Finance and General Purposes Committee Extraordinary Meeting
23 March 2016

Appendix 5

Summary Business case	Service Delivery Redesign – Fire as Health Asset Work-stream (SDTP moving to Implementation)
Date of SMT meeting	February 2016

Description and objectives

The project aim is two-fold:

- Firstly to create an operational capability (trained staff alerted with the right equipment and vehicles) to attend additional medical emergencies.

- Secondly, to broaden the role of the Services prevention activity to support the wider public health and wellbeing agenda.

Selective Alerting
To have fully tested a proof of concept and have in place a means to alert the right number of staff, with the right skills to match the emergency call through a selective alerting method.

IEC
Build on our current first aid and co-responding capability and have implemented a new medical response capability "IEC", to be rolled out by September 2016. This will align equipment, skill base, and clinical governance (including Patient Report Forms) that ensure a sustainable model.

Through our IEC capability, expand our range of calls so the Service is attending a triaged call to a "non injury mechanical fall" with support from a clinical support desk within SCAS Control and Life Threatening Incidents (LTI's) using our "Red Fleet". To be in place by March 2017.

Up-Stream Prevention
Expand our Health and Wellbeing offering and be delivering a range of up-stream prevention programmes under our wider Safe and Well agenda with the support of CCG's, Vanguard Programmes and Public Health. These programmes will include STEER, Falls Champions, and Better Me Courses.

Safe and Well
Further expansion of Community Safety's new Safe and Well visit to be delivering key health messages in the course of visits. This is subject to the needs of health and social care partners but in principle it should serve their core priorities).

Academic and Evidence Based Research
We will have academic and evidence based reports that demonstrate what we have delivered, why we have delivered it, where have delivered it and, where

achievable, what impact it has had through both a quantitative and qualitative assessment that shows both outputs and outcomes (both immediate and sustained) and that are accepted by health and social care colleagues.

Timescales
12 months

Why does this need to be done now?
Fire as a health asset (both in response and prevention) not only improves our core work but enables us to add value to the work of key Health and Social Care partners. These partners are under ever increasing pressures from public need and demand whilst also needing to find efficiencies and alternative means of effective delivery. The nature of health and social structures and funding has, historically, not led it to take a strong preventative approach. Their activity tends towards responding to acute issues and intervention at the point that a problem surfaces (such as a person having a fall in their home). With Public Health now forming part of Local Authorities and better aligning with social care there appears to be, at times, a gap in understanding between Public Health (PH) and Clinical Commissioning Groups (CCG's). Whilst we do not profess or wish to be health professionals, we are experts in prevention. We have the ability to support partners by bringing in this expertise and assisting them in understanding the need for a more advanced approach to demand management through prevention and education. We also see a role to play in response (supporting SCAS) and intervention (measures such as fitting hand rails) that may also speed up responses and interventions with a net gain for public and patient outcomes and effectiveness of partnership delivery. This is not to say that we have latent capacity. Where we are already going to someone's home, such as through a Safe and Well visit, then it is sensible and smart that we take the opportunity to address the wider public and health wellbeing needs and priorities. Equally, if the difference between someone living and dying is an attendance by HFRS crews to provide a defibrillator or stem blood flow, then this can only be in the public interest and an appropriate use of resources. Alongside this, we can reprioritise some of our time and resources to deliver activity in support, and on behalf of partners, that helps address their priorities, reduces risk in the community and raises public health and wellbeing. This later work should bring a financial recognition which we can reinvest in core services.

Investment requested
£481,375 for staffing costs over one year

Are there ongoing costs?
Ongoing implications are being identified as are income streams.

Financial return on the investment
The detailed case for development of our work was made in the original DCLG business case and the SD Transformation Mandate. Capabilities developed to date and that are to be implemented through the next phase do inherently support the redesign of Service Delivery and our future operating model, as set out in Risk Review proposals. In developing our evidence base we will need to establish a model that shows the value to the wider public purse. This will assist in placing a value of fire as a health asset. It is our intention to bring an early assessment of the value in the 2016/17 financial year to give ourselves the assurance that we should be continuing with the planned product deliverables. This assessment will be based on the proof of concept work that is planned.

Key risks
The project maintains an overarching risk log and this can be provided as necessary.