Champs Public Health Collaborative

PHI Public Health Institute LIVERPOOL JOHN MOORES UNIVERSITY

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An evaluation of the Fire & Rescue Service Safe & Well Visits in Cheshire and Merseyside

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CHESHIRE FIRE & RESCUE SERVICE

Merseyside FIRE & RESCUE SERVICE

About the Champs Intelligence & Evidence Service

This work was conducted under the remit of the **Champs Intelligence & Evidence Service**. Commissioned by the **Champs Public Health Collaborative Intelligence Network**, the service aims to provide high quality research in response to collaborative priorities across the nine local authority public health teams in Cheshire and Merseyside.

Matthew Ashton, Joint Director of Public Health, Knowsley and Sefton, leads the Public Health Intelligence Network with support from **Sharon McAteer, Public Health Development Manager, Halton Borough Council** and the wider network. Their role in the Intelligence & Evidence Service involves setting the work programme, providing strategic direction and facilitating collaborative links between the Public Health Institute, LJMU and the wider public health community. They also contribute to editing and final approval of reports.

The evaluation was carried out by research staff from the **Public Health Institute (PHI), Liverpool John Moores University**. Hannah Timpson, Janet Ubido, Cath Lewis and Ellie McCoy planned and carried out the evaluation with support from Karina Kinsella. **Charlotte Smith (Specialty Registrar Public Health, Halton Borough Council)** collected outcomes data from the referral services on behalf of PHI. This evaluation report was prepared by Lisa Jones, Janet Ubido, Ellie McCoy, Cath Lewis and Charlotte Smith.

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1 INTRODUCTION

1.1 WHAT DID THIS EVALUATION AIM TO DO?

The aim of the project was to provide an interim evaluation of Safe & Well visits, an initiative through which Cheshire Fire and Rescue Service (FRS) and Merseyside FRS have extended their current approach to safety in the home. The project utilised a mixed methods approach (including the analysis of qualitative and quantitative data) and aimed to provide an evaluation of both *process* and *outcome*. This involved critical examination of what and how much has been accomplished during phase 1 of delivery (the *process*) and the reach of the initiative, and exploration of the effects and changes that have resulted from the Safe & Well visits (the *outcome*).

1.2 WHAT DATA DID WE COLLECT?

The evaluation sought the perspectives of FRS staff, householders who had received a Safe & Well visit and wider stakeholders on:

- Experiences of delivering the Safe & Well visits (*FRS staff*)
- Experiences of receiving the Safe & Well visit (*householders*)
- Awareness of the Safe & Well visits (*wider stakeholders*)
- The effectiveness of the Safe & Well visits (*FRS staff, householders, wider stakeholders*)
- What could be done to improve the Safe & Well visits (*FRS staff, wider stakeholders*)

The evaluation also involved the analysis of secondary data. This included analysis of:

- Data collected routinely by the FRS during Safe & Well visits
- Data held by the services into which householders may be referred by FRS (where available)

1.3 HOW WILL THE FINDINGS OF THIS EVALUATION BE USED?

The findings of this evaluation will be used to inform intervention content, delivery and design of Safe & Well visits both locally and nationally.

2 BACKGROUND

2.1 NATIONAL CONTEXT

Since 2004, the FRS have had a statutory duty under the Fire and Rescue Services Act (2004) to carry out community safety interventions to reduce injury from fires. Fire safety is one of the core functions under the Act. Duties include making provisions for the promotion of fire safety in the FRS area, including for the provision of advice about fire prevention and how to escape in the case of fire. Home Fire Safety Visits are one such community safety initiative designed to manage fire risks. Visits are targeted towards households judged to be at a higher risk of fire and in England and the FRS deliver in the region of 670,000 Home Fire Safety Visits every year. How the initiative has been implemented has differed across the FRSs in England, but most visits involve the fitting/testing of a free smoke alarm and a discussion about fire safety in the home (Arch and Thurston, 2012). As well as a shift in focus to the prevention of fire, a number of FRSs in England have begun to engage in collaborative work with local government, the NHS and other public, private and voluntary sector organisations (Local Government Association, 2015). As part of this collaboration, local commissioners and FRSs have been encouraged to expand the current scope of the Home Fire Safety Visits to incorporate a 'Safe & Well' check (NHS England et al.). It is suggested that collaborative working, such as is demonstrated through Safe & Well visits, supports the aims of the NHS Five Year Forward View (2014), which called for greater engagement with patients and the public, and for an increasing focus on prevention and wellbeing. The purpose of the Making Every Contact Count (MECC) initiative, a movement that has grown within the NHS, also intersects with these aims to improve public health by supporting the opportunistic delivery of healthy lifestyle information and by providing opportunities to engage people in conversations about how they can make healthy choices.

2.2 WHAT IS A 'SAFE & WELL' VISIT?

2.2.1 Principles

The concept of a Safe & Well visit is underpinned by a set of principles that inform the design of locally agreed approaches (NHS England et al., 2015). These principles are based on the view that the public perception of FRS (its 'brand') and the esteem in which it is held, gives the FRS access to people's homes that "others cannot achieve". It has been suggested that the public perceive the FRS as a neutral service and therefore may be more willing to engage with the FRS (NHS England et al., 2015).

Principles for a 'Safe & Well' visit by a Fire and Rescue Service:

- That every fire and rescue service should consider extending its current approach to safety in the home to include risk factors that impact on health and wellbeing and which lead to an increase in demand for health and local authority services.
- The content of a 'Safe & Well' visit in any fire and rescue service area should be co-designed through discussions with local health and local authority colleagues and should be based on information regarding local risks and demand.
- When considering risk factors other than fire, the process should not be confined to merely signposting to other agencies, but also to how these can be mitigated during the initial visit.
- Wherever possible the approach adopted should be one of:
    - A light touch health check of all individuals in the home;
    - Identification of risk while in the home;
    - Provision of brief advice;

    - Provision of appropriate risk reduction equipment;
    - Referral to specialist advice and support where appropriate.
- To ensure that referrals to specialist advice and support are limited to those in need of such support; health and local authority colleagues should support fire and rescue services in training and raising the awareness of their staff, where necessary.
- Consistent referral pathways into specialist services should be developed across each fire and rescue service area; Chief Fire Officers Association (CFOA) and NHS England will agree principles and guidance to assist in achieving this. However, it is recognised that due to the number and nature of organisations involved, absolute consistency is, at this stage, an aspiration.
- To ensure that visits improve quality of life outcomes, and lead to reduced demand for services, the quality of the visit should be balanced against the number delivered; with the probability that this will result in fewer than the [annual] 670,000 currently delivered nationally by FRSs.
- The number and scope of 'Safe & Well' visits completed by each fire and rescue service will be determined by the capacity within each organisation, which may differ significantly from service to service.

2.3 Extending the current approach to safety in the home

Cheshire and Merseyside FRSs have been early adopters in expanding their Home Fire Safety Visits to incorporate the Safe & Well checks. In 2015, a Cheshire and Merseyside Health and Fire Summit was held to discuss further ways of collaborative working to reduce risk to vulnerable people in the community. The Health and Fire Summit identified the following issues for consideration: slips, trips and falls; supporting hospital discharge for over 65s admitted to ward for a fall; supporting bowel cancer screening; and supporting smoking cessation and alcohol reduction. Following the Summit, high blood pressure monitoring was also added for consideration.

2.3.1 Local risks and demands

One of the key challenges to the state of health among the population of Cheshire and Merseyside is that while people are living longer, many people are spending these extra years of their life in poor health. This is due to the burden of preventable long-term conditions. Changes are needed to reduce the impact of chronic disease in the population and to reduce their prevalence through prevention. Drawing on the Marmot report (Marmot et al., 2010), tackling the social conditions that give rise to unfair and avoidable variations in health should be a key focus of efforts to support people to make healthy choices. Communities are important for health and wellbeing, and the physical and social characteristics of communities enable and promote healthy behaviours to different degrees.

Fire risk

There has been a continuing downward trend in fire incidents and fire-related fatalities over the last decade (Bryant and Preston, 2017). Research shows that older people, people with disabilities, those living in single parent households, males aged 46-60 who live alone and drink and smoke in the home, and young people aged 16-24 (including students) are at a greatest risk of dying in fires (Department for Communities and Local Government, 2006). Fires within the home and injuries from fire are more likely to occur in areas of social deprivation and in areas with a high proportion of people from these risk groups. A study of unintentional dwelling fires on Merseyside found that the biggest risk factors for deaths from fire in the region were mental health problems, disability and living alone (Taylor et al., 2012). Binge drinking and smoking were also statistically significant fire risk factors.

People aged over 65 years

People aged over 65 years are one of the key target groups for community fire safety interventions. The Projecting Older People Information System (POPPI) predicts that nationally the proportion of people aged over 65 will increase substantially over the next decade. Based on 2016 population estimates, there are 476,806 people aged over 65 years living within the nine local authority areas of Cheshire and Merseyside. The proportion of people aged over 65 is slightly higher in Cheshire than it is in Merseyside (Table 1). The number of people aged 60 years and over is projected to increase substantially over the next decade, with the increase particularly marked in those over 85 years. This emphasises the need to ensure good health and wellbeing for older adults.

Table 1. Population aged 65 years and over in Cheshire and Merseyside

	Cheshire (%)	Merseyside (%)	England
Total population	1,048,087	1,406,447	55, 268,067
Aged 65 and over	214,174 (20.4)	262,632 (18.7)	45, 285,226 (18.1)

Source: Office for National Statistics (ONS) 2016 data

Deprivation

Cheshire and Merseyside are characterised by large areas of deprivation locally, and by wide variations in health inequalities. Health inequalities vary both between and within local authority areas; for example, life expectancy is 10.9 years lower for men and 7.9 years lower for women in the most deprived areas of Knowsley than in the least deprived areas[1]. Ranked by Index of Multiple Deprivation (IMD) scores at the local authority level, Knowsley is the most deprived local authority area within Cheshire and Merseyside, and Cheshire East is the least deprived. With the exception of the Cheshire East and Cheshire West and Chester local authority areas, all IMD scores at the local authority level are higher (indicating that they are more deprived) than the England average.

2.3.2 Health behaviours targeted in Phase 1 Safe & Well visits

A range of health behaviours were selected for targeting in phase 1 of the Safe & Well visits undertaken in Cheshire and Merseyside, specifically uptake of bowel cancer screening, falls preventions, smoking and alcohol consumption.

Bowel cancer screening

According to Cancer Research UK, bowel cancer is the second most common cause of cancer death in the UK, accounting for 10% of all cancer deaths. The national NHS Bowel Cancer Screening Programme began in 2006 with the aim of reducing mortality from bowel cancer among men and women aged 60-69 years, with screening age extended to 74 years in 2010. Figure 1 shows the uptake of bowel cancer screening in Cheshire and Merseyside, defined as the number of people aged 60–74 with a screening test result recorded in the previous 2½ years, as a proportion of those who are eligible for bowel cancer screening. Compared to the national average, there is a significantly higher uptake of bowel cancer screening across the two Cheshire local authorities and Warrington. However, uptake is significantly lower in many of the Merseyside local authorities, with the exception of St Helens, where uptake is similar to the national average.

[1] *Data from PHE fingertips Local Authority Health Profiles (fingertips.phe.org.uk)*

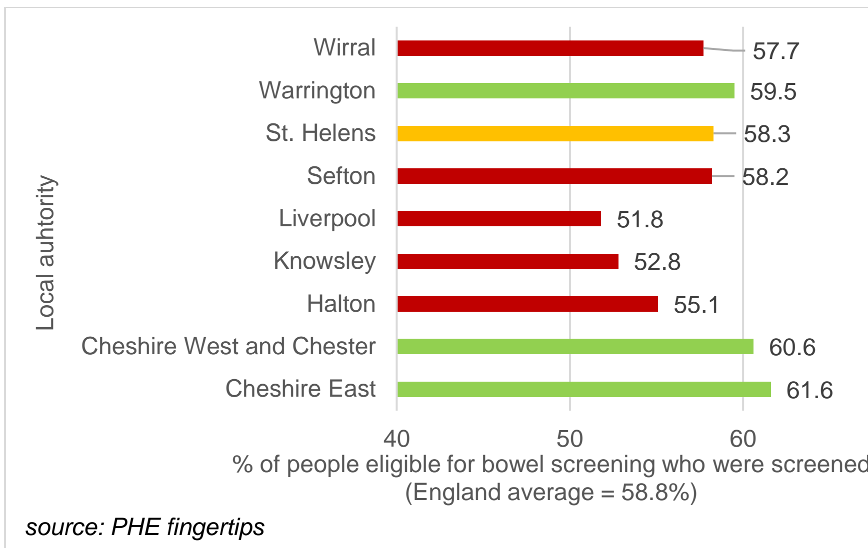

Figure 1. Bowel cancer screening coverage: proportion screened aged 60-74, Cheshire and Merseyside, 2017

Falls prevention

Each year one in three people over the age of 65, and half of people over the age of 80 have a fall (National Institute for Health and Care Excellence, 2013). Falls can result in life-changing consequences for older people and their families, often leading to increased dependence on others for care or even a move into a residential care setting. The estimated cost of falls to the NHS alone is over £2.3 billion pounds per year, reflecting the severity of these impacts (National Institute for Health and Care Excellence, 2013). In each local authority in Cheshire and Merseyside, rates of falls per 100,000 persons amongst the elderly are significantly higher than the English average of 2,114 (Figure 2).

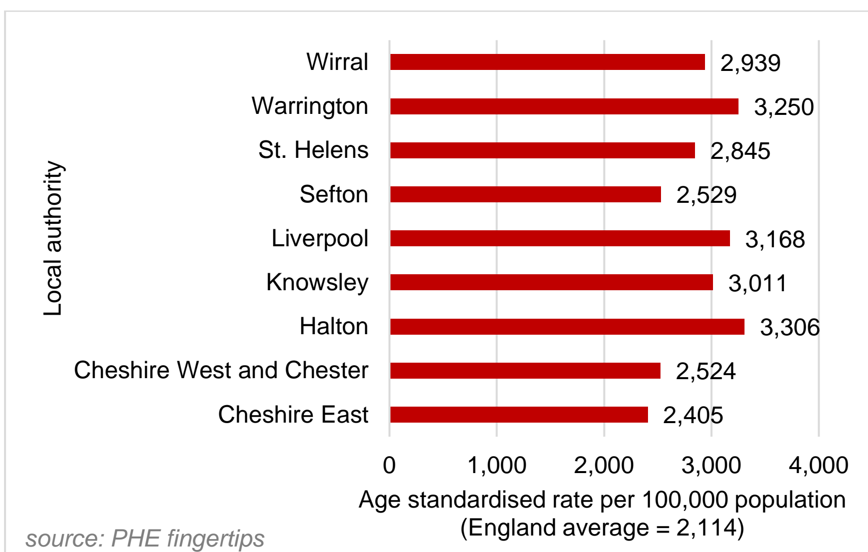

Figure 2. Emergency hospital admissions for injuries due to falls in people aged 65 and over in Cheshire and Merseyside, 2016/17

Smoking

Smoking remains one of the leading causes of preventable morbidity and premature death in England. Across Cheshire and Merseyside, smoking levels are significantly higher than the national average in Knowsley and Liverpool, and significantly lower in Cheshire West and Chester, Sefton and Warrington (Figure 3). People aged 60 years and over are the least likely to smoke, but smokers within that age group smoke more per day than any other age group (Office for National Statistics, 2018).

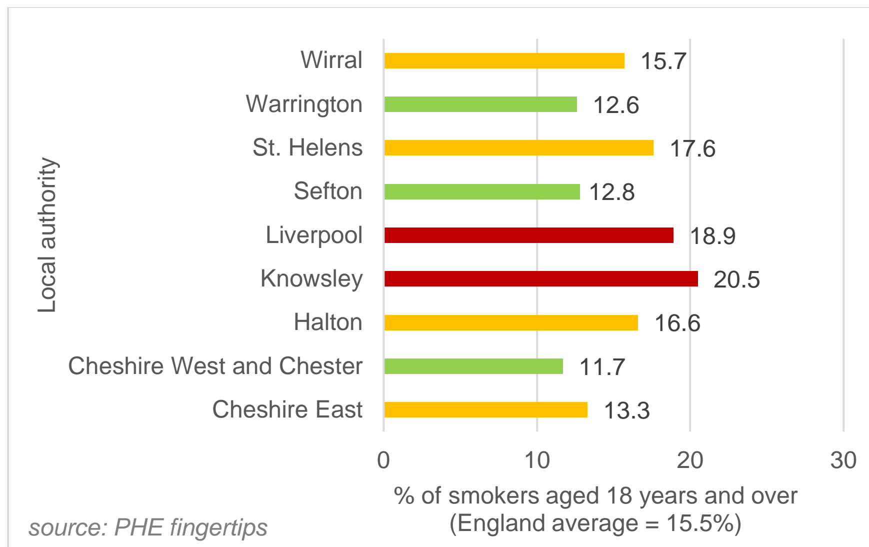

Figure 3. Smoking Prevalence in adults - current smokers (Annual Population Survey, APS) 2016

Alcohol consumption

Alcohol consumption is linked to harmful consequences for both the drinker and society as a whole. Nationally, around 1 in 4 adults (25.7%) drink over the recommended maximum of 14 units of alcohol a week. In Cheshire and Merseyside, levels are similar to or slightly higher than the national average, except in Halton, where levels are significantly higher, at 42.7% (Figure 4).

Figure 4. Percentage of adults drinking over 14 units of alcohol a week, 2011 – 14.

The Royal College of Psychiatrists has advised that people over 65 should not to drink more than 1.5 units of alcohol a day based on physiological and metabolic changes associated with ageing

(Royal College of Psychiatrists, 2018). Despite an overall fall in population levels of alcohol consumption, consumption has been rising amongst people aged 65 years and over (Royal College of Psychiatrists, 2018). Alcohol-related hospital admissions among people aged over 65 are making up an increasingly higher proportion of admissions - up from 14% in 2010/11 to 30% in 2016/17. Overall hospital admission episodes for alcohol-related conditions for all ages are significantly higher than the national average in all of the Merseyside local authority areas and Warrington. Among people aged over 65, levels of hospital admissions are significantly higher than the national average in Knowsley, Liverpool and Wirral. They are significantly lower in Cheshire East and Cheshire West & Chester and similar in the remaining local authorities. A recent study found that older adults are often overlooked or even excluded from alcohol treatment and support (Wadd and Dutton, 2017).

3 HOW WE CARRIED OUT THIS EVALUATION

The evaluation was undertaken between April 2017 and March 2018. It included the collection of qualitative and quantitative data and a range of methods were used to gather information from different sources including householders, FRS staff and wider stakeholders. The Appendices provide a detailed overview of the evaluation methods, data access procedures and data sharing arrangements.

3.1 SURVEYS

- **A survey of householders who have received a Safe & Well Visit**

A householder survey was developed to explore householders' experience of the Safe & Well visit. 500 surveys were distributed to a cohort of householders in Cheshire and Merseyside who received a Safe & Well visit during the evaluation period. All householders who participated in the survey could participate in telephone interviews to develop in-depth case studies about their experiences of the visit. In total, 75 surveys were returned (33 Cheshire, 41 Merseyside, and 1 with no postcode). Eight householders participated in the case study interviews. Case study participants were selected as far as possible to represent a balance of those who had either accepted or declined Safe & Well assessments and whether they had expressed any concerns or not. Demographic information is provided in Appendix 2a & b.

- **A survey of staff members of the FRS who deliver the Safe & Well visits**

An online survey was developed for Cheshire and Merseyside FRS staff who were involved in delivering the Safe & Well visits. The survey asked about their experiences of delivering the visits, how effective they felt the visits were, and how they felt they could be improved. In total, 49 FRS staff completed the survey (25 CFRS; 24 MFRS).

- **Engagement with wider stakeholders (Safe & Well referral services)**

An online survey was conducted with 44 wider stakeholders including representatives from Clinical Commissiong Groups (CCGs), local authorities and service providers (this included falls, alcohol and smoking services) to explore the awareness of the Safe & Well initiative, views, perceptions and experiences of the initiative, and suggestions for improving delivery. Details of stakeholders are listed in Appendix 2c.

3.2 SECONDARY DATA

- **Analysis of secondary data collected by the Fire & Rescue Services**

An analysis of routine data collected by Cheshire and Merseyside FRSs for the Safe & Well initiative was undertaken. This analysis explored demographics of the householders receiving and participating in a visit and what referrals were made as a result of the visit (referrals for a bowel cancer screening gFOBt kit, and referrals to local falls teams, alcohol services and smoking cessation services).

- **Analysis of secondary data provided by the Safe & Well referral services**

Data was requested from the services receiving referrals as a result of the Safe & Well visit to explore impact of the visits. Appendix 3 includes a detailed description of the process of requesting and receiving data. Data received for local falls services, alcohol services and smoking cessation services included brief information around number of referrals received and engagement with services. Data from the national Bowel Cancer Screening Hub in Rugby was requested, including the number of gFOBt kits requested and returned, and results of the test and further investigations (number of positive tests and cancers identified).

4 Process evaluation

4.1 Adopted approach to Safe & Well

4.1.1 Number and scope of Safe & Well visits

Cheshire

Safe & Well visits are targeted to 40,000 households per year (up to 65,000 individuals). All households that consent to a fire safety check visit in Cheshire are also asked a range of health assessment questions, covering (in Phase 1) risks relating to falls, bowel cancer screening, smoking and alcohol. These households have been identified as being most at risk of fire, taking into account the following variables:

- Age of the householder, using Exeter data[2].
- Mosaic Category[3] for the household. Deprivation is linked indirectly to this variable.
- Distance from the station for the PDA (pre-determined attendance), which for house fires is the average time for the three nearest appliances.
- Whether the property is single occupied.
- Whether the property has had a Home Safety Assessment/Safe & Well visit within the last 5 years.

Each variable has a scoring matrix related to the likely risk of fire (e.g. as the age of the occupier increases then the higher the score for the variable). Households are graded platinum, gold, silver and bronze, with platinum households being identified at greatest risk of fire. The top 10,000 'platinum' households are prioritised for Safe & Well visits, which begin at the start of the financial year. In future there are plans to add categories for alcohol, smoking and mobility, using health data in the Mosaic Category. Figure 5 shows the areas covered by the visits between April 2017 to March 2018.

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[2] *Exeter data is GP registration data that will enable those in different age groups to be identified (year of birth, gender and address).*

[3] *The Mosaic tool classifies postcodes into types of household, including 'vintage value' (elderly people reliant on support to meet financial or practical needs) and 'municipal challenge' (urban renters of social housing facing an array of challenges).*

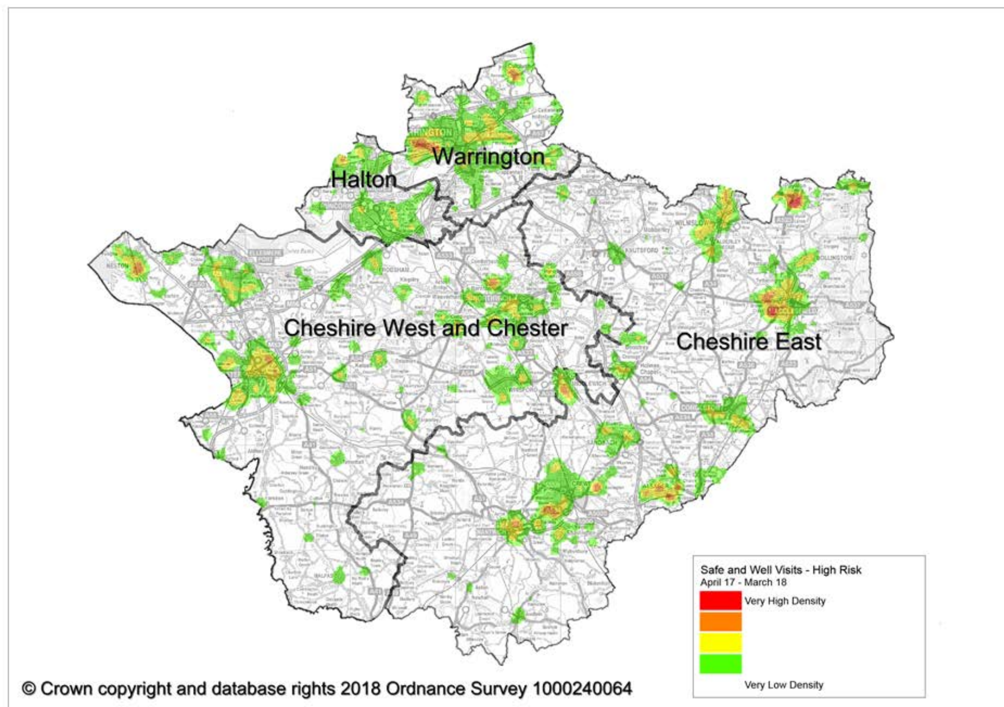
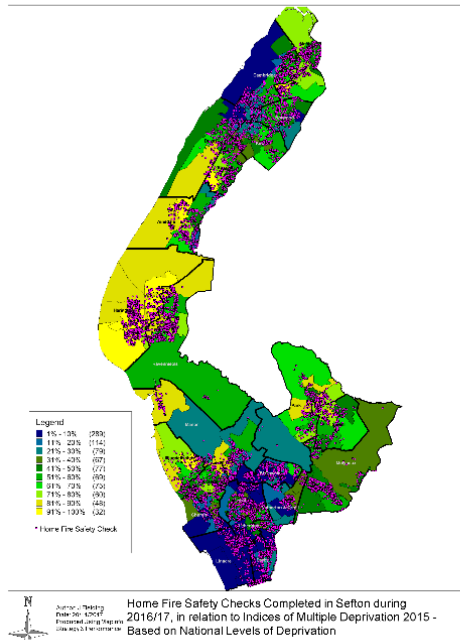


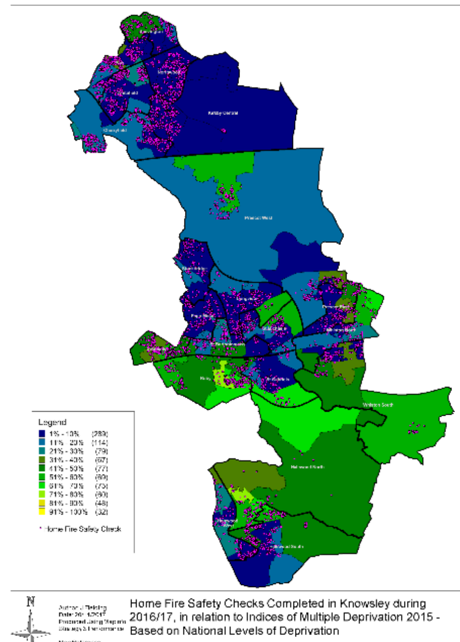
Figure 5. Density of Safe & Well visits by Cheshire FRS

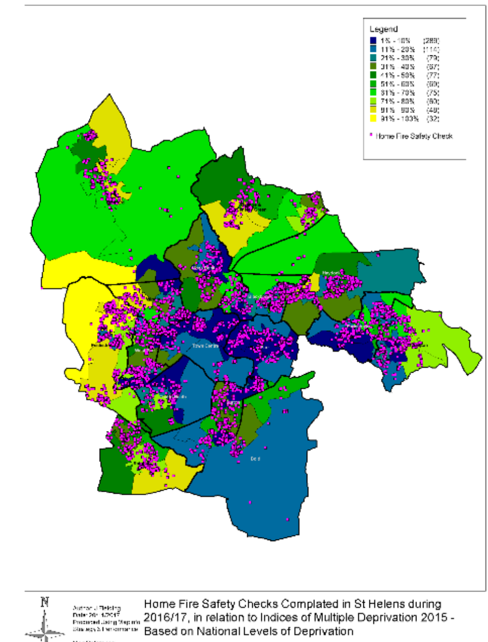
Merseyside

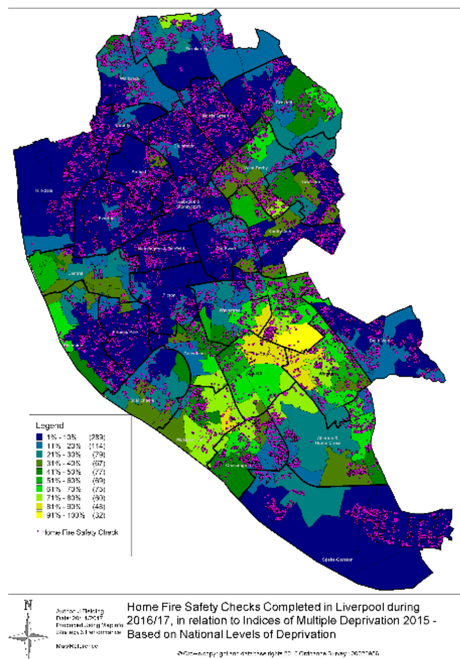
On Merseyside, operational firefighters complete Home Fire Safety Checks (HFSCs) to around 50,000 households per year. Lists are provided to operational crews that have been produced using Exeter data and other partner shared information from sources such as adult social services and registered social landlords that assist in identifying possible vulnerabilities from fire. Staff utilise these lists and target areas within their station boundary, based on local knowledge and recent fire activity. Risk factors include, but are not limited to, age, those living alone, those with poor mental health, smokers and those who drink in excess. A HFSC includes fire safety information and the importance of fitted and working smoke alarms. Staff have the ability to refer persons who they perceive to be at a higher risk to fire or with other complex needs to the advocate team.

Fire & Rescue Service Advocates will complete a *high-risk* HFSC (now called a Safe & Well visit). Advocates have been specifically trained to deliver the Safe & Well initiative. The advocate will offer the health elements appropriate to the occupiers within the property. Advocates visit properties that have been determined high risk by the operational fire crews and/or their partner agencies (such as care workers, oxygen providers, housing associations, police, and hospital discharge teams) and all referrals are triaged and pre booked via the prevention call centre. Individuals, family members and neighbours can also make referrals. Visits are for any age and in any area where increased fire risks have been identified. Advocates engage with 10,000 properties per year (potentially 15,000 people). Merseyside FRS have produced maps showing profiles of the areas where the HFSCs took place during 2016/17 (Figure 6 below).









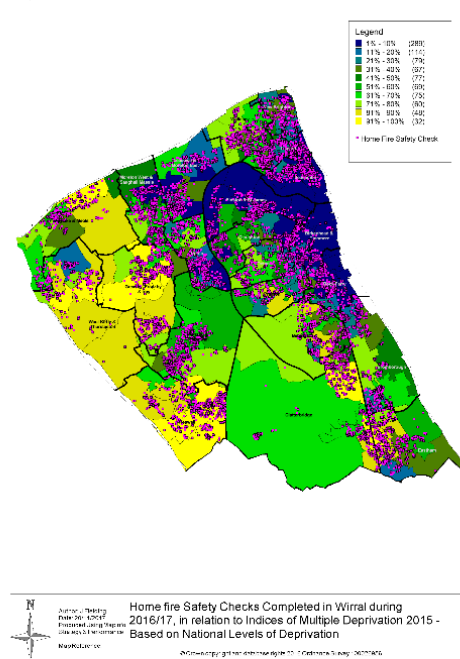


Figure 6. Household location of HFSCs completed by Merseyside FRS in 2016/17

4.1.2 Who delivers the intervention

In Cheshire, Safe & Well visits are delivered alongside all HFSCs, which may be undertaken by either operational firefighters or specially trained advocates. In Merseyside, advocates have been specifically trained to deliver Safe & Well visits (i.e. high-risk HFSCs). Advocates are uniformed non-operational personnel with local knowledge of their communities and offer the health elements appropriate to the occupiers within the property. Advocates are trained to engage and work with their communities to promote HFSCs and Safe & Well health checks. Several of the advocates are bi lingual or have the ability to communicate via BSL which allows effective engagement with all communities.

4.1.3 Risk factors addressed in Phase 1

Health topics included within the first phase of the Safe & Well visits in Cheshire and Merseyside (and which are the focus of this evaluation) were: bowel cancer screening; falls, trips and slips; smoking cessation; and alcohol reduction. Cheshire and Merseyside FRSs have developed and delivered the Safe & Well visits within the boundaries of existing resources, without additional budget. During the fire safety check, householders are asked if they consent to a health and wellbeing assessment (Cheshire) or a Safe & Well assessment (Merseyside). The visit provides the opportunity for the FRS to identify key health issues and signpost householders to relevant support and services. The questionnaires used during Safe & Well visits in Cheshire and Merseyside are provided in Appendix 1.

Bowel cancer screening

Bowel cancer screening aims to detect the disease at an early stage when treatment is more likely to be effective. In England, the NHS Bowel Cancer Screening Programme (BCSP) has been available since April 2006 via the offer of a home testing kit (known as the faecal occult blood test; gFOBt). Initially the screening was offered every two years to all men and women aged 60-69 years registered with a GP in England. In 2010, this was extended to include people up to the age of 75. The uptake of bowel cancer screening is particularly low in Merseyside, where only one in every two eligible men and women participate (see Section 2.3.2).

The assessment starts with a brief explanation of what this section of the visit is about. Householders who consent to participate in the bowel cancer screening element within a Safe & Well visit are asked whether they have previously received a home testing kit (gFOBt) and whether they have previously returned the gFOBt. FRS may discuss the benefits of screening and can offer to show householders what the kit looks like. Householders may consent for the FRS to request a gFOBt on their behalf. FRS are able to request kits in a variety of languages other than English and in braille, audio and easy read formats.

Falls prevention

NICE guidance (National Institute for Health and Care Excellence, 2013) states that professionals and organisations who have health and care as part of their remit should routinely ask the older people they come into contact with about falls. This is the route through which adults aged over 65 years of age will typically become engaged with the Falls & Fracture system (NHS England). Within the pathway, health and social care professionals should screen older people for falls risk and refer those at a high risk of falls for a multifactorial risk assessment. Adults determined to be at a low to moderate risk may benefit from strength and balance exercise programmes.

Cheshire and Merseyside FRSs both use the Falls Risk Assessment Tool (FRAT) to screen for falls risk as part of the Safe & Well check (see Appendix 1). FRAT has been developed as a pragmatic, simple tool to help identify those accessing primary care who would benefit from further investigation or intervention in relation their risk of falling (Nandy et al., 2004). Nandy et al. (2004)

suggest that the presence of three or more risk factors may be the most appropriate cut-off point for the FRAT. However, the threshold used by the FRSs to offer a referral has varied by local authority. In Cheshire, and in Liverpool, Sefton and Wirral on Merseyside, householders were offered a referral to a local falls team if they score 3 or more on the FRAT. In Knowsley and St Helens, referrals were offered to those scoring 2 or more on the FRAT.

Smoking cessation

The smoking assessment of the Safe & Well check starts with a brief explanation of what this section of the visit is about. In Cheshire, householders are advised on the fire and health risks involved asked if they would like advice on stopping smoking. If they answer 'yes', they are asked if they would be happy to be referred to the relevant public health or CCG team for assistance. In Merseyside, for those answering 'yes' to smoking, advocates have a MECC ('Make Every Contact Count') conversation relating to the benefits of stopping smoking, with a focus on having positive conversations with people. If consent is given, referrals are made to local authority smoking cessation services, which are available in each of the five Merseyside local authorities.

Alcohol reduction

In Cheshire and Merseyside, the alcohol reduction assessment starts with a brief explanation of what this section of the visit is about, followed by screening with the AUDIT C tool (see Appendix 1). In Merseyside, the Brief Information and Advice (BIA) package is offered to those scoring 5+ on the AUDIT C screening tool, together with a discussion around the benefits of reducing alcohol consumption. For those identified as higher risk and possible dependence, referrals to services are made if consent is given. Cheshire FRS also incorporated the AUDIT C screening tool in July 2017.

4.2 Training and raising awareness among FRS staff

FRS staff in Cheshire and Merseyside began receiving Safe & Well training from early 2016 onwards. Cheshire FRS began their training earlier than Merseyside FRS, with Cheshire receiving the majority of their training between January to September 2016, and Merseyside receiving the majority of their training in September 2016 to April 2017.

Training for staff in both FRS was based on existing public health guidance and training packages around the specific health topic areas. It was felt that general behaviour change training was not needed. This is because personnel are already experienced at this in relation to fire behaviour, with a wealth of experience in engaging with people and convincing them to have a fire safety check (personal communication, Phil Byrne).

Bowel cancer screening

The bowel cancer screening training package was developed by Cancer Research UK and Halton Borough Council, in collaboration with partners including the NHS Bowel Cancer Screening Programme, Public Health England, and Cheshire and Merseyside Fire and Rescue Services.

Falls prevention

Both Cheshire and Merseyside FRS used a 'train the trainer' approach. The local authority falls team in St. Helens trained two of the MFRS and two of the CFRS advocates on how to use the FRAT to screen for falls risk. These two advocates then went on to provide the training to all Merseyside FRS advocates and Cheshire fire service personnel.

Smoking cessation

In Cheshire, training on the smoking assessment and intervention was provided in-house by the FRS occupational health team who were already trained to the requisite level. In Merseyside, Sefton Public Health Team provided MECC ('Making Every Contact Count') training to all FRS advocates.

Alcohol reduction

In Cheshire, as with smoking, training on alcohol assessment and intervention was provided in-house by the FRS occupational health team who were already trained to the requisite level. In Merseyside, a training package was agreed with the five local authority teams and delivered by Whiston Hospital Alcohol Team to all advocates. This was based on the use of the AUDIT C screening tool, with BIA. For smoking and alcohol, practice in MFRS was based on the evidence for behaviour change interventions suggesting that 1 in 8 people who have conversations make positive changes as a result, even if they do not go on to have a referral to services.

4.3 Referral pathways into specialist services

During phase 1 delivery of the Safe & Well visits, householders who agreed to receive health and wellbeing advice could be supported to engage with community services for falls prevention, smoking cessation and alcohol reduction via a referral on their behalf from the FRS. For both Cheshire and Merseyside FRS, referral pathways were developed in collaboration with the local authorities and CCGs across the four Cheshire and five Merseyside boroughs. Contact details for service providers relating to each health topic were entered into a spreadsheet by each Local Authority/CCG. This was considered to have worked well overall, although Merseyside FRS noted that problems did occur when there were changes in providers or when referral pathways were inaccessible to householders because of governance issues.

Falls prevention

The commissioning arrangements for falls services, and what is offered locally, varies across Cheshire and Merseyside. Commissioning responsibilities sit with either the CCG or the Local Authority and as there are multiple CCGs in some local authorities, there is a lack of consistency in the services offered. Falls services have different tiers of service, with a higher tier requiring specialist assessment and input usually completed by healthcare professionals. Lower tier services usually focus on falls prevention and are more likely to include a range of interventions delivered in classes. Merseyside FRS were required to apply different FRAT thresholds for referral to falls prevention services and had found this to be problematic. They also found that there were often delays in setting up referral pathways to falls prevention services, because many of the commissioned services did not have the secure email addresses required to process individual NHS data.

Smoking and alcohol

For householders who consented to referral in relation to their alcohol consumption or smoking, arrangements were made for follow-up by local authority commissioned smoking cessation and community alcohol services as required.

4.4 How well is the workforce prepared to deliver the Safe & Well visits?

4.4.1 FRS staff views on the training received

Of the 49 respondents to the FRS staff survey, nine reported that they had not received training for Safe & Well visits. All but one of the nine respondents who had not received training reported that they had delivered Safe & Well visits. Staff responding to the survey who recalled receiving training to carry out the Safe & Well visits (n=40; 23 staff in Merseyside and 17 staff in Cheshire) had received their training throughout 2016 and 2017. They were asked for their views on the training they had received in relation to the falls risk, bowel cancer screening, smoking cessation and alcohol reduction elements of the Safe & Well visit. As shown in Figure 7, the majority of respondents reported that they had very good or good views of the training they had received. The most positive views were in relation to the training received for the bowel cancer screening element; with no respondents reporting that there was 'room for improvement'. Staff based in Merseyside had more positive views of the training received compared to staff in Cheshire (87.0% [20/23] of Merseyside staff compared to 35.3% [6/17] of Cheshire staff rated training for two or more elements as 'good' or 'very good').

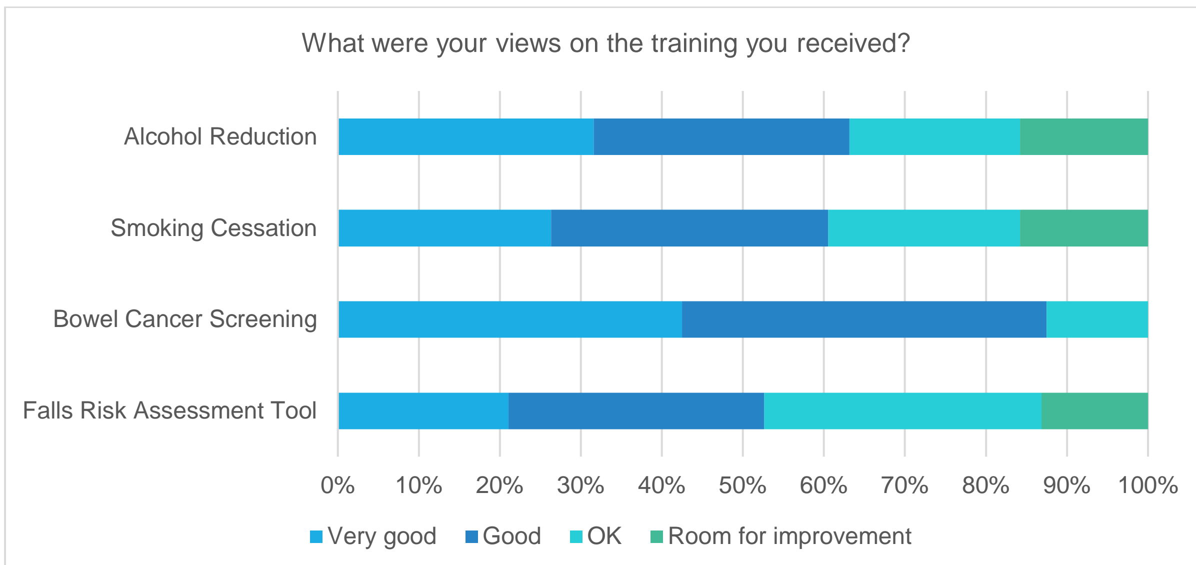


Figure 7. Views on training had received for delivering Safe & Well Visits

Positive comments from the staff who responded to the survey included:

> *"[I] thought the trainers were very good and knowledgeable in their fields and put it across to the Advocates in a positive way so we could discuss the individual topics with the general public." (Advocate, 51-100 Safe & Well visits)*

> *"I thought all training was well presented and in-depth." (Advocate, 10-50 Safe & Well visits)*

One staff respondent who had expressed negative views of the training for the falls risk assessment, smoking cessation and alcohol reduction elements commented:

> *"We were introduced to the questionnaire but received no guidance on answering any questions that may arise from the information we were requesting. Basically,*

great if the response was negative, atrocious if the response was positive." (Firefighter, more than 100 Safe & Well visits)

Two staff respondents who had expressed negative views of the training for the falls risk assessment commented:

"Falls risk assessment quite vague on when to refer and when not to. Questions asked could be improved." (Advocate, 51-100 Safe & Well visits)

"Question – 'Is the client unable to raise safely from a chair at knee height' - can be worded better. Is this with or without equipment i.e. chair raisers, recliner etc....? All training sessions were very fast." (Advocate, 51-100 Safe & Well visits)

4.4.2 Staff views on how well training had prepared them

The staff were asked how well they felt the training that they had received had prepared them to undertake the falls risk assessment, bowel cancer screening, smoking cessation and alcohol reduction elements of a Safe & Well visit. The responses indicated that generally staff felt well prepared to undertake the bowel cancer screening element of a Safe & Well visit (Figure 8). For the three other areas, there were a proportion of staff who did not feel all that well prepared based on the training that they had received. Staff based in Merseyside had more positive views about how well the training had prepared them to carry out a Safe & Well visit compared to staff in Cheshire (78.3% [18/23] of Merseyside staff compared to 35.3% [6/17] of Cheshire staff reported that the training had prepared them 'well' or 'very well' on two or more elements).

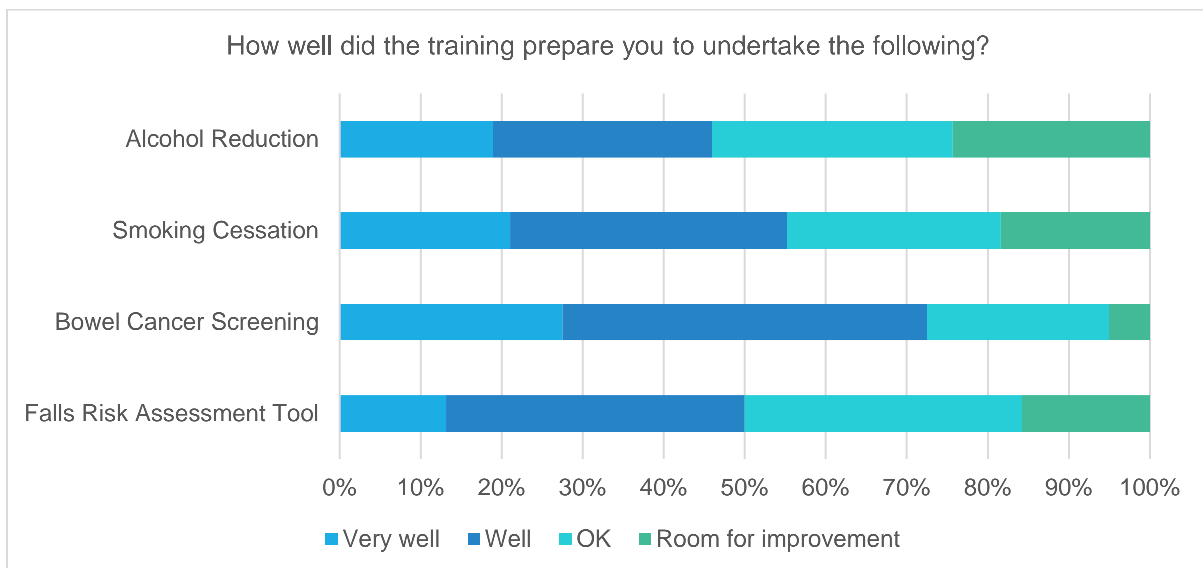


Figure 8. Views on how well the training prepared them to undertake the Safe & Well visit

One respondent who had fairly positive views about how well they felt the training had prepared them commented:

Bowel cancer screening is a good idea. Alcohol cessation is a difficult one as anyone who drinks too much may not be truthful and also may be offended by us asking. (Firefighter, 51-100 Safe & Well visits)

Two respondents who had more negative views about how well they felt the training had prepared them commented:

“When you first start to ask people the questions they don't prepare [you] for how embarrassing it can be for us asking the questions.” (Firefighter, 10-50 Safe & Well visits)

“The training was to ask the question and what details to take depending on the response. It didn't cover answers to questions we may be asked. Only that we would pass on their details...” (Firefighter, more than 100 Safe & Well visits)

Two respondents provided comments suggesting that staff may perceive there to be a gap in the training in relation to what happens following a referral, commenting:

“I don't know what happens once the client takes up the offer of smoking and drinking help, e.g., precisely what’s on offer, how long it takes etc.” (Advocate, more than 100 Safe & Well visits)

“Would be beneficial to know what happens when referrals are made.” (Advocate, more than 100 Safe & Well visits)

4.5 How were Safe & Well Visits experienced?

4.5.1 Fire & Rescue Service staff experiences of Safe & Well visits

Confidence in delivering Safe & Well visits

Staff were asked to indicate how confident they felt in delivering each element of a Safe & Well visits (Figure 9). Confidence was highest in relation to the delivery of the bowel cancer screening element of the visit. Whilst the majority of staff reported feeling at least fairly confident across each element of the visit, the proportion reporting that they didn’t feel confident (those indicating ‘not very’ or ‘not at all’ confident) was 9% for the Bowel Cancer Screening, 17% for the Falls Risk Assessment Tool, 26% for smoking cessation and 40% for alcohol reduction. In total, 20 respondents (41.7%) to the staff survey reported that they didn’t feel confident (those indicating ‘not very’ or ‘not at all’ confident) on at least one element of the Safe & Well visit. By job role, 59.1% of firefighters reported that they didn’t feel confident on at all least one element compared to 30.8% of advocates.

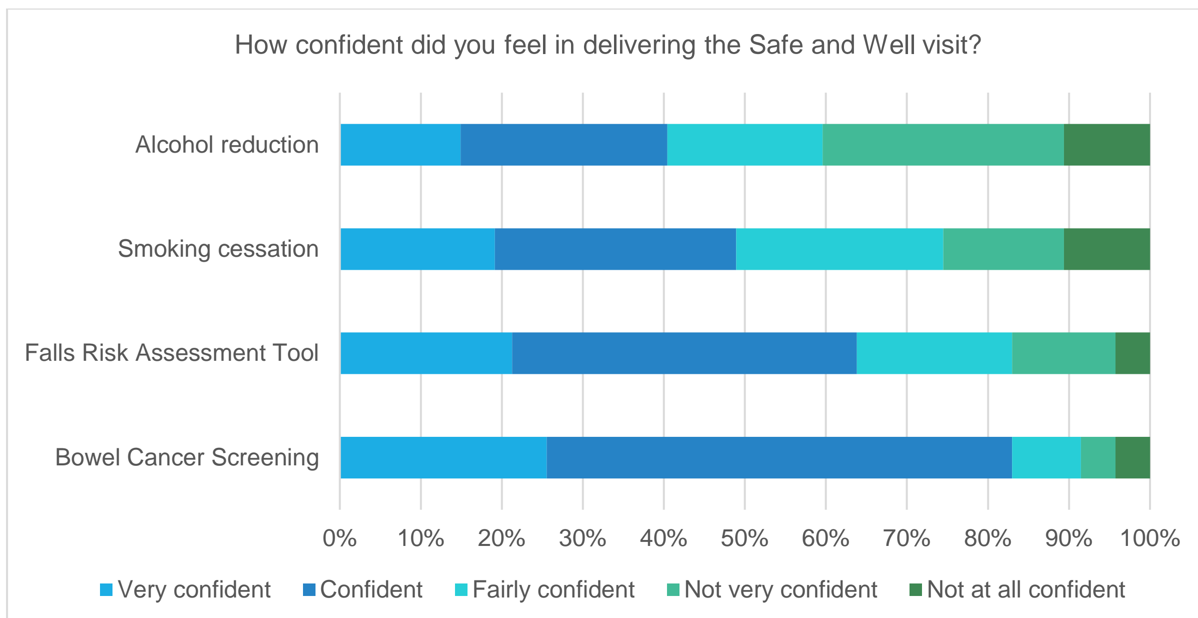


Figure 9. Perceived staff confidence in delivering a Safe & Well visit

Staff were asked whether their confidence had changed over time and 63.8% reported that ‘Yes’ they felt that their confidence had increased. None of the staff surveyed indicated that their confidence in delivering Safe & Well visits had decreased over time. Among staff who reported being confident in the delivery of all elements of the Safe & Well visit, comments about how their confidence had changed over time were all in relation to how it had improved, including:

> *“It has become more familiar and over time have been able to try different approaches to the questions and responses” (Advocate, 51-100 Safe & Well visits made)*

> *“When accompanying fellow advocates on visits (due to lack of vehicles) and seeing how they deliver safe & well, my confidence has improved. Also over time getting used to the new format. My confidence has improved from regular CPD days too.” (Advocate, more than 100 Safe & Well visits made)*

For respondents who reported that they didn’t feel confident (those indicating ‘not very’ or ‘not at all’ confident) delivering at least one element of the Safe & Well visit, only 45.0% reported that ‘Yes’ they felt that their confidence had changed. Among these staff, comments about how they felt their confidence had changed over time were also all in relation to how it had improved, including:

> *‘I have got use (sic) to asking the questions so my confidence has got better but I still feel awkward asking the questions.” (Firefighter, 10-50 Safe & Well visits made)*

> *“Confidence has improved due to number of visits made, but still get asked questions, I've not got answers to.” (Advocate, more than 100 Safe & Well visits made)*

Views on how Safe & Well visits were received by householders

Staff were asked for their views on how well they felt the different elements of the Safe & Well visits had been received by householders (Figure 10). Elements of the Safe & Well visit that were viewed as being received well by householders were the Bowel Cancer Screening and Fall Risk elements of the visit. Among staff responding to the survey, 21.7% felt that the smoking cessation element was badly or very badly received, and 32.6% felt that the alcohol reduction element was badly very badly received.

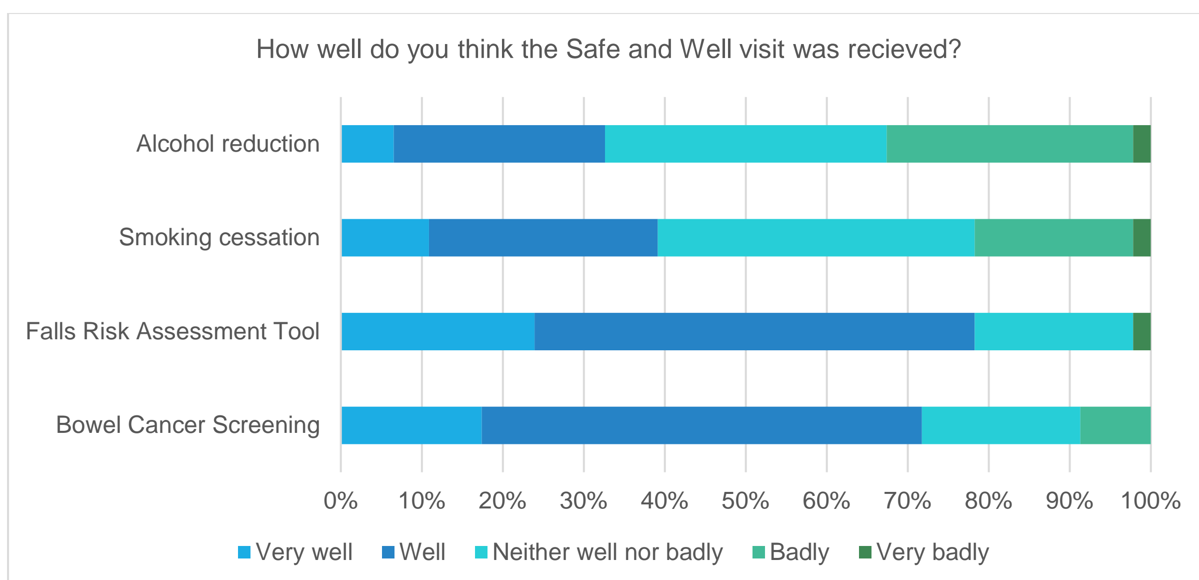


Figure 10. Views on how Safe & Well visits were received by householders

A third of respondents (16/48; 33.4%) reported that in their view that at least one element of was badly or very badly received. By job role, 75.0% were firefighters. Comments provided on how well they felt different elements were received by householders included:

> *"Most people are aware of the bowel cancer screening program and its benefits, even if they are embarrassed to mention it. They are confused by the falls risk section, and insulted by the alcohol section. Smokers don't care." (Firefighter, more than 100 Safe & Well visits)*

Among those with a more positive view of how the different elements had been received, comments included:

> *"Depends on the person you are delivering it to, some people find it as poking our nose in the business other people don't mind so much, I've not come across anyone that hasn't got no issue with it." (Firefighter, 10-50 Safe & Well visits)*

> *"They are being received very well and I have had comments that it is a great idea for fire service and health teams to be working together." (Advocate, more than 100 Safe & Well visits)*

Specific comments made in relation to how the alcohol reduction element of the visit was received included:

> *"People do not appear to like being asked about their alcohol intake despite explaining it is of benefit to them." (Advocate, 51-100 Safe & Well visits)*

> *"The alcohol section is hard to approach with householders as they feel like you are implying they are an alcoholic. When you explain the reasons they still feel like the alcohol that they drink is not an issue. It's a hard sell especially when the threshold is very low. Some of the advocates feel a little hypocritical when they have reached the threshold themselves." (Advocate, 51-100 Safe & Well visits)*

Perceptions of the effectiveness of Safe & Well visits

Respondents to the staff survey were asked to rate on a scale of 1 to 5, how effective they thought the Safe & Well visits were (with 5 being very effective, and 1 being not effective at all). Over half of respondents (51.0%) rated the Safe & Well visits a '4' (Figure 11).

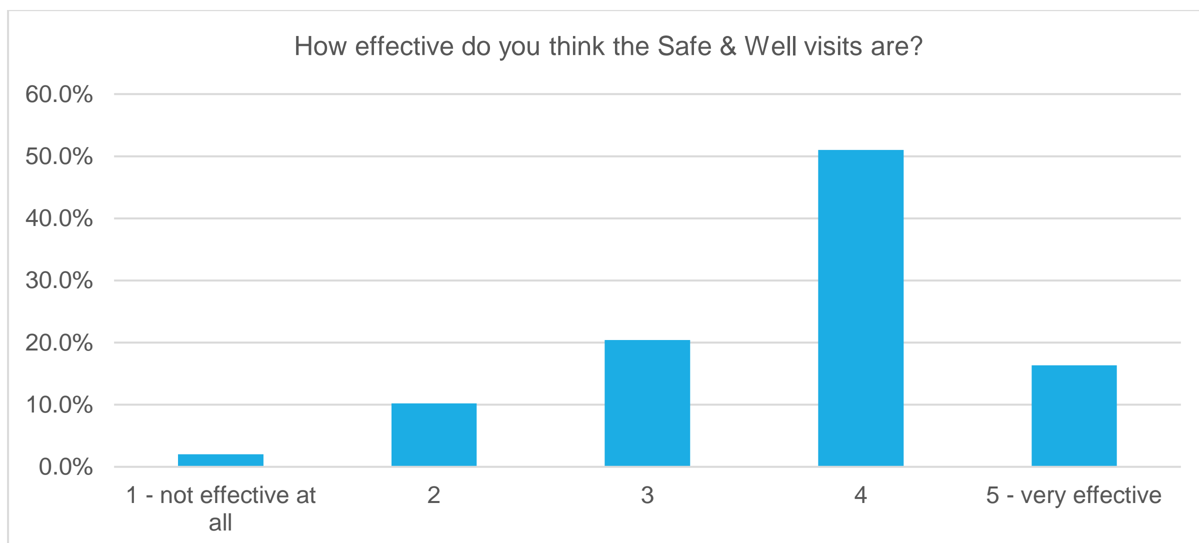


Figure 11. Staff views on effectiveness of Safe & Well visits

4.5.2 Householder experiences of Safe & Well visits

General views of the Safe & Well visit

Of the 75 householder survey respondents, just under half (45.3%) had heard of the FRS Safe & Well visits before they were visited and three-quarters (74.7%) thought the visits were a good idea. Open question responses indicated that respondents may not have realised there would be a health aspect to the visit. Some respondents were taken by surprise at people from the fire service asking them health questions. On reflection after the visit, most considered it an appropriate activity for the fire service and a good use of resources.

'I think it's like that Tesco sign isn't it, 'every little helps'…. if they're coming around with them smoke detectors or whatever the case, I think it's a reasonable idea yeah'

Alan aged 66 from Kirkby

> *"I was not aware beforehand that health questions would be asked. I feel this is beneficial with our ageing population. I am nearly 84". (Postal survey respondent)*

The majority of survey respondents (80.0%) agreed or strongly agreed that the visits were a good use of the FRS (Figure 12). More than half of respondents agreed that the visits would help people stay healthy (65.3%) and that the visits would help to detect health problems (60.0%). Around half of respondents (52.0%) agreed or strongly agreed with the statement that they would be more likely to accept a referral to a health service because of their visit. More than two-thirds (69.3%) agreed that it was helpful to be visited in their own home and that the visit is a good way to promote health (68.0%). Some of the case study interviews demonstrated that householders thought the visits could help to improve the quality of life of certain vulnerable groups of people, such as those who are hard of hearing, by identifying and addressing on their particular home safety needs. The potential for improving the quality of life of those who are socially isolated and otherwise vulnerable was also recognised, with an opportunity to refer people on to the appropriate services.

Q:'and do you think it would help to detect health problems for some people?'
'yes for some people, you know say somebody living on their own who maybe had no family ….. maybe would it be a good idea for them – well it might be too much – I was going to say for them to get in touch with the doctor for the person who's lonely, would they get in touch with any services, you know would they pass it on? ... or if they go to the home and it's not warm enough they could pass that on to whatever services would deal with things like that'

Doreen aged 71 from Everton

One survey respondent made a comment that indicated how people's positive attitudes towards the fire service may make them more likely to be able to reach some groups of people:

> *"I think if a person is living alone with no support etc. but they feel comfortable about the Fire Service, this may be a useful scheme" (Postal survey respondent).*

The impact of the recession and budget cuts was touched on by some, making preventive approaches such as those used in these visits all the more important. At the end of the householder survey, respondents were invited to add further comments. Several (n=25) respondents provided further comments, which were mostly positive (84%, 21/25).

'it's a great thing, because social services are stretched to the limit and if someone can sort of pinpoint a problem before a problem occurs, it gives people time to do something about it. It depends on the approach actually – you know if you get someone who's a bit bossy or that kind of thing – but these ladies were very nice'

Harry aged 80 from Sandbach

Positive comments included:

"Makes us feel at ease and very grateful that it is taking place. Helps with early prevention." (Postal survey respondent).

"Very useful to be visited in own home for lonely people who may not be aware of all the services offered, especially the health benefits". (Postal survey respondent).

The small number of negative comments included:

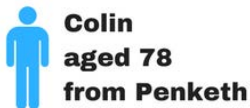
"A total waste of money and very intrusive". (Postal survey respondent).

"Not good use for the Fire and Rescue resources. Two ladies (probably on £20,000 p.a., total £40,000). Surely better use could be made of this money! Why are NHS giving my details to Fire Brigade" (Postal survey respondent)

Fire safety focus

The survey responses and case study interviews showed that respondents often saw the focus or purpose of the visit as relating to fire safety and smoke alarms rather than health.

'it was an excellent service – I was gobsmacked when they came – and he wouldn't go before he took my chip pan'



"I was happy to answer the questions. The lady & man who came were very nice and made me feel comfortable and helped me to remember to be safety conscious" (Postal survey respondent).

The health and wellbeing assessment part of the visit was often interpreted in terms of fire safety, for example, when asked about the smoking assessment, one the case study participants talked about the dangers of e-cigarette chargers bursting into flames and in the survey, one respondent said they declined the assessment because *"I only smoke outside"*. However, comments suggested that people could see that fire safety, safety in the home and health are all linked. The offer of a free smoke alarm was seen as a good way to win people's trust and encourage them to be involved in the health assessment part of the visit.

Q: 'the questions about alcohol, smoking and falls – do you think that's okay for fire officers to be asking that sort of thing?' *'yes, because they're just about your safety in the home aren't they?'*

Concerns

Householders were asked if they had any concerns about their visit, prior to receiving it. Respondents were asked to tick whether any of three options applied to them: 'privacy/confidentiality', 'talking to a stranger about my health', 'finding out there might be a problem with my health'. Twelve respondents (16.0%) had concerns about privacy/confidentiality; four respondents (5.0%) had concerns about talking to a stranger about their health; and two respondents (2.7%) were worried about finding a problem with their health. Respondents could also state reasons for any 'other concerns' they may have had beforehand. One respondent added a comment that embarrassment was a concern and another noted that they were not aware of the health aspect of the visit. Most comments added to this question were positive, but there was one negative comment.

"Two female strangers turn up at my door asking personal questions about my house and health" (Postal survey respondent).

For the close-ended questions, there was no significant difference between respondents from Merseyside and Cheshire regarding whether they had concerns before the visit (20.0% vs. 24.2%). Any concerns respondents held before their visit appear to have been short-lived, with only a small minority agreeing or strongly agreeing that they found the questions intrusive (n=6) or that the visit left them worried (n=3). None of the case study interviewees felt that embarrassment was a problem for them, not even around the topic of bowel cancer screening, although some thought it might be a problem for other people. Several made the point that people may feel less embarrassed once they get to a certain age.

'well I was surprised to be honest with you. I think it could be embarrassing for the firemen, I really do, because I don't think they're in a position, you know, they haven't spent years studying health like nurses and doctors etcetera. It's like sending a soldier in – when I done first aid training and stuff like that and how to stitch a person up and stuff but I wouldn't dream of telling anyone about their health and stuff like that......I think perhaps the people who came might have been, well, a little bit reticent, you know, discussing bowel things..... if people are going to fire questions back at them, that's where a problem might lie because they might not be that knowledgeable, but apart from that , I mean, I thought they done very well'

Alan aged 66 from Kirkby

Embarrassment was seen as a potential barrier to preventing and dealing with health problems in younger people. One case study participant suggested that if anyone was embarrassed, it was probably the fire service people, possibly because they may feel out of their depth, with a lack of knowledge of health matters.

Home visits

More than two-thirds of survey respondents (69.3%) agreed that it was helpful to be visited in their own home. In the case study interviews, one participant commented that being visited at home helped to put people at ease and another thought that home visits were a good way of reaching people.

Attributes of the personnel undertaking the Safe & Well visit

It was apparent that interviewees held the fire service in high esteem, which helped the fire service gain the trust of people they were visiting. There were compliments from both survey respondents and case study participants on the natural, friendly, yet professional approach of the fire service staff, and on their knowledge.

'it was exceptional, outstanding – and whoever that gentleman was, he was very good..... but you get frightened, because they're losing fire (officers) and everything aren't they?'

Freda aged 72 from Netherton

"The interview was conducted very professionally. Comforting to know someone cares, especially for elderly people living alone and of course fire alarms for free" (Postal survey respondent).

"Good informative information from the team. I didn't find anything intrusive. I thought they handled subjects very well in a friendly manner. A good experience" (Postal survey respondent).

Although as mentioned above, one case study participant did make the point that a lack of in-depth knowledge could be a cause of embarrassment for fire service staff if they were to face further questions.

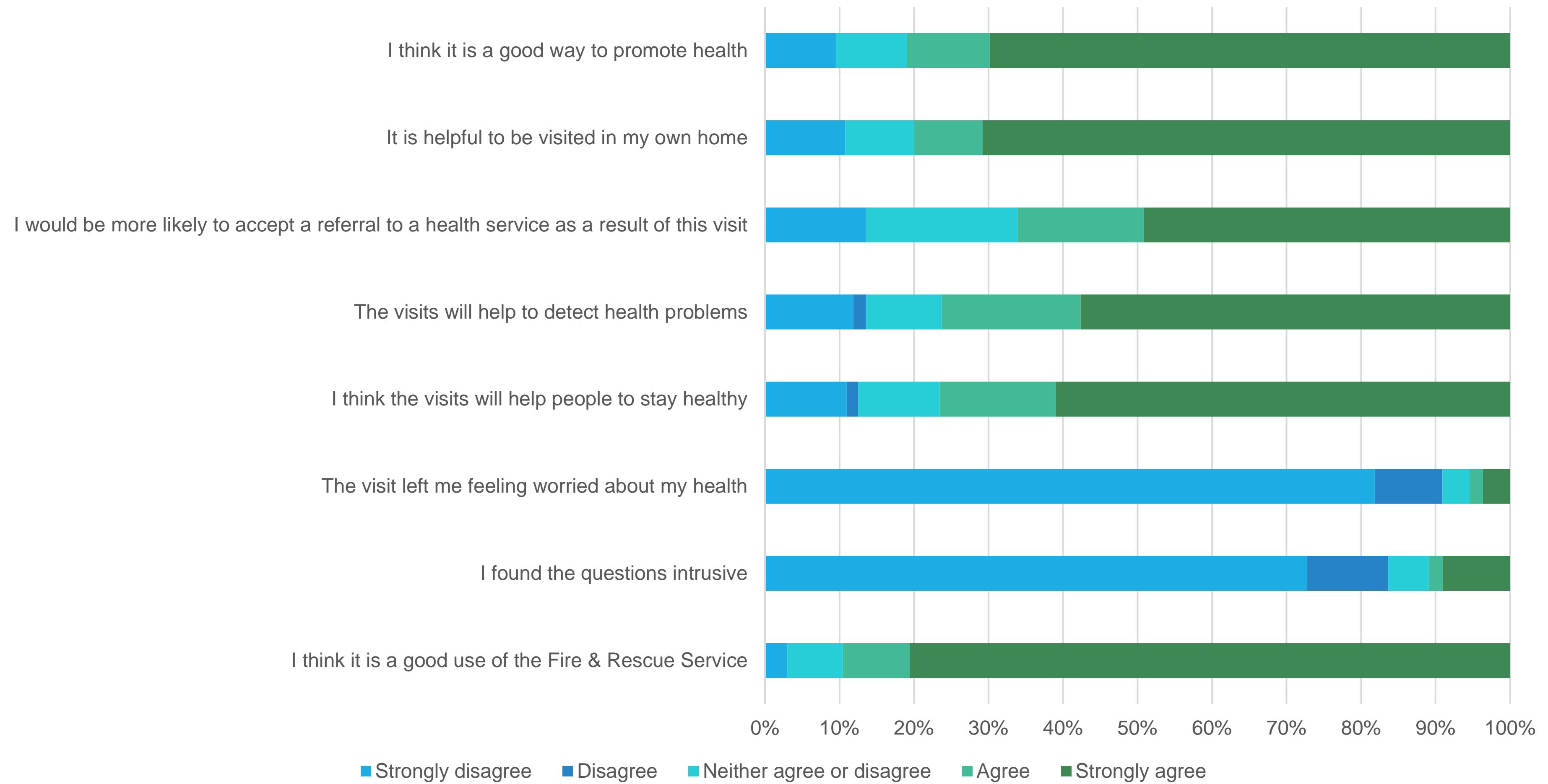


Figure 12. Householder general views on the Safe & Well visit

4.5.3 Wider stakeholder experiences of the delivery and design of Safe & Well visits

Across the organisations represented in the wider stakeholder survey (Appendix 3c), all but one of the 43 respondents reported that they were aware of the FRS Safe & Well initiative. Twenty-four respondents reported that their organisation had supported the delivery and/or design of the Safe & Well initiative; this included 13 CCGs, six local authorities, two third sector organisations and one service provider. Nineteen respondents reported that their organisation received referrals from the Safe & Well initiative. This included two representatives from CCGs, seven local authority, one NHS trust, Cheshire Police, two representative of the National Bowel Cancer Screening Programme and six service providers.

Respondents were asked to provide open ended responses to the question "What has been your experience of delivering a service to people who have been referred via Safe & Well?" and were asked to provide comments on how effective they thought the initiative was in providing advice and support, in addition to ticking boxes on a sliding scale (Figure 13). Four respondents that reported a low number of referrals did not comment further on their experiences of delivery. Six respondents representing local authorities and service providers provided positive comments about their experiences of delivery:

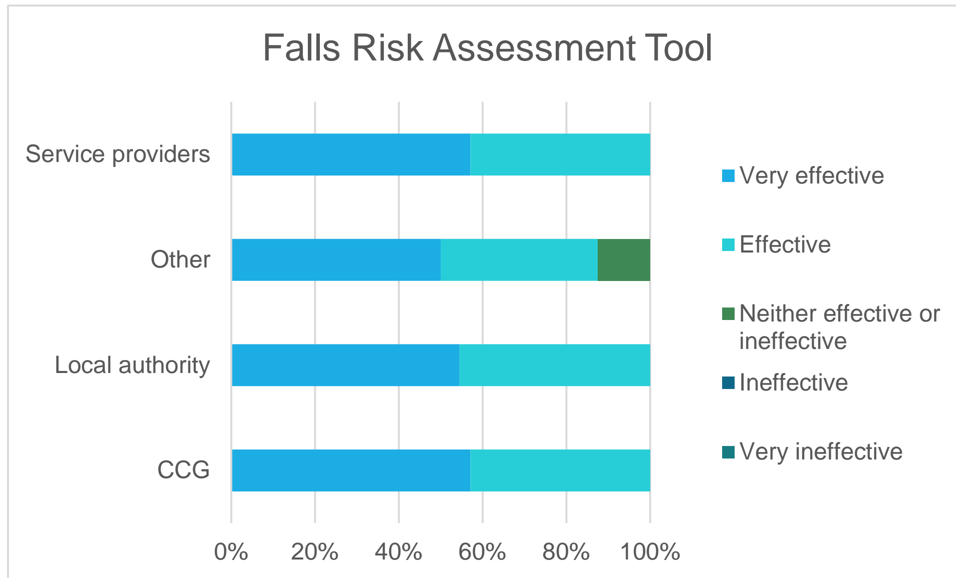
> *"This has been excellent…" (Local authority, Merseyside)*
>
> *"Really pleased as identifying people not previously known to services." (Local authority, Cheshire)*
>
> *"Very good have engaged well with support." (Service provider)*
>
> *"It has been great to be a partner in this project." (Service provider)*

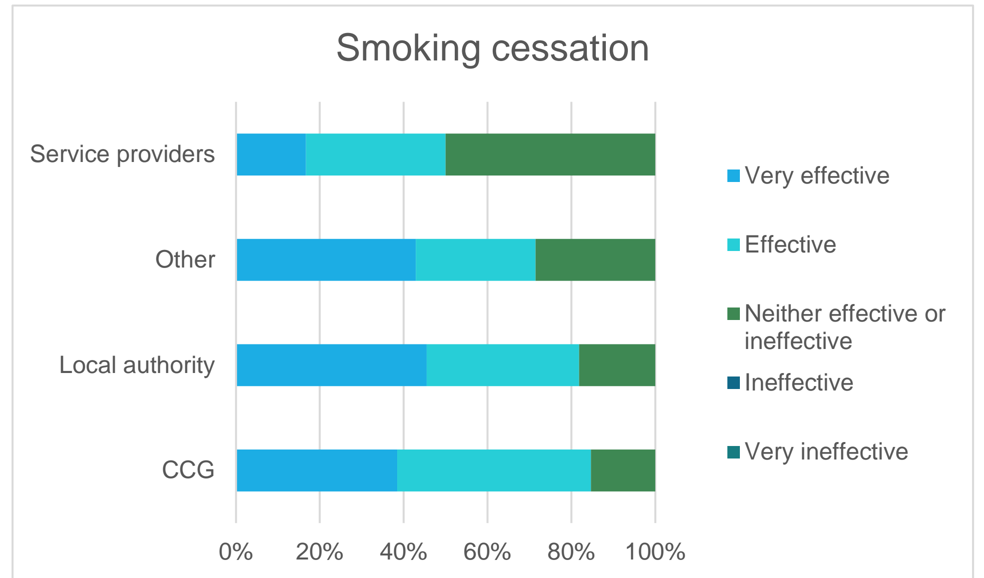
Respondents also provided generally positive comments on how effectively they thought the Safe & Well visits were providing health and wellbeing advice:

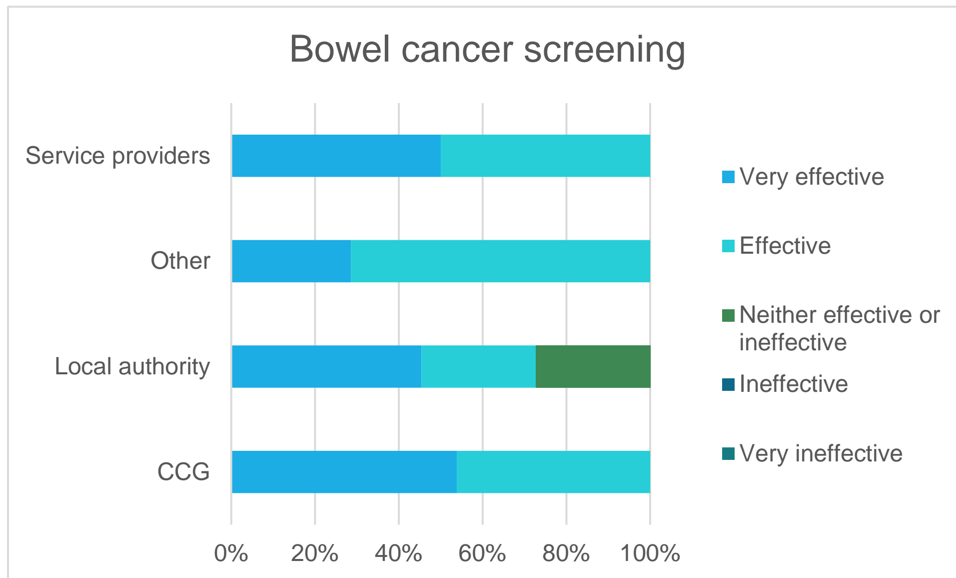
> *…I think there is a limit to what can be achieved in a single visit but any referrals received or awareness raised is very positive" (Local authority, Cheshire)*
>
> *"It is a great idea to bring this sort of advice and information directly to people that need it the most. It is one of the major challenges that we have in engaging with people on their terms." (Service provider)*

Respondents were also very positive about the partnership aspect of the work:

> *"I think the initiative is a brilliant example of how local organisations can work together to help members of the community…" (Local authority, Cheshire)*
>
> *"Partnership working at its best" (CCG, Cheshire)*
>
> *"Really pleased that this is a real example of Making Every Contact Count, and such investment of time and resource by F&R as a partner organisation." (Local authority, Cheshire)*







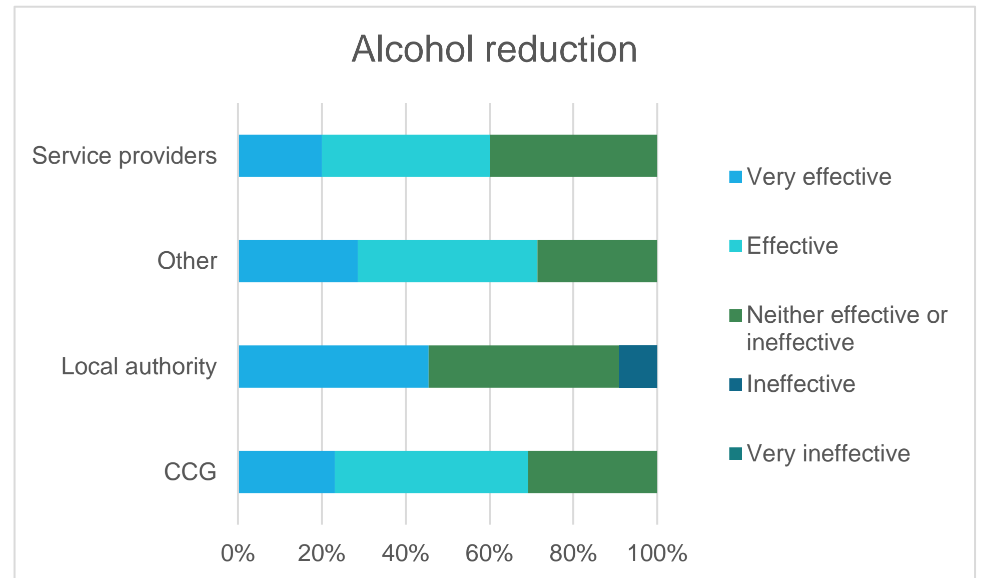


Figure 13. Wider stakeholder views on how effective Safe and Well visits could be across the four elements

5 REACH & OUTCOMES OF THE SAFE & WELL VISITS

5.1 WHAT WAS THE REACH OF THE SAFE & WELL VISITS?

5.1.1 Households identified for a Safe & Well visit

Cheshire

Between February 2017 and January 2018, Cheshire FRS identified 35,869 households for a Safe & Well visit (Table 2). Household visits are scheduled to begin at the start of the financial year, with the top 10,000 'platinum' households prioritised for a Safe & Well visit. The data reflect this, showing an increasing number of households identified for a visit through March to May 2017 (n=3,590, 10.0%). By local authority area, 38.9% of households were in Cheshire West and Chester (n=13,946 households), 35.7% were in Cheshire East (n=12,815 households), 10.0% were in Halton (n=3,595 households) and 15.4% were in Warrington (n=5,513 households). By level of deprivation (based on 2001 Carstairs scores[4]), over half of all households identified for a Safe & Well visit by Cheshire FRS (n=18,461, 52.0%) were in the least deprived quintile of areas in England.

Merseyside

Between May 2017 and January 2018, Merseyside FRS identified 6,756 households for a Safe & Well visit (Table 2). During the reporting period, the number of households identified by month remained steady. In the first month of the reporting period (May 2017), 629 (9.3%) households were identified for a visit, and around 800 households were identified each month until an increase in November 2017 (n=958, 14.2%), followed by a tailing off in visits towards the end of 2017 and throughout January 2018 (n=382, 5.7%). By local authority area, a third of households were in Liverpool (n=2,267, 33.6%). The proportion of visits across the other local authority areas were 21.1% for the Wirral (n=1,424 households), 19.9% for Sefton (n=1,344 households), 13.1% for St Helens (n=884 households), and 12.4% for Knowsley (n=837 households). By level of deprivation (based on 2001 Carstairs scores[3]), almost half of the households identified for a Safe & Well visit by Merseyside FRS (n=3,296, 48.8%) were in the most deprived quintile of areas in England.

Table 2. Profile of households identified for Safe & Well visits

	Cheshire		Merseyside	
	n	**%**	**n**	**%**
Total	35,869	100.0	6,756	100.0
Month of visit				
Feb-17	2,349	6.5	-	-
Mar-17	2,175	6.1	-	-
Apr-17	2,790	7.8	-	-
May-17	3,590	10.0	629	9.3
Jun-17	3,314	9.2	812	12.0
Jul-17	2,976	8.3	839	12.4
Aug-17	3,501	9.8	816	12.1
Sep-17	2,991	8.3	804	11.9
Oct-17	3,170	8.8	838	12.4
Nov-17	2,953	8.2	958	14.2
Dec-17	2,328	6.5	678	10.0
Jan-18	3,732	10.4	382	5.7

[4] *www.ons.gov.uk/ons/rel/hsq/health-statistics-quarterly/no--31--autumn-2006/measuring-deprivation-in-england-and-wales-using-2001-carstairs-scores.pdf*

Local authority area				
Cheshire East	12,815	35.7	-	-
Cheshire West and Chester	13,946	38.9	-	-
Warrington	5,513	15.4	-	-
Halton	3,595	10.0	-	-
St Helens	-	-	884	13.1
Knowsley	-	-	837	12.4
Liverpool	-	-	2,267	33.6
Sefton	-	-	1,344	19.9
Wirral	-	-	1,424	21.1
Deprivation quintile*				
1 - least deprived	18,461	52.0	111	1.6
2	429	1.2	756	11.2
3	14,269	39.8	1,306	19.3
4	428	1.2	1,287	19.0
5 - most deprived	2,012	5.9	3,296	48.8

*Based on 2001 Carstairs scores

5.1.2 Participation in Safe & Well assessments

Cheshire

In 8,756 households (24.4%), all householders declined the opportunity to proceed with the health and wellbeing elements of the Safe & Well visit; giving 27,113 households (75.3%) where at least one householder participated. Across these households, 33,383 householders gave consent to participate in the health and wellbeing elements of the visit (n=20,850 householder 1; n=6,256 householder 2; n=7 householder 3). The proportion of households refusing to participate differed significantly by month of visit, local authority area and deprivation quintile (all Pearson chi-square $p<0.001$). The proportion of households declining participation was highest through September to January, among households in Halton (35.2%), and among households in deprivation quintile 2 (30.1%) and deprivation quintile 5 (32.3%) (Table 3).

Table 3. Cheshire households consenting to and declining the health and wellbeing assessments

	Households			
	Consenting		Declining	
	n	%	n	%
Total	27,113	75.6	8,756	24.4
Month of visit				
Feb-17	1,714	73.0	635	27.0
Mar-17	1,683	77.4	492	22.6
Apr-17	2,139	76.7	651	23.3
May-17	2,803	78.1	787	21.9
Jun-17	2,596	78.3	718	21.7
Jul-17	2,338	78.6	638	21.4
Aug-17	2,674	76.4	827	23.6
Sep-17	2,169	72.5	822	27.5
Oct-17	2,355	74.3	815	25.7
Nov-17	2,150	72.8	803	27.2
Dec-17	1,706	73.3	622	26.7
Jan-18	2,786	74.7	946	25.3
Local authority				
Cheshire East	9,517	74.3	3,298	25.7
Cheshire West & Chester	11,112	79.7	2,834	20.3
Halton	2,330	64.8	1,265	35.2
Warrington	4,154	75.3	1,359	24.7
Deprivation quintile*				
1 – least deprived	14,599	78.3	4,042	21.7
2	300	69.9	129	30.1
3	10,460	73.3	3,809	26.7
4	331	77.3	97	22.7

5 – most deprived	1,423	67.7	679	32.3
*Based on 2001 Carstairs scores				

Merseyside

An estimated 1,640 households (24.3%) did not engage with any elements of the Safe & Well assessments, giving a total of 5,117 households (75.7%) that had engaged in at least one of the four Safe & Well assessments. The proportion of households not engaging with any element of the Safe & Well visit differed significantly by month of visit, local authority area and deprivation quintile (all Pearson chi-square p<0.001). The proportion of households declining all elements was highest in the first two months of delivery, among households in St Helens (30.0%), and among households in the most deprived quintile (28.5%) (Table 4).

Table 4. Merseyside households consenting to and declining the health and wellbeing assessments

	Households			
	Engaging in at least 1 element		**Declining all elements**	
Total	5,117	75.7	1,639	24.3
Month of visit				
May 17	401	63.8	228	36.2
Jun 17	597	73.5	215	26.5
Jul 17	634	75.6	205	24.4
Aug 17	609	74.6	207	25.4
Sep 17	627	78.0	177	22.0
Oct 17	633	75.5	205	24.5
Nov 17	762	79.5	196	20.5
Dec 17	554	81.7	124	18.3
Jan 18	300	78.5	82	21.5
Local authority				
Knowsley	632	75.5	205	24.5
Liverpool	1,687	74.4	580	25.6
Sefton	977	72.7	367	27.3
St Helens	619	70.0	265	30.0
Wirral	1,202	84.4	222	15.6
Deprivation quintile*				
1 – least deprived	96	86.5	15	13.5
2	630	83.3	126	16.7
3	1,062	81.3	244	18.7
4	972	75.5	315	24.5
5 – most deprived	2,357	71.5	939	28.5
*Based on 2001 Carstairs scores				

5.1.3 Householder survey

The demographics of the householders that responded to the survey are shown in Appendix 2. The majority of respondents were aged 70 and over (66.7% vs. 28.0%) and more respondents were from Merseyside than Cheshire (54.7% vs. 45.3%). By level of deprivation, around two-thirds of householders who responded to the survey were in quintile 3 (66.7%) and a third (30.7%) were in quintile 1, the least deprived quintile.

Comparing residents according to the whether they lived in Merseyside and Cheshire, there was no statistically significant difference in the proportion of householders who reported that they had declined the assessments for bowel cancer screening (36.6% vs. 36.4%), falls (17.1% vs. 12.1%) or smoking (70.7% vs. 54.5%) (Figure 14). Significantly more respondents from Merseyside reported that they had declined the assessment of their alcohol use (56.1% vs. 27.3%; Fisher's Exact Test p=0.018).

In a comparison of respondents categorised as residing in deprivation quintiles 1 and 3, there was no significant difference in the proportion of householders who reported that they had declined the assessments for bowel cancer screening (30.4% vs. 40.0%), falls (8.7% vs. 18.0%) or smoking

(52.2% vs. 70.0%). Significantly fewer respondents residing in deprivation quintile 1 reported that they had declined the assessment of their alcohol use compared to those residing in deprivation quintile 3 (21.7% vs. 54.0%; Fisher's Exact Test p=0.012).

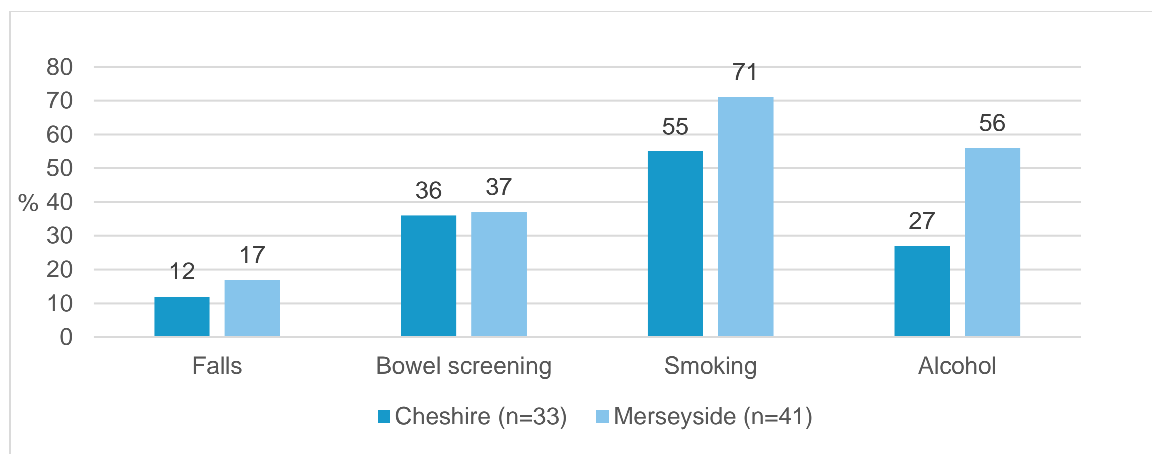


Figure 14. Percentage of household survey respondents who declined Safe & Well assessments

The reason given for declining assessments was explored (Table 5). In Cheshire, among householders that gave a reason, a large proportion of those declining assessments reported doing so because they already carried out the activity (in the case of bowel cancer screening) or because they didn't smoke or drink. A similar proportion of respondents from Merseyside reported this reason for declining assessment in the case of bowel cancer screening. In relation to the smoking assessment, one respondent from Merseyside stated that they had been *"smoking a long time and at my time of life it's the only pleasure I have"* and another declined because *'I only smoke outside'*. Two others said they were already receiving help to quit. In the case of bowel cancer screening there was an indication from a small number of householders that assessments were declined because of fear or embarrassment. In relation to the falls assessment, reasons given by a small number of respondents included that they did not consider the assessment necessary or that they were already receiving support.

Table 5. Numbers and reasons for declining assessments among responders to the household survey

	Cheshire	Merseyside	Total*
Total	33	41	75
Falls assessment			
Declined	4	7	11
Bowel cancer screening			
Declined	12	15	27
Reason given 'already do'	*9*	*10*	*19*
% of declined	*75%*	*67%*	*70%*
Smoking cessation			
Declined	18	29	47
Reason given 'don't smoke'	*17*	*18*	*36*
% of declined	*94%*	*62%*	*75%*
Alcohol reduction			
Declined	9	23	32
Reason given 'don't drink or hardly drink'	*7*	*11*	*18*
% of declined	*78%*	*48%*	*56%*
NB: Some respondents gave no reason *Total column Includes an additional respondent who did not provide a postcode			

Bowel cancer screening assessment

In the household survey, general comments about the bowel cancer screening element of the visit were positive overall, with many stating they had already been screened. Other comments were mixed, including:

> *"[I] did find it strange that the fire service were involved in this" (Postal survey respondent)*

> *"I always complete the kits when sent by NHS screening service. Why did I have two females from the Fire Brigade ask me about this?" (Postal survey respondent)*

In the householder cases study interviews, one participant noted that the visit might prompt people to use the bowel cancer screening kit, when they might otherwise ignore it. If not for the visit, two of the case study participants would not have had the kit and returned it, as they are over the age limit of 74 for routine screening. In the householder survey, nine respondents aged 75 and over reported that they accepted the offer of a bowel cancer screening kit.

Falls risk assessment

Most of the respondents to the survey did not report any obvious changes or improvements relating to their health because of their Safe & Well visit. However, it would appear that the visits helped to raise people's awareness of health matters and for some may prompt them into action. For example, for one of the case study participants ('Bob'), the visit had encouraged him to think more seriously about preventing falls by making his bathroom safer.

Of the survey respondents, eight reported that they had been offered a referral to a local falls team as a result of the Safe & Well visit. Six of the eight respondents offered the referral declined, reasons given included that they *"did not need"* the referral or that they already had *"other support"*.

'funnily enough we were in the middle of thinking of taking the bath out and having a walk-in shower instead…. that was possibly my biggest worry beforehand'
Q: 'so that was something you thought of yourself, it wasn't as a result of the visit?'
'er well it probably made us think a bit more about it'

Bob aged 77 from Cheshire East border

Alcohol reduction assessment

In the householder survey, open question responses around the alcohol assessment indicated that some found the assessment informative:

> *"I was shocked a few drinks were a risk but learned a lot from the fire officer". (Postal survey respondent)*

For one case study participant ('Freda'), the visit made her re-assess her drinking habits. There may have potentially been a missed intervention opportunity in another participant's visit, as although they did not think they were at any risk relating to their alcohol use, in the case study interview they shared that they regularly drove after drinking 2 pints of bitter.

'when he left, I thought oh my god, I've never been questioned about having a drink, but I don't go over the top – but it made me think, so that if I was a heavy drinker, he's doing a good job...... (it's not made me change) what I do but it's made me very aware of things – I mean I think I'm a little bit sensible, because you've got to when you're on your own – but, even about having a drink, he made me think – I'd never sat and thought about it, but he made me think. I mean my husband looking down, I would never have drank like that, I would never have had a drink every day! ……I speak to a lot of people every day, and after he'd gone, I sat and thought god, I didn't realise different things he pointed out to me – he was just lovely'.

Freda aged 72 from Netherton

5.2 Pathways to impact

5.2.1 Bowel cancer screening

Cheshire

For Cheshire, whether householders had previously received and returned a gFOBt kit was reported as one data item. Of those participating in the bowel cancer screening element, 94.6% of householders (n=26,577/28,106) reported that they had previously received and returned a gFOBt kit. 8.4% of householders (n=2,351/28,106) accepted the offer of a request for a gFOBt kit. Of householders accepting the offer of a request for a gFOBt kit, 57.8% (n=1,360/2,351) reported that they had not previously received and returned a gFOBt kit (termed a 'new request').

Examining findings at the household level, 60.6% of households (n=21,752/35,869) included at least one householder who reported that they had previously received and returned a gFOBt kit. 3.3% of households identified for a Safe & Well visit (n=1,168/35,869) generated a 'new' request for a gFOBt kit. The profile of households generating 'new' requests did not differ by local authority area, but 'new' gFOBt kit requests were highest among households in deprivation quintile 4 (9.4% households) and lowest among households in deprivation quintile 5 (4.1% of households). Based on householder 1, mean age of households generating a 'new' gFOBt kit request was 77.2 years (SD 7.3).

Of the data available for type of kit requested[5] (n=1,230), 96.6% (n=1,188) were for the 'Bowel Cancer Screening: The Facts – English (standard kit)'. Smaller proportions of other kits were also requested, this included 'Bowel Cancer Screening: The Facts – English (Large print)' (n=33, 2.7%), 'An Easy Guide to Bowel Cancer Screening – English' (n=6, 0.5%), and 'Bowel Cancer Screening: The Facts – Audio kit' (n=3, 0.2%).

Merseyside

Of the householders who participated in the bowel cancer screening assessment, 54.5% of householders (n=2,510/4,604) reported that they had previously received a gFOBt kit and 78.0% of these (n=1,957/2,510) reported that they had returned the kit. 29.8% of householders (n=1,372/4,604) accepted the offer of a request for a gFOBt kit. Of householders accepting the offer of a request for a gFOBt kit, 83.5% (n=1,146/1,372) had not previously returned a gFOBt kit (termed a 'new request').

Examining requests by household, 55.4% of households (n=1,962/6,756) had previously received a gFOBt kit and 22.7% of households (n=1,534/6,756) included at least one householder who reported that they have received and returned a gFOBt kit. 14.4% of households targeted for a Safe & Well visit (n=970/6,756) generated a 'new request' for a gFOBt kit. The profile of households generating 'new requests' differed significantly by local authority and level of deprivation. By local authority area, 'new requests' were more likely among households in Wirral (18.8%) and least likely among households in St Helens (10.9%). By level of deprivation, 31.5% of households in the least deprived quintile (1) generated a 'new request' compared to 11.7% in the most deprived quintile (5). Based on householder 1, mean age of households generating a 'new' gFOBt kit request was 79.3 years (SD 9.0).

Of the data available for type of gFOBt kit requested (n=1,329[6]), 96.3% (n=1,280) were for the 'Bowel Cancer Screening: The Facts – English (standard kit)'. Smaller proportions of other kits were

[5] *Details of the type of kits ordered is missing for 1,121 householders;*

[6] *Details of the kits ordered is missing for 42 householders.*

also requested, this included 'Bowel Cancer Screening: The Facts – English (Large print)' (n=34, 2.7%), 'An Easy Guide to Bowel Cancer Screening – English' (n=11, 0.8%), 'Bowel Cancer Screening: The Facts – Audio kit' (n=1, 0.1%) and 'Bowel Cancer Screening: The Facts – Chinese' (n=3, 0.2%).

5.2.2 Falls prevention

Cheshire

All households who provided consent to particpate in the health and wellbeing elements of the Safe & Well visit completed the falls checklist. Of the individual householders who participated in the assessment, 10.6% (n=3,226) had a history of falls in the last year, 21.4% (n=6,505) were prescribed four plus medications, 1.0% (n=303) had a diagnosis of stroke, Parkinson's disease or dementia, 9.4% (n=2,859) reported problems with their balance, and 3.1% (n=928) were unable to rise from a chair of knee height.

12.2% of households (n=3,303/27,112) included at least one householder who answered 'yes' to two or more statements on the FRAT and 5.3% of households (n=1,439/27,112) included at least one householder who answered 'yes' to three or more statements (Figure 15). The profile of these households differed significantly by local authority, with the highest proportion of households scoring three or more on the FRAT falling within Halton (7.9%) and Warrington (7.8%) (Pearson chi-square $p<0.001$). Households in the most deprived quintiles were more likely to include a householder who reached the FRAT threshold for a referral (i.e. a score of three or more); 7.3% of households in deprivation quintiles 4 and 5. Mean age according to householder 1, of the households with at least one householder who answered 'yes' to three or more statements on the FRAT was 71.6 years (SD 22.8).

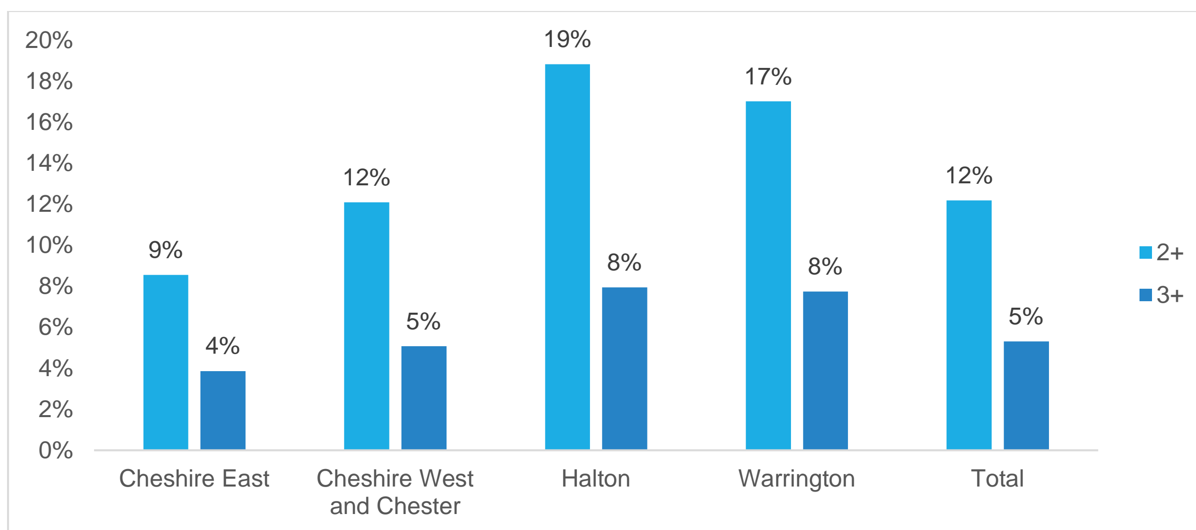


Figure 15. Proportion of Cheshire households scoring 2+/3+ on FRAT (by LA)

At the household level, 2.5% of households identified for a Safe & Well visit (n=682/27,112) included at least one householder who gave their consent for referral to a falls prevention service. The profile of households who consented to referral differed significantly by local authority and quintile of deprivation (both Pearson chi-square $p<0.001$). Households in Halton (4.3%) and deprivation quintile 4 (4.8%) had the highest proportion of households consenting to referral and households in Cheshire East (1.9%) and deprivation quintile 2 (0.7%) had the lowest. Mean age according to householder 1, of the households with at least one householder who consented to referral was 70.8 years (SD 24.1). Focusing on the 1,439 households that included at least one

householder with a FRAT score of three or more, 40.6% of these households accepted a referral (n=584). There was no statistically significant difference in acceptance of referral by area or by quintile of deprivation.

Merseyside

A third of the householders participating in a falls assessment (33.7%: n=1,776) had a history of falls in the last year, over half were prescribed four plus medications (56.6%; n=2,983), 17.9% (n=944) had a diagnosis of stroke, Parkinson's disease or dementia. Over a third (37.3%; n=1,965) reported problems with their balance, and 16.8% (n=887) were unable to rise from a chair of knee height.

At the household level, 34.4% of households identified for a Safe & Well visit (n=2,321/6,756) included at least one householder who answered 'yes' to two or more statements on the FRAT and 20.9% (n=1,414/6,756) included at least one householder who answered 'yes' to three or more statements (Figure 16); 24.3% (n=1,639/6,756) of households included at least one householder at the threshold for referral[7]. The profile of householders with at least one householder who answered 'yes' to two/three or more statements on the FRAT, differed by local authority (Pearson chi-square p<0.001) and level of deprivation (Pearson chi-square p=0.01). Households in Knowsley (39.8%) and in deprivation quintile 4 (26.9%) had the highest proportion of householders over the FRAT threshold for a referral.

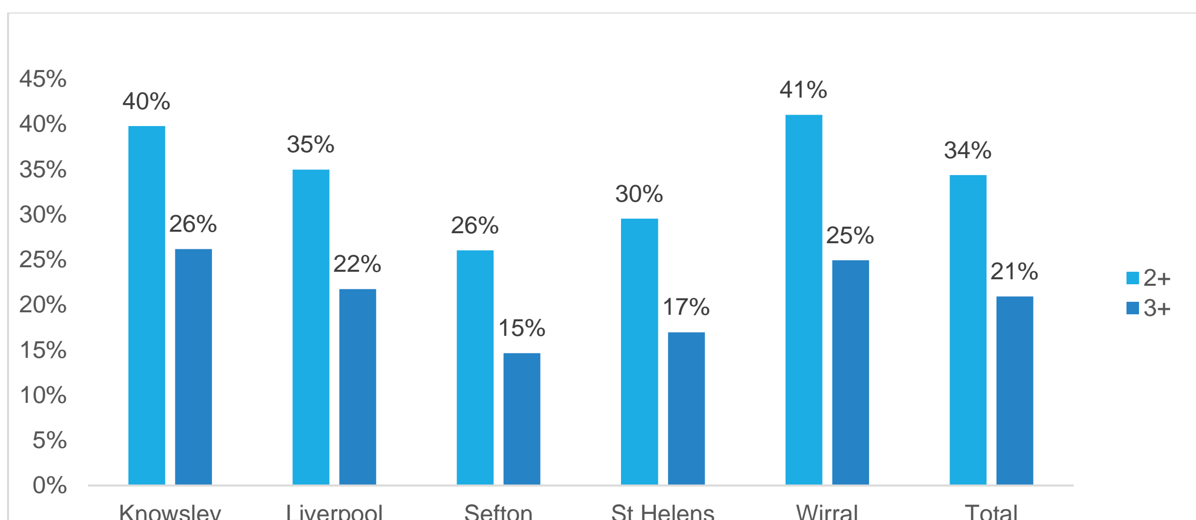


Figure 16. Proportion of Merseyside households scoring 2+/3+ on FRAT (by LA)

At the household level, 16.5% of households identified for a Safe & Well visit (n=1,116/6,756) included at least one householders identified for referral to the local falls team. The proportion of households recommended for referral differed by local authority and area level of deprivation (both Pearson chi-square p<0.001). The proportion of households recommended for referral was highest in St Helens (24.1%) and in deprivation quintile 4 (19.0%) and lowest in Sefton (11.2%) and deprivation quintile 5 (15.1%). Mean age according to householder 1, of the households with at least one householder who was recommended for referral was 77.9 years (SD 10.7). Focusing on the 1,639 households that included at least one householder with a FRAT score at the threshold for referral, 59.5% of these households accepted a referral (n=976). There was no statistically

[7] *Answering 'yes' to two or more questions triggered the offer of a referral for households in Knowsley and St Helens. In Liverpool, Wirral and Sefton, 'yes' to three or more questions was required.*

significant difference in acceptance by quintile of deprivation, but acceptance was highest in St Helens (Pearson Chi-square p<0.001).

5.2.3 Smoking cessation

Cheshire

There was at least one smoker in the household in 5.0% of households (n=1,807/35,869) who participated in a Safe & Well visit. In 4.8% of these households (n=86/1,807), at least one householder gave their consent for referral for Smoking Cessation advice. Consent for referral differed significantly by local authority but not according to level of deprivation. Consent was highest among households in Warrington (8.5%) and lowest among households in Halton (1.2%). Rates of consent were highest between April and August corresponding with efforts to target individuals at highest risk of fire. Based on householder 1 age, the mean age of households with at least one householder consenting to a referral was 77.6 years (SD 10.8).

Merseyside

At least one householder in 29.0% of households (n=1,957/6,756) had information recorded about their engagement in the smoking element of the Safe & Well visit. Of these households, 14.0% (n=274/1,957) included at least one householder who declined a discussion about their smoking, 73.9% consented to the MECC ('Making Every Contact Count') conversation (n=1,447/1,957), and 13.7% (269/1,957) consented to a referral to their local stop smoking service.

As a proportion of all households visited, 21.4% (n=1,447/6,756) included at least one householder who received a MECC conversation relating to their smoking. The proportion of households in which at least one householder received a MECC conversation about their smoking differed significantly by quintile of deprivation (Pearson Chi-square <0.001; Figure 17) and by local authority (Pearson Chi-square <0.001; Figure 18).

As a proportion of households with information recorded about their engagement in the smoking element, the profile of households who consented to receive a referral did not differ significantly by quintile of deprivation (11.8% in the least deprived quintile compared to 14.6% in the most deprived quintile), or by local authority; consent was highest among households in St Helens (16.8%) and lowest in Knowsley (11.5%). Based on the age of householder 1, the mean age of households consenting to receive a referral to their local stop smoking service was 58.9 years (SD 16.7).

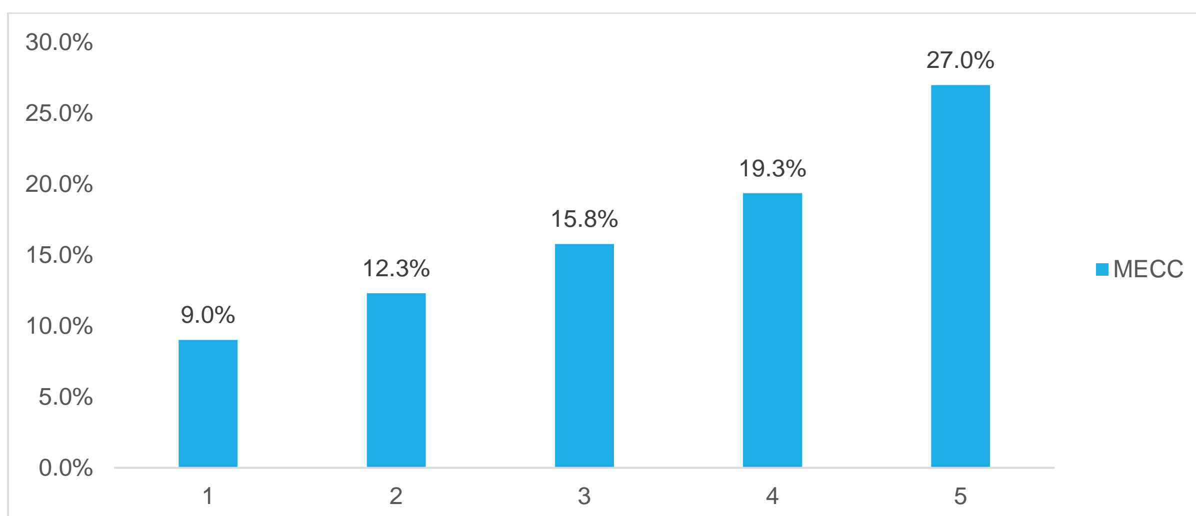


Figure 17. Proportion of Merseyside households receiving information about their smoking – by quintile of deprivation (1 – least deprived, 5 – most deprived)

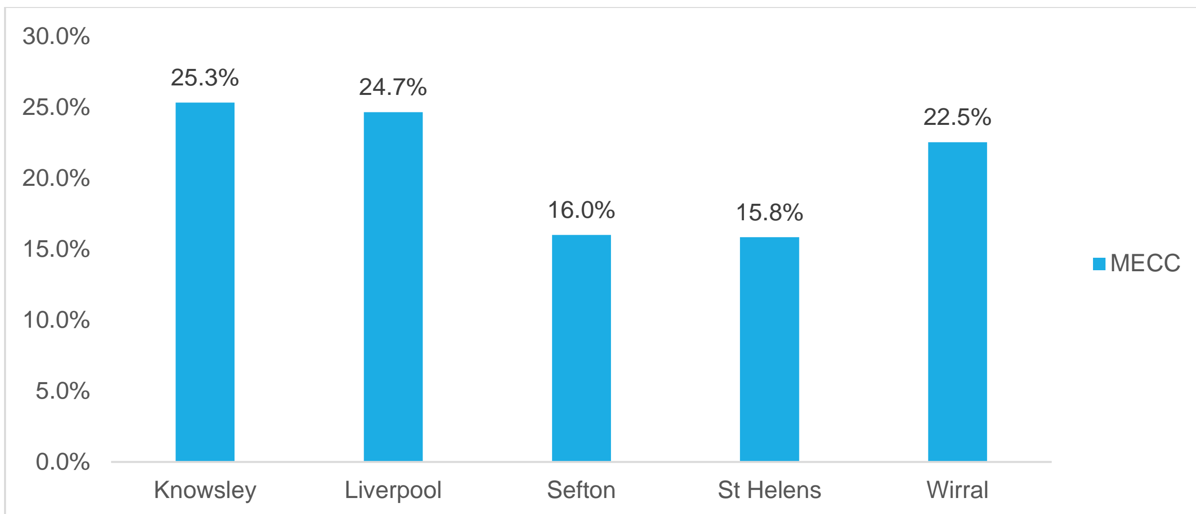


Figure 18. Proportion of Merseyside households receiving information about their smoking – by local authority

5.2.4 Alcohol reduction

Cheshire

At least one householder in 34.0% of households (n=12,211/35,869 households) engaged in a discussion about their alcohol use. Participation in this element of the Safe & Well visit was lowest among households in Warrington (20.4%) and in deprivation quintile 2 (23.1%) and highest among households in Halton (40.8%) and deprivation quintile 1 (35.6%). Of the households where at least one householder engaged in a discussion about alcohol, 0.10% of households (n=10/12,211) gave consent for referral to the Alcohol Harm Reduction Team. Given the small number of referrals, a mean age was not calculated, and there was no significant difference in the profile of households consenting to referral by local authority or deprivation quintile.

Merseyside

At least one householder in 31.7% of households (n=2,145/6,756) had information recorded about their engagement in the alcohol element of the Safe & Well visit. At least one householder in 12.2% of these households (n=261/2,145) declined a discussion about their alcohol use (i.e. completion of the AUDIT C tool), 84.7% engaged in a discussion about their alcohol use and received BIA (brief intervention and advice), and 3.3% of households (n=71/2,145) consented to a referral to their local alcohol reduction service.

As a proportion of all households visited, 26.9% (n=1,817/6,756) included at least one householder who received BIA relating to their alcohol use. The proportion of households in which at least one householder received BIA differed significantly by quintile of deprivation (Pearson Chi-square <0.001; Figure 19) and by local authority (Pearson Chi-square <0.001; Figure 20).

As a proportion of households with information recorded about their engagement in the alcohol element, the profile of households agreeing to the provision of a referral differed significantly by local authority (Pearson Chi-square $p<0.05$); the proportion of households consenting was highest in Liverpool (6.5%) and lowest in Wirral (2.0%). The proportion of households consenting did not differ significantly by deprivation quintile, but were highest among households in the most deprived quintile (4.4%) and lowest in the least deprived quintile (0.0%). Based on the age of householder 1, the mean age of households consenting was 62.0 years (SD 15.4).

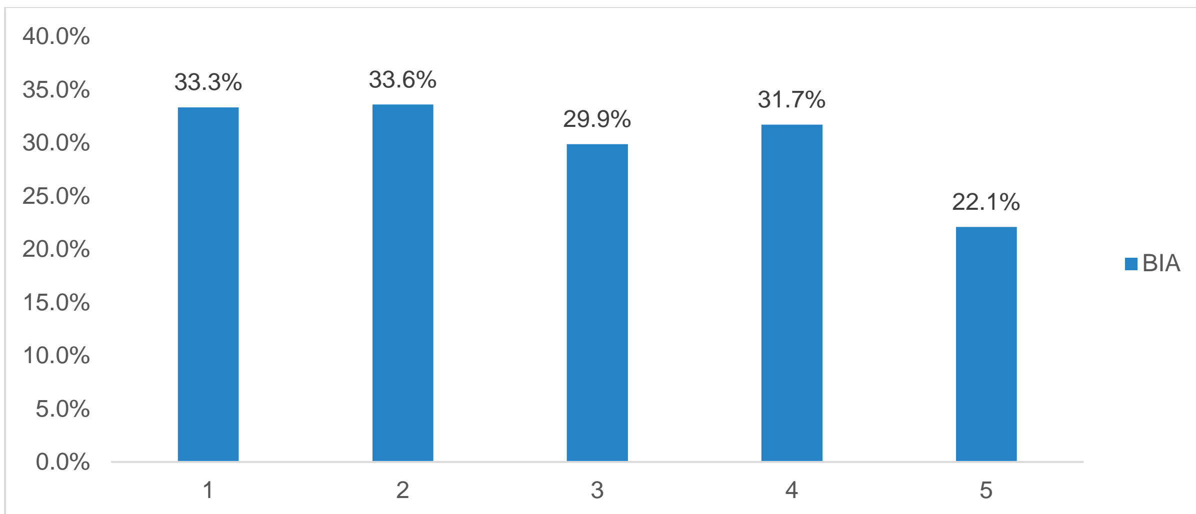


Figure 19. Proportion of Merseyside households receiving information about their alcohol consumption – by quintile of deprivation (1 – least deprived, 5 – most deprived)

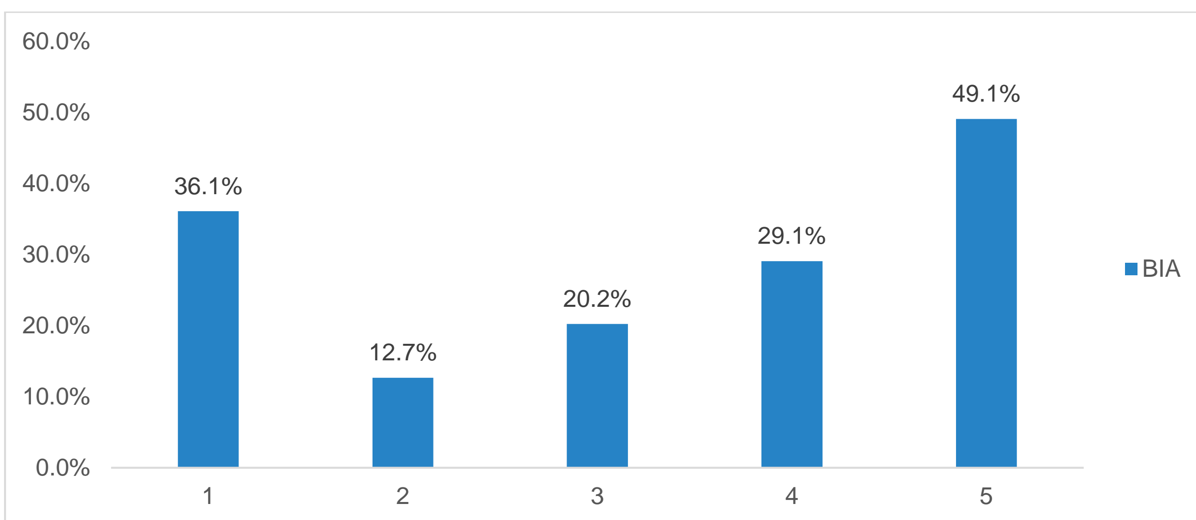


Figure 20. Proportion of Merseyside households receiving information about their alcohol consumption – by local authority

5.2.5 Stakeholder views

Stakeholders reported that had been challenges with referrals following from the Safe & Well visits. Three of the 43 survey respondents (including two service provider representatives and one NHS trust) provided comments that referred to the 'inappropriateness' and 'quality' of some referrals.

> *"One third of referrals are inappropriate for our service, clients have not fully understood what they have been referred for and so decline our service when we contact them… many of the clients have already been seen by other services and their needs have been met." (Service provider to NHS and local authority).*
>
> *"Tend to be of a lower level need. Some are inappropriate for this [falls] service." (NHS Trust, Cheshire)*
>
> *" 3 out of 16 referrals engaged with the service with 1 person going on to quit. I think further training on what the service provides is required." (Smoking cessation service provider)*

"I can only speak for smoking cessation - considering we have 20,000 plus smokers in the borough the volume and quality of referrals was lower than expected." (Stop Smoking service provider)

Additionally a local authority and a service provider representative commented that they were seeing people drop out between referral and acceptance in services:

"…We are looking at the onward acceptance of referrals as we know there is a big drop off between referral and acceptance into services particularly for falls. Therefore we are not sure the pathway is good enough at the moment and we may be missing opportunities." (Local authority, Merseyside)

"There are delays between fire service screening and actual submission of a referral to the Falls Team. Often clients have forgotten about the referral when we contact them." (Service provider to NHS and local authority, Merseyside)

Two local authority and one NHS Trust representative commented that a 'lower level' of lifestyle advice might be more appropriate than referral in some circumstances.

"…For example all the alcohol referrals refused to engage with the specialist service. This maybe that some lower level lifestyle advice may have been more appropriate for this cohort." (Local authority, Merseyside)

"It is our understanding around the Falls Tool that there is no advice just referral onto us, which isn't very useful as the Fire Service could be giving low level advice as well." (NHS Trust, Cheshire)

Respondents were asked to share their views on how effective they thought the Safe & Well visits could be by rating the four phase 1 elements. There was generally agreement across the organisations represented that the Falls Risk Assessment Tool and the Bowel Cancer screening element would be effective or very effective. Responses were more mixed in relation to how effective smoking cessation and alcohol reduction could be. Nine respondents felt that smoking cessation advice would be neither effective nor ineffective, 11 respondents felt that alcohol reduction advice would be neither effective nor ineffective, and one respondent felt that alcohol reduction advice would be ineffective.

Respondents were asked to provide comments about whether there was anything that they felt could be improved about the Safe & Well visits initiative. Respondents provided a range of responses and these are group under four key themes below:

- Communication

"We need to ensure it is communicated and the local community are aware." (CCG)

"Large scale rollout, and supported by a strong coms (sic) plan." (Local authority)

- Delivering more effective advice and support

"I would like to see a greater number of alcohol and smoking referrals but this is difficult because it depends on the commitment of members of the public. There may opportunities to fine tune language used to increase referrals." (Local authority, Cheshire)

"The work around Falls is just a screening tool which is not very effective on its own. So we are currently working with the Health Improvement Team to deliver training to

our local Fire Service, to enable them to give more effective advice and support. Which will lead to more appropriate referrals." (NHS Trust, Cheshire)

"Improved awareness for Fire service of the service that they are screening for e.g. falls and ensuring that the questions provide an appropriate filter." (Service provider to NHS and local authority, Merseyside)

"The training for FRS needs to be quality and consistent with regular updates." (Local authority)

- Referral pathways

"Falls risk assessments need to be referred to an alternative service at lower risk to offer more value for money." (Local authority)

"Ensure that all onward referrals are complete and that people know to expect contact from other services." (Local authority)

- Data collection, sharing and accuracy

"Improved information gathering such as GP details so that once the client is accepted into the service we are able to access clinical information." (Service provider to NHS and local authority)

[Referring to 'the quality and volume of referrals']: "It was suggested CO readings could be taken by the Safe & Well officers when referring clients to our service." (Stop Smoking service provider)

"Sometimes service users have advised that they hadn't given consent to us contacting them." (Local authority, St Helens)

5.3 Impact

5.3.1 Bowel cancer screening

Cheshire

Between February 2017 and the end of January 2018, the Hub received requests from Cheshire FRS for 1,935 gFOBt kits. Of these 78.8% of requests were responded to with a kit sent out to householders (n=1,524/1,935) (Table 6). In total, 639 kits were returned, 41.9% of those sent out to householders (Table 7). Of the kits sent out, where known, 41.3% were sent to males and 55.6% were sent to females. Return rates were similar for males and females at 43.2% and 42.0%, respectively. Examining by age, 24.0% of the kits were sent to householders aged 60-74 years (i.e. within the eligible age range) and 76.0% were sent to householders 75 years of age and over. Return rates were lower among householders within the eligible age range; 27.3% of kits were returned among 60-74 year olds compared to 46.5% of kits among 75+ year olds. Examining by area level deprivation, the highest proportion of kits (36.2%) were sent to the households in the least deprived quintile and the lowest proportion of kits (10.2%) were sent to households in the most deprived quintile. Return rates were higher in the least deprived compared to the most deprived quintile (48.4% in the least deprived quintile vs. 39.7% in the most deprived quintile).

In total, 10 kits were returned that had an abnormal result. Eight householders were provided with an offer of colonoscopy at a screening centre and all eight attended their appointment (Table 8). The outcome of the eight investigations were as follows: one householder was recorded as having bowel cancer and three householders were found to have low risk adenomas[8].

Merseyside

Between May 2017 and the end of January 2018, the Hub received requests from Merseyside FRS for 1,185 kits. Of these 84.0% of requests were responded to with a kit sent out to householders (n=995/1,185) (Table 6). In total, 243 kits were returned, 24.4% of those sent out to householders (Table 7). Of the kits sent out, where known, 32.3% were sent to males and 51.1% were sent to females. Return rates were similar for males and females at 27.4% and 25.6%, respectively. Examining by age, 20.5% were sent to householders aged 60-74 years (i.e. within screening age) and 79.5% were sent to householders 75 years of age and over. Return rates were lower among householders within screening age; 13.7% of kits were returned among and 60-74 year olds compared to 27.2% of kits among those 75 years and over. Examining by area level deprivation, the highest proportion of kits (31.2%) were sent to the households in the most deprived quintile and the lowest proportion of kits (12.1%) were sent to households in the least deprived quintile. Return rates were higher in the least deprived compared to the most deprived quintile (33.3% in the least deprived quintile vs. 18.4% in the most deprived quintile).

In total, 18 kits were returned that had an abnormal result. Fourteen householders were provided with an offer of colonoscopy at a screening centre and eight attended their appointment (57.1%; n=8/14; Table 8). The outcome of the eight investigations were as follows: one householder was found to have low risk adenomas[7].

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[8] *Low risk adenomas are defined as one or two adenomas <1 cm diameter. Patient with adenomas categorised as low risk are discharged from that round of screening and invited again for screening in 2 years time (if they are still within the eligible age range).*

Table 6. Regional hub data – kits sent to householders

	Cheshire		Merseyside	
	n	**%**	**n**	**%**
Total	1,524	100.0	995	100.0
Sex				
Male	629	41.3	321	32.3
Female	847	55.6	508	51.1
Unknown	48	3.1	166	16.7
Age				
60-74 y	366	24.0	204	20.5
75+ y	1,158	76.0	791	79.5
IMD deprivation quintile				
1 – least deprived	552	36.2	120	12.1
2	369	24.2	198	19.9
3	224	14.7	202	20.3
4	223	14.6	165	16.6
5 – most deprived	156	10.2	310	31.2
Local authority				-
Cheshire East	577	37.9	-	-
Cheshire West & Chester	592	38.8	-	-
Halton	120	7.9	-	-
Warrington	217	14.2	-	-
Knowsley	-	-	107	10.8
Liverpool	-	-	278	27.9
Sefton	-	-	210	21.1
St Helens	-	-	128	12.9
Wirral	-	-	266	26.7
Other	18	1.2	6	0.6

Table 7. Regional hub data – kit returns to the hub

	Cheshire		Merseyside	
	n	**%**	**n**	**%**
Total	639	100.0	243	100.0
Sex				
Male	272	42.6	88	36.2
Female	356	55.7	130	53.5
Not known	11	1.7	25	10.3
Age				
60-74 y	100	15.6	28	11.5
75+ y	539	84.4	215	88.5
IMD deprivation quintile				
1 – least deprived	267	41.8	40	16.5
2	147	23.0	50	20.6
3	94	14.7	58	23.9
4	69	10.8	38	15.6
5 – most deprived	62	9.7	57	23.5
Local authority				
Cheshire East	257	40.2	-	-
Cheshire West & Chester	246	38.5	-	-
Halton	38	5.9	-	-
Warrington	85	13.3	-	-
Knowsley	-	-	*	*
Liverpool	-	-	60	24.7
Sefton	-	-	53	21.8
St Helens	-	-	31	12.8
Wirral	-	-	71	29.2
Other	13	2.0	28	11.5

*Hub data were suppressed due to low numbers.

Table 8. Regional hub data – diagnostic outcomes

	Cheshire	Merseyside
	n	**n**
Offer of colonoscopy	8	14
Attended appointment	8	8
Diagnostic outcome		
Cancer	1	-
High risk & intermediate adenomas	-	-
Low risk adenomas	3	1
Other abnormalities	-	-

Previous screening participation

For householders aged 60-74 years who had accepted a request for a screening kit, it was possible to explore their previous participation in the national screening programme prior to their acceptance of a kit request from the FRS. Householders were categorised as previous responders, non-responders and first time responders[9] based on their response to the previous screening invitations, sent to all age-eligible adults every 2 years.

Of the kits returned in Cheshire, 32.0% of householders were identified as first time responders (n=32/100); that is they only responded to a screening invitation following the Safe & Well visit. Of the first time responders, 53.1% were male and almost half (46.9%) were from Cheshire West and Chester. Further breakdown by level of deprivation was not possible due to low numbers.

Of the kits returned in Merseyside, 21.4% of householders were identified as first time responders (n=6/28). Of the first time responders, 83.3% were male; further breakdown was not possible due to low numbers.

5.3.2 Falls prevention

Cheshire

Data were available from three of the four Cheshire LA areas:

- **Cheshire West & Chester** – Healthbox CIC received CFRS referrals during the evaluation period and provided information in relation to 221 referrals (period unknown). 10.9% of householders could not be contacted and following contact, 71.1% refused the opportunity for either NHS support or Strength and Balance Classes. Of those who accepted intervention, 26.9% were attending Strength and Balance classes and 2.0% were referred to the NHS Community Care Team.
- **Warrington** – Warrington Wellbeing CIC receive CFRS referrals and provided information in relation to 25 referrals received between September and November 2017. Information was only available about onwards referral so information is lacking about service uptake; 24.0% were referred to the falls team and 28.0% were referred to Strength and Balance classes; 48.0% of referrals were subject to 'other' actions.
- **Halton** – Bridgewater NHS Trust (a higher tier service) receive CFRS referrals and provided information about 77 referrals received into the service between February 2017 and February 2018. Following telephone triage, 50.6% of referrals did not meet the referral criteria for the service. 49.4% received a multifactorial falls risk assessment in the home;

[9] *Householders could be categorised in more than one of these categories; they could be both a previous responder and a previous non-responder to screening rounds, or they could be both a previous non-responder and a first-time responder.*

50.0% of whom were discharged and 28.9% of whom received support (14.3% of all the referrals received).

Merseyside

Data were available from two of the five Merseyside LA areas:

- **Sefton** – Within the area covered by Southport and Formby CCG, Lancashire Care NHS Trust (a higher tier service) receive MFRS referrals and provided information about 14 referrals received into the service between September 17 and January 18. 28.6% of referrals were not accepted and 64.3% received a multifactorial falls risk assessment. No further information was provided. Within the area covered by South Sefton CCG, Merseycare (a higher tier service) only began receiving direct referrals from MFRS in November 2017 and provided information about eight referrals.
- **Wirral** – Information was provided about 153 referrals received between July 2017 and February 2018. 79.7% of referrals were declined (unclear if declined by the service or by the householder) and 20.3% accepted and were triaged. No further information was provided.

5.3.3 Smoking

Cheshire

Data were available from two of the four Cheshire LA areas:

- **Cheshire West & Chester** – Information was provided about 12 referrals received between February and October 2017. 83.3% of referrals engaged with Stop Smoking Services. 4 householders were reported to be smokefree at 4 weeks.
- **Warrington** – Information was provided about 9 referrals received between September 2017 and February 2018. 55.6% of referrals engaged with Stop Smoking Services and 1 successful quit attempt was recorded.

Merseyside

Data were available from three of the five Merseyside LA areas:

- **Knowsley** – Information was provided about 19 referrals received between April 2017 and February 2018. 26.3% of referrals engaged with Stop Smoking Services and set a quit date. 3 householders were reported to be smokefree at 4 weeks.
- **Liverpool** –Information was provided about 71 referrals received during 2017. 8.5% of referrals engaged with Stop Smoking Services and set a quit date. 3 householders were reported to be smokefree at 4 weeks.
- **Sefton** – Information was provided about 12 referrals received up to October 2017. None of the referrals had engaed with Stop Smoking Service to set a quit date.

5.3.4 Alcohol

Cheshire

No data were available on the outcomes of referral in the Cheshire LA areas.

Merseyside

Data were available from two of the five Merseyside LA areas:

- **Liverpool** – LiveWire Liverpool Health Trainers receive referrals from Merseyside FRS. The reporting period was not provided but information about 8 referrals were provided. None of the referrals had engaged with the service.

- **St. Helens** – Information was provided about 11 referrals received between May 2017 and February 2018. 36.4% of referrals didn't engage with the service and 45.5% of referrals were in the process of engaging. One householder was engaged with the service and one had disengaged after assessment.

Table 9. Secondary referral data - Cheshire

	Cheshire FRS Safe & Well visits (Feb 17 – Jan 18) N=35,869 households			
	Alcohol	**Smoking**	**Falls**	**Bowel cancer screening***
Cheshire E	No data provided	No data provided	No data provided	557 kits sent 257 kits returned
Cheshire West & Chester	No data available	(Feb – Oct 17) 12 referrals 10 engaged with Stop Smoking Services 4 quit smoking after 4 weeks	(Dates not provided) 221 referrals 24 unable to contact 197 contacted 140 refused support 53 attended Strength & Balance classes 4 referred to Community Care Team	592 kits sent 246 kits returned
Halton	No referrals received	No data provided	(Feb 17 – Feb 18) 77 referrals -> telephone triage 39 did not meet referral criteria 38 home assessment 19 discharged 11 received support 1 awaiting assessment	120 kits sent 38 kits returned
Warrington	No referrals received**	(Sep 17 – Feb 18) 9 referrals 5 engaged with Stop Smoking Services 1 successful quit attempt	(Sep – Nov 17) 25 referrals*** 6 referred to Falls team 7 referred to exercise programme 2 referred to Warrington Wellbeing 4 no action 6 unknown	217 kits sent 85 kits returned

*Some kits requests reported as 'Other' rather than to a particular LA; **As of March 18; ***Don't have data directly from the falls service. Data are for referrals received from CFRS to Warrington Wellbeing.

Table 10. Secondary referral data - Merseyside

	Merseyside FRS Safe & Well visits (May 17 – Jan 18) N=6,756 households			
	Alcohol	**Smoking**	**Falls**	**Bowel cancer screening***
Knowsley	No data provided	(Apr 17 – Feb 18) 19 referrals 14 declined to engage 5 set quit date 3 smoke free at 4 weeks	No data available	107 kits sent (unknown) kits returned**
Liverpool	(Dates not provided) 8 referrals 4 could not be contacted 4 didn't engage	(Jan – Dec 17) 71 referrals 65 declined to engage 6 set quit date 3 smoke free	*Service not accepting referrals*	278 kits sent 60 kits returned
Sefton	No data available	(up to Oct 17) 12 referrals 0 set quit date	Southport & Formby CCG (Sep 17 – Jan 18) 14 referrals 4 not accepted 9 assessed 1 awaiting assessment South Sefton CCG*** (Nov – Dec 17) 8 referrals 2 not accepted (out of area) 2 assessed 4 awaiting triage & assessment	210 kits sent 53 kits returned
St Helens	(May 17 – Feb 18) 11 referrals 5 attempting to engage 4 didn't engage 1 engaged 1 disengaged after assessment	No data provided	No data provided	128 kits sent 31 kits returned
Wirral	No data provided	No data provided	(Jul 17 – Feb 18) 153 referrals 31 accepted & triaged 122 declined****	266 kits sent 71 kits returned

*Some kits requests reported as 'Other' rather than to a particular LA; **Number of kits returned suppressed because of low numbers; ***Merseycare only recently re-started direct referrals from the fire service (mid November); ****Unclear if declined by service or by householder.

6 LEARNING

6.1 A REALIST EVALUATION PERSPECTIVE

The findings were brought together (triangulated) informed by a realist evaluation approach (Pawson, 2013). Aspects of the realist evaluation that were particularly influential in this interpretation were:

1. The realist evaluation question – How does an intervention work, what aspects, to what extent, for whom and under what circumstances?
2. Identifying underlying causal mechanisms and understanding how the Safe & Well approach triggers them.
3. The idea that it is not an intervention or programme that changes people, it is how people interpret and respond to what the intervention or programme provides (the 'resource') that causes change.

Context is an essential component of any realist explanation for how a programme or intervention works (Dalkin et al., 2015). It describes those features of the situations into which programmes are introduced that affect the operation of programme mechanisms; in realist terms this means the social relationships, rules, norms and expectations that constitute them, as well as the resources available (or not). The task in realist evaluations is therefore to understand what in particular it is that functions as a context, and to understand how this context shapes the mechanisms through which a programme works (Wong et al., 2017). From a realist perspective, programmes offer (and sometimes take away) resources to (and from) participants; for example resources may be material, social, emotional or political. In realist terms, the 'programme mechanism' describes the interaction between these resources, and how participants interpret and act upon them.

6.1.1 How do we think a Safe & Well visit might 'work'?

A realist evaluation approach uses the construct of 'reasoning and resources' to explain how programmes or interventions cause outcomes. Taking a realist perspective we might consider the mechanisms through which the Safe & Well visit works as follows:

> The FRS have privileged access to people's homes and householders and this provides a means for them (i.e. the householder) to engage in conversations about health and wellbeing that they may not have otherwise had (the 'reasoning'):
>
> i. Providing awareness training to FRS staff prepares them to deliver health and wellbeing advice (the 'resource'), and affects how they think about their role in engaging householders in discussions about their health and wellbeing (the 'response');
> ii. Provides opportunities for householders to discuss health and wellbeing with a 'trusted' professional in a setting that is familiar and convenient to them (the 'resource'), and affects how they perceive their own health and wellbeing (the 'response');
> iii. Provides opportunities for householders to be connected to health and wellbeing services they may not have otherwise had contact with or engaged with (the 'resource'), and affects how they feel about engaging with health and wellbeing services (the 'response').

We can follow these hypothesised mechanisms of action through to the expected outcomes of a Safe & Well visit as follows: Householders agree to engage in conversations about health and

wellbeing (a 'response') and accept referrals when they are identified as appropriate to them (a 'response'). This engagement in discussions about health and wellbeing and/or acceptance of a referral, when identified as appropriate, leads to the householder voluntarily changing their behaviour and/or engaging with health and wellbeing services to support behaviour change (the 'outcome'). Appropriate engagement with services and early identification and intervention may then be thought of as leading to reduced burden on the NHS due to behaviour change, falls support, and early diagnosis for those at risk of bowel cancer. It is this reduced future burden on the NHS that provides the opportunities for cost savings to emerge.

6.1.2 Testing the hypothesised mechanisms of action

The purpose of the triangulation is to understand whether the hypothesised understanding of how a Safe & Well visit 'works' is plausible by drawing on the data collected in the evaluation.

Health and wellbeing assessment as part of Home Fire Safety Visits

In relation to context, Safe & Well visits have been introduced into an existing setting, that of the FRS conducting Home Fire Safety Visits. This has happened against a background shift in organisational procedures and priorities in the FRS, and work practices towards fire prevention, and greater involvement in community engagement activities. In the words of Clarke (2016): "*when FRS began to engage both broadly and proactively with discourses of safety, relative risk and vulnerability and were compelled to change work practices, space was created allowing them to operate in non-traditional and innovative ways to deliver public sector services… this space has been used creatively… to engage in a range of activities that 15 years ago would have been considered beyond the remit of a fire brigade.*" Therefore an important part of the context to Safe & Well visits has been this change in remit of the FRS. It is likely that the public understanding and perception of the role and remit of the FRS affect householder acceptance and willingness to engage in the health and wellbeing aspects of the Safe & Well visit. From an FRS perspective, there is a belief that the public identify positively with the FRS 'brand' and hold it in high esteem (Chief Fire Officers Association, 2015), which is supported by surveys of public satisfaction. It is this aspect of the context within which the FRS is perceived to operate (i.e. *"the unique public respect afforded to our firefighters")* that gives rise to the belief that the FRS *"are able to access client groups that other public agencies find difficult to reach"* (Chief Fire Officers Association, 2015). If we extend this to the specific context of Safe & Well visits, this builds into the rationale of offering the visit in that "*people seem more likely to engage in difficult conversations with [FRS] staff than with others*" (NHS England et al., 2015).

That householders hold the FRS in high esteem comes across in the responses to the householder survey and from the case studies. The FRS appear to be particularly respected in terms of the fire safety aspects of the home visits and this is what householders appear to remember most prominently about the visit. Householders responding to the survey considered the Safe & Well visit to be an appropriate activity for FRS and a good use of resources. Some of the responses from householders suggests that there may be boundaries for some householders in their acceptance of FRS asking health questions; they rationalise that the topics of the Safe & Well visit are *'about safety in the home'*. This suggests an acceptance of the role of FRS in fire prevention but perhaps, as yet, a lack of understanding (but not necessarily a lack of acceptance) of the extended remit of FRS to engage with the community about health and wellbeing. From another perspective, it may be that householders consider the seriousness of the risks associated with fire safety differently to those that affect their health and wellbeing. The potential for the visits to improve quality of life was recognised in the householder responses to the survey and householders appeared to understand the preventative nature of the approach. However, as Laybourne et al. (2011) report in relation to falls prevention, older people consider that "*it is others who are frail and might fall*". That is

householders may perceive there to be benefits of the Safe & Well visit for '*others'* but perhaps not directly for themselves. It is likely that it will take time for householders to adapt, and for the expanded role of the FRS into health and wellbeing to become recognised. Only a minority of householders who participated in the survey had concerns about privacy and confidentiality, reinforcing the finding that the FRS 'brand' is trusted. It is concerning that one local authority representative reported that some service users had advised them that they hadn't given consent to be contacted. Fire service staff delivering Safe & Well visits are made fully aware of the requirement to gain consent before referring householders to services. While this may reflect the age and vulnerability of the householders visited, it also reinforces the need to improve referral pathways into local services. Householders should continue to be clearly informed of the intended use of the information they provide and assured that any concerns they have about confidentiality and consent will be respected.

Staff responses to health and wellbeing assessments

The FRS has gone through a rapid period of change in work practices and culture within the last decade. The Safe & Well visit represents a further extension of their remit in relation to prevention and community engagement. Our evaluation highlights that the majority of staff had good or very good views of the training they received and generally felt well prepared to deliver a Safe & Well visit. There were, however, a small proportion of FRS staff who didn't feel confident delivering at least one of the health and wellbeing elements of the Safe & Well visit, indicating that they lacked confidence and did not feel all that prepared for the role. These staff were more likely to be operational firefighters than advocates, suggesting not unexpectedly, that the new tasks involved in delivering the Safe & Well visits have greater compatibility with the existing skill set of the FRS advocates. Most staff indicated that their confidence in delivery had increased with experience and therefore how staff view their role in relation to Safe & Well visits is likely to change over time and may be influenced by wider public perceptions of their role in health and wellbeing. Both advocates and operational firefighter staff providing open responses raised that they encountered issues regarding a lack of confidence in responding to 'difficult questions', and responses suggested that staff may lack knowledge about what happens next for householders who take up the offer of a referral. A third of staff felt that at least one element of the health and wellbeing aspects of the Safe & Well visit were badly or very badly received by householders. Comments suggested staff have encountered a range of opinions from householders; the alcohol element of the visit, in particular, was highlighted as being poorly received.

Householder engagement

There was a good level of engagement in the Safe & Well visit among householders in both Cheshire and Merseyside. Householders responding to the survey agreed it was helpful to be visited in their own home and supported the idea that a convenient/familiar setting promoted engagement. However, engagement may be socially patterned with levels of engagement lowest among households in the most deprived areas of Cheshire and Merseyside. Due to the small number of householders providing a reason for declining assessments, the householders responses to the survey don't provide any additional findings about why householders may have declined to participate in particular elements of the Safe & Well visit.

Bowel cancer screening

The NHS bowel cancer screening programme has been running since 2006 but overall uptake has been lower than has been seen with other national cancer screening programmes (Koo et al., 2017). There is a gradient in uptake by socioeconomic status but Wardle et al. (2016) note that the factors thought to explain the differences in uptake are difficult to address within the national screening programme. Health literacy is thought to play a role in uptake because information about

the screening programme is delivered solely through mailed, written communications. The Safe & Well visit may therefore work as a beneficial supplement to the provision of mailed information. During the Safe & Well visit, FRS are able to demonstrate the kit to householders and can request special format kits, tailored to householder needs (e.g. language, large print). Therefore the discussion that the Safe & Well visit offers may act as a form of 'enhanced' reminder for householders within the national programme screening age (i.e. 60-74 years) who have not yet returned a kit. The ASCEND trial (Wardle et al., 2016) found that a one-page enhanced reminder letter that included a simple restatement of the screening offer and a "A reminder for you" banner reduced the socioeconomic gradient in bowel cancer screening uptake.

Among the households that received a Safe & Well visit, a large proportion of householders reported that they were already participating in the National Bowel Cancer Screening Programme; although a smaller proportion of households reporting returning the kits in Merseyside compared to Cheshire. Householders responding to the surveys and case studies felt that the FRS visit may prompt people to actually use the gFOBt kit, therefore agreeing with the idea that the Safe & Well visit may act as a form of enhanced reminder. The analysis of the data from both FRSs and the regional Hub show that a large proportion of gFOBt kit requests were among older householders (75+ years). Whether this is an unintended consequence of the intervention requires further exploration with stakeholders involved in the national screening programme. For householders within the programme screening age, a proportion of those who returned the gFOBt kit were first time responders to the programme; they had not previously returned a kit despite getting invitations through the national screening programme.

Falls prevention

The assessment of falls risk during a Safe & Well visit provides another point of access into the Falls & Fracture system, and therefore potentially widens opportunities for case finding among community-dwelling older people (Public Health England, 2017, Laybourne et al., 2011). The Safe & Well visit may therefore be of benefit to people who have been missed or not engaged through the traditional referral routes into the Falls & Fractures system (Laybourne et al., 2011). Following initial falls screening within the Safe & Well visit, householders determined to be at risk (i.e. those reaching a particular threshold on the FRAT) are asked to provide their consent for referral to a local falls prevention service for further assessment. Merseyside FRS were required to apply different thresholds for referral across the Merseyside local authority areas and had found this to be problematic. The burden of fall risk appeared to be higher among householders in Merseyside, and a higher proportion of households in Merseyside, than in Cheshire, included at least one householder who was identified for referral to the falls service. Merseyside FRS refers into the higher tier services, as there is a higher threshold for referral. With the exception of Halton, Cheshire FRS refers to lower tier services, where these exist, or may advise residents to see their GP with regard to falls. It is difficult to draw conclusions about the outcomes of the Safe & Well visits in relation to falls, as data was not uniformly available across LA areas. Additionally, the commissioning arrangements for falls services and the local offer vary across and within the LA geographies of Cheshire and Merseyside. Within Cheshire West and Chester, a high proportion of householders who had consented to referral declined the opportunity for intervention, although CFRS have since worked with West Cheshire CCG to improve engagement. In Halton, where referrals were made into a higher tier service, the service found that around half did not meet their referral criteria. Around a quarter of referrals were not accepted in to the higher tier service covering Southport and Formby CCG. The wider stakeholder survey identified that in some cases, services were seeing householders drop out between referral and before connection had been made with the falls service provider. Additionally, service providers responding to the wider stakeholder survey commented that in some cases, referrals were inappropriate and that householders may already

have had their falls related needs met. Both local authority and NHS Trust stakeholders commented that advice and support could be delivered more effectively if the FRS were providing low-level advice on falls prevention as well as offering referral. This suggests a lack of understanding or clarity about the nature of the Safe & Well visit as both CFRS and MFRS do provide lower level advice to householders. For example, Cheshire FRS leave householders with a Safe & Well booklet that includes advice on falls and how to reduce the risk of falling. Findings from the staff survey suggest that FRS staff delivering Safe & Well visits may lack knowledge about the referral process following a Safe & Well visit.

Smoking and alcohol use

The smoking and alcohol screening elements of the Safe & Well visit provide the opportunity for householders to receive motivation from a credible source to take self-directed behaviour change in relation to their smoking and/or alcohol consumption. For householders who engage with the assessment and who are found to be experiencing a problem with their alcohol use or who are in need of support to stop smoking, the Safe & Well visit provides them with an additional point of access to local services. In relation to the provision of alcohol identification and brief advice (IBA) in non-health settings, Thom et al. (2015) highlight that integrating this within the opportunities offered by the MECC agenda, requires careful consideration of the tensions that may arise in different delivery contexts.

Responses to the staff survey show that the FRS advocates and operational staff who deliver the Safe & Well visits perceive there to be a low level of acceptability among householders for the smoking and alcohol screening elements of the visit. At least one member of the household had participated in alcohol screening in around a third of households in both Cheshire and Merseyside. Participation in the smoking element of the Safe & Well visit appeared to be particularly low. Subsequently, only a very small number of householders consented to referral to their local stop smoking or alcohol service. Data on the outcomes of referral were available for two LA areas (both in Merseyside) for alcohol referrals and for five LA areas for smoking referrals. The Merseyside areas that provided referral data suggested a low level of engagement from householders with both smoking and alcohol services. In comparison, although a small number of householders in Cheshire consented to a referral to their local stop smoking services, for those that did consent, engagement appeared to be better. Taken together these findings suggest that there is the need for further developmental work to be undertaken to ensure that the intervention approach in relation to smoking and alcohol use is relevant and appropriate for the setting and target group (Thom et al., 2015).

6.1.3 Value for money

An assessment of whether the Safe & Well visits represent value for money was beyond the scope of this evaluation. As a starting point, any future economic evaluation of the initiative will need to collect and analyse data on the marginal additional costs associated with the planning, development and delivery of the Safe & Well visits. Although these costs are not borne by the health service, assessment of the value for money of the Safe & Well visit should consider wider public sector costs. The secondary referral data currently available to assess the impact of the Safe & Well visits in terms of falls prevention, smoking cessation and alcohol reduction is not sufficiently robust to support an assessment of the value for money. We identified data gaps at a local authority level in both Cheshire and Merseyside. Further, engagement with services following a referral was low among householders, particularly in the case of falls services. The pathways into referral services require strengthening so that the costs and resources spent on time to administer unattended appointments don’t outweigh the benefits of the intiative.

6.1.4 Summary

Our evaluation found that householders were willing to engage in conversations with FRS about their health and wellbeing, supporting the central premise of the Safe & Well visit that it provides access to people that other public agencies may find difficult to reach. However, our findings also suggest that householders may be less keen to engage in conversations about their smoking and alcohol use, behaviours that they may perceive to be stigmatised. A limitation of our evaluation is that we did not have access to a broader cross-section of householders and therefore we cannot be certain that the central premise of the Safe & Well visits that householders will engage in conversations with FRS extends across contexts. For example, research undertaken with deprived communities in the West Midlands found that people's more general views of the FRS may be influenced by their negative experiences and distrust of other statutory services (Hastie, 2017).

FRS staff perceived themselves to be generally well prepared to deliver health and wellbeing advice but the evaluation found that they may lack confidence in engaging householders in discussions about their smoking and alcohol use; elements of the visit that FRS staff perceive to be poorly received by householders. The Safe & Well visit clearly provides opportunities for householders to discuss health and wellbeing, and the FRS are engaging with households who may not have otherwise engaged in a conversation about their health or considered accessing local support services. However, there is a great deal of uncertainty about how individuals will react in a given situation to efforts to shape and change their behaviour (Kelly and Barker, 2016). Even if householders hold a positive view of FRS and are willing to engage in conversations about health and wellbeing with them during a Safe & Well visit, this evaluation has not provided a clear idea of the circumstances under which these conversations with the FRS would be likely to trigger or contribute towards a ('favourable') self-directed change in behaviour.

A gap in the national principles underpinning the Safe & Well visit is the consideration that well-meaning initiatives that have an overall benefit to health may also increase social inequalities in health (Macintyre, 2000). A common characteristic of interventions that may widen socio-economic inequalities in health appears to be 'a reliance' on self-directed behaviour change (White et al., 2009), as is the case with the Safe & Well visit. Inequalities may be introduced at different stages; such as in uptake and engagement, and in how individuals respond to an intervention. White et al. (2009) note that "the problem with 'one-size-fits-all' interventions has been recognised" and that interventions tailored to the needs of sub-groups within a target population may be more likely to result in outcomes that are more equitable. Cheshire and Merseyside FRS have different approaches for identifying householders for a Safe & Well visit; although both primarily target householders to fulfil their statutory duty to reduce injury from fire. Cheshire FRS have extended all of their home safety visits to over 65 years olds to encompass the Safe & Well 'check' while Merseyside FRS target only those they perceive (of any age) to be at higher risk to fire or with other complex needs. As a result of the targeting of the visit in Merseyside, householders from more deprived areas formed a large proportion of the households identified for a Safe & Well visit. Our analyses of participation based on the secondary data and householder survey suggests that engagement in the health and wellbeing assessment elements of the Safe & Well visits is socially patterned across both FRS areas; with households in more deprived areas being less likely to engage. This evaluation therefore raises issues regarding the 'fit' of the extended health and wellbeing assessments within the home fire safety checks that FRS deliver as part of their statutory duty. It is also apparent from the evaluation that wider system issues, particularly in the case of the falls prevention assessment of the visit, have influenced delivery and implementation of the Safe & Well visits. Providing appropriate referrals and supporting householder engagement with services requires a successful chain of interactions to occur, between FRS and the householder, and

between FRS and the wider health system. In the case of falls, consistent referral pathways have been challenging to develop despite the ongoing efforts of the FRS.

Based on the findings of this evaluation we suggest that a better understanding of the potential opportunities for FRS to 'intervene' within the context of a Safe & Well visit is required. As Laybourne et al. (2011) note, there are fundamental differences between the FRS and health services in how practitioners promote client behaviour change and this would suggest a need to further tailor and refine intervention content to take account of both the format of delivery (i.e. typically a single occasion of contact with householders) and the organizational factors that may hinder or promote successful implementation. This should be achieved through theory-based development, by using behaviour change theory to help guide and shape design, content and delivery of the Safe & Well visit. The COM-B model (developed as a simple model to understand behaviour; Michie et al., 2011), for example, provides a clear framework of the determinants of behaviour and has been used successfully applied to explain or change a range of health behaviours. Design and development should as a priority involve consideration of the perspectives and insights of householders. Gaining a better understanding of whether and how the Safe & Well visit can become integrated to the point of becoming embedded as normal practice for the FRS and the communities they serve will also assist with implementation.

6.2 Recommendations

Recommendation 1: Further develop the concept of the Safe & Well visit using theory, evidence and insight from householders.

Who should act? Wider stakeholders and FRS working with support from academic partners.

- Identify ways to support householder engagement among 'hard to reach' groups to support a more person-based approach to the development of Safe & Well visits.
- Draw on theory to clarify assumptions in relation to the mechanisms through which the Safe & Well visit is expected to produce change across different contexts.

Recommendation 2: Tailor the content of Safe & Well to local risks and demands.

Who should act? Wider stakeholders and FRS working with support from academic partners.

- Explore whether specialist referral is the right option for householders and how the offer from referral services could be better tailored to the needs of local populations.
- Develop a framework to guide and facilitate investment (and where required, disinvestment) in the different elements that make up the Safe & Well check.

Recommendation 3: Target Safe & Well to households most in need of health and wellbeing advice.

Who should act? Wider stakeholders and FRS.

- With the offer of the Home Fire Safety Check remaining for all households, explore whether certain areas/populations could be targeted at different times of year for the Safe & Well health and wellbeing assessments to provide a tailored offer.

Recommendation 4: Build public perceptions and an understanding of the extended remit of FRS into community engagement related to health and wellbeing.

Who should act? FRS and wider stakeholders.

- Develop opportunities to promote and communicate the expanded remit and value of FRS's role in health and wellbeing to the public.
- Maintain good practice on sharing information and ensuring confidentiality.

Recommendation 5: Further develop training for FRS staff.

Who should act? FRS and wider stakeholders.

- Provide more generalised training on the MECC agenda to build an understanding of the broader and generic mechanisms that are involved in promoting and supporting behavioural change.
- Pay attention to how different staff personalities and roles may respond and adapt to the expanded role; consider whether tailored training is required to support the differing skillset of operational firefighters.

- Provide on-going opportunities for staff to share best practice, role-play difficult situations and provide opportunities for staff delivering the Safe & Well visits to find their own solutions to different scenarios.
- Ensure that FRS staff are consistently providing clear information to householders about who and what is involved should they consent to referral.
- Provide feedback on the results of the Safe & Well visits to FRS staff, so they can see the importance of what they are doing.

Recommendation 6: Participation in the national bowel cancer screening programme.

Who should act? Stakeholders representing the National Bowel Cancer Screening Programme.

- Consider whether there are unintended consequences of the bowel cancer screening element of the visit in terms of its role in promoting a self-referral route for bowel cancer screening among adults outside of the upper screening programme age.
- Change systems to accommodate a record of householder preference for special format kits in subsequent screening rounds.

Recommendation 7: Ensure that referrals are limited to those in need.

Who should act? Wider stakeholders working in partnership with FRS.

- Provide further support and timely feedback to enable FRS staff to follow appropriate procedures to determine how and to whom householders should be referred.
- Provide support to ensure householders understand what the referral services offer, what the referral services can do to help them and what happens when they get there.
- Review pathways to cut down on time between the Safe & Well visit and engagement with the system. For example, by putting systems in place to support FRS to make telephone referrals with householders during a Safe & Well visit.
- Identify whether and how householders are engaged in the health system (e.g. the falls and fractures system) as part of the health and wellbeing element of the Safe & Well visit.

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APPENDICES

Appendix 1	Safe and well assessment questions
Appendix 2	Survey methods and demographics
	a. Householder survey
	b. Case studies
	c. Stakeholder survey
Appendix 3	Further details of methods and data sources
	a. Analysis of secondary data
	b. Methodological issues with secondary data
	c. Methodological issues with householder survey

Appendix 1. Safe & Well assessment questions

The following tables are extracts from the full Safe & Well assessment, detailing the health and wellbeing part of the assessment.

Health and Wellbeing questions in Cheshire FRS S&W visit

4. Completion of general falls Checklist	(tick box)
General Falls Checklist Flooring: ☐ Is it in poor condition? ☐ Are there loose mats? ☐ Are there trailing cables? ☐ Is there clutter? ☐ Are threshold strips between rooms secure? Lighting: ☐ Is it too dull? ☐ Shadows across the room? ☐ Excess glare? Are there steps up or down between rooms? Are there hand prints on walls and doorframes where people steady themselves? Consider how the person would call for help if they fall in each room. Where is the telephone? Is it hard to reach? Eye sight? Walking aid?	

5. Completion of Falls Risk Assessment Checklist (FRAT)	
Has history of any fall in previous year	(tick box)
On four or more medications	(tick box)
Has a diagnosis of stroke, Parkinson's disease or dementia	(tick box)
Reports problems with his/her balance	(tick box)
Unable to rise from a chair of knee height	(tick box)
Carry out 'Get up and Go' as part of balance assessment where practical. If you answer 'yes' to three or more statements in FRAT are you content for me to refer you to the relevant CCG Falls Team for follow up help and support?	

6. Consent given to refer to Falls Prevention (mandatory)	
Yes	(drop down)
No	(drop down)

7. Bowel Cancer Screening	
Did you receive bowel cancer screening kit and return it? (Tick if 'yes')	(tick box)
Would you like CFRS to request a kit to be sent out again?	(tick box)
Do you remember getting an invitation to do a bowel screen test kit in the post? The NHS sends them every 2 years to anyone over 60 and less than 75 years old. ☐☐ If you remember, did you send off and get a result letter? ☐☐ If not:	

- The test shows if there is a little bit of invisible blood in the poo and, if that's positive, then you will get invited for a further test to check for bowel cancer. The further test means you can have treatment early if needed.
- Would you like to see what a kit looks like'?
- In order to request a kit is sent to you CFRS will need to send your name and address to the NHS Bowel cancer screening Hub in Rugby.

8. Special Requirements	
Standard Kit; Bowel Cancer Screening: The Facts – English	(drop down)
Bowel Cancer Screening: The Facts – Large Print	(drop down)
An Easy Guide to Bowel Cancer Screening - leaflet	(drop down)
Braille kit instructions	(drop down)
Audio kit instructions	(drop down)
Bowel Cancer Screening: The Facts - Chinese	(drop down)
Bowel Cancer Screening: The Facts - Greek	(drop down)
Bowel Cancer Screening: The Facts - Hindi	(drop down)
Bowel Cancer Screening: The Facts - Polish	(drop down)
Bowel Cancer Screening: The Facts - Punjabi	(drop down)
Bowel Cancer Screening: The Facts - Somali	(drop down)
Bowel Cancer Screening: The Facts - Turkish	(drop down)
Bowel Cancer Screening: The Facts - Ukranian	(drop down)
Bowel Cancer Screening: The Facts - Urdu	(drop down)

9. Smoking	
Are you a smoker? (Tick if ‘yes’)	(tick box)
Consent to refer to Smoking Cessation Team	(tick box)
Does anyone in the household smoke? Are you aware of the risks of smoking? Would you like advice on stopping smoking? Are you happy for me to refer you to the relevant CCG Smoking Cessation team for help and support?	

10. Alcohol	
Public Health Guidance discussed	(tick box)
Consent to refer to Alcohol Harm Reduction Team	(tick box)
Are you aware of the risks of drinking? Knowing your limits will help you stay in control of your drinking. To reduce the risk of harming health if you drink most weeks: Men and women are advised not to regularly drink more than 14 units of alcohol a week	

Would you like advice on alcohol reduction? Are you happy for me to refer you to the relevant CCG Alcohol Harm Reduction team for help and support?

AUDIT C questions	Scoring system				
	0	1	2	3	4
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Safe & Well element in Merseyside FRS S&W visit (version 1 07).

Safe and Well

2nd Person: Yes ☐ Full Name (inc. Title) [ ] D.O.B d d m m y y

Falls Risk Assessment Tool (FRAT) (applicable to 65+) P-1 P-2

☐ Declined to discuss ☐ N/A

	P-1 YES	P-1 NO	P-2 YES	P-2 NO
Is there a history of any fall in the previous year?	☐	☐	☐	☐
Is the client on 4 or more medications a day?	☐	☐	☐	☐
Does the client have a diagnoses of stroke, parkinsons or dementia?	☐	☐	☐	☐
Does the client report problems with his/her balance?	☐	☐	☐	☐
Is the client unable to rise safely from a chair of knee height?	☐	☐	☐	☐
If the answer to two or more questions (three or more for Liverpool & Sefton) is YES, a referral to local falls team is recommended	☐	☐	☐	☐

Bowel Cancer Screening (applicable to 60+)

☐ Declined to discuss ☐ N/A

	P-1 YES	P-1 NO	P-2 YES	P-2 NO
Did you receive bowel cancer screening kit?	☐	☐	☐	☐
Did you return kit and receive results?	☐	☐	☐	☐
If no, explain benefits and ask:				
Would you like MFRS to request a kit to be sent out again?	☐	☐	☐	☐
Kit No	☐		☐	

Blood Pressure Screening

☐ Declined to discuss ☐ N/A

	YES NO	YES NO
Are you under the care of your Primary Care Team (GP, Nurses) for your blood pressure?	☐ ☐	☐ ☐
Would you like us to check your blood pressure today to show how simple it is?	☐ ☐	☐ ☐
Blood Pressure taken?	☐ ☐	☐ ☐
Outcome - use relevant code: 1 2 3 4 5 6 7	☐	☐

Smoking Cessation

☐ Declined to discuss ☐ N/A

	YES NO	YES NO
Following discussion around the benefits of stopping smoking, would you like MFRS to provide information / referral to your local stop smoking service?	☐ ☐	☐ ☐

Alcohol Reduction

☐ Declined to discuss ☐ N/A

	YES NO	YES NO
Following discussion around the benefits of reducing your alcohol intake,would you like MFRS to provide information / referral to your local service?	☐ ☐	☐ ☐

Road Safety

Does anybody (in the property) aged over 65 drive a vehicle? YES ☐ NO ☐

Form updated by the Community Risk Management Team - July 17

Appendix 2. Survey Methods and Demographics

a. Householder survey methods and demographics

A total of 500 questionnaires were distributed, 250 each to Cheshire and Merseyside Fire and Rescue Services who handed them out to households that they visited. Of these, 75 were completed and returned, 33 from Cheshire and 41 from Merseyside (the other one respondent did not give their postcode), giving an overall response rate of 15%. For the householder survey, demographic data was collected on age, gender, ethnic group, local authority of residence and deprivation score.

Two thirds of the respondents were aged 70 and over (67%, 50/75), giving a median age of 74 years. There were equal proportions of respondents aged 70+ from Cheshire (67%) and Merseyside (68%). Of the 75 respondents, 36% were male (27), 60% were female (45) and 5% (3) did not indicate their gender. Amongst the Cheshire respondents, over half were female (55%, 18/33) and in Merseyside, around two-thirds (66%, 27/41) were female. In terms of location of residence of the 75 respondents, most were from Cheshire East (40%), Sefton (23%) and Liverpool (21%). There were no respondents recorded from Halton, or Cheshire West & Chester. Of the 97% (73) of respondents who indicated their ethnic background, all were white. There was only one respondent from an area ranked as most deprived, and 31% (23) from areas ranked as least deprived. The majority of respondents were from middle-ranking areas in terms of deprivation (67%, 50/75).

Table 11 Householder survey: Full demographic data table

	n	%
Total	75	100.0
Sex		
Male	27	36.0
Female	45	60.0
Other	1	1.3
Missing	2	2.7
Age		
Median (min-max)	74	(37-93)
Missing	4	5.3
Ethnicity		
White	72	96
Missing	1	1.3
Local Authority		
Knowsley	3	4
Liverpool	16	21.3
Sefton	17	22.7
St Helens	2	2.7
Wirral	3	4
Cheshire East	30	40
Warrington	3	4
Missing	1	1.3
Deprivation quintile		
1 – least deprived	23	30.7
2	-	-
3	50	66.7
4	-	-
5 – most deprived	1	1.3

b. Case study methods

Of the 75 survey respondents, 25 indicated that they would be happy to be contacted by telephone to be interviewed for a more in-depth case study. The initial aim was to contact eight households, choosing those where an individual had been referred to other services as part of the Safe & Well visit, with the purpose of building up case studies of experiences of the Safe & Well visits.

However, of the survey respondents who were happy to participate, none of them had been referred to any services as a result of the Safe & Well visit. The eight case study participants were therefore selected as far as possible to represent a balance of those who had either accepted or declined Safe & Well assessments, whether they had expressed any concerns or not and whether they were male/female and from Cheshire or Merseyside.

c. Stakeholder survey details

There are ten Clinical Commissioning Groups within Cheshire and Merseyside (4 in Cheshire and 6 in Merseyside). There was representation from all four Cheshire CCGs. Of the 14 respondents who represented a CCG, four respondents represented NHS Eastern Cheshire CCG, six represented NHS South Cheshire CCG and 1 respondent each represented NHS Vale Royal CCG and NHS West Cheshire. There was representation from only one of the Merseyside CCGs, with two respondents representing NHS St Helens CCG.

Eleven respondents represented the nine local authority areas in Cheshire and Merseyside. Of the Cheshire local authority areas, two respondents each represented Cheshire East and Warrington, and one respondent each represented Cheshire West & Chester and Halton. Of the Merseyside local authorities, two respondents each represented Knowsley and St Helens, and one respondent represented the Wirral. There were no respondents representing Liverpool or Sefton.

Of the remaining respondents, nine represented a service provider and nine respondents stated they represented another type of organisation. The respondents who stated ‘other’, included third sector organisations (including Cancer Research UK and one unstated), NHS trusts (including Bridgewater Community Healthcare NHS Foundation Trust, East Cheshire NHS Trust and one unstated), Public Health England (two respondents), Cheshire Police and the National Bowel Cancer Screening programme.

Appendix 3. Further details of methods and data sources.

A. Analysis of secondary data

Analysis Fire & Rescue Service Safe & Well data

An analysis of routine data collected by the Fire & Rescue Service for the Safe & Well initiative was undertaken. This included demographics on households, whether support is accepted and referrals are made.

In order to obtain the data, the research team developed a data protocol which outlined the data that would be required to explore the impact of the initiative. The PHI research team met with data teams from Cheshire and Merseyside Fire & Rescue Services in August 2017 to discuss the feasibility of accessing the required data and the logistics of data sharing. The type of data collected by each fire service differed slightly (see Box 1 for details).

In order to access the data, PHI developed a data sharing protocol that was signed off by each of the Cheshire and Merseyside Fire & Rescue Services. Data were shared using a secure Sharepoint.

Box 1. Safe & Well data collected by Fire & Rescue Services

<table>
<tr><th>Merseyside Fire & Rescue Service</th><th>Cheshire Fire & Rescue Service</th></tr>
<tr><td>Date of birth

Date of Safe & Well visit

Station ground

Postcode (only first part and second number provided for evaluation)

Bowel cancer screening (60+)

- Declined to discuss
- Did you receive bowel cancer screening kit?
- Did you return kit and receive results?
- If no, explain benefits and ask:
- Would you like MFRS to request a kit to be sent out again?</td><td>Date of Safe & Well visit

Age range of occupants (under 5s; 5 to 64; over 65 years)

Gender

Bowel cancer screening (60+)

- Did you receive bowel cancer screening kit and return it? (Tick if ‘yes’) (tick box)
- Would you like CFRS to request a kit to be sent out again? (tick box)
- Do you remember getting an invitation to do a bowel screen test kit in the post? The NHS sends them every 2 years to anyone over 60 and less than 75 years old.
- If you remember, did you send off and get a result letter?
- If not:
- Would you like to see what a kit looks like'?
- In order to request a kit is sent to you CFRS will need to send your name and address to the NHS Bowel cancer screening Hub in Rugby.

Special requirements:

Standard Kit; Bowel Cancer Screening: The Facts – English</td></tr>
</table>

	Bowel Cancer Screening: The Facts – Large Print An Easy Guide to Bowel Cancer Screening - leaflet Braille kit instructions Audio kit instructions Bowel Cancer Screening: The Facts - Chinese Bowel Cancer Screening: The Facts - Greek Bowel Cancer Screening: The Facts - Hindi Bowel Cancer Screening: The Facts - Polish Bowel Cancer Screening: The Facts - Punjabi Bowel Cancer Screening: The Facts - Somali Bowel Cancer Screening: The Facts - Turkish Bowel Cancer Screening: The Facts - Ukranian Bowel Cancer Screening: The Facts - Urdu

Analysis of Bowel Cancer Screening Programme data

In order to assess the outcomes and impact of the Safe & Well visits on bowel cancer screening, the research team required access to national bowel cancer screening programme data held by Public Health England (PHE). A list of data items was developed with evaluation commissioners (see Box 2 for details). In order to access the data, a number of applications and processes have been required:

- We developed and submitted an application for review to the national Bowel Cancer Screening Programme (BCSP) Research Advisory Committee on the 25th September 2017.
- The project application was reviewed at the committee meeting on 18th October 2017 Notification of approval was received on the 2nd November 2017.
- A subsequent Office for Data Release (ODR) data request form was requested. This application was then submitted on 22nd November 2017.
- The BCSP Safe & Well outcomes data was delivered to the PHI research team on 18 June 2018.

Box 2. Requested BCSP Safe & Well Outcomes Data

- Number of FOBt screening kits requested by Fire & Rescue staff
- Number of FOBt screening kits requested in language other than English
- Number of householders that requested further information
- Number of householders who went on to complete a FOBt kit as a result of the Safe & Well visit
- Number of positive tests (including number of polyps and cancers identified)

B. Methodological issues with secondary data

During the early stages of this evaluation, the PHI research team identified a number of key data and analysis questions that would enable the ability to evidence the impact and outcomes of the Safe & Well visits. Meetings were held with representatives from each fire service to explore the feasibility of accessing the required data and to understand the types of data currently collected. All data collected by Cheshire and Merseyside Fire & Rescue Services, since they commenced their Safe & Well visits, were shared with the PHI research team. Data have been cleaned and analysed and the findings presented here. The bowel cancer screening questions asked at Safe & Well visits differed slightly between the two Fire & Rescue services:

CFRS	• Did you receive bowel cancer screening kit and return it? • Would you like CFRS to request a kit to be sent out again? • Do you remember getting an invitation to do a bowel screen test kit in the post? The NHS sends them every 2 years to anyone over 60 and less than 75 years old. • If you remember, did you send off and get a result letter? If not: • Would you like to see what a kit looks like'? • In order to request a kit is sent to you CFRS will need to send your name and address to the NHS Bowel cancer screening Hub in Rugby.
MFRS	• Declined to discuss • Did you receive bowel cancer screening kit? • Did you return kit and receive results? • If no, explain benefits and ask: • Would you like MFRS to request a kit to be sent out again?

Analysis of the FRS datasets

Bowel data

- In the datasets provided by both Cheshire and Merseyside FRSs, some householders had no information for consent but had data for the bowel cancer screening questions; therefore, a total was produced from including anyone who had some form of data in the bowel cancer screening section.

- In the datasets provided by both Cheshire and Merseyside FRSs both Cheshire and Merseyside FRSs, there are some queries around age and inputting errors for date of birth. A number of householders in the CFRS data set had date of births in the future and both data sets had householders with ages that are most likely to be inputting errors (e.g. age 6 and age 117).

- In the datasets provided by Cheshire FRS, date of birth is recorded for householders who request a screening kit. In the datasets provided by Merseyside FRS, date of birth is recorded for all householders who give consent.

- In the datasets provided by Cheshire FRS, 'previously received and returned a kit' is recorded as one data item. In the datasets provided by Merseyside FRS, received and returned are recorded as separate items.

- In the datasets provided by Cheshire FRS, only yes answers to the bowel cancer screening questions are recorded, therefore it has not been possible to separate those who have not

previously received and returned a kit, from missing answers or householders who have not answered the questions.

- In the datasets provided by Merseyside FRS, responses to the bowel cancer screening questions were not consistently recorded, for example **Y**es and **y**es. A drop down function would reduce free text and inconsistency in reporting.

All data

- Data restrictions were a problem - access to full postcodes for FRS data would help to give a more accurate indication of areas of deprivation reached e.g. in the Cheshire IMD map it looked like visits roughly corresponded with areas of deprivation, but the findings of the report do not support this, because of limits in the way deprivation could be measured in the data provided.
- There was no record of numbers of people given brief advice/interventions – this would be useful to collect in future

C. Methodological issues with householder survey

In Merseyside, most of the visits were done by advocates, whereas in Cheshire, all visits were done by firefighters. For the householder survey, it was reported[10] that some advocates stayed after the visit, while the householder completed the questionnaire, then the advocate posted it for them. This may introduce some bias, with responses more likely to be favourable if the questionnaire is completed in the presence of the person undertaking the visit.

Was this a '*good use of the Fire & Rescue Service?'* (qu.3 'before the visit' and qu.6 'after the visit'): It is possible that householders may say 'yes' to this question and be thinking of the fire safety aspect of the visit, rather than the health check aspect.

Some respondents skipped several questions, so the fact that they did not tick a box should not be taken as a negative response. For example, 42 respondents indicated that they felt the purpose of the bowel cancer screening assessment was fully explained, but that does not mean that the rest did not think it was well explained.

[10] *At the evaluation stakeholder meeting on 24/11/17*

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CHESHIRE
FIRE & RESCUE SERVICE

Merseyside
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SERVICE