home visit taking place.

### **Beneficiaries perceived the home visit to focus mainly on fire safety**

Fire safety was reported by all beneficiaries as the main focus of the home visit. All beneficiaries reported that the home visit resulted in the identification of fire risks, actions to improve fire safety and the provision of IAG on fire safety. The MI data shows that all home visits resulted in actions to address fire safety risks within the home, alongside the provision of fire safety IAG.

Most beneficiaries reported that having the fire service conduct a home visit gave them ‘*peace of mind*’ or reassurance that they were now in a safer home environment. They also reported that they were taking additional measures to reduce the risks of fires, including removal of materials obstructing heating secondary heating systems, the use of specialised fire alarm equipment to alert people who are hard of hearing, and caution when using household appliances (for example, cookers) and open flames (such as candles).

All beneficiaries reported receiving adaptations to improve the fire safety of their home, including the installation and repair of smoke alarms, alterations to home electrical equipment and security of doors and windows.

## Outcomes for staff

The survey of frontline staff shows that as a result of the training:

- around two-fifths improved their knowledge and skills to deliver home interventions addressing issues relating to falls prevention to vulnerable people, particularly in Staffordshire and Gloucestershire
- around two-fifths improved their knowledge and skills to deliver home interventions addressing issues relating to cold homes to vulnerable, particularly in Staffordshire and Gloucestershire
- less than a third improved their knowledge and skills to provide information and guidance to households regarding flu vaccinations
- nearly half improved their knowledge and skills to assess the risk of households to social isolations and link households with support to address their needs

## Outcomes for partners

Nearly all partner organisations indicated that the pilot had led to improved communication and working relationships between the pilot areas and partner organisations and would be continuing to work with the FRS in the future. Most partner organisations reported that the pilot had led to an increase in referrals and demand for their services throughout the course of the pilot, supporting the aims of partner organisations to deliver services to people in need. For example, one partner organisation was able to compare the number of referrals they had received from the FRS during the pilot (350-60 new referrals during first three months) with the number they had received during the same period last year (106).

## Impacts

As yet impacts cannot be measured to estimate the pilot's social return on investment (SROI) so far. This is due to data not being available at a granularity that would allow an assessment of the impact to be made. At this point, it has been possible to identify what type of impact the programme will have and the unit cost of individual impacts. Using this data it is possible to identify the impact the programme would need to achieve in order for the benefits of the programme to equal the cost.

The impacts of the programme which have been identified and a unit cost assigned are:

- number of A&E episodes (unit cost £204)<sup>15</sup>
- number of emergency admissions (unit cost £1,570)<sup>16</sup>
- number of falls assessments undertaken and their benefit to society (unit cost £150; societal benefit £1,150)<sup>17</sup>

---

<sup>15</sup> Taken from 2015/16 National Tariff Payment System. The £204 is an average between Category 3 investigation with category 4 treatment (£220) and Category 3 investigation with category 1-3 treatment (£187).

<sup>16</sup> Department of Health (2015) NHS Reference Costs 2014 to 2015. Average cost of a non-elective inpatient admission (£1,565) inflated to 2015-16 prices using GDP deflators



This information was used to estimate the impacts the programme would need to achieve in order to cover the cost of delivering the pilot programme.

## Costs of pilot

### The total cost of the pilot is estimated to be £154,900

Information on the additional cost of delivering the Winter Pressures Pilot, as part of the Safe and Well visit, was collected from each of the pilot areas. The information covers the pilot budget (including training), in-kind staff time (based on the average additional time<sup>18</sup> it took to conduct the Winter Pressures components of the home visit as part of the Safe and Well visit outside payments covered in the budget) and costs of equipment and other contributions to the pilot. A breakdown of this information is present in Table 3. The analysis excluded the cost of fire safety related components of the visits, as this would have been used to conduct home visits in the absence of the pilot. Therefore, estimates indicate that the total financial input of the pilot was £25,400 and that the total additional cost of the Winter Pressures Pilot was £154,900.

**Table 3: Total additional cost of winter pressures pilot**

Cost Item		Greater Manchester (£)	Staffordshire (£)	Gloucestershire (£)	Total (£)
Financial input	<i>Pilot budget</i>	5,300	12,400	7,700	25,400
In-kind staff time	<i>Pilot management</i>	24,800	13,500	7,800	46,200
	<i>Opportunity staff cost of providing visits</i>	36,300	15,000	18,200	69,400
Equipment and other contributions	<i>Specific contributions for winter pressures pilot</i>	11,900	0	2,000	13,900
	<i>Wider fire service contributions</i>	120,300	6,900	19,500	146,800
<b>Total additional cost</b>		<b>78,300</b>	<b>40,900</b>	<b>35,700</b>	<b>154,900</b>

Information provided by FRS, values rounded to nearest £100.

<sup>17</sup> These ratio values are taken from research published in the Skills for Justice (2015) Creation of Social Value through the Community Risk Intervention Team. The social benefits associated with a falls assessment include increased confidence and independence, reduced risk of falls and falls related incidents (including reduction in stress and anxiety among beneficiaries and wider benefits to family who no longer need to support beneficiaries with mobility, improved access to the outdoors (resulting in improved social networks and psychological wellbeing), increased feelings of safety, and lives saved

<sup>18</sup> The pilot areas estimated this time to be 30 minutes.

The evaluation also estimated the set-up and additional ongoing costs of the pilot to assess the sustainability of the pilot<sup>19</sup>. A breakdown of these costs is presented in Table 3. In total, the set-up costs of the pilot were £71,600. The additional ongoing cost of the pilot is estimated to be £83,300; with an average ongoing cost of £13 per visit.

**Table 3: Set up and ongoing costs**

Cost item	Greater Manchester (£)	Staffordshire (£)	Gloucestershire (£)	Total (£)
Set-up costs	30,100	25,900	15,500	71,600
Additional ongoing costs	48,200	15,000	20,200	83,300
Number of visits	2,707	2,236	1,357	6,300
Average additional ongoing cost per visit	18	7	15	13
<b>Total cost</b>	<b>78,300</b>	<b>40,900</b>	<b>45,700</b>	<b>154,900</b>

*Information provided by FRS, total cost values rounded to nearest £100; cost per visit rounded to nearest £1.*

## Social Return on Investment

Calculation of social return on investment requires access to A&E data to be broken down by age, gender, reason for A&E episode and whether the episode led to an emergency admission. Because this level of data will not be available until 2017, it has not been possible to assess the total SROI. Therefore, this section details the monetary impact of falls only and provides information on the number of impacts which the programme would need to achieve in order to cover the costs associated with delivery.

## Estimate of benefits needed to cover programme costs

The unit cost of an A&E episode, emergency admission and the costs and benefits of a falls assessment have been used to estimate the impacts needed to cover the costs of the programme delivery. This does not include reductions in excess winter deaths, primary care appointments or changes in quality of life.

The total cost of the programme has been estimated to be £154,900 including set up costs of £71,600 and additional ongoing costs of £83,300 on an ongoing basis. In order for the benefits of the programme to exceed the cost, the number of attributable impacts would need to be as follows:

---

<sup>19</sup> This assumed that all staff training costs, letters and postage and programme management costs were set-up costs, only incurred in the initial stages of the programme. All staff time used to carry out the assessments and equipment provided to beneficiaries was defined as on-going costs.



**Table 3: Examples of numbers of episodes which need to be avoided if the costs of the intervention are to balance with the savings**

		<b>Number to cover set up and ongoing costs</b>	<b>Number to cover ongoing costs</b>
	Avoided A&E episodes <sup>20</sup> :	760	408
or	Avoided emergency admissions <sup>21</sup>	99	53
or	Avoided mid to high risk fall <sup>22</sup>	34	18

This is for illustrative purposes. In reality, a combination of avoided outcomes is likely to result.

## Limitations of the evaluation

While it has been possible to provide a detailed evaluation of the process of implementing the pilots and qualitative feedback on their impact, not all of the aims and objectives of the evaluation can be met from the information available to the evaluation at this point. This is because as yet, some data is not available or accessible on the following to enable a SROI to be estimated:

- a) Excess winter deaths: it is likely that any meaningful impact on excess winter deaths will require the use of trend data, which will take three years to materialise. Even with this data, it will be necessary to compare change in excess winter deaths or hospital admissions with changes in comparable areas to try to avoid confounding by difference in winter temperatures or flu activity unrelated to the pilot. This will therefore be methodologically challenging to demonstrate conclusively.
- b) Health and wellbeing outcomes experienced by beneficiaries: the evaluation has not been able to assess the potential improvements to quality of life and improvements in health outcomes that might have occurred as a result of the pilot, through sources of data, such as beneficiaries’ patient records. There is also limited available data in relation to social isolation and cold homes (the data is not disaggregated by area and is lagged).

---

<sup>20</sup> An episode avoided is an Accident and Emergency episode which would have taken place in the absence of the pilot, but which did not take place due to the intervention delivered through the pilot.

<sup>21</sup> An Emergency admission avoided is an admission which would have taken place in the absence of the pilot, but which did not take place due to the intervention delivered through the pilot. Department of Health (2015) NHS Reference Costs 2014 to 2015. Average cost of a non-elective inpatient admission (£1,565) inflated to 2015-16 prices using GDP deflators

<sup>22</sup> Average cost of a mid to high risk fall (£4,530) CSP Falls Prevention Economic Model (2016)  
<http://www.csp.org.uk/documents/falls-prevention-economic-model>

- c) Associated costs and benefits to organisations affected by winter pressures: there is limited available data from partner organisations to support the evaluation in establishing the associated costs and benefits to these organisations. There is also limited available data on the associated costs and benefits to other organisations that may be affected by the pilot, including primary and secondary care services, social care services and voluntary care services.

This is described more fully in the Technical Annex.

As a consequence of the gaps in data available to the evaluation, and because of the early stage of assessment (that is, some behavioural changes and impacts will not have been realised over the evaluation period), a longer period of assessment is needed to establish the true benefits/level of return of the pilot.

## Conclusions and recommendations

This section presents the main conclusions from the evaluation of the pilot, together with a set of recommendations about future implementation of Safe and Well visits.

### Conclusions

The pilot aimed to increase capacity within local FRS areas to deliver home visits to focus on a broader range of issues relating to health and wellbeing, to support the Safe and Well initiative. Brief interventions focused on prevention of falls, cold homes and social isolation as well as signposting to flu immunisation were incorporated into the visit.

The main objectives of the pilot were to:

1. Build capacity within pilot areas to deliver Safe and Well<sup>23</sup> visits which systematically focus on a broader range of health issues, including issues relating to winter-related ill-health (including falls, social isolation, cold homes and flu).
2. Identify households vulnerable to falls, social isolation, cold homes and flu within pilot areas.
3. Provide targeted interventions to reduce the risk of falls, social isolation, cold homes and flu which may lead to a reduction in the pressures on public services in local areas (for example, A&E admissions to hospital, fire service call-outs, demands for GP and social care services).

---

<sup>23</sup> The concept of the Safe and Well visit broadens the scope of home fire safety checks to identify and act on a wider range of risks to help and support people's good health and wellbeing.

4. Build and strengthen relationships between the FRS and local service partners, including development of referral pathways into other forms of help and support within the community.
5. Reduce the risk of excess winter deaths.
6. Demonstrate the value of the FRS in supporting partners to improve health and wellbeing and reduce demand on health and social care services.

**This evaluation considered three questions:**

- I. How have the specific interventions being considered in the three pilot areas had an impact on winter pressures?
- II. What was the impact of the interventions on the individuals who received a home visit?
- III. What was the return on investment of the intervention?

**Summary of findings**

The pilot aimed to increase capacity within local FRS areas to deliver home visits to focus on a broader range of issues relating to health and wellbeing, to support the Safe and Well initiative. Brief interventions focused on prevention of falls, cold homes and social isolation as well as signposting to flu immunisation were incorporated into the visit.

Overall the pilot achieved four of the six objectives:

1. Build capacity within pilot areas to deliver Safe and Well visits which systematically focus on a broader range of health issues, including issues relating to winter-related ill-health (including falls, social isolation, cold homes and flu).

A total of 1,200 staff received training to deliver the intervention. Staff reported improved skills and knowledge in relation to falls prevention, cold homes, flu vaccinations and social isolation. Face-to-face training was more effective than webinars at achieving this.

2. Identify households vulnerable to falls, social isolation, cold homes and flu within pilot areas.

A total of 6,304 visits were conducted. Of these, 4,917 (78%) households included at least one person over 65 years old, 1,800 (29%) households included someone with a long-term condition and 1,619 (26%) reported someone living with a disability.

3. Provide targeted interventions to reduce the risk of falls, social isolation, cold homes and flu which may lead to a reduction in the pressures on public services in local areas (for example, A&E admissions to hospital, fire service call-outs, demands for GP and social care services).

A total of 3,296 people (52%) received advice to prevent a fall and 1,378 (22%) were referred for a falls assessment;

In all, 3,296 people (52%) received advice to prevent cold homes and 406 (6%) were directly referred or signposted to further support.

A total of 462 people (7%) were identified as at risk of social isolation and offered advice or referral.

The majority had already received their flu immunisation.

Beneficiaries trusted FRS to provide safe and well visits

4. Build and strengthen relationships between the FRS and local service partners, including development of referral pathways into other forms of help and support within the community.

Nearly all partner organisations indicated that the pilot had led to improved communication and relationships between themselves and the FRS and they intended to further develop joint working in the future. Most partner organisations reported that the pilot has led to an increase in referrals and demand for their services. Referrals were considered appropriate supporting the aims of partner organisations to deliver services to people in need. Partners indicated that a longer lead in time to the start of the pilot would have supported better joint planning around data sharing and referral pathways.

Implementation was more effective when developed on a smaller scale and gradually increased.

5. Reduce the risk of excess winter deaths;
6. Demonstrate the value of the FRS in supporting partners to improve health and wellbeing and reduce demand on health and social care services

The pilot was not able to report on objectives 5 and 6 within the timeframe because a detailed breakdown of the use of NHS services has not yet been released.

This report is therefore presented as an interim report; further analysis of the data will be commissioned by CFOA in 2017/18.

Although it has not been possible to assess return on investment, this report does outline the additional cost of delivering the intervention and compares this value to the cost of the outcomes the intervention seeks to avoid. It also highlights the perceived value of the interventions by beneficiaries and partners.

The additional time required to add the winter pressures components to the safe and well visit was estimated to be 30 minutes per visit.

The additional cost was £13 per visit on an ongoing basis.

To break even, every 1,000 visits would need to prevent 65 A&E attendances or 8.4 emergency admissions or 3 mid to high risk falls.

### Some lessons from the implementation of the pilot

The pilot has demonstrated some degree of transferability across three different models of delivery within the FRS. However, there is an indication that implementation is more effective on a smaller scale, across a single area, compared to large scale implementation across a metropolitan area, with a diverse population. Both Staffordshire and Gloucestershire delivered the pilot incrementally over a smaller geographical area than Greater Manchester and reported fewer challenges and problems in delivering the home visits. The benefits of this approach were that they could learn from problems as they went along and alter parts of the pilot without too much disruption.

Using data about local populations to identify and target vulnerable households takes considerable time and resource. Involving local partners and agencies, with their specialist knowledge of vulnerable people within local areas, would be beneficial.

Existing experience and capacity to deliver home visits, combined with an established referral pathway, enabled pilot areas to hit the ground running. Staffordshire had already been delivering a similar pilot to the Winter Pressures Pilot (under the SAfER pilot) and were able to draw on this experience and local networks. It is likely that this helped the FRS to exceed its target number of home visits and reduced the chances of setbacks and delays. In addition, having sufficient time to plan and prepare for delivery was important to the smooth implementation of the pilot.

Face-to-face training was the preferred method of delivery by staff. Feedback from the staff e-survey and interviews with frontline staff indicate that staff who received face-to-face training were more confident in their ability to deliver home visits and had a better understanding of the winter pressures components and their purpose.

Engaging with partners from the planning stages of the pilot was also important. The majority of partners reported that they felt the pilot would have benefited from greater collaboration at the beginning of the pilot, potentially through a pilot area steering group, to better establish data sharing mechanisms between the FRS and partners to support the referral pathways, but also support the FRS in reaching the right people.

The pilot was more effective at identifying and addressing households vulnerable to some issues compared to others. Analysis of data on flu vaccinations, together with evidence from qualitative interviews with beneficiaries, suggests that the pilot had little impact on vaccination rates across all three pilot areas. This is largely because recipients of a home visit reported receiving their flu vaccine from local health services at the beginning of winter.

Systems of data collection to support the monitoring of the pilot and information shared with referral pathways could be improved. All three pilot areas had different mechanisms for collecting and presenting data. This affected the comparability of the pilots and the type of information shared through the referral pathways. A standardised approach would be useful in improving the data collection process.

There is data being collected by national and local health and social care partners that could support the measurement of the pilot's outcomes and impacts. However, accessing this data is challenging because it is not being collated in a systematic way. Efforts should be made by the pilot areas, advisory group, partners and the wider health and social care system to improve mechanisms for data sharing and quality assurance.

## Recommendations

1. **Sufficient preparation time:** This is required in the lead up to delivering the home visits before winter begins to allow adequate time to train staff to deliver the home visit, develop and test data collection methods, work with partner organisations to support the pilot, develop and test formal referral pathways, establish local provision of services to avoid duplication, and draw on local knowledge from partners to identify target households.
2. **Targeting:** FRS covering areas of high deprivation should re-evaluate their target groups. Households in areas of high deprivation may experience vulnerability and support needs at an earlier stage in the life course compared to areas of lower deprivation.
3. **Data sharing:** Improved data sharing agreements between FRS and partners will improve the targeting of vulnerable populations. It will also help the FRS to better assess its role and impact on health and wellbeing outcomes and health inequalities.
4. **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.
5. **Training:** Face-to-face training is preferable because it gives trainees adequate opportunity to ask questions about what they are being asked to deliver. Training should reflect the cultural and organisational changes being placed on staff with respect to the delivery of the activities included in the Winter Pressures Pilot, as well as the whole Safe and Well visit. In particular, training should focus on equipping staff with the skills to approach difficult and personal topics (for example, income benefits, loneliness, mental health).

6. **Delivery:** Incremental roll-out of interventions allows for any problems to be overcome and appropriate improvements and alterations to be made to the approach without too much disruption to the service.
7. **Engagement:** A range of approaches to engaging households in a home visit will be needed. Combining proactive approaches, such as canvassing of individual streets and areas through knocking on doors and offering home visits through telephone calls and local promotions, with reactive approaches, such as responding to referrals and requests from individual households or other organisations for a home visit, will increase rates of home visits.
8. **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 of organisations operating in the home setting. It will also improve the alignment of the FRS with other services, and vice versa.
9. **Content of the home visit:** A review of the four issues covered in home visits should be undertaken to ensure they focus on the areas where the home visit can have the largest impact. The evaluation found that the home visits were more effective in addressing falls, cold homes and social isolation than flu vaccinations.
10. **Commissioning:** Local commissioners should ensure that there is adequate funding to support local organisations in providing referrals pathways to beneficiaries and the wider health and social care infrastructure. This will improve the value of the Safe and Well visit (including the winter pressures component) and ensure that it is sustainable in the future.
11. **Longer-term evaluation:** Data collected in this pilot can be used with emerging national and local data to improve understanding of the longer-term impact and return on investment.
12. **Next steps:** PHE and FRS should complete the estimation of the pilot's SROI using data that will become available in 2017/18.