Agenda Item No. 6

WEST MIDLANDS FIRE AND RESCUE AUTHORITY

SCRUTINY REPORT

20TH JANUARY 2014

1. PREVENTION STRATEGY

Report of the Chief Fire Officer.

RECOMMENDED

1.1. THAT the Committee endorse the strategic approach described in this report.

1.2. THAT the Committee proactively support data sharing initiatives especially in their own areas and organisations.

1.3. THAT the Committee proactively support Command Teams to develop local partnerships especially in their own areas and organisations.

1.4. THAT the Committee support the process gathering intelligence and embedding learning outcomes from the Serious Incident Review process.

2. PURPOSE OF REPORT

This report is submitted to provide the Committee with an overview of the Prevention strategy and approach and the relationship and links to key Performance Indicators so that they can ratify the methodology and approach adopted.

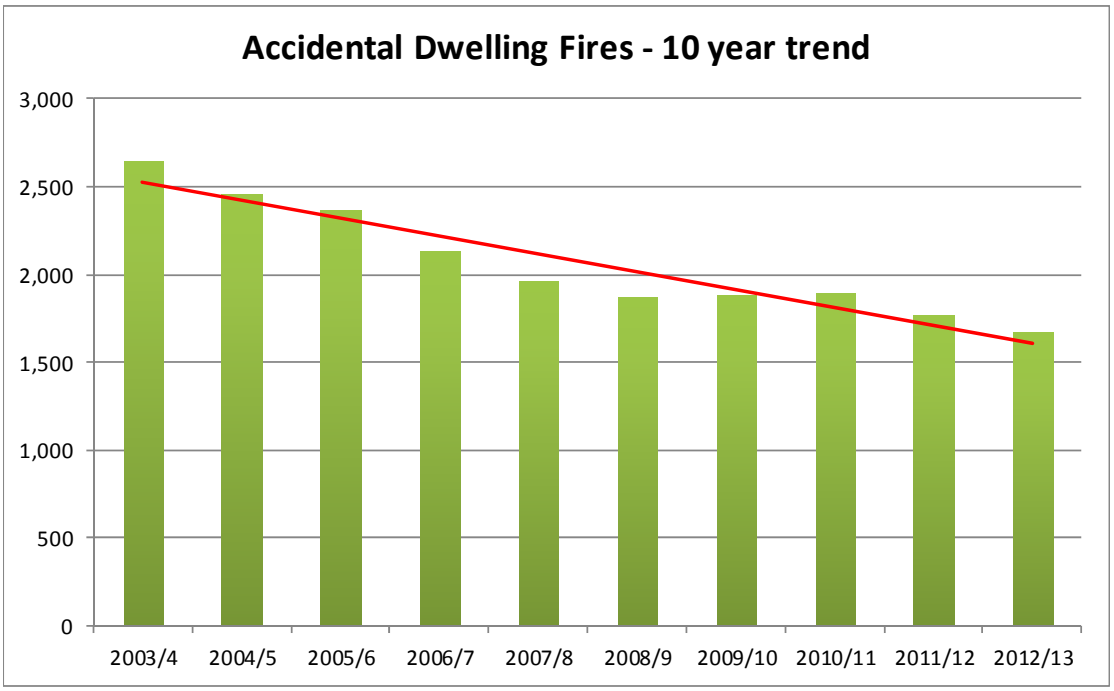
3. BACKGROUND

3.1 Process of setting annual targets for Performance Indicators (PI)

The process of setting PI targets starts in Sept/Oct when draft plans are made.

These are passed to Directors during November and December before going to Fire Authority during January for final sign off.

During the last 10 years the number of Accidental Dwelling Fires responded to by West Midlands Fire Service has decreased dramatically (36.9%). If we only consider the trend line on the graph below we would assume that the numbers of Accidental Dwelling Fires will continue to decrease indefinitely until reaching 0. This is not the case. Over the last few financial years the rate of decrease in Accidental Dwelling Fires has reduced and numbers are starting to plateau. It is safe and sensible to assume that whatever education or safety is put in place to reduce Accidental Dwelling fires the very nature of accidents is that there will always be some.



We strive to continue to reduce the number of incidents and are always looking at new ways to make contact with and support the most vulnerable. In our approach of striving for excellence the targets set have demanded significant reductions over the last few years. However, influencing the number of incidents becomes ever harder as we get down to situations that are hard to predict and where people are hard to reach and the current economic climate starts to have a significant impact.

Historically, targets relating to incidents have not been set that result in an increased figure compared to the previous year, although there has been examples in other areas that challenge this. This has resulted in some challenging targets being set for 2013/14. For example there was a predicted increase in PI1 Accidental Dwelling Fires during this current year, compared to last. However the decision was taken to continue to set challenging targets with an understanding that they would be very difficult to meet.

Table 3.2 overleaf shows both the year-on-year actual and predictions alongside the 3 year rolling averages. Given our methodology of setting targets over the 3 year average, in the future it will mean that a target will be set that will be an increase in comparison to the previous year. The use of the 3 year average has been useful to show the continued downward trend whilst taking into account yearly anomalies. For PI1 the financial year 2012/13 was recognised as one such anomaly.

As the variation of number of incidents from year to year becomes smaller other additional factors could be used to measure impact. For example, looking at the severity of the incident or the spread of fire. In the first instance our approach to using this data will be run it in the background to validate the data to ensure the relevance and the accuracy of analysis.

It is also likely that the current economic situation will start to have an impact in the next year or two. The impacts of welfare reform and the priorities that families face are expected to cause a rise in the number of incidents as people make tough choices about where to spend limited income. This is also likely to be compounded by reductions in front line public services that support the most vulnerable. Services are struggling and large scale job cuts are predicted within Local Authorities in the West Midlands with some already talking about whole areas of service being cut.

3.2 Performance Record

PI	Performance Indicator	2009/10 Actual	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Predicted	Overall target 2013/14	%age Diff One Year Only (2012/13 to 2013/14)
PI 1	The number of accidental fires in dwellings	1,877	1,889	1,773	1,668	1,725	1,603 (-9.8% 1777 down to 1603)	-3.9% (1668 down to 1603)
PI 1	3 year rolling average		1,846					
				1,777				
					1,722 (predicted)			

PI	Performance Indicator	2009/ 10 Actual	2010/ 11 Actual	2011/ 12 Actual	2012/ 13 Actual	3 yr baseline average	Overall target	Overall Target 13/14	Predicted 2013/14	%age Target Diff One Year Only
PI 2	Injuries from accidental fires in dwellings (Taken to hospital for treatment)	99	95	78	61	74	-9.5%	67	57	36.7%
PI 3	The number of deaths from accidental fires in dwellings	16	11	18	7	N/A	We seek to minimise deaths from fires	No target set	N/A	N/A

3.3 **Connections between Performance Indicators**

There are obvious links between the number of accidental dwelling fires and the subsequent number of people killed or injured.

Recent analysis undertaken across operations shows some common experience where:

- the vast majority of accidental dwelling fires start in the kitchen and are caused by cooking.

- those considered at a higher risk of accidental dwelling fires are:

    - occupiers aged 25 to 44
    - Black African/Caribbean/Black British
    - living in purpose built flats
    - living in social rented accommodation

Fire deaths are thankfully small in number however some common themes can be seen with links to some, or a combination of:

- older age
- dementia
- mental health issues
- drugs and alcohol use
- lack of mobility
- social isolation

Further in depth analysis on PI1, 2 and 3 is being undertaken currently to determine what some of the “causes of the causes” are, e.g. whilst we know that most accidental dwelling fires start in the kitchen and are related to cooking what was the root cause? Was it due to distraction from children, substance misuse, unsafe cooking practice? And then what are the links to different sections of the community, age, ethnicity etc.

Even before this work is completed what we understand is that after taking all these factors into account there is still an overarching link between all these performance indicators and social inequality and deprivation.

3.4 Home Safety Check (HSC) - Points System

In 2011, WMFS reviewed the HSC process. The HSC process identifies potential causes of accidental fires in the home and educates occupiers on how to make changes to their environment and behaviours in order to reduce risk of a fire occurring. HSCs were previously targeted at properties, not the individual. The review concluded that an improved targeting of resources to risk would be more appropriate. The outcome of the review resulted in the introduction on 28 November 2011 of the current HSC points system.

The current HSC process moved away from completing high numbers of HSCs (targeted around 45,000 HSCs per year) to using a point allocation system based on an individual's risk. If the individual is deemed to be minimal risk and does not achieve any points, they are sent a Home Safety Information Pack. If the individual is identified to be of a higher risk they will be offered a full HSC. If the individual is vulnerable and requires specialist services, they may be referred to a Vulnerable Persons Officer.

The performance management of this points target approach is intended to encourage more effective engagement with partner organisations working with the most vulnerable people within our communities.

An annual points total for WMFS was set at 150,000 based on assumptions around the average expected points per HSC of 5. The actual average number of points being achieved currently stands at 2.9 which has resulted in the total number of points this financial year so far of 47258. It is anticipated that the total point score for the financial year will be 76,566 (51.24% of the target) which includes those referrals yet to be completed.

Further evaluation of the HSC Points system has been undertaken by the WMFS Data Team. The point scoring system is a critical toolkit in the development of a robust system to deliver home safety messages and to reduce risk. This ongoing collaboration with the Data Team will further enhance the targeting high risk groups and individuals.

The review of the points allocated against specific risks determined that some of the risk criteria points should be adjusted to give greater weighting against specific risk. For example currently an individual who smokes receives 0.1 points whilst an individual who is in rented property receives 0.5 points. The proposed change would result in the smoker receiving 1.0 point. The point allocation changes have been agreed but the implementation of the updated points scoring system has been delayed as a consequence of conflicting priorities and capacity within ICT (See 3.11 Barriers to Implementation).

The target annual points total for WMFS of 150,000 based on assumptions around the average expected points per HSC of 5 points was established by Community Safety and Statistics using data from previous HSC's. At the time this target was established it was based on a number of untested assumptions and it was recognised as needing constant monitoring and reviewing. We believe that this target is achievable given better targeting, better use of resources and the updated points system being in place. At this point we don't have a feel for the impact the changed points system will have. A period of testing with the changes in place is needed to be able to test these theories (See 3.11 Barriers to Implementation).

In addition to the point scoring refresh, post incident Serious Incident Review's will continue to identify and shape how points are allocated in the future as part of the ongoing targeting of vulnerable persons Level 2 planning.

3.5 Our Current Prevention Strategy

The strategy is to ensure that our commitment to reducing risks and improving community safety as determined in The Plan through prevention based activities is maintained to the highest possible standards to meet our social, moral and legal responsibilities in making the West Midlands Safer. It also ensures we get value for money extracting the most benefit from our prevention and protection activities.

The aim is to embed the principles of the Health and Wellbeing Agenda within this strategy to ensure that our prevention based activities supports both vulnerable individuals and vulnerable properties with particular reference to the economic and community value.

Our service is delivered in a variety of formats and where appropriate by specialised trained personnel in conjunction with partner agencies, to meet the needs of individuals within our community. While it is impossible to ensure that every person that lives, works and commutes in and through the West Midlands would never come to harm, the policies and procedures set out in this strategy will assist the delivery prevention services efficiently in an innovative and creative manner within the identified parameters to provide a bespoke service to those most vulnerable and at risk.

- Our structure proactively targets our prevention activities based upon profiled risk. Work with other agencies drives reactive targeting through referral of people with increased levels of vulnerability.

- Identifying and engaging with people deemed to be at greater risk from fire by targeting the most vulnerable members of our community.

- Targeting our services in the community to reduce risks and improve safety, health and wellbeing where there is correlation of either environment or behaviours that is mutually beneficial.

- Identifying and engaging with community groups, our partners and other stakeholders who have a shared responsibility for the safety of vulnerable people, thus ensuring that together our community is safer.

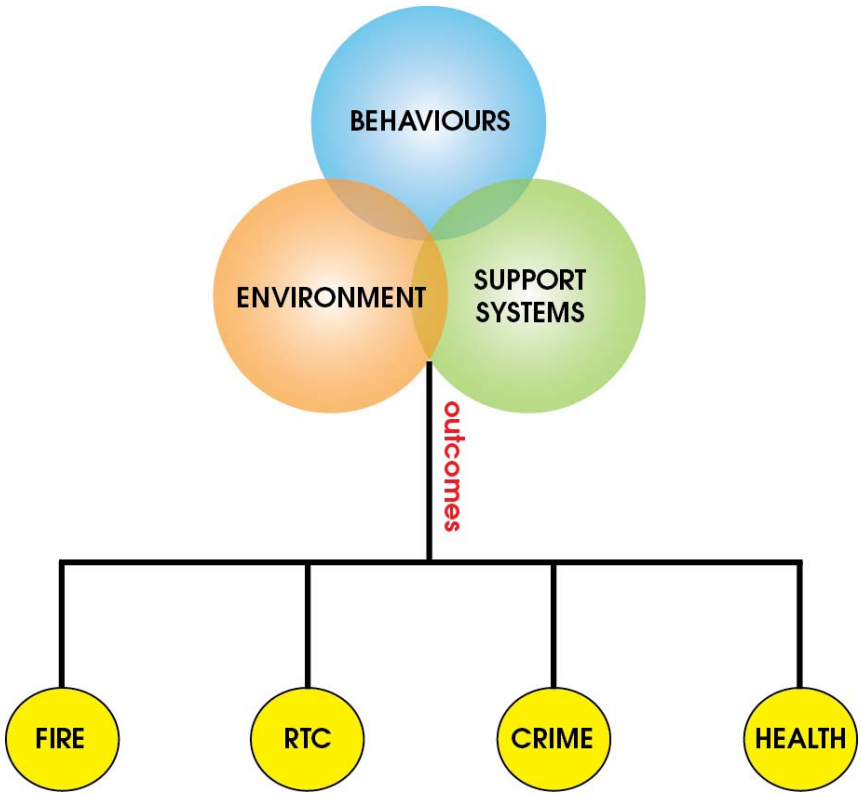
- Empower our communities to make decisions, change behaviours and attitudes to encourage individuals to take ownership of their own safety and that of those around them.

- Maintaining systems and procedures that safeguard vulnerable people from abuse.

- Promote and lobby with our partners from all sectors to change and support legislation that makes our communities safer and improves health and wellbeing.

We will continuously evolve our prevention based activities to meet the changing needs of our communities and therefore will take into consideration that where resources are reallocated or redistributed to other areas, scanning process will continue to ascertain whether any pro-active measures by prevention or protection would be required. Vulnerability will be the driver for the allocation of resources. A summary of the approach being taken to deliver prevention activities is attached as Appendix 1

WMFS has developed an understanding of "vulnerability" in terms of the cumulative effect of a number of factors contributing to a person's risk of fire and other incidents requiring emergency response. We see them as falling in 3 broad categories: Behaviour, Environment and Support Systems.



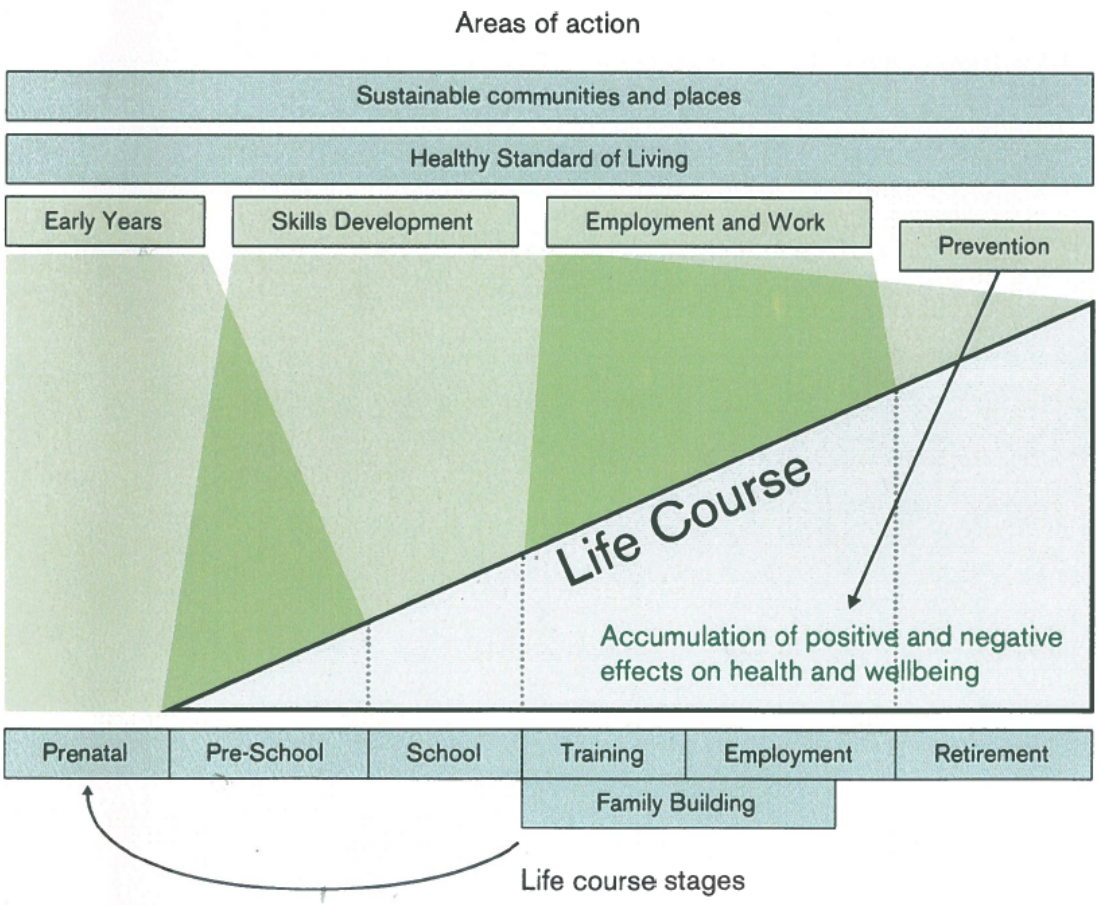
If a person's vulnerability is due to a combination of these factors then conversely the positive changes or prevention activities that we can put in place will also need to tackle these 3 areas of a persons life to decrease their vulnerability. The Marmot report makes it clear that to reduce the gradient in health requires action across all the social determinants of health.

In the same way, for WMFS, a long term investment in reducing the gradient in health will also result in a reduced vulnerability to fire, RTC and other emergency incidents. The activity that WMFS undertakes to reduce the gradient in health also makes a significant contribution, and has great value to the wider health and wellbeing agenda.

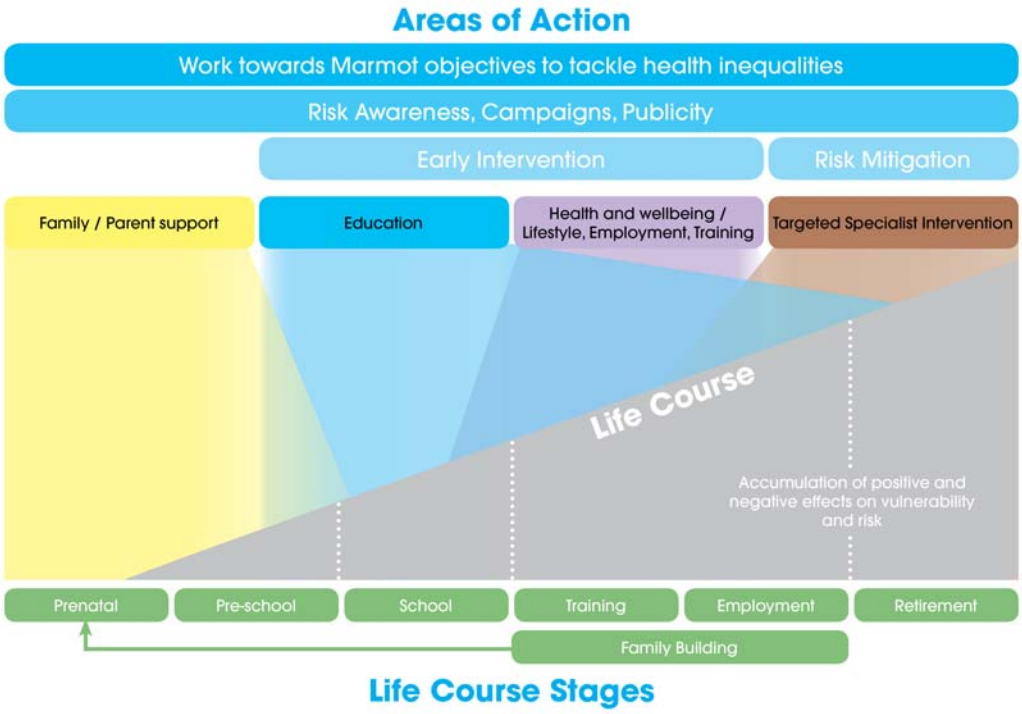
3.6 **Tackling Health Inequalities – The long term investment in reducing risk**

WMFS have adopted both the “Marmot” and “Making Every Contact Count” (MECC) strategies as a means of reducing the vulnerability of local communities with the understanding that by working with other agencies to contribute to an individual’s improved health and wellbeing that this will reduce their vulnerability to fire and other emergency situations. More details of the Marmot and MECC approaches are contained in Appendix 2 and 3

The Marmot Review “Fair Society, Healthy Lives” proposes action against health inequalities across the whole life course on the basis that disadvantage starts before birth and accumulates throughout life. The diagram below from the report portrays the Areas of Action throughout the life course.



The diagram below uses the same graphical idea to portray the WMFS approach to Prevention across the life course. There are overarching activities that continue for the whole life course. At different life stages, different interventions and activities also come into play to provide education, early intervention and to mitigate risk. These activities are intended to act as a positive accumulation of resilience factors in terms of awareness, understanding, improved behaviours and environment that reduce the risk to the individual.



Building partnerships with other agencies to tackle the challenge of people taking more responsibility for their own health and well-being and adopting positive lifestyles forms part of the Corporate Level 2 plan for Vulnerable People and also each of the Level 3 plans for the Command areas.

The Joint Health and Wellbeing Strategy for an area drives the collective actions of the NHS and local government, both commissioners and providers, and engages communities in the improvement of their own health and wellbeing. The adoption of the Marmot objectives within local Joint Health and Wellbeing Strategies is continuing to develop.

3.7 Strategic Influences

3.7.1 FACING THE FUTURE: Findings from the review of efficiencies and operations in fire and rescue authorities in England

The report by Sir Ken Knight acknowledges that it "*is a really good news story that there has been a massive reduction in emergency incidents in the last decade, particularly in fires of all kinds. Fire and rescue authorities have played a pivotal role in this, and have moved from predominantly emergency response organisations to organisations that look to reduce risk.*

There is little doubt that prevention is better than cure. But the reduction in fire risk is not solely due to the actions of fire and rescue authorities – societal changes, technological improvements, the increase in smoke alarm ownership, safety campaigns and government regulations for both buildings and furniture have played a huge part."

Under the chapter "Deploying resources" Sir Ken states *"Authorities are right to capitalise on their reputation to help deliver other services to hard-to-reach communities. But this should only be where they are commissioned to do it, or have identified a clear cost benefit to their own aims."*

3.7.2 **Improving Health And Wellbeing In The West Midlands: Towards A Collaborative Framework**

Communities and Local Government WM, Public Health England WM and Learning for Public Health WM are undertaking a piece of project work that is due to be completed during December 2013. The project looks at how councils can use a 'whole council' approach to support the health and wellbeing agenda. Strong leadership and councils committed to working with communities and partners to improve the health of their communities and address health inequalities is at the very heart of the project.

The project recognises the challenging financial context facing local government and public services due to the combination of rising demand for care due to demographic changes and real-terms cut in funding; that there are persistent health inequalities across the region – despite improvement in overall health, the health profile for the West Midlands shows that the region continues to remain below the England average on many of the health indicators; and, restructuring of the national and local leadership and management of public health, with local government having a leadership role for improving public health.

The key findings will be shared with the Health and Wellbeing Boards, local authority Chief Executives, Directors of Public health, Children's Services and Adult Services, Healthwatch, partners from CCGs and providers and support agencies in the voluntary sector. The three commissioning agencies will be organising regional and local events to discuss how the key findings can be taken forward and implemented.

3.8 **Partnerships**

WMFS will only be successful in targeting the most vulnerable individuals and households in the community through collaborative working between WMFS and partner agencies that also have contact with, and hold data on, those vulnerable within the community. Adopting the understanding that the Marmot approach provides suggests that a vulnerable individual is highly likely to be known to a number of other agencies before an incident occurs that WMFS respond to. These agencies would include: housing, social services, police, health, education and the 3rd sector.

It is therefore essential that WMFS build partnerships with these agencies so that we can identify those vulnerable people early enough for our prevention activities to have an effect. Practically this means establishing referral pathways, data sharing protocols and partnership agreements to be able to share information and intelligence on individuals and households so that we can target activities effectively. The HSC points system described above drives this partnership approach. Put simply, the only way that the HSC points targets are going to be achieved is through high numbers of high quality referrals being made through partners.

The recent Command Team review has restructured and refocused the teams towards this partnership approach by providing Partnerships Officers and Community Risk Reduction Officers to support the Command Team to deliver this agenda.

A recent review of partnership working has identified that there were previously 367 partnerships on the database of which many were no longer current. Following the review there are now 72 current partnerships. This work has encouraged Station Commanders to work more effectively with local partners to assist in the identification of high risk individuals within their community. The Standing Order and associated guidance documents are currently being rewritten to give clarity in developing effective partnership referrals to assist in this process. These arrangements are also monitored quarterly under Corporate Risk 4.

The Level 2 Vulnerable Persons Plan identifies that the focus is on achieving 80% of HSC referrals from partners.

3.9 **Data Sharing**

Referrals from partners occur at many levels. In the simplest form information is passed on by a partner agency for the individual to independently make contact with WMFS. At its most sophisticated data sets are shared between agencies that provide a range of information about individuals or households. This approach has to be managed very carefully to ensure data protection, authorisation and security issues are addressed. The advantage is that we can develop early interventions based on the information about risk factors that are already known, rather than a worker having to identify the risk and make a formal referral.

We have data sharing agreements with some agencies and are working towards agreements with many others including local authorities, housing providers and social care and health agencies. These agreements can take time to establish and for the ICT and security issues to be overcome.

As a stepping stone towards full scale data sharing, which may never happen with some agencies, then protocols are established agreeing what information is shared and how. An example would be a care agency submitting a HSC referral form already partly completed with basic information that we require.

The quality and number of referrals versus the time and effort required to establish and maintain a partnership

Facing the Future - the report by Sir Ken Knight states *"Best practice in this area comes from those who are finding ways to share intelligence with local delivery partners to identify homes for risk checks and to equip or support those agencies to deliver the vital safety message. This data sharing seems to work best in County and Unitary fire and rescue authorities by default; due to the connectivity between different parts of the wider council and the likelihood of partners using the same IT platform as the fire and rescue service, though this is by no means assured. In combined and metropolitan authorities, where a fire service sits across a large number of different unitary authorities, there is a crucial role for the fire and rescue authority members in going back to their home authority and pressing for better data sharing to identify those most at risk in their own community"*

Some examples of successful inroads being made on data sharing with housing providers is attached as Appendix 5

3.10 **Serious Incident Reviews**

The aim is to investigate all serious fire incidents that result in serious injury or death. The types of incident that require a SIR are:

- Any fire fatality.
- A potential fire fatality.
- Incident involving a person over 65 with significant smoke inhalation.
- Incident that involves children and burns.

This process brings together vital information from various departments to assist West Midlands Fire Service identify any learning outcomes or changes that may need to be made internally to brigade policy/procedures. The SIR form has several sections that are chronological but interconnected and are completed by the following departments:

- Flexi Duty System (FDS) Officer at incident
- Local Station personnel
- Command Teams (Operations Commander, Partnership Officer, VPO Lead Officer)
- Fire Research & Investigation Officer
- Legislative Fire Safety
- Community Safety Headquarters

The other key outcome from the SIR process is to identify their involvement before the incident and then possible learning outcomes for partner agencies post incident. All stakeholders are consulted and invited to discuss the issues raised and how to address them. The conclusions and recommendations of this process are developed as learning outcomes with an action plan. This information is then shared internally and with partners to ensure that recommendations are implemented.

Where it is clearly identified that there has been serious neglect leading to the fatality or serious injury, consideration must be given to referring to the relevant local Safeguarding Board for a Serious Case Review. Examples of 2 recent cases are attached as Appendix 6.

3.11 Current Barriers to implementation

There is a real strategic shift towards adopting the Marmot and MECC principles to support the existing prevention strategy. However a number of barriers remain that inhibit the full and widespread implementation of the approach.

3.11.1 Organisational culture – Insufficient awareness of the Marmot/health and wellbeing agenda within the WMFS

There remains work to be done to raise awareness amongst staff about the rationale behind the adoption of the Marmot/MECC approach. Training is currently being delivered and further work is planned including production of DVDs etc. A number of other communication and launch events are being planned including for the “Endorsement” of the work of WMFS by the Marmot Team.

3.11.2 External Perception - Insufficient understanding by Partners of the value of the Fire Service to contribute to the wider determinants of health

The “Endorsement” by the Marmot Team of the work undertaken by WMFS is a key milestone in the ongoing work to raise the profile of the value that WMFS brings to the wider health and wellbeing agenda. The publication of the WMFS Marmot Brochure and subsequent launch events should continue to raise awareness with partners, especially in the health sector. The longer term intention is that this should pave the way for WMFS to be a more valued partner with the opportunity to be commissioned to deliver activities in the future. There is a key role for Fire Authority Members to assist with the work.

3.11.3 **ICT Systems – Improved efficiency and ease of delivery**

A number of ICT systems have been planned to be developed or improved that will assist operational crews to deliver and record prevention activities more efficiently. Due to capacity issues within ICT this work is yet to be completed. This includes:

- Updating the HSC Workbook to reflect new points scores
- Developing the Serious Incident review workbook
- Updating the Partnerships Database
- Secure means of receiving and reconciling data shared by partners

3.11.4 **Lag between implementing strategy and evidencing improvement**

Developing partnerships and joint programmes of work takes time. Personal relationships need to be developed with key individuals in partner agencies. This is being attempted at a time of significant uncertainty and movement of staff within the public sector.

The Marmot agenda especially is a longer term investment in reducing disadvantage and improving life chances. Data sharing protocols also take time to develop. These positive impacts will not be measurable in the short term.

Rather, we need the confidence to remain focussed on the long term aims and develop short to medium term indicators to have confidence we are moving in the right direction.

4. EQUALITY IMPACT ASSESSMENT

In preparing this report an Equality Impact Assessment has been undertaken in the constituent parts. The constituent parts of this report (HSC policy, Prevention Strategy etc.) have previously been the subject of EIAs and this report does not propose any significant change to these approaches.

5. LEGAL IMPLICATIONS

The prevention based activities and policies within this report support the direction given within the National Framework in particular the targeting of resources to the most vulnerable to community.

6. FINANCIAL IMPLICATIONS

The report does not have any direct financial implications as all restructures and resource allocations have been subject to previous reports.

7. ENVIRONMENTAL IMPLICATIONS

There are no proposed environmental changes discussed within this paper that have not already been subject to previous reports.

BACKGROUND PAPERS

Appendix 1	**Summary of approach to Prevention Activities**
Appendix 2	**The Marmot Review**
Appendix 3	**Making Every Contact Count**
Appendix 4	**Repeat Incident Flagging System and Data Sharing**
Appendix 5	**Recent Example Serious Incident Reviews**

The contact name for this report is Peter Wilson, telephone number 0121 380 6730.

PHIL LOACH
CHIEF FIRE OFFICER

Appendix 1

Summary of Approach to Prevention Activities

Prevention Activities

Prevention activities generally fall into 3 broad categories.

1. **Targeted specialised intervention**

   These services are for those who are identified as being at a higher risk or vulnerability and are in need of more formal interventions tailored to their individual needs or circumstances.

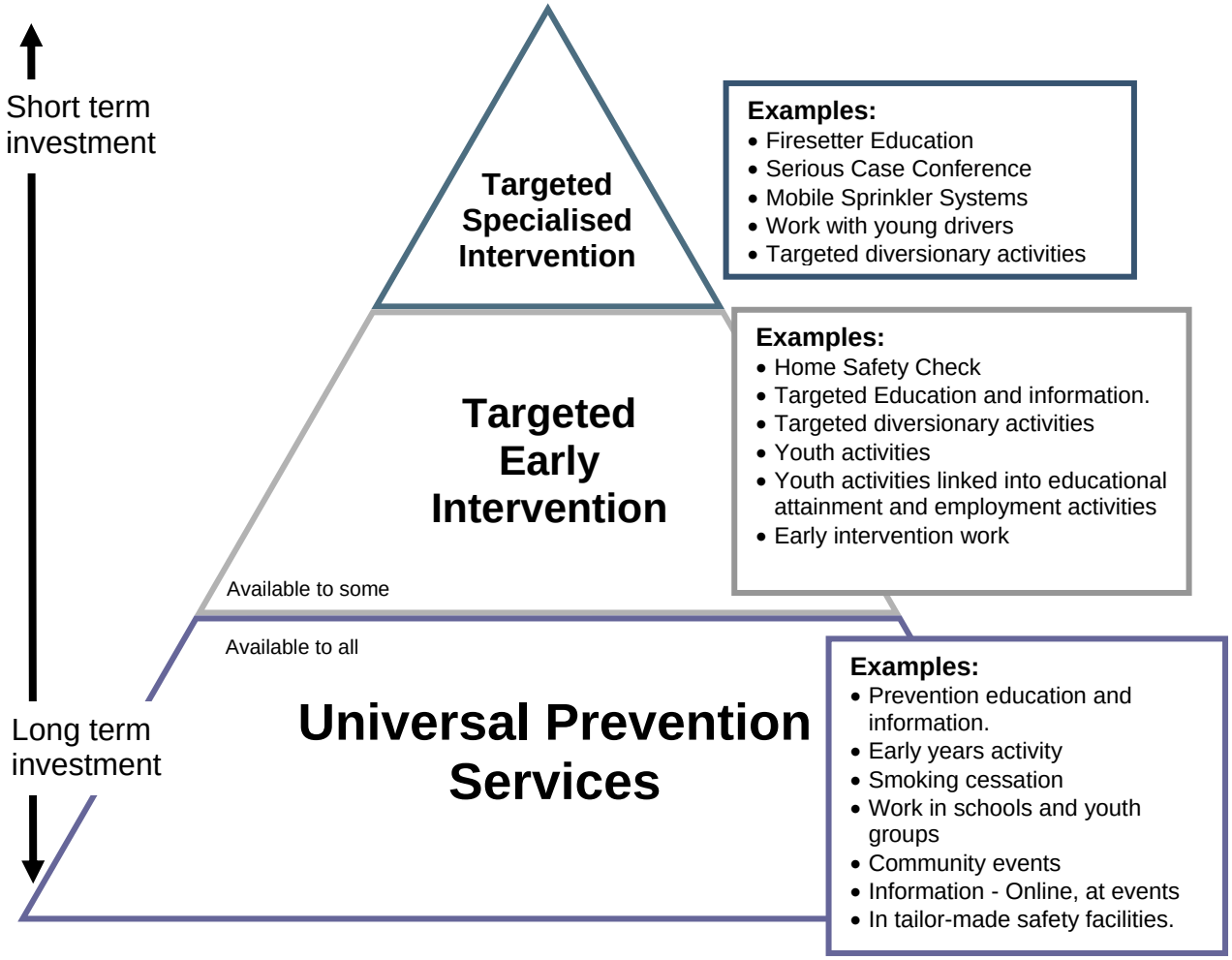
2. **Targeted early intervention**

   These early-intervention services are targeted at people who are identified as being vulnerable. The services are designed to mitigate risks and change behaviours.

3. **Universal prevention services**

   These prevention services are available or applied universally across the service area to the community as a whole. Individual activities might be targeted to certain sections of the community (e.g. age ranges) but are universally available to that section. As resources become more scarce these services could be targeted to those who are most at risk.

As the interventions become more targeted the number of individuals becomes smaller such that there is a triangle of activities within these broad categories.



This approach adopts the principle of "Proportionate Universalism". The idea that - on its own, targeting the most disadvantaged or vulnerable will not reduce risk sufficiently. To reduce the steepness of the risk gradient linked to disadvantage, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.

At all levels adopting a partnership approach is essential to ensure that resources are used effectively and efficiently and that interventions complement and support the work of other agencies. Also that we use the data and intelligence we have to drive targeted prevention activity.

Appendix 2

The Marmot Review

The Marmot Review "Fair Society, Healthy Lives" is a strategic review of health inequalities in England post 2010. The final report was published in February 2010, and concluded that:

1. Reducing Health inequalities is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.

2. There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.

3. Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.

4. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

5. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

6. Economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.

7. Reducing health inequalities will require action on six policy objectives:

- give every child the best start in life
- enable all children young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all
- ensure healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill health prevention

8. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies

9. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

The review recognised that in order to bring about a positive change people will need to take more responsibility for their own health and well-being and change long held beliefs and cultural lifestyles. The review also recognised the long term value of making changes early in a child's life. To achieve this, a partnership approach must be adopted using the wider determinants of health as the basis, and that the Fire Service, NHS, Schools, Police, Sport and Leisure, Housing and other organisations would all figure highly in the strategic and operational development of this approach.

In April Dr Mike Grady, Marmot Senior Research Fellow, delivered a workshop to a management briefing that explained the Marmot concept and identified the wide variety of work that WMFS already undertakes towards these objectives.

We have secured the services of a health professional to assist with WMFS gaining a formal "endorsement" from the Marmot Team (who currently operate as the UCL Institute of Health Equity). This endorsement is recognition of our commitment and contribution to this agenda and to provide increased confidence for partner organisations about our value in this area.

Appendix 3

Making Every Contact Count

The objective of “Making Every Contact Count” (MECC) within the NHS was to systematically utilise the millions of contacts that people have with providers of health and social care (such as GP, outpatient appointments, etc.) to deliver brief advice on healthy lifestyle behaviours and to signpost people to appropriate behaviour change services in order to:

- Increase the prevalence of healthy lifestyle behaviours amongst NHS staff as well as the population they serve.

- Reduce the inequalities in health outcomes associated with lifestyle behaviours.

The MECC approach has been adopted by WMFS as a means of signposting individuals that we are in contact with to other services that will contribute to improved health and well-being. Operational staff are being trained in the MECC approach and DVDs and training aids are being developed. This will maximise the impact of the contact time that a home safety check affords by also signposting people to other support services e.g. smoking and healthy eating. Every opportunity will also be taken to communicate positive health and well-being messages at open days and other times when we engage with the public.

Appendix 4

Repeat Incident Flagging System and Data Sharing

Automated orders e-mails

Following a spate of repeat incidents for a domestic dwelling in Coventry it finally by luck became apparent arson was regularly used to make fraudulent insurance claims £78,000 over a four year period. WMFS had no systems in place to automatically highlight to managers such incidents. The Arson Task Force (ATF) developed an e-mail flagging system (RIFS) automatically picking out and sending out emails to managers highlighting repeat incidents at any address within the West Midlands area.

All station commanders are receiving automated (RIFS) emails. This e-mail will contain the calls history for properties, domestic and commercial, where WMFS have attended any type of incident more than once in a rolling eighteen month period for domestic properties and three years for commercial properties. E-mails will contain instant links to completed incident work books and HFSC history for domestic properties and any other relevant information for commercial including SRS details

The intention is to give boroughs and station commanders lead performance information on trends that will assist in use of resources and where.

Level 1 Data sharing with partners

Additional to the above partnerships with Local authority social landlords have been formed informing partners electronically of any incidents we attend in their housing stock. This cuts across all WMFS performance indicators and has culminated in the forming of the West Midlands Social Housing Group (WMSHG) representing approximately 290,000 social properties including most of the high rise across the West Midlands. This two way data sharing agreement is producing tangible results for reducing incidents and providing VFM. Statistical data can now be shared with WMSHG members showing partners trends and areas of high resource usage.

To share data we need to store property data on WMFS servers in a unique property reference number format (UPRN). In simple terms a spread sheet that allows enormous numbers to be stored and manipulated with relatively no impact on server capacity. Currently continuity within WMFS is having impact on this flow of information. An IT priorities list has been developed that if met would future proof our services and create additional opportunities.

Level 2 and beyond

WMSHG are now in a position to share additional data with WMFS to include known vulnerable tenants in their properties. This work will allow WMFS to electronically target the most Vulnerable within our communities. A pilot scheme is being conducted to correlate tenant's vulnerable data with WMFS data identifying the highest HSC point scorers electronically. It has been agreed by WMSHG members this project when fit for purpose will be emulated across the West Midlands. This has potential to dramatically increase our involvement with the most vulnerable in society at little cost and resource usage.

WMSHG is a one stop shop for other WMFS departments to utilise. including the following.

- **High rise -** All members are keen to work with the SRS team mapping their high rise buildings. This work would dovetail into electronic identification of vulnerable groups for HSC purposes by building up a picture of the locations for vulnerable people in the event of fire.

- **Sprinklers -** Currently all members are carrying out scoping exercise's for fitting sprinkler systems into their properties as part of retro fits, new fits and specific risk situations. To support this work a WMSHG sub with a fire safety lead is to be established in the New Year.

- As a direct result of the WMSHG seminar hosted by WMFS, Riversleigh group housing have asked WMFS to assist in options for the fitting of sprinkler(s) in a sheltered housing scheme. This would not have happened outside the WMSHG.

WMSHG member Alan Atkins representing White friars (Coventry) has announced they are fitting sprinklers into 4 high rise blocks.

- *Meadow House*
- *Falkner House*
- *Longfield House*
- *Mercia House*

- **Communal Areas**, Once again a sub group supported by a fire safety lead are to look at communal area problems and develop joint solutions across the West Midlands.

Appendix 5

Recent Example Serious Incident Reviews

1. Walsall on 02/12/13

The occupier had life threatening conditions and had both of her legs amputated due to injuries received and died the following day. The incident occurred in a ground floor flat within a three storey block of traditional construction.

The alarm was raised by the hard wired alarm in the communal area. An adjacent neighbour went to investigate at a first floor property where there had been a previous alarm caused the week before. On her way back down she saw hazy smoke at ground floor level and then flames through the window and immediately dialled 999. WMFS was informed at 1504 hrs. The first appliance was mobilised at 15:04:50 and was in attendance at 15:09:57, 2nd appliance in attendance at 15:11:08 and 3rd 15:14:19.

The fire was contained within the bed area in one room, this was extinguished immediately and the casualty removed to the grassed area to the front of the building where trauma care was commenced by Fire Service personnel. The ambulance first responder arrived after an estimated 12 minutes, the land ambulance arrived after a further 8 minutes and the casualty's care was then taken over by the ambulance service and she was removed to a suitable site for evacuation to the Q.E. Hospital by service helicopter.

The casualty is disabled white female living by herself in a rented property. It appears she is cared for by her family and a private care provision company. It is understood that she is alcohol dependant and smokes in bed. There was evidence in the flat that wiring was underway for the provision of a telecare call point, the flat had a hardwired fire alarm system which had two detectors which were tested by Fire Investigation as working.

On November 21st 2013 Walsall Social services contacted our Contact centre to request a HSC for this address, a voicemail was left for the occupier on 28th November, she was further contacted on 29th November (3 days before the incident) when she refused the offer of an HSC, so consequently a HSC was not completed.

2. Coventry on 05/12/13

This incident involved a fire in a first floor front bedroom of a two storey terrace private domestic dwelling. One 80 year old man was rescued by fire service personnel from the first floor rear bathroom suffering smoke inhalation and minor burns after trying to tackle the fire. Ambulance crews at the scene said that his injuries were life threatening.

The man lived alone in the premises which is a two story terraced private dwelling of traditional brick construction. FRIT are still investigating the cause of the fire but early indications are showing that the fire started in an electric blanket (an old style blanket which was a duvet and not an under blanket). The BA crew upstairs searched and after a short period of time found the fire in the upstairs front bedroom and started to extinguish the fire whilst continuing to search. They then found the man in the upstairs rear bathroom with the door shut. The man was brought out of the property and handed to the paramedics. The fire was fully extinguished and the scene preserved awaiting the arrival of FRIS.

The house had two single point smoke detectors fitted; one on the ground floor and one on the first floor in the hallway. They were activating on arrival of the fire crews. There is no record of any fire service engagement at the premises including both incidents and prevention activity.