HM Fire Service Inspectorate

Inspection of Operational Assurance in the Scottish Fire and Rescue Service

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Integrity, Objectivity, and Fairness.

Acknowledgements

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Foreword

As Chief Inspector of His Majesty's Fire Service Inspectorate, it is my pleasure to introduce this thematic inspection report, which considers arrangements for Operational Assurance within the Scottish Fire and Rescue Service.

In an occupation where staff are regularly exposed to hazards and consequent risk, there is a need to ensure that learning is proactively captured and changes successfully implemented. The operational assurance policy, procedures and systems in place are a positive indication the Service has the processes to safeguard organisational learning. I am pleased to commend the Service, and its staff, for this clear commitment to continuous operational improvement.

This report serves as a constructive evaluation, driven by evidence, and has the intention to assist the Scottish Fire and Rescue Service in continually refining and enhancing its systems and processes. Our goal is to build upon the existing and mature operational learning tools, and provide a roadmap for further improvements, creating a safer environment for those who work hard to protect our communities.

The recommendations presented within this report are born out of a desire to nurture the positive atmosphere that the Service has worked diligently to cultivate. Each recommendation is presented with the hope of encouraging meaningful change and progress. It is imperative to view these suggestions not as shortcomings but as opportunities for growth and refinement.

In conclusion, HM Fire Service Inspectorate in Scotland is grateful for the cooperation and dedication of the Scottish Fire and Rescue Service in carrying out this inspection and for its efforts in the pursuit of improved firefighter safety.

Robert D Scott QFSM
HM Chief Inspector of the Scottish Fire and Rescue Service

Contents

1. Background

1. This is the report of a thematic inspection by His Majesty's Fire Service Inspectorate (HMFSI) into Operational Assurance (OA) provision within the Scottish Fire and Rescue Service (SFRS). The commissioning of this inspection was born in part from our experience within the West Service Delivery Area (WSDA). During that inspection we found many positive OA practices but also a degree of adverse response from some Service personnel interviewed. Our report stated that we found *'a degree of apathy and disappointment towards the OA system with many staff reporting that they almost never got any feedback from being part of a process and when learning did get communicated it had taken far too long to be disseminated…it is concerning that the face to face debrief process and subsequent positive learning aspects, seem to be diminishing within the WSDA'*[1]. Consequently, we felt it appropriate to examine the SFRS OA process in its entirety and how it is being delivered across the whole of the organisation.

2. OA is often referred to or synonymous with the terms, Operational Learning (OL), intraoperability National Operational Learning (NOL) and/or interoperability Joint Operational Learning (JOL). The terms detailed above are normally intricately linked to the 'People' concepts of Organisational Learning (ORL) and Learning Organisation (LO). ORL could be described as the process of creating, retaining, and transferring knowledge within an organisation, whilst LO is an organisation that facilitates the learning of its members and continuously transforms itself. *'OL and LO were used interchangeably, before being later separated into two streams. OL focuses on the processes, while LO is about the organisation that is continuously changing its behaviour…. it can be said that organisational improvement and development fundamentally revolve around the general idea of ORL'*[2]. As such, OA within the SFRS is a function of ORL process that attempts to ensure the Service does not simply repeat existing operational practices but also learns from them.

3. The Service's long term vision details that *'as a confident, modern, efficient, outward looking, learning organisation, our mission remains clear'*[3]. The Service also details in its Strategy 2022 – 2025[4] that People are an aspect of its operating environment and that it *'will continue to place a strong focus on meeting people's needs as we change how we work. This includes ensuring that our people continue to receive the appropriate equipment and the training they need to carry out their crucial role'.* In addition, the OA Policy *'supports the concept of a LO and supports the SFRS commitment to the continuous improvement of operational response and Health & Safety performance standards within the context of operational activity'*[5]. It is clear from these statements that the Service aspires to be a LO and that it believes there are corresponding ORL processes in place to do this. Our inspection was clearly focussed on OA in that operational context, as it is an essential element of the ORL process encapsulating some of the most risk critical facets of its service delivery.

1 HMFSI Inspection of the Scottish Fire and Rescue Service West Service Delivery Area

2 Science Direct - Organisational learning, learning organisation, and learning orientation: An integrative review and framework

3 SFRS Long Term Vision

4 SFRS Strategic Plan 2022-2025

5 SFRS, Training Safety and Assurance, Safety and Assurance, Assurance Policy, Version 6, 22/03/2024

4. In an emergency service context OA could easily be described as the actions that are taken, to give confidence that policies, procedures, training, equipment etc. all come together to deliver a safe and effective emergency response. OA and the associated terms such as OL, NOL and JOL, are primarily focussed on learning from operational incidents as well as associated training and exercising. As such, the HMFSI focus for this thematic inspection was mainly based on Training Safety and Assurance (TSA) policy and procedures, Operations (Ops) policy and procedures, connections to OL, NOL and JOL as well as the expected link to the LO. However, and inevitably, there is a need to understand whether the Service is effective at ORL as that would provide comfort that it is able to encourage the use of positive practices and safeguard from repeating errors.

5. The SFRS definition of OA is *'a safety management system, underpinned by the key 'Safe Person Principles' (Health, Safety and Welfare Framework for the Operational Environment), which aims to support the delivery of a safe, effective and efficient operational response using planned and systematic processes to minimise organisational risk'*[6]. It is detailed that this system should assure the effectiveness of the SFRS arrangements for the implementation of the guidance contained within generic hazard and risk statements, Standard Operational Procedures (SOP), Incident Command Systems (ICS), operational training and the maintenance of operational competence. To achieve this, the Service details that it has robust OA processes, such as pre-incident audits, during-incident monitoring and post-incident reviews, which should support the concept and ethos of a LO focussed on continuous improvement (CI).

6. The concepts, systems and processes detailed above were lightly assessed during the HMFSI Service Delivery Area (SDA) inspections of the East, West, and latterly North, areas. As well as areas of good practice, common themes also emerged which gave rise to potential concern and consequently this thematic inspection was commissioned. As such, our approach was to assess the SFRS's OA Policy, which provides a framework for the provision of OA and sets out the SFRS position in relation to the information gathering and assurance of operational activities. The inspection was to also consider the application and operation of this policy and related processes, procedures and systems. During the course of this inspection and taking particular account of our stated purpose, we focussed on the following general areas:

- organisational strategy, policy, procedures and processes for OA that are in place within the SFRS;
- scrutiny, governance, and the structures in place to ensure appropriate oversight of OA;
- responsibilities for ensuring OA and the discharge of legal obligations;
- audit, monitoring and measuring performance of OA to ensure internal compliance and continuous improvement;
- review and analysis of SFRS data which should support audit and monitoring;
- consideration of ORL, including NOL and JOL; and
- staff development and LO processes, which support the application, understanding and implementation of OA.

6 SFRS, Training Safety and Assurance, Safety and Assurance, Assurance Policy, Version 6, 22/03/2024

2. Introduction

7. The inspection outline set out the terms of reference for our team to work within and guided our fieldwork. Inevitably new areas of interest arose during the fieldwork process, and these are also set out within the report. This thematic inspection into the SFRS's OA provision, the utility of these services and cultural aspects that could impact upon the use of them was based on key lines of enquiry. Ultimately our key lines of enquiry focussed on management, performance, pre- during- and post-incident processes as well as outcomes. The findings for each of these key lines of enquiry are set out within this report alongside complementary additional findings. Our report includes a number of observations, areas for consideration, as well as noted areas of good practice and recommendations.

8. Whilst conducting our inspection, we have come to understand that OA is both a function of management as well as command and as such, responsibility for it cuts across most staff groups within the SFRS. Furthermore, many uniformed staff have both command and management responsibilities intrinsic to their role. Whilst examining the evidence throughout this inspection we identified that nomenclature used in the vast array of documents can be interchangeable, confusing and seem complicated to the unacquainted. Consequently, we feel it necessary to provide a brief explanation to some terms for clarification.

9. For the purposes of OA there are three main managerial categories, which are Strategic, Middle and Supervisory, as detailed in Table 1 below.

Management Role	Command Role		
Supervisory Manager	WC/CC	IC	OiC
Middle Manager	SC/GC	IC	FDO
Strategic Manager	AC/DACO/PO	IC	FDO

Table 1 – Role nomenclature comparison

10. Crew Commander (CC), Watch Commander (WC) and corresponding support staff grades are designated Supervisory Managers. Station Commander (SC), Group Commander (GC) and corresponding supports staff grades are Middle Managers and Area Commander (AC), Deputy Assistant Chief Officer (DACO), Principal Officer (PO) and corresponding support staff grades are Strategic Managers.

11. From a command aspect, all commanders from PO to CC may be conferred the role and responsibilities of Incident Commander (IC) depending on the size, scale and type of incident. An Officer in Charge (OiC) is a commander in charge of an appliance, crew or watch and as such, will normally be a CC or WC. Whilst a Flexi Duty Officer (FDO) is a commander providing supervision for more complex incidents, normally working the Flexi or Continuous Duty Shift system (FDS/CDS). As such, FDO refers to a SC or above.

12. Lastly, throughout the documentation related to OA the terms ‘incident’, ‘event’, ‘training’ and ‘exercising’ are used routinely to describe aspects of service delivery that OA should encompass. For the purposes of this inspection report and simplicity the term ‘incident’ can be applied to non-operational events that impact the organisation as well as training for, exercising for, preparing for and responding to operational incidents, including all operational control room activity that supports this.

3. OA Management

13. The Health and Safety at Work Etc. Act 1974 (HSAW) provides the legislative framework for occupational Health and Safety (H&S). The legislation sets out the statutory duties on both employer and employee in relation to H&S at work. This includes a duty as an employer to ensure, so far as reasonably practicable, the health, safety and welfare at work of all its employees. Additionally, employees have a duty under the Act to take reasonable care for their H&S and to cooperate with the employer to comply with their duties. The ability to capture, record and track information is essential in adhering to the Service's duties under the Act.

14. The SFRS has further statutory duties as an employer under the Management of Health and Safety at Work Regulations 1999 (MHSWR), to manage the workplace appropriately in relation to H&S and to put arrangements in place to control H&S risks. The regulations place a duty on the employer to review workplace activity, such as preventative and protective measures, as well as review risk assessments. In the case of the SFRS, this includes operational activity on the incident ground.

15. The Fire Standards Board (FSB) is an independent body which oversees the identification, organisation, development and maintenance of professional standards for Fire and Rescue Services (FRS) in England, with the National Fire Chiefs Council (NFCC) as an integral partner. The Board details that a desired outcome for OL is that an FRS will have *'developed a learning culture, acting on learning from operational and non-operational activity as well as external sources, to improve their operational response. The Service will have embedded the management of learning into their policies, procedures, tailored guidance and training. The Service will have developed a culture which seeks to share their learning with others to improve operational response within their own service; with other fire and rescue services; and with the wider sector if appropriate.'*[7]

16. The NFCC also provide guidance regarding OL from a national basis, which forms the foundations of NOL. The NFCC NOL good practice guide[8] states that the principle of learning from incidents *'goes beyond simply identifying what went well or what might have gone wrong. While this information is useful in determining how things should be done, learning has truly been achieved only when some form of change is implemented that ensures actions will be different in the future.'* It further states that: *'learning should also consider the organisational vulnerabilities that are identified during monitoring, audit and review processes. Effective learning from incidents also gives the opportunity to reflect on and understand the information and take action to reduce risk. It involves the organisation embedding changes so that, even if there are staffing changes, measures to prevent reoccurrence stay in place.'*

7 Fire Standards Board, Operational Learning 15/02/21

8 NFCC, National Operational Learning: Good Practice Guide

Strategy, Policy, Process and Procedures

17. The SFRS H&S policy[9] details that the Service is '*committed to the continual improvement and compliance with its legal duties under the HSAW, and other supporting regulations, to ensure the safety of…staff and others who may be affected by…activities in the communities we serve.' To achieve this, the SFRS has implemented a 'H&S management system supported with topic-specific management arrangements, improvement plans and assurance processes to ensure legal compliance. Performance is monitored and reviewed by senior management through established governance processes ensuring continual improvement of our safety culture.'* It also details that *they 'are committed to sensible and proportionate H&S management that recognises the need to balance operational risk against firefighter and public safety. This policy is inclusive of and supports the content outlined within the SA Strategy 2022-2026.'*

18. The SFRS Safety and Assurance (SA) Strategy 2022-2026[10] details that the number one priority is to *'work together for a safer Scotland and safety is at the core of everything we do'. It then goes on to detail that the safety objective is that 'we will care for our people through progressive health, safety and wellbeing arrangements'*. The strategy identifies five themes which are underpinned by priority actions.

19. The five themes are Compliance, Culture, Control, CI, and Communication and Engagement with related actions over a five-year period. Regarding CI, the Service details that it will monitor the effectiveness of H&S arrangements, to maintain continual improvement and performance and aim to enhance through ORL and implementation of assurance processes. Priority actions cutting across the five themes are OA-specific and some include:

    a. create a programme for the development and implementation of topic-specific Health and Safety Management arrangements and OA procedures which are prioritised based on risk;

    b. develop an OA campaign to embed and enhance the outcomes of robust operational assurance on the incident ground;

    c. develop feedback arrangements to inform staff involved in changes following lesson learned;

    d. develop business partner engagement feedback processes;

    e. review operational performance through OA processes and make recommendations for improvement where necessary;

    f. development of a lessons learned programme for organisational learning; and

    g. develop and implement a programme of topic-specific SA audits.

9 SFRS, Safety and Assurance, Health and Safety Policy, Version 7, 07/02/24

10 SFRS Safety and Assurance Strategy 2022 - 2026

20. The SFRS OA Policy details that the Service shall ensure that there *'are suitable OA processes in place to provide effective feedback and review of performance at operational incidents and training events, to influence future practice, enhance performance and improve firefighter safety. This policy supports the concept of a learning organisation and supports the SFRS commitment to the continuous improvement of operational response and Health & Safety performance standards within the context of operational activity.'*[11]

21. The SFRS has aligned its OA management with the guidance model contained within the Health and Safety Executive (HSE) publication HSG65 - managing for health and safety, known as the 'Plan, Do, Check, Act' cycle. Figure 1 shows the key links between OA processes and the HSG65 cycle:

HSG65 Cycle		SFRS OA Processes
PLAN	• Policy • Planning	• Supports Policy and Procedure review process • Audit & Review Programmes
DO	• Risk profiling • Organising • Implementing your plan	• Data Analysis • Reporting
CHECK	• Measuring performance • Investigating accidents, incidents and near misses	• Station Audit • Operational Review • OA21 Investigations
ACT	• Reviewing performance • Learning lessons	• Debriefing • Communication Platforms

Figure 1 - HSG 65 Cycle mapped against SFRS OA process

11 SFRS Safety and Assurance, Operational Assurance Policy, Version 6, 22/03/24

22. The SFRS details that the primary function of OA is to review and assure all aspects of operational activity and capture learning, to improve individual and organisational performance in support of strategic objectives. To achieve this, an OA model and process diagram have been created to provide a clear and integrated approach to CI, underpinned by a targeted and robust methodology. Figure 2 shows the OA Cyclical Model and the key inputs and outputs.

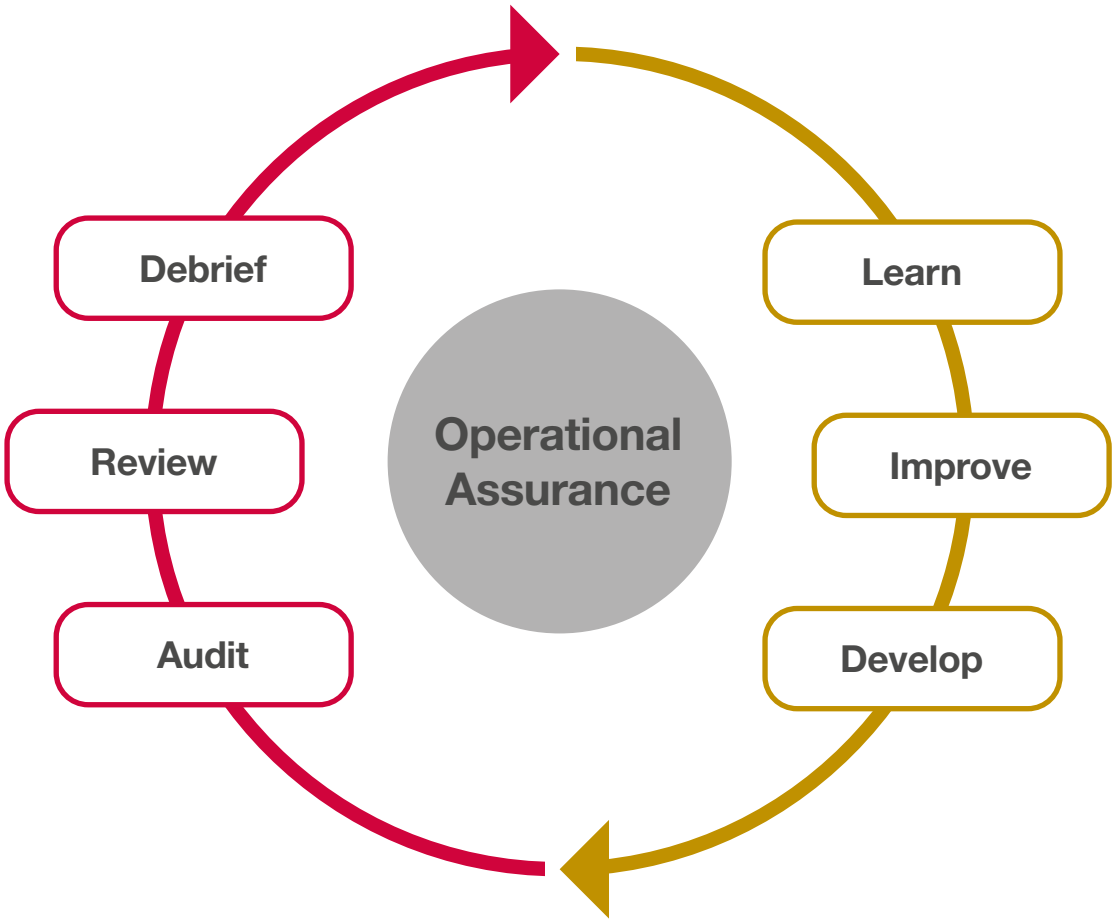


Figure 2 – OA cyclical model

23. The OA Model details three key areas of input;

- **Station / Thematic Audit** – a measure of pre-incident station preparedness, looking at how effectively policies and procedures have been implemented and how standards are being applied at Community Fire Stations (CFS);
- **Operational Review** – active auditing and monitoring during an operational incident, enabling the collection of information on the efficiency and effectiveness of policies and procedures; and
- **Debriefing** – reactive auditing and review of post-incident debriefs within a structured process, enabling the collection of information on the efficiency and effectiveness of policies and procedures.

24. The OA Model details three key areas of output;

- **Learn** – the gathering, analysis and reporting of pre-incident preparedness, operational performance and review of activities are key components of the OA process and support organisational learning;

- **Improve** – by learning from activities, the organisation will improve in terms of procedures, equipment and training which will ultimately enhance firefighter safety; and
- **Develop** – by reviewing activities, the organisation will continuously learn and develop with support from the OA processes.

25. The OA process diagram (Appendix 1) has been developed by the Service to capture the key workflow processes undertaken by OA and which can be summarised into five distinct areas:

- **OA Inputs** –the OA Department (OAD) primarily work with internal partners but also react to information provided from other stakeholders, such as other FRS, the NFCC, National Operational Guidance (NOG) and NOL;
- **OAD** – the OAD is responsible for the gathering, analysis, reporting and dissemination of operational activity information with a focus on organisational learning to promote firefighter safety;
- **OA Outputs** – the inputs are then processed by the OAD, resulting in a variety of internal outputs (Action Plans, Regional Safety and Assurance Improvement Groups (SAIG) Reports, Briefing Reports, etc.) and external outputs (NOL submissions and Multi-Agency reports);
- **OA Governance** – all OA activities and outputs are subject to a governance process; and
- **Organisational Outcomes** – the outcomes from the OA process support the continual review of SFRS policy and procedure, training standards, and assets and equipment, with a focus to continually improve firefighter safety.

26. The Service has developed a series of General Information Notes (GIN) that manage the processes with the cycle/model, so that input and output are consistent and align with pre-, during- and post-incident issues. These GINs are titled During Incident OA GIN, Station Audits and Thematic Audits GIN, and Operational and Event Debriefing GIN, and are discussed later in the report.

27. It is noted that Service documentation indicates a strong link between relevant statute and standards with the inclusion of a learning ethos in strategy, policy, process, models and procedures. This whole structure would appear to provide a positive foundation for the management of OA and subsequent ORL.

Governance

28. It can be observed from the OA process diagram (Appendix 1) that there is a linear process for managing OA input and outputs to achieve improved outcomes. Most commonly, information is collected by the OAD, which is then reported through their Functional Management Team. Primarily, outputs result in tasks that require to be actioned by ‘Local’ level managers with ‘Regional’ level matters actioned by the SAIG, i.e. a matter that is contained to just an SDA. ‘National’ or Service-wide learning are approved by the Safety & Assurance Sub-Group (SASG), actions progressed through the Operational Learning Group (OLG) and, thereafter, progress monitored by the Training Safety & Assurance Board (TSAB).

29. The purpose of the SAIGs is to support the delivery of the objectives at the SDA regional level, by providing strategic control within a local area context. The SDA SAIG Chair or 'Lead' (sometimes referred to as the SA Coordinator (SAC)) provides strategic guidance and direction to area-based managers, to ensure all H&S and OA processes are fully supported, and emerging issues are actioned accordingly. They are responsible for ensuring TSAB strategies are implemented at a local level and that Service standards are maintained. The SAIG deliverables are both a blend of Safety and OA business. Attendees normally required at the meeting are the Chair, an OA representative, GCs from Service Delivery (SD), Training, Prevention Protection and Preparedness (PPP) and Ops. In addition, the Service has designated Safety and Assurance Liaison Officers (SALO), and deputies, for each LSO area.

30. We found robust evidence that the SAIG meetings are routinely held and form an integral part of the OA governance and communication process which extends into the SD areas. OAD managers routinely attend these meetings to discuss reports with the local teams. The meetings have an order of business and a commensurate action plan, although this can be heavily weighted to safety issues rather than being OA-specific. SA management are aware of this and are working to improve understanding of assurance as part of the SA function which, supports the identification of learning and improvements in support of the safety of people. Managers provided feedback to us regarding the lack of attendance of some Directorates at the meetings, which occasionally restricted issue resolution, but this did not seem to stop the overall business.

31. Disappointingly, when speaking to SD middle and supervisory managers, we found limited awareness of SAIG meetings and their content, unless staff had been directly involved in attendance at the meetings previously. These SD staff were unable to articulate or provide evidence that OA-specific issues had been fed down or fed back up via this route and were unable to link this as a legitimate route for their OA issue resolution. Many supervisory staff were not able to provide evidence of interacting with a SALO or deputy SALO and could not recall being briefed about ongoing OA issues covered within the SAIG forum.

Area for Consideration 1

The SAIG, SAC and SALO are an integral part of the OA management and governance process. There is scope to improve the understanding of these roles for middle and supervisory managers. The Service should consider this potential improvement for any future training, development or review in relation to OA.

32. The SASG is a group established with the authority of, and under the remit of, the TSAB. The SASG is directed by and has its work agreed by the TSAB. The primary purpose of the SASG is to ensure priority is given to the introduction of control measures to manage H&S risks at operational incidents. The scope of the SASG includes, but is not limited to, considering any safety and assurance matter that assists the TSAB in the discharge of its responsibilities. This should include consideration of SA matters and determining the route to address identified risk.

33. The TSAB provides a forum where the strategic review of operational performance is undertaken. The TSAB is designed to provide visible leadership and ensure any relevant recommendations developed from OA activities are accepted by the

appropriate Directorates and implemented timeously. Work streams and/or any Service-wide response should be agreed and allocated by the TSAB. Any subsequent action plans will be monitored through the OLG and OA processes with progress reports available to the TSAB. For scrutiny purposes, the TSAB reports to the Board of the SFRS, Service Delivery Committee (SDC) and People Committee (PC), via the Strategic Leadership Team (SLT) (Appendix 2).

34. The Service has recently supplemented the OA governance structure with the addition of an OLG. The purpose of the OLG is to support the SFRS in meeting its statutory obligations in relation to H&S, both in the operational and non-operational environment. Its scope includes, but is not limited to, considering any relevant safety and assurance matter that arises both externally and internally to the SFRS, and progress to completion of actions required to assist the TSAB and SASG in the discharge of their responsibilities. In effect it is a cross-directorate group that has a sufficient level of responsibility and leadership to be able to work through outputs in a timeous manner, thus speeding up the ORL process. Staff perceived that the ORL process was taking too long to improve outcomes and this group was created following the completion of a proactive Compare and Contrast (C&C) benchmark process.

Good Practice 1

Staff involved in the processing and management of OA provided positive feedback on the OLG and its development as a 'clearing house' for actions. It has been a positive addition to the governance process.

35. The Service has an OL Governance GIN[12] that contains internal processes and arrangements for OA in the first instance. It focuses in the main on external sources of learning such as NOL, JOL, NFCC, HSE, Scottish Multi-Agency Resilience Training and Exercising Unit (SMARTEU) and other FRSs, as well as the process for feeding learning back to these organisations. The document details the responsibility for the learning and how it is integrated into the existing OA management and governance processes. The Service provided evidence to suggest that interagency (JOL) and intra-agency (NOL) learning is being used proactively and fed into the governance process to create OA outputs for TSAB consideration. This included examples of NFCC National Operational Learning User Group (NOLUG) case study information notes, NFCC NOL reports to SASG and SMARTEU multi-agency debriefs (JOL) involving Service personnel.

36. The Service provided evidence that a GC had been appointed the NFCC NOLUG chairperson, giving the SFRS a prominent national position within the UK FRS OL community. It also detailed that it had entered into a formal data sharing agreement that allowed sensitive information to be transferred between the two organisations. Additionally, and following a C&C benchmark process, the Service identified a need to have a dedicated Single Point of Contact (SPoC) for NOL contact and communication. It was considered that the SPoC should have suitable seniority and experience to deliver the learning activities identified in the NFCC guidance and manage the subsequent learning outcomes that arise from them, as well as outcomes received

12 SFRS Operational Assurance GIN, Operational Learning Governance, Version 2, 17/05/23

from and submitted to the wider sector. Consequently, the OAD GC was appointed on behalf of the SFRS.

Good Practice 2

The Service has developed a positive connection within the UK OL community and is viewed as a productive partner. Having a GC as NOLUG chair and the Service SPoC is an extremely encouraging indicator of the success of this relationship and should be given ongoing support.

37. The Service has a mature OA governance structure that is used for both internal and external information input and output management. It involves clear lines of reporting as well as key stakeholder and business partners who can contribute and engage with the learning process at an appropriate level. Action Plans and responsibilities are developed and monitored to ensure the effective management of tasks and timelines. Criticisms from staff of the process are the length of time it takes to deal with serious issues, compounded by, what is perceived by some, as the overly bureaucratic nature of the process and cross Directorate working. As detailed, this was recognised by the Service and the creation of the OLG, as well as improved OAD administration, has gone someway to improve this. Another criticism cited by some of those we interviewed, included a lack of reporting transparency, probably precipitated by the potential sensitive and litigious nature of the subject, leading to a level of frustration and suspicion. Lastly, difficulty in measuring success, or linking output to improved outcomes, was an ongoing issue throughout the inspection (and is discussed later in the report).

Systems

38. The Operational Assurance Recording and Reporting System (OARRS) is a bespoke software package hosted within the Service's Information and Communication Technology (ICT) network, which is available via the SFRS intranet platform. The OARRS system was developed inhouse and has had a number of modifications over the intervening period. Ongoing redevelopment requires engagement with the original developers which has both financial, prioritisation and capacity implications for the Service and as such, has been limited. The system has several preset forms and parameters that prompt staff and allow a degree of free text flexibility to provide feedback and storage of information regarding incidents and audits. It is also linked to the email system which allows for a degree of automation and communication. The OAD can monitor the information input and are then able to extract data for assessment and analytics. Managers cannot access the system on the incident ground and as such input is always conducted post-incident.

39. Primarily, managers can input information regarding the pre-incident station audit process (OA02 Form), the during-incident review process (OA06 Form) and the post-incident review process (OA13 Form). This information is then stored within the OARRS. Operational staff can also self-generate these forms and there is a high degree of reliance placed on staff doing this, especially for smaller-scale incidents. In addition, OAD staff routinely undertake a review of incident activity and are then able to generate the requirement for an OA06 and OA13 submission, based on pre-agreed incident triggers, factors, types and scale.

40. Staff reported that the OARRS system was accepted as easy enough to use but was apt on occasion to be unavailable and unreliable. They reported that there was a high degree of manual intervention required in the use of the system as well as restrictions with access to submitted information from out with the OAD. In addition, staff also detailed limitations on functionality for analytics, interrogation and data retrieval to allow effective and efficient monitoring, analysis and reporting. OARRS is an integral part of the OA system within the Service allowing the collection of vast amounts of information and data input. The restrictions to the system are inhibiting the maximisation of that data and information use, to the detriment of developing efficient and effective output. It is understood that management acknowledge this position and notwithstanding the redevelopment issues previously mentioned surrounding capacity, finance and priorities, are in the process of procuring a replacement system.

Area for Consideration 2

The Service should consider the prioritisation of the OARRS replacement to improve OA data analytics and output development.

Structures and Administration

41. The Chief Officer is responsible for the discharge of the legal obligations that apply to OA and the content of the Policy. Whilst the Director of TSA is the strategic lead for OA and provides strategic direction and policy. The Head of SA has the delegated responsibility from the Director of TSA for strategic management of OA, whilst the OA Manager has a day-to-day responsibility for the effective delivery of the OA Policy. As detailed, the OAD GC is the NOL SPoC.

42. The OAD sits as part of the SA Function within the TSA Directorate. The department has six dedicated personnel, a GC who is the designated OA manager, two SCs and three WCs. The GC reports to the Deputy Head of SA who reports to the Head of SA. There is also an Operations Control (OC) SC who has the partial reference for OA and whilst not sitting directly within the OAD, does routinely engage and communicate with them. OC have indicated that they are actively assessing whether this manager becomes a full-time OA role.

43. The OA Policy[13] details that the OA manager and the department are responsible for:

a. supporting the Director of TSA in the development and review of the OA Policy;

b. managing and delivering key business planning processes that support OA;

c. developing, monitoring and reviewing the OA processes and procedures;

d. developing operational performance audits and review programmes to support the delivery of agreed operational strategies and business plans;

e. ensuring an appropriate balance of proactive and reactive performance audits are conducted that support continuous improvement;

13 SFRS Safety and Assurance, Operational Assurance Policy, Version 6, 22/03/24

f. working collaboratively with other Directorates and using available resources in an efficient manner;

g. collating, reviewing, reporting and disseminating OA outcomes across all relevant areas of the SFRS;

h. assist in the development of operational performance audits and review programmes to support the delivery of agreed operational strategies and business plans;

i. manage and, where appropriate, deliver OA arrangements, e.g. pre- / during- / post-incident audits, monitoring, review and debrief;

j. support managers undertaking planned audit and monitoring activities at SDA and local level;

k. co-ordinate and collate data gained from pre- / during- / post-incident audits, monitoring, reviews and debriefs undertaken at SDA, Local Senior Officer (LSO), Station and Watch level;

l. liaise with national / SDA H&S teams in relation to timely progression of safety-critical information;

m. prepare reports on national, SDA and local performance;

n. collate and analyse national, SDA and local performance information;

o. liaise with LSOs, GC and SC on local performance issues;

p. monitor progress of areas of improvement actions; and

q. contribute to the effective delivery of the OA management system.

44. In addition, the Service also details[14] the OA Department is responsible for:

a. ensuring the outcomes from SDA station audits are reviewed to identify SDA or national trends with the support of OA;

b. ensuring thematic audits are applied / supported, where deemed necessary, to ensure that lessons identified become lessons learned;

c. ensuring any notable practice(s) arising from operational activity is shared appropriately at a local and national level;

d. the support of a cross-directorate strategy for dealing, as necessary, with findings from internal and external investigations;

e. ensuring trends in OA activity are identified and disseminated as appropriate;

f. ensuring the OA21 investigation process is implemented at SDA level on instruction from the TSAB;

14 SFRS Health and Safety, SA Engagement and Governance Management Arrangements, Version 7, 13/01/23

g. ensuring localised issues identified through OA processes are managed by the SAIGs through appropriate channels;

h. ensuring any issues identified through the OA process that cannot be resolved at a local level and/or have national implications are advanced to the SASG and/or the TSAB for consideration; and

i. ensuring NOL is shared across the SFRS.

45. It is observed that this is a significant amount of responsibility and workload for a small team, which we understand can be very labour-intensive and require a high degree of manual intervention, given the issue with OARRS previously mentioned. Throughout the inspection it was observed that staff were frustrated and/or disappointed by the lack of support, feedback, communication and engagement that could be provided by the OAD due to capacity issues. We noted that tasks and aspirational outputs assigned to the team seemed to outweigh the actual capacity of the team. Frequent comments indicated the perception that there was 'a lot going into the system but not a lot coming out'. Many staff recognised this as one reason that OA may not be as effective as it could be and empathised with the OAD position.

46. We observed that the level of responsibilities assigned to the OAD was considerable and that focus on administrative tasks was done at the sacrifice of ongoing awareness development, communication and engagement. Given the voluminous nature of input and output generated, there seemed to be a need to review the blend of capacity, responsibilities and technological tools to assist with management. It is noted that the C&C benchmark process did not address this issue and as such, there is no reference point as to comparable team size, capacity and responsibilities for OAD in other FRSs.

Area for Consideration 3

We are confident that the OAD is performing but within its limitations as detailed. The Service should consider a review of the team size and responsibilities as well as use of automation and analysis tools to help improve ORL outputs.

47. A related issue raised on several occasions was the structural position of OA sitting within the SA Function and TSA Directorate. Staff referred to the preferred historic position whereby OA was a department within Ops Function within the SD Directorate. This could have been perceived as a recent change management issue, many staff articulated compelling arguments for and against being within both SA or Ops. The overriding sentiment was that OA outputs have on many occasions an impact on Ops and the extended links between the workforces made problem resolution less efficient and less effective.

48. In addition, there was also the perception that OA was inevitably subservient to Safety within a busy professional H&S department. As such, staff thought that prominent issues within OA maybe had less significance for management and therefore less impetus for resolution. Many staff kindly used the analogy of OA 'living next to the noisy neighbour' of safety, as a means to express their concerns. That concern being that if OA was so important to the organisation that it should not be perceived as subservient and should be championed, visible and have a higher profile.

49. Whilst the Service accept and understand these challenges, they believe that OA is correctly positioned within the organisational structure and that it provides a healthy degree of independence from the workloads of other Functions and Directorates. Additionally, TSA have recognised the need for strategic operational focus on OA within the Function and have recently reassigned a dedicated AC to lead the team.

Area for Consideration 4

Structural positioning of a department within the organisation is a management function. The Service should continually review whether the current structural position allows for OA to be given the appropriate focus, visibility and profile, whilst ensuring managers can resolve issues as efficiently and effectively as possible.

50. As detailed, the OAD has a number of responsibilities and consequential administrative tasks. One of the main tasks is operational incident debriefing, which can be scaled up depending on the size and type. To ensure a degree of quality assurance a series of task cards were developed which assists staff regarding consistency in actions, timescales, engagement, reporting and review. These task cards were born from the C&C benchmark analysis and are a positive addition to the OAD management as they provide targets and process for keeping inputs and outputs in a reasonable and consistent timeline.

Good Practice 2

The OA debrief tasks cards are a positive addition to the internal administrative procedures and the OAD should be commended for their innovation.

4. Performance

51. The Service has a Performance Management Framework 2023 - 2024[15] (PMF) which defines how the SFRS will manage its performance and how it uses information to inspire change and improvement. It also provides *'the Board with the relevant information on…performance to support their role in scrutinising the Service'*. From an OA perspective, the PMF details a Key Performance Indicator (KPI), KPI 19, which is the *'number of audit actions arising from operational assurance processes'*.

52. As previously detailed, OA is a Function within the TSA Directorate and its Strategy[16] details that the number one priority of safety, and the safety objective, will be delivered by the five themes of Compliance, Culture, Control, CI, and Communication and Engagement. To accompany this strategy, and as part of the PMF process, H&S provide quarterly SA performance business reports to TSAB. They also publish quarterly performance reports and an Annual Performance Report (APR). Within these reports strategic actions and SA KPI, including KPI 19, are reported along with trend analysis and contextual narrative.

53. In addition, the OA Policy details specific requirements to monitor and measure performance as well as audit, hopefully leading to continuous improvement and improved outcomes.

Measuring

54. Specifically, the OA Policy details that there is a need to measure a range of generic performance indicators to support the analysis of safety systems. It goes on to detail that the OA Manager and TSAB should develop and establish a full suite of performance measures. The data listed should include but is not exclusive to:

    a. accident statistics and trends;

    b. near miss statistics and trends;

    c. number of systematic themed audits / inspections per year;

    d. number of systematic themed audits / inspections undertaken against the set target;

    e. number of pre-incident audits / inspections undertaken per year (OA02);

    f. number (and subject) of Awareness Briefings (AB) or Urgent Instructions (UI) issued;

    g. number of during incident audits / inspections undertaken per year (OA06);

    h. number of post-incident / events debriefs undertaken per year (OA13);

15 SFRS Performance Management Framework 2023-2024 Version 1.0

16 SFRS Safety and Assurance Strategy 2022 - 2026

i. number of pre / during / post-incident audits / inspections / debriefs undertaken against targets;

j. number of non-compliance issues identified; and

k. number of non-compliance issues resolved.

55. Accident and near miss statistics and trends (bullet points 'a' and 'b') are historically perceived as H&S performance indicators with OA now being linked due to its recent merger within the department. The SA APR 2023 – 2024[17] details a reducing trend in accidents and an increasing trend in reported near misses from the period 2018/19 to 2023/24. These figures are considered to be a positive position for the Service and could potentially be attributed to OA process and demonstrate improved outcomes.

56. Thematic audits / inspections (bullet points 'c' and 'd') are part of the pre-incident OA process and the Service has set within the guidance a target of two audits per fiscal year. It is understood from the OLG Action Tracker that within the six-year period 2019 to 2024 there were three thematic audits completed in total, for the Service Breathing Apparatus (BA) set, Analytical Risk Assessments (ARA) and Incidents involving Asbestos. From a self-determined target of twelve across the measured period, this represents a 25% completion rate.

57. Pre-incident audits (bullet points 'e' and 'i') also form part of the pre-incident OA process and predominantly comprise of CFS audits and any follow-up interim audit. As such, they are administered and managed by LSOs within their geographical area. The target set within the guidance is that all Wholetime (WT) CFSs will be subject to a minimum of one mandatory recordable audit per fiscal year. The audit frequency for On-Call stations shall be determined by the LSO but, as a minimum, each On-Call Retained Duty System (RDS) CFS shall be audited at least once every two years and On-Call Volunteer Duty System (VDS) CFSs shall be audited at the discretion of the LSO. Completed station audits (OA02) are input into the OARRS systems with local management systems used to capture improvements and action plans.

58. LSOs have a planned annual audit programme and this is monitored locally, however from a national perspective there is limited evidence that the completion targets and subsequent outputs are measured routinely and that there is ongoing national oversight. Having said that, we are aware that an isolated audit was recently conducted by the OAD. The report, titled 'Station Audit report for 2023 – 2024'[18], details that from 74 WT CFSs, 99 audits were submitted to OARRS providing a 134% completion rate. This position that some areas are completing and recording a higher number of audits than the official target is addressed later in the report. No data was provided for On Call stations.

59. AB or UI (bullet point 'f') are an output of OA and represent two of the means for communicating ORL that the Service use. The Service has recorded that there were 34 ABs, and 15 UIs issued between 2018 and 2024. The numbers themselves are not necessarily a positive or negative indication but would suggest that they are being actively used.

17 SFRS SA Annual Performance Report 2023-2024

18 SFRS, Safety and Assurance, Operational Assurance, Station Audit report 2023 – 2024, 16/01/25

60. During-incident audits / inspections (bullet points ‘g’ and ‘i’) are undertaken by middle or strategic managers when they physically attend an incident and take on an OA role rather than that of the IC or other incident command function. They utilise an Action Checklist (OA07A) and Aide Memoire (OA07B) and input their return via OARRS utilising the OA06 form. The Service provided partial data for the number of these audits completed for a five-year period up to 2023. In the year 2022 – 2023 there were 1,751 audits completed but no context as to whether this related to a target or comparison to the overall number of incidents attended for the role of OA. There was no evidence to suggest that this metric is being routinely measured, compared or reported. Staff provided feedback that extracting this data from OARRS was very problematic due to the restrictions with the system previously detailed.

61. Post-incident debriefs (bullet points ‘h’ and ‘i’) can be undertaken by any IC when they attend an incident. They can be done in a structured or unstructured ‘hot debrief’ format. If deemed appropriate staff input their return via OARRS utilising the OA13 form. The Service provided partial data for the number of debriefs completed for a five-year period to 2023. In the year 22/23 there were 2,699 debriefs completed but no context as to whether this related to a target or comparison to the overall number of incidents attended. For context, in the same period the Service attended 99,607 incidents of all types. This correlated to roughly 3% of all incidents having a formal OA13 debrief recorded.

62. We found that the Service has reported the number of structured debriefs carried out by the OAD in the SA quarterly reports to TSAB and then in the SA Annual Performance Report 2023/24. For the period 2023 – 2024 the number of structured debriefs conducted by the OAD and reported was five in total. Outside this, there was little evidence to suggest that this metric is being routinely measured or reported. Staff provided feedback that extracting the data from OARRS was very problematic due to the restrictions with the system previously detailed.

63. Number of non-compliance issues identified and Number of non-compliance issues resolved (bullet points ‘j’ and ‘k’). We found these data sets relate to the Station Audit processes, which are managed locally by LSO teams. The output from this data stream and challenges with subsequent measurement are discussed later in the pre-incident audit section of the report.

64. As previously detailed, from an OA perspective, the PMF KPI 19, measures the ‘number of audit actions arising from operational assurance processes’. The SA APR 2023 – 2024, detailed (Appendix 3) that for the year 2023 - 2024 there were 83 significant recommendations identified through the OA structured debrief process, which is a large jump from the previous year and an upward trend across the six reported years. The numbers themselves are not necessarily a positive or negative indication, as they provide little context, but would suggest they are being actively tracked and measured. Nonetheless, we found the KPI to be vague and when discussed, staff were unable to articulate its use as an effective indicator of continuous improvement and tool for scrutiny. The SFRS management acknowledge this position and have indicated that the KPI may require review.

65. We found that there are numerous quantities of OA-related quantitative data being generated from both an input and output perspective. Historic H&S data and related KPIs are tried and trusted metrics that provide an indication of safety improvement

that could be attributed in part to OA. On the other hand, we found the use of specific OA data to provide meaningful metrics and indicators to demonstrate the performance of OA limited. Some examples of potential gaps cited within our fieldwork, which we thought may be useful to understand were, the limited measurement of timescales for the governance process for actions to be completed and for form completion rates. There is a lot of data being generated within the system from the volume of incidents and there are heavy restrictions to OARRS functionality for extracting and cleansing the data. However, the underutilisation of the data is a missed opportunity regarding performance management, quality assurance, identifying operational improvements and providing meaningful scrutiny.

66. Throughout our fieldwork we received feedback regarding both positive and negative performance of OA but very few members of staff could provide any quantitative metric for their particular position. Neither could staff provide many examples of qualitative evidence in support that OA provided continuous improvement. Isolated examples of reports, OL outputs, completed actions and improvement plans were cited on a number of occasions but were limited. When asked, much of the evidence was anecdotal and not linked to any tangible measurement but more aligned to the management or end user experience of using the process. In summary, we observed that the OA management process is highly effective at gathering data but struggles to utilise that data to demonstrate how it improves performance management and outcomes. This confirmed the general feeling by staff of a lot going in and not a lot coming out. We found that the Service was unable to demonstrate effective measurement of OA performance and therefore potential ineffective scrutiny.

Recommendation 1

We recommend that measurement of OA be reviewed in order that appropriate indicators be developed for robust performance management and scrutiny.

Monitoring

67. OA performance is monitored Service-wide utilising the existing governance system previously mentioned. The OLG has an Action Plan managed by an Action Tracker, which can detail actions by year, owner and status from 2019 onwards. From February 2025 the tracker details that there have been 489 actions from 29 significant events or incidents. 350 of the actions have been completed, with 92 either on track or overdue, and 47 not yet started. Of those overdue there are 14 actions outstanding greater than two months, with some dating back to 2019. SA business reports are delivered to the TSAB on a quarterly basis and include information on working group updates, the OLG overview, the OLG Action Tracker and an OLG spotlight report as well as information on Operational Discretion (OD) and NOL. In addition, the SA Function publish a quarterly performance report that provides an overview of progress against the SFRS annual Health and Safety Improvement Plan 2024-25 and the SFRS H&S KPIs. KPI 19 amongst other related SA KPIs form the basis of this report. Lastly, as previously detailed, SA publish an APR which is a consolidation of the quarterly reports for the year and details progress against the SA Strategy as well as OA audit actions.

68. Each regional SAIG has an action plan which is managed by the Lead and is monitored by them. Responsibility for these action plans is devolved to the DACO for that particular SDA and there is no national oversight or monitoring of these action plans. Locally, each LSO reports to the regional SAIG and top-down or bottom-up OA issues are either monitored via this forum or local strategic management performance arrangements. The CFS audit process is planned and managed by each LSO management team and the subsequent improvement plans are monitored locally utilising available computer software tools and systems. From an ORL perspective, there is limited national oversight or monitoring of these improvement plans and possible trends. As such, it is unclear how the Service identifies and monitors OA trends across its whole CFS structure.

Audit

69. As detailed earlier we identified that the Service employs two specific OA audit processes, which are the pre-incident CFS audits and any follow up interim audits as well as pre-incident thematic audits. The former is administered and manged by LSOs whilst the latter is administered and managed by the TSAB and by extension the OAD. The merits, application, and output of both are discussed later in this report.

70. In the monitoring section we detailed that there was limited service-wide oversight of the local and regional OA improvement action plans that would allow for national trend understanding and audit. The City of Glasgow (CoG) LSO provided a comprehensive audit report[19] regarding the station audit outcomes that detailed notable areas of good practice and improvement within the area. However, this was an isolated example and there was no evidence of this being replicated or scaled up across other areas of the organisation. We accept that there are audits being completed on specific aspects within the OA process but found no evidence to suggest that there had been an overall audit on OA and the consequent action plans to get a national oversight and understanding of potential local, regional and national improvement.

Recommendation 2

We recommend that there be a review of the monitoring and audit processes to provide assurance that the Service has a complete understanding of OA trends and potential ORL throughout the organisation.

Scrutiny

71. The SA strategy details that as SA is a corporate governance matter it is integrated into the SFRS governance structures, including the SFRS Board, relevant Board sub committees, and the SLT. Scrutiny from this occurs annually at the Board, quarterly at the PC and six monthly at the SLT. Associated risks are also scrutinised at the Audit and Risk Assurance Committee. The PMF[20] details that progress against the full suite of SFRS corporate performance measures is reported to the SFRS Board on a quarterly basis. It also notes that the SDC is the forum that provides additional scrutiny for OA.

19 SFRS, CoG, Station Audit report, Version 1, 15/01/24

20 SFRS Performance Management Framework 2023-2024 Version 1.0

72. We believe that this duplication and mixture of scrutiny is in some way linked to the fact that all other SA KPIs are deemed to be 'People-related' and probably linked to the merging of the departments and subsequent reporting mechanisms. Regardless of the apparent duplication, we found that OA was routinely reported for scrutiny through both quarterly and annual performance management reports to the PC and SDC. We observed that the content of the reports was a mixture of both quantitative and qualitative information with a reliance on KPI 19 and the OLG Action Tracker for measurement. Given previous comment regarding the value of these figures and limit to any other type of measurement, there may be a challenge to be assured of the OA process performance and continuous improvement of outcomes.

Area for Consideration 5

The Service should consider reporting improved measurement data in order that performance management and improved outcomes are able to be scrutinised effectively.

Benchmark

73. As previously detailed the NFCC has published a NOL good practice guide[21] which sets out their advice for identifying new or emerging risks, monitoring trends in the sector, recommending remedial actions, promoting good practice and sharing learning. In 2022, OAD conducted a benchmark assessment process to C&C the role of OA within the SFRS against the NFCC guide and with other United Kingdom Fire and Rescue Services (UKFRS). To undertake this task, the OA team conducted a desk-top review, comparing the SFRS processes with the guide as well as peer interviews with London Fire Brigade, Kent Fire and Rescue Service, West Midlands Fire and Rescue Service and Greater Manchester Fire and Rescue Service. The C&C assessment provided conclusions regarding process, standard and compliance but did not necessarily provide a root and branch review of the OAD.

74. The Service completed this benchmark process and subsequently developed an OA Improvement Action Log and tracker, which captured 21 recommendations for improvement. The Service has reported that to date, 20 of the recommendations are complete with the one outstanding recommendation recorded as unattainable due to its link to ICT incident ground-based solutions. Many of the actions identified in the recommendations relate to aspects of this report and as such have been drawn upon to support conclusions.

Good Practice 4

The C&C benchmarking process is good management and performance practice and provided constructive recommendations for improvement. The OAD should be commended for undertaking this process and proactively identifying these actions.

21 NFCC National Operational Learning: Good Practice Guide

5. Pre-Incident OA arrangements

75. The Service arrangements for pre-incident OA are contained within the GIN, Station Audits and Thematic Audits[22]. The two main components of the process are station and thematic audits with the former being the responsibility of SD staff and the latter the responsibility of the TSAB. The GIN details that the *'Station audits and thematic audits are vital components in promoting and assuring operational preparedness, ensuring that operational standards, health and safety and policy implementation within stations…can be measured accurately across Scotland and the outcomes used to drive continuous improvement'.*

Station Audit

76. The station audit and inspection programme measures pre-incident station preparedness and is designed to complement the 'during incident' and 'post-incident' review processes. Elements of the station audit include, but are not limited to:

a. Operations;

b. Training;

c. Health and Safety;

d. Prevention, Protection and Preparedness;

e. People;

f. Finance and Contractual Service; and

g. Knowledge and Performance.

77. Each element of the audit is scored from one to three:

a. significant areas for improvement required / risk critical issues identified – 1;

b. acceptable standard demonstrated / some minor areas of improvement identified – 2; and

c. no areas for improvement identified / notable practice demonstrated – 3.

The sharing of good practice and points for development and improvement are deemed vitally important by the Service, in order that the SFRS can develop its position as a LO and to ensure that policies, procedures and guidance continue to be developed so that they remain relevant and fit for purpose. The scorecards give a measure of compliance for each station. We were provided a copy of a CoG Station Audit report[23], which detailed how the scoring mechanism worked and how it could be used to provide a consolidated understanding of station performance regarding operational preparedness. This was a good example of localised audit.

22 SFRS TSA, Operational Assurance, GIN Station Audits and Thematic Audits, Version 5, 06/05/24

23 SFRS, City of Glasgow LSO, Station Audit report 23/24, Version 1, 15/01/24

78. As detailed earlier, the target set within the guidance is that all CFSs will be subject to a recordable audit and that there is evidence they are being conducted as well as being integrated into routine management planning. However, there was an inconsistency with the application of the target for WT CFS. It was noted that some management teams were content with doing a minimum of one audit per year whilst others chose to do up to five (one per watch) audits per year and submit one formally as a record on OARRS. Whilst this increased use is commendable and could be argued as enhanced performance management, there is a degree of concern that it is not efficient use of managerial capacity. The Service recognised this issue within its recent station audit report and indicated that there was an over recording issue.

Area for Consideration 6

The Service should consider the different frequency standard being applied to the CFS audit process and review guidance to ensure consistency of application and most efficient use of managerial capacity.

79. There is a planned audit programme each year and outputs as well as subsequent improvement plans are the responsibility of LSOs. However, from a service-wide perspective, there is limited evidence that the audit outputs are collated routinely and that there is ongoing national oversight, measurement or trend analysis. The Service has a desire for standardisation of practice within the process and it is incumbent upon local management teams to achieve this, but it is difficult to comprehend how overall understanding of this aspect of performance can be achieved without national involvement.

80. This is aptly demonstrated by the publication of the Station Audit report[24] which highlighted 18 significant areas for improvement required and/or risk critical issues identified, utilising analysis of all the OA02 forms submitted for that year. Recommendations involved informing appropriate directorates for further action and the review of OA process. We note that a SA strategic priority action was to develop and implement a programme of topic-specific SA audits, which the report detailed above appears to achieve.

Good Practice 5

The Station Audit report process is good management and performance practice in line with the SA strategy and provides positive recommendations for improvement. The OAD should be commended for undertaking this process and should be encouraged to repeat it.

81. An important aspect of station audits is that standards are maintained across LSO Areas and SDAs. To support this, several WT CFS audits include managers from neighbouring LSO Areas and/or from adjoining SDAs. Station audit teams consist of a minimum of two middle managers. Wherever resources permit, a GC leads WT CFS audits. The audit team should not include a manager that holds a management responsibility for that station. On-Call CFS audits are led by a GC where possible, however a flexible approach may be considered depending on location and availability of FDOs.

24 SFRS, SA, Operational Assurance, Station Audit report 2023 – 2024, 16/01/25

82. We found that in general, audit teams were of a high standard, well received by station staff and that their composition tended to reflect the desired levels. There were occasional reports of single-person teams and SCs visiting their own station, which was usually confined to the North SDA (NSDA) where geography and capacity for travel are a routine challenge. There was a slight concern that this practice could be biased and may limit improved performance, but we found no evidence to support this. There was also comment regarding the limited development of audit teams and that consistency of audit across the country may be an issue. Some staff proposed that a routine forum for standardisation may be beneficial to ensure uniformity of application and limit subjectivity. This desire seemed to be amplified by the high turnover in staff being experienced by the Service.

83. One notable practice within the audit process is that the audit team leader should provide the relevant CFS and SC with notice, by email, of the intent to undertake the audit with a proposed date, giving a minimum of two weeks' notice. We found that this was the general standard and, on many occasions, more notice than this was given. Most staff, including those on station, agreed that giving notice for the audit was reasonable but potentially gave a false output due to post-notification preparation. As such, there was an acknowledgement that the audits did not necessarily improve standards outside the immediate pre- and post-audit preparation window. There was routine feedback regarding the acceptance that the audits should be completed on a no- or limited-notice basis to get an accurate understanding of standards.

84. Many staff welcomed this approach on the caveat that giving no notice may be disruptive to community safety, training, or operational preparedness planning. We spoke to staff in an LSO area where a pilot of limited notice audits was being conducted. The feedback was positive particularly because there was still an opportunity to alter planned work and that there was increased sensitivity and pragmatism from the audit teams of stations being an operational workplace. Staff in this area believed that the limited notice audit approach was a better tool for improving station performance throughout the year.

Area for Consideration 7

The limited-notice station audit pilot was well received throughout the pilot area with most staff reporting that it would be a positive development. The Service should be commended for this innovation and consider the outcome of the pilot for incorporation into any future review of OA process.

85. Another notable practice within the audit process is that station personnel will be required to demonstrate both core practical and technical skills through a training scenario selected from the FRS Manual: Volume 4 – Foundation Training and Development. The practice of physically demonstrating operational competence for the audit is extremely important and there is an argument that it could form a larger part of the audit. Staff generally had the opinion that this part of the audit was frustrating and that routinely conducting a 'standard drill' as defined in the manual may not significantly improve standards.

86. There was general agreement that other operational preparedness could be audited which may be of more benefit. This issue was illustrated where we observed one LSO area assessing themes such as the application of BA Emergency Air Supply

Equipment, BA Impound procedures, Personal Protective Equipment (PPE) contamination protocols and Asbestos protocols in place of the standard drill. Most staff agreed that auditing these types of themes would have a greater effect on continuous improvement outcomes and could also possibly form part of the thematic audit process.

Good Practice 6

We found that altering the core practical and technical skills element of the station audit to include practical operational preparedness testing to be a positive innovation. The Service should be commended for this and consider it for incorporation into any future review of OA process.

87. Following the audit, the auditing team provide initial feedback prior to leaving the station. The OA02 form must be completed on OARRS and submitted in accordance with the standard for recording outcomes. On completion of the Station Audit and following submission on OARRS, the audit team download the OA02 to PDF and forward this on to the LSO with responsibility for the station being audited. LSOs are then responsible for taking action to address any areas identified for improvements. The SC responsible for the station being audited should agree the improvement plan for any improvements identified and action as appropriate.

88. In our WSDA report[25] we detailed *'that staff were unaware of their Station Audit outcome and that the information was not being routinely shared or debriefed. This was a bit disappointing, given the fact that they had been completed and the opportunity to improve was being missed'*. During our thematic inspection we consistently found that informal verbal feedback was given to the on-duty station staff before the audit team left the site, which was sometimes accompanied by an email confirming the verbal feedback. Staff generally felt that the manner and delivery of the feedback was appropriate and positive.

89. However, formal feedback seemed less consistent with some staff reporting very formal and structured processes whilst others could not provide evidence that there had been any formal feedback. Staff who had been given formal feedback recognised the PDF document as well as the subsequent improvement plan and seemed more engaged in the process. There was evidence of a pervasive culture whereby, the on duty watch at WT stations being audited appeared predominantly responsible for the outcome and therefore other WCs on station had limited engagement with subsequent improvement. There was evidence of the audit outcome and improvement plan being routinely discussed at SC management meetings, when convened, but these meetings also were inconsistent and as such, there was limited confidence that this encouraged engagement in the improvement process.

Area for Consideration 8

The station audit output and subsequent improvement action plan is an effective process; the Service should consider reviewing its local management systems to ensure continued understanding and engagement with improvement from all staff.

25 HMFSI Inspection of the Scottish Fire and Rescue Service West Service Delivery Area

90. Administering audit outcomes was another source of frustration with OARRS functionality. Staff reported that access to information once submitted into OARSS was extremely limited and that use of the data for any local analysis and management can be challenging. This has led to workarounds utilising other ICT systems and software, which although innovative and commendable would seem an inefficient use of capacity.

91. Lastly, we are aware that there is a feeling that the term station 'audit' may not be appropriate for this aspect of OA and that the process is more aligned to that of station 'inspection', with audit of the output completed independently at a later point. TSA management are aware of this nuance and are assessing potential changes as part of ongoing review.

Operations Control

92. OC are a critical component within OA and as such are included within the ethos of the OA Policy. OC have three sites in Scotland, which are in Edinburgh (EOC), Dundee (DOC) and Johnstone (JOC). These sites are not designated as CFS and as such are technically omitted from the Station Audit process as laid out within the current GIN. Even so, it would seem appropriate to audit the operational preparedness of these workplaces, albeit with OC-specific elements. This issue was recognised by OC staff and that, in the absence of the current GIN being reviewed, OC-specific procedures were developed to mimic the station audit process for the three sites. OC staff confirmed that the procedures remain in draft format and have not been progressed beyond that stage.

Recommendation 3

We recommend that the Station Audit GIN should be reviewed to include OC sites. In the interim period the Service should consider publishing and implementing the OC-specific procedure to complement the existing GIN.

Thematic Audit

93. The thematic audit programme allows the SFRS to target specific areas of organisational performance and may have both compliance and performance audit objectives. Thematic audits are undertaken at the request of the TSAB. The subject for each thematic audit would normally be agreed by the TSAB, with the audit programme running through a fiscal year. The OAD aims to undertake a minimum of two thematic audits over the fiscal year, subject to Service requirements. As previously reported, over a six-year period from 2019 there were only three thematic audits completed, which falls short of the aspiration and target set within policy.

94. The three previous audits covered issues surrounding BA, ARA and Asbestos. It is understood that another has been commissioned to start in early 2025 covering the subject of Smoke Hoods. The most recent published thematic audit report was titled Incident Involving Asbestos[26], which was commissioned at the direction of TSAB. The driver for this audit was a noticeable rise in the number of incidents where staff were

26 SFRS, Operational Assurance, Thematic Audit, Incidents Involving Asbestos Report, 14/03/24

suspected to have encountered asbestos during operational activity. In general, it was the only audit that SD staff recalled being completed in recent times.

95. The asbestos report would appear to be very thorough and examined areas such as operational activity, incidents of note, data analysis, SFRS documentation, training, NOG, equipment and key learning. Sixteen recommendations were made to TSAB, which were then adopted into the OLG action list and are currently being progressed. As a tool the thematic audit process would seem to be highly effective in sense checking potential issues and emerging trends. It is disappointing to note that the target, set by the Service, for completing these audits has fallen noticeably short. Some staff have indicated they believed the Frontline Update (FLU) process is a substitute for thematic audit and as such, should be considered in the target figures. We found this perspective slightly confusing as a FLU is primarily considered a communication output for learning and engagement, as opposed to an audit, which is a formal inspection of thematic aspects of the Service. Regardless, there is a need for regular thematic audit in some format as it can focus on routine trending issues and provide recommendation for improvement.

Area for Consideration 9

The Service should consider conducting more thematic audits as the recommended changes from robust data analysis are tangible and can be aligned to continuous improvement.

Training and Development

96. Although not detailed in any procedure, we felt that as part of the pre-incident process, it would seem incumbent on the Service to train and develop staff regarding OA to ensure that it is being applied efficiently and effectively. Throughout our fieldwork we discussed with staff the function of OA within the command element of their role, as well as its function within their management role. It became apparent that staff could be divided into three distinct groups in relation to OA. Middle and Strategic Managers (FDOs and support staff), Supervisory Managers (WC & CC), and OC staff across all management groups. In addition, we also explored the provision of acquisition training as well as ongoing competence training within these groups of staff.

97. From a FDO command aspect we found a mixture of training and development. Staff provided evidence that there was limited input regarding the OA process within the Incident Command Level (ICL) 2 (ICL2) programme, which was mainly focussed on the OA Officer (OAO) role and hot debriefing process. An FDO induction handbook also detailed that it required new officers to indicate awareness of the OA Policy and OARRS, but it is unclear whether the process of demonstrating understanding is a requirement or whether it was just to acknowledge awareness. The Service also provide an FDO OA-specific package within their Training for Competence (TFoC) Learning Content Management System (LCMS) which supports ongoing competence development. Data provided by the Service demonstrates the completion rates for the package for the year 21/22 as 62% (3 out of 5), 22/23 as 81% (4 out of 5) and 23/24 as 86% (6 out of 7). The completion rate is slightly disappointing particularly in the earlier years, but it does indicate an improving picture.

98. Finally, from a FDO aspect, we did find limited evidence of localised induction and awareness training being conducted with varying emphasis on aspects of OA performance improvement processes. It is understood that the C&C benchmark process identified the need for FDO induction guidance, and a subsequent electronic presentation was developed by OAD, which is now being used to some extent.

99. From a supervisory manager aspect, staff provided evidence that there was limited input regarding the OA process within the ICL1 programme, which was mainly focussed on the hot debriefing process. We found no evidence of nationally sponsored induction-, acquisition- or competence-related OA training for this group of staff in relation to their management responsibilities for improving performance. However, we found that there were pockets of LSO-sponsored managerial training being delivered locally that included some aspects of OA awareness.

100. OC and support staff have no formal development pathway and are not included within the ICL programme or the TFoC LCMS for command competence. We found no evidence of nationally sponsored induction-, acquisition- or competence-related OA training for these staff groups in relation to their management responsibilities for improving performance. However, we found that there were pockets of managerial training being delivered locally within OC that included OA awareness.

101. The evidence regarding the three staff groups mentioned is generally indicative of a downward sliding scale of OA awareness and understanding from strategic to middle to supervisory managers. The ability to link the various aspects of OA together is heavily reliant on exposure and experience of performance management and larger scale incidents, rather than any service development and training. In particular, the limited development and training at supervisory manager level is a significant gap and may inhibit the effectiveness and efficiency of OA as a ORL tool.

102. The C&C benchmark process identified a gap in debrief training and concluded that OAD staff should be prioritised with the bespoke SMARTEU debrief training. However, this decision, albeit potentially correct, was at the expense of FDOs, OAO, debrief facilitators and OA Liaison officers. From our understanding of current training and development for managers and commanders, there is a need to provide bespoke OA debrief training to at least a portion of the command cadre, and as such any strategy should take account of this.

103. In addition, the C&C benchmark process also detailed the potential need for OAD staff to be developed to the incident level above the one assigned to their current role. For example, a WC would normally be developed to ICL1 but should be developed to ICL2 etc. This would be a reasonable position as it would allow OAD staff to proficiently understand the standards and expectations expected of FDOs who they will be making assessment of, within their administrative role. It was therefore disappointing that this recommendation was not adopted.

104. In our WSDA report[27] we recommended that *'the Service should conduct a review of its leadership and management development processes to provide a national standard and syllabus for delivery at all levels'*. We are aware of a Management Development Framework (MDF) currently being proposed and piloted by the Service that includes OA within its extended syllabus. We are also aware that the Training function is reviewing the content of ICL training to potentially include a greater emphasis on OA both of which are welcomed but not currently delivered.

Recommendation 4

We recommend that the Service review its leadership, managerial and command development processes to include generic OA training for all staff and that it further reviews its development of OAD staff or those with a specific OA remit to ensure they have suitable competency-based training for their role.

27 HMFSI Inspection of the Scottish Fire and Rescue Service West Service Delivery Area

6. During-Incident OA arrangements

105. The Service arrangements for during incident OA are contained within the GIN - During Incident Operational Assurance[28]. The GIN details that the *'SFRS has a statutory duty to manage the workplace safely. Part of that duty, defined by the Management of Health and Safety at Work Regulations (1999), is a requirement to review workplace activity. In the case of the SFRS, this also includes the requirement to review operational activity on the incident ground'*. We have identified that the three main components of the process are Active Monitoring (AM), OA Support or Mentoring roles, and the role of the OAO.

106. In addition to the GIN detailed above, the Service also maintains a Control Operating Procedure (COP) – Flexi Duty Officer and Principal Officer Mobilising document[29], which details that the SFRS should ensure a professional and effective response be made to meet the full range of incidents which may be encountered. Mobilising such a response should guarantee the appropriate deployment of resources to ensure operational crews can undertake a safe system of work. It further details that the speed and weight of response for an incident is important but consideration must also be given to ensure the most appropriate type of resource, is mobilised at an early stage. It accepts that most incidents are likely to be dealt with safely and effectively by first attending crews. If, however an incident escalates, FDOs and/or PO will be informed of or mobilised to incidents by OC in accordance with the principles of the ICS. It details that '*FDOs and POs may be informed of, or mobilised to, incidents for a variety of reasons. On some occasions, this will be pre-defined for specific incident types or to support the ICS.'*

107. The Service has five main incident levels, Level 1 to Level 5, which is based primarily upon the number of pumping fire appliances that are mobilised to the incident, as detailed in Table 2.

LEVEL	PUMPING APPLIANCE
1A	1
1B	2
1C	3
1D	4
2	6
3	9
4	12
5	15+

Table 2 – Comparison of Incident Levels and Pumping Appliances

28 SFRS, Operational Assurance, GIN During Incident Operational Assurance, Version 2, 25/11/22

29 SFRS, Operations, Control Operating Procedure (COP) - Flexi Duty Officer and Principal Officer Mobilising Version 10, 13/11/23

108. The increased number of pumps normally correlates to the type, size, scale and complexity of the incident. Most incidents will require a Level 1 response, with a CC, WC or SC as the IC. The structured incident debriefing triggers are based predominantly upon the level of incident, with the requirements correlating to it being either a Level 1 (L1) incident, Level 2 (L2) or 3 (L3) incidents or a Level 4 (L4) and above incident (L4+).

Active Monitoring

109. AM is where a FDO gathers pre-attendance information, monitors incident radio messages and, using professional judgement and/or experience, acts where necessary. The decision to start and stop AM is communicated to OC to ensure FDOs are contacted correctly for message acknowledgments. AM requires the FDO to be proactive in the gathering of information through the monitoring of incident messages and related information via the main scheme fireground radio.

110. When an FDO is 'informed' by OC of an incident, AM is considered best practice and adopted, whenever possible. AM facilitates early FDO mobilisation, not only for the purposes of OA, but also for mentoring and support. AM is only used for incidents where OC notify an FDO for 'information only'. Upon receiving notification of an incident, the FDO informs OC if they intend to monitor the incident via the main scheme radio. OC will thereafter contact the FDO via radio for confirmation of messages and not via pager or phone.

111. During AM, an FDO is not classed as 'assigned' to the incident they are monitoring and may be mobilised to another incident by OC, as required. In these circumstances, the next nearest FDO of the same level is informed of the initial incident to undertake AM. When an FDO decides, they are no longer required to monitor the incident, they inform OC of this decision by passing a message over the radio, stating they are no longer actively monitoring the incident. This will be recorded in the incident log by OC. Where an FDO decides to mobilise to an incident based on their assessment of the incident information, they inform OC of their intention to mobilise, whereupon the next level FDO is informed and that next level FDO will take on the AM of the incident.

112. In general, we found that the process of AM was followed on a regular basis and used routinely as a tool to support the IC. Staff at all levels believed that AM enhanced IC and provided a higher degree of OA than there had been historically. Staff cited that on occasion they had been asked to monitor more than one incident at the same time. Staff felt that this practice had reduced considerably and was not so much of an issue as it had been previously. Staff also reported that there had generally been no training or development to prepare them for the process of AM, this feedback was mainly consigned to SCs who were at the initial stages of their career and had made the move from supervisory to middle manager level recently. These staff predominantly fed back that there was limited development for the role preparation overall, which is consistent with earlier findings of HMFSI. They did feedback that the command group learning and support processes were positive, which was again consistent with earlier findings.

113. Lasty, it was noted that AM was used throughout the SFRS geographical area, as the main scheme fireground radio system provides near perfect coverage and would seem an adequate tool for the purpose. However, this use of the main scheme radio

would seem to have allowed the transition between AM and IC to become blurred, specifically for very remote rural areas where travel distances and access to islands can be problematic and lengthy. FDOs monitoring incidents remotely from their location used the AM process to informally move into IC on occasions. Although not a potential critical failing, there was a sense that AM was being used as a crutch to support the ICS for remote areas, where investment in other technology and tools, such as body-worn cameras etc., may be more effective and efficient for IC.

OA and Mentoring

114. On arrival at smaller incidents (Level 1), an FDO is expected to assess the incident and, based on information received or the nature of the incident, decide to either assume command or remain in attendance for OA or Mentoring. If the decision of the first attending FDO is to take charge or carry out OA or mentoring, the next-level FDO will continue to actively monitor the incident until the indicators suggest AM is no longer required. The OAD undertake a daily review of incident activity and where a FDO takes on an OA or mentoring role at an incident, they may be issued with an OA06 via OARRS. The OA06 is an incident review form completed from observation specifically in an OA role, utilising the OA07A/B documents. Where OAD do not issue an OA06 following the daily activity review, FDOs who have captured learning at an operational incident can still submit their findings on OARRS and there is no requirement to wait on an OA06 to be issued.

115. We found that FDOs attending incidents actively decided to either take command of the incident or remain for OA or mentoring, as it is a defined function with the ICS. This was generally well received by subordinate commanders although the decision making and motivation for doing one or the other was sometimes misunderstood and could potentially be communicated better between the command levels. It would appear from the guidance provided that remaining in an OA role is very much an ORL tool, whilst remaining for the mentoring role was used predominantly for supporting individual learning and developing competence of the mentee. It was unclear whether staff were aware of or could make the distinction between the two.

116. When remaining for OA or mentoring, FDOs seemed comfortable providing feedback with the predominant focus being on individual learning as opposed to ORL. This position was normally illustrated by the limited examples given of FDOs voluntarily completing OA06 forms and only doing so if prompted by the OAD. Mentoring and the resultant completion of competence paperwork, as well as generally supporting more junior commanders, seemed a focus and is commendable. However, this led us to the conclusion that FDOs remaining in attendance for the OA role, even when declared as such, was not an effective and efficient ORL tool for smaller incidents.

117. We also found that there was a confusing mix of terminology used by officers that did not provide confidence of a clear delineation and understanding between remaining for OA or providing Mentoring. Different phrases ranged between operational review, mentoring and support, tactical advice and operational support, which is potentially an indication of the need for improved learning and development as detailed previously.

Operational Assurance Officer

118. For larger incidents, Level 2 and above (L2+) or when requested by the IC, an FDO is mobilised specifically to undertake the role of OAO. As detailed in the GIN, the primary role of the OAO is to support the command team to ensure a safe conclusion of the incident. Where, on arrival at the incident, the OAO is required to perform a more risk-critical role within the command team, the IC can decide to reassign them. The details of the role change are passed immediately to OC, who should also be informed whether or not a further OAO is required to attend. Where an additional OAO is not required, the original OAO role should be re-instated as soon as reasonably practicable. The OAO role is designed to provide the necessary independent level of assurance at operational incidents. The OAO will:

a. be minimum role of SC;

b. use the step-by-step guidance provided in OA action checklist templates, utilising forms OA07A and OA07B to ensure a standardised approach;

c. provide support to the IC;

d. undertake OA duties when appropriate to do so in accordance / agreement with the IC;

e. observe operational activity;

f. observe decisions made by the IC and command team;

g. observe operational tactics;

h. correct any safety-critical issues immediately and inform the IC;

i. provide feedback to the IC on safety-critical issues, areas of concern and notable practice;

j. where applicable, remind the IC of the requirement to initiate the Post-incident Support Procedure (PISP); and

k. on completion of the incident, submit all operational learning using form OA06 (Incident Review) on the OARRS.

119. The gathering of OA-related information on the incident ground is informed using the OA07A Action Check list, OA07B Aide Memoire and captured utilising the OA06 form. These forms provide the OAO with common templates to ensure a consistent approach to the assurance of activities across the Service. The awareness and use of these documents was positive, FDOs routinely detailed that they had hard copies in their vehicle and would expect to use them if and when asked to be an OAO. It should be noted that the C&C benchmark process identified that the OA07A should be reviewed and updated with NFCC good practice guide information included and will conclude by 2025.

120. There was some negative feedback related to the complexity of the OA07B form, but this mainly related to the number of fields that needed completed. Again, improvement within the C&C benchmark process provided the impetus to review and update this form with NFCC good practice guide information included. Finally, another recommendation from the C&C benchmark process was the identified need for a digital reporting form to make assessment and reporting easier on the incident ground. The target completion date for this recommendation was deemed unattainable due to ICT restrictions and this remains open. There was no overwhelming evidence to suggest staff thought that this would be a benefit one way or the other.

121. The information gathered on the OA07 form is transferred to the OA06 form and submitted into OARRS, which is then forwarded to the IC for debrief and personal development purposes. We found sporadic evidence of ICs receiving a completed OA06 form and were not convinced of routine normalised use. The Service provided partial data for completed OA06 forms for the period of 2018/19 to 2022/23 which indicated that this process is being completed to a degree. However, the Service was unable to provide completion rate data to contrast with the actual number of incidents, or evidence to support the ongoing use of OA06 information for debriefing and/or trend analysis toward ORL.

122. As detailed previously the OAO is automatically mobilised for L2+ incidents, as well as on request for smaller incidents. The OAO is deemed to be a functional officer that supports the initial command team and is mobilised by OC. Other functional officers may include a Safety Officer, a Command Support Officer, an Operations Commander and a Firefighter Safety Resource Officer. Depending on the size, scale and nature of the incident, this team can be augmented with additional officers who have specific training and can give tactical advice to the IC. These FDOs are called Tactical Advisors (TacAds). All these officers can attend the incident ground at varying times due to the location of the incident and the starting location of being mobilised. The need for some or all these officers can understandably place a burden on resourcing and attendance times at incidents. As such, the IC has discretion to use or reassign arriving officers on a needs and risk basis.

123. The ICS within the Service is a very mature system, which is initiated routinely and consistently for all levels of incident. Since the OAO is normally only mobilised for L2+ incidents, there was a varying degree of exposure to this role and experience was normally consigned to staff who had been an FDO for some time. Of the staff who had experienced the role, there was consistent feedback that the OAO would normally be the role that would be reassigned dynamically by the IC at an incident and occasionally not then reinstated, potentially due to competing priorities and resourcing issues. The guidance does not state that the IC must reinstate the OAO.

124. In addition, the OAO is required to be a minimum SC, which indicates a higher degree of responsibility and status on the fireground, as detailed in the GIN where it states, that there is a requirement to provide an independent level of assurance at operational incidents. It was confirmed by OC that there is no requirement for the role to be a competent or substantive SC and as such can result in relatively inexperienced FDOs being assigned and exposed to situations where they are required to assure FDOs who are at times much more senior and more experienced. An extreme example could be that of a not-yet competent, non-substantive, newly promoted SC being assigned OAO to an incident where a substantive competent AC with numerous years'

experience is IC. The C&C benchmark process reviewed the role and concluded that the FDO level was appropriate for the OAO and that ICL 2 training was appropriate training and qualification for the role. However, their analysis did not identify any issues with the SC role potentially being non-substantive and not yet competent.

125. Staff mostly reported that they had never experienced conflict being put in this position and that personal relationships normally defused any possible tension. It does however raise the question as to whether a role that is meant to provide an independent level of assurance should potentially be so junior to the level of command being applied and that competence in role is not a prerequisite. In addition, there was also a perception that the perceived sacrificial nature of the role and therefore lower command status could be deemed to reduce the credibility and utilisation of OA and the OAO.

126. We have detailed previously that the learning and development for OA appears to be limited within the Service. However, the OAO role is one of the aspects better understood by middle and strategic managers. It is believed that this is partly due to new SCs understanding that they may be asked to fulfil the role and therefore undertaking a degree of self-learning and preparation. We also found evidence that the OAO role formed part of the TFoC FDO OA module, the ICL2 syllabus as well as local and informal FDO development within either management or command teams. That said, we got a sense that this development had gaps particularly around a consistent approach to acquisition learning, understanding of OA responsibilities and process that would assist new FDOs in role who may have to fulfil the OAO.

127. It is interesting to note that the OAO is an assigned role for L2+ incidents and has the responsibility to provide a necessary independent level of assurance at operational incidents. Yet, aside from completing the OA06 and returning it to the IC, they appear to play no significant part in the debrief process. The responsibility for conducting debriefs lies with the IC but we feel that failure to utilise the OAO in this process diminishes the potential learning process, inhibits support for the IC and reinforces the culture of being the first role sacrificed on the incident ground.

128. We found that the OAO was a particularly good concept but that it seemed to struggle with an identity, between being deemed part of the initial functional command team or the role potentially being something more akin to that of a TacAd. We believe there is an opportunity for the role to add real value, as a champion for learning and to assist ICs with debrief, but the culture of it being sacrificial on the incident ground and potential limits to the experiential credibility of the FDO assigned, appear to diminish the role.

Recommendation 5

We recommend that the OAO role be reviewed to ensure development is provided, correct competence is assigned and involvement in the OA debrief process is ensured to appropriately support ORL and the IC.

129. As detailed previously OCs are a key component within the OA process and as such are included within the ethos of the OA Policy. The nature of the role within the Service, whilst operational, does normally include attendance on the incident ground and as such, many of the aspects of the During-Incident GIN do not apply. Nonetheless, there is a cadre of OC FDOs who operate within a similar command group structure and are required to attend a designated OC site when certain operational triggers dictate. We found that it was normal practice for the OC FDOs to AM calls and activity levels of their designated OC. The OC FDOs would routinely attend OC when formal triggers required them to do so but also complemented this with attendance when they felt there was a need for additional support. Staff reported that whilst this attendance was normally informal, it provided a welcome level of supervision and support.

130. Many of the cells within the existing OA06 form are specific to incident ground attendance and do not apply directly to OC operational procedure or systems. We were pleased to note that OC have developed their own version of the OA06 form (OA06OC) in order that they can formally capture learning from FDO attendance so that learning and improvement can be identified. This form is not accommodated within the OARRS and the input and output are administered by the OC management team. This innovation was pleasing to observe and OC staff should be commended for it. However, it is disappointing to note that OC and their role in operations is not subsumed within the holistic OA systems and as such ORL may be less efficient and effective.

Area for Consideration 10

The Service should consider how integrated OC is within the current OA processes and ensure that OC staff are fully involved in the development and review of future 'during incident' process change.

7. Post-incident OA arrangements

131. The Service arrangements for post-incident OA are contained within the GIN – Operational and Event Debriefing[30]. The GIN details that: *'Effective debriefing plays an important part in maintaining and improving standards across the Service. Debriefing also plays a vital role in supporting a learning culture necessary to promote a safe and effective workforce… Debriefs are an essential and robust evaluation technique, used to identify significant factors giving rise to shortcomings or achievements. By debriefing, the SFRS can review, evaluate and amend policies, practices and procedures appropriately'*. The two main components of the process are 'hot debriefing' and 'structured debriefing'.

132. A hot debrief is the informal method of reviewing activity and sharing learning immediately after an incident, preferably at the scene and, where possible, involving all personnel. Partner agencies, such as Police, Ambulance and other organisations involved, can also be included in the hot debrief to provide their perspective on the resolution of the incident. This can help to promote collaborative multi-agency working. The Service considers hot debriefing as mandatory for all incidents, irrespective of whether a structured debrief process is expected to take place thereafter. When hot debriefing an incident, the IC or debrief lead are required to make notes of discussion points for future reference and to inform a subsequent structured debrief, if required. If there is ORL it is captured electronically on an OA13 debrief report form on OARRS.

133. A structured debrief is a documented and auditable procedure for obtaining, collating and reviewing information about incidents, for the purposes of continuous improvement. Wherever possible, a structured debrief is expected to be conducted as soon as is reasonably practicable after the event. Ideally, the Service expects that this should be within 28 days, to ensure learning points are still fresh in the minds of those involved in the incident. To adequately prepare for a structured debrief, all relevant information should be collated to enable an understanding of the sequence of actions from start to finish of the incident. To streamline the debrief process, individual OA13 debriefs may be issued electronically and automatically collated on OARRS, thus reducing the logistical challenge of trying to bring large numbers of personnel together at the same location.

134. Non-operational events, such as those impacting on SFRS 'business as usual,' e.g. power outages, severe weather, ICT-related issues and Pandemic Flu, may be subject to a debrief process where ORL is apparent. In addition, local or regional event debriefs can be carried out by staff, where applicable, following the principles set out in the debrief processes and utilising the OA13 report on the OARRS for recording the debrief outcomes.

135. A key component of any process is the ability to progress identified learning points raised through the debrief process and ensure they are actioned with subsequent improvement made. To support a learning culture, it is vitally important that individuals can raise learning points, have a process for them to be progressed, and to receive feedback as to whether the points raised have been actioned or otherwise. It is the

30 SFRS, Operational Assurance, GIN Operational and Event Debriefing, Version 2, 22/12/22

responsibility of all managers to ensure that any learning that can be addressed locally is actioned at the earliest opportunity.

136. Where learning is addressed locally, it should be recorded on the OA13 form, to close off the learning identified. Where learning cannot be addressed locally, it should be passed to the next level of authority for progression and/or decision. This is recorded on the OA13 form and includes the proposed route for progression, i.e. submit to the regional SAIGs for progression etc. Wherever possible, OAD should feedback to the submitting IC or debrief lead on the progression of items that have been submitted and accepted for progression.

Hot Debriefing

137. Staff were very conversant with the hot debrief process and provided a lot of good evidence surrounding the positive use and learning from this form of debrief being conducted at incidents. We found that the process in Figure 3 was generally followed well and there was an expectation that a hot debrief would be completed at any operational incident of note. In most instances, staff used the hot debrief immediately after an incident but there was a level of pragmatism regarding its application depending on the type of incident, weather conditions, welfare consideration, exposure to contaminants, ongoing incident ground risk etc. In such instances staff were more than comfortable conducting the debrief back at a workplace when it was more appropriate.

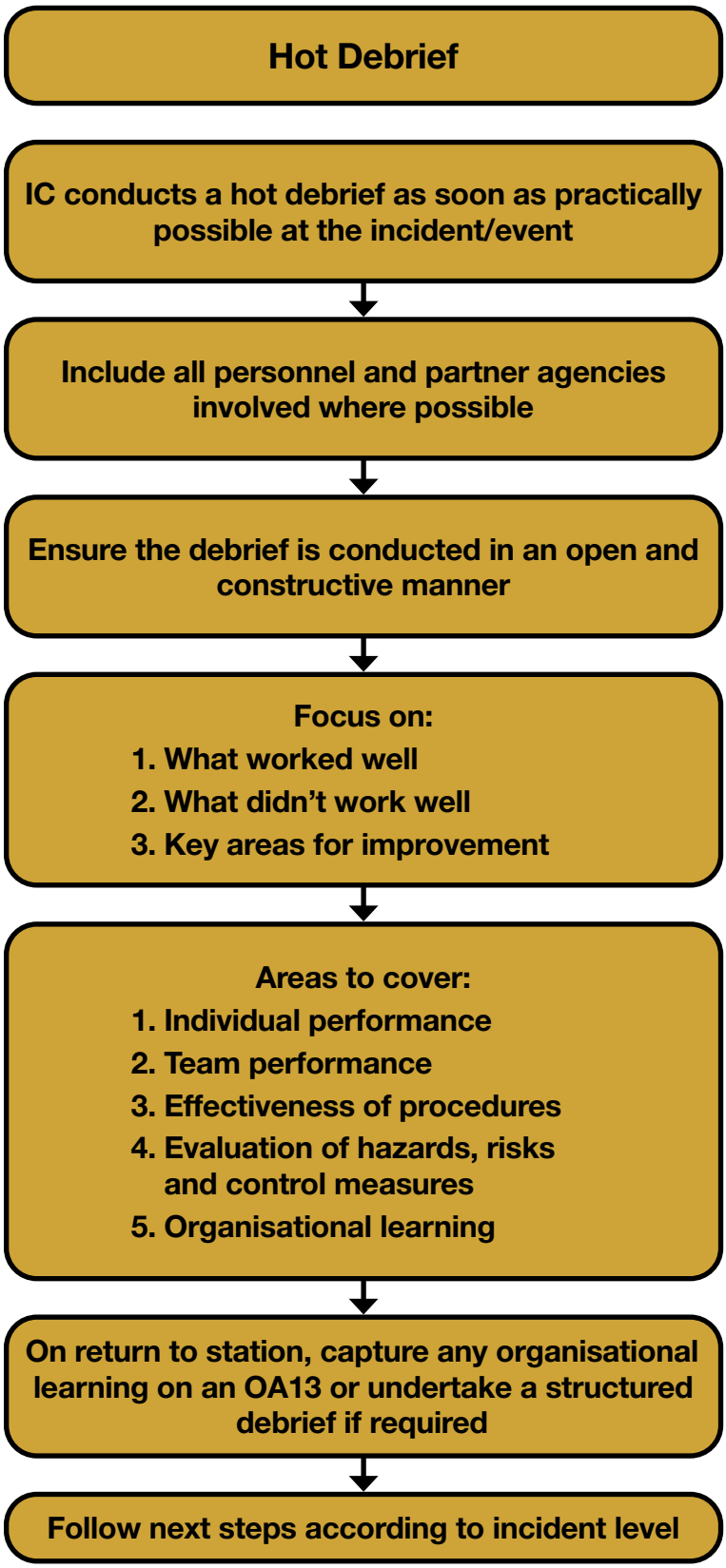


Figure 3 – Hot Debrief process

138. Staff also reported the increased use of the hot debrief for checking post-incident Mental Health and Wellbeing (MHW) and initiation of the PISP. This evolution of the process was considered an extremely positive practice.

Good Practice 7

We found examples of the changing culture to include PISP and MHW within the Hot Debriefs to be incredibly positive and that this good practice should be used to influence future IC development.

139. An aspect of the hot debrief process was that it tended to result in somewhat localised learning. Staff were very proactive in discussing learning within their own watch or crew, however, this normally remained consigned within that team with informal transfer of learning between WCs on station only happening occasionally. Formal learning transfer at station management meetings appeared to be limited, due in part to there being inconsistent examples of management meetings and reluctance to 'air dirty linen', but also with occasional examples of good practice and innovative use of digital systems. There was limited evidence of regional transfer and rare examples of transfer of learning within the whole SDA or Service-wide. We found that many of the local meeting fora and agendas were focussed predominantly on management performance issues and that operational performance and assurance did not feature highly or equitably. It was concerning that local OL did not seem to be routinely communicated in a structured fashion or to be part of station culture.

Area for Consideration 11

The Service should consider reviewing how local OL is informally transferred within its management structures and reinvigorate the need to ensure that learning is reported appropriately.

140. Many managers reported that the value of hot debriefs diminished in direct relation to the size, scale and protracted nature of the incident. This was because crew turnover at larger incidents meant that debriefing the initial stages of the incident and original crews in attendance was very unlikely. In addition, staff felt that it was also unlikely that the attending crews and IC teams' changeover would be exactly aligned, so the opportunity to debrief that phase of the incident could be problematic. As such, conducting a hot debrief was sometimes viewed as being 'belts and braces' as opposed to adding value.

141. We found reference to hot debriefing in many of the OA documents and within the ICL and TFoC processes but no direct reference to acquisition training for managers. Reference to debrief training within the Road Traffic Collision Instructor and Breathing Apparatus Instructor courses was also cited, however, staff reported that access to these courses could be limited and could therefore not be relied upon as routine training. The structure and standard of hot debriefs was generally not formally taught, and learning and development was based mainly on experience and observation of other ICs. Staff generally found the standard of hot debriefs to be constructive and positive but felt that the success of many depended on the experience, leadership style and personality of the conducting IC and any historic observation. Many managers felt that they had not been properly prepared to conduct hot debriefs to a standard expected by the Service.

Structured Debriefing

142. On conclusion of a L1 incident, the IC is required to conduct a hot debrief and, if appropriate, should then undertake a structured debrief on return to station (Figure 4). If a structured debrief is required, the IC should consider the inclusion of all other parties involved, i.e. OC, Police, Ambulance, etc. Where OL is identified that cannot be addressed at a local level, the IC should complete an OA13 on OARRS and submit the debrief report to the respective local SC responsible for the station area where the incident occurred. The reason for submitting the OA13 to the respective local SC is to ensure that local matters arising are addressed promptly, e.g. lack of Operational Intelligence (OI), multi-agency issues, poor water supplies, etc.

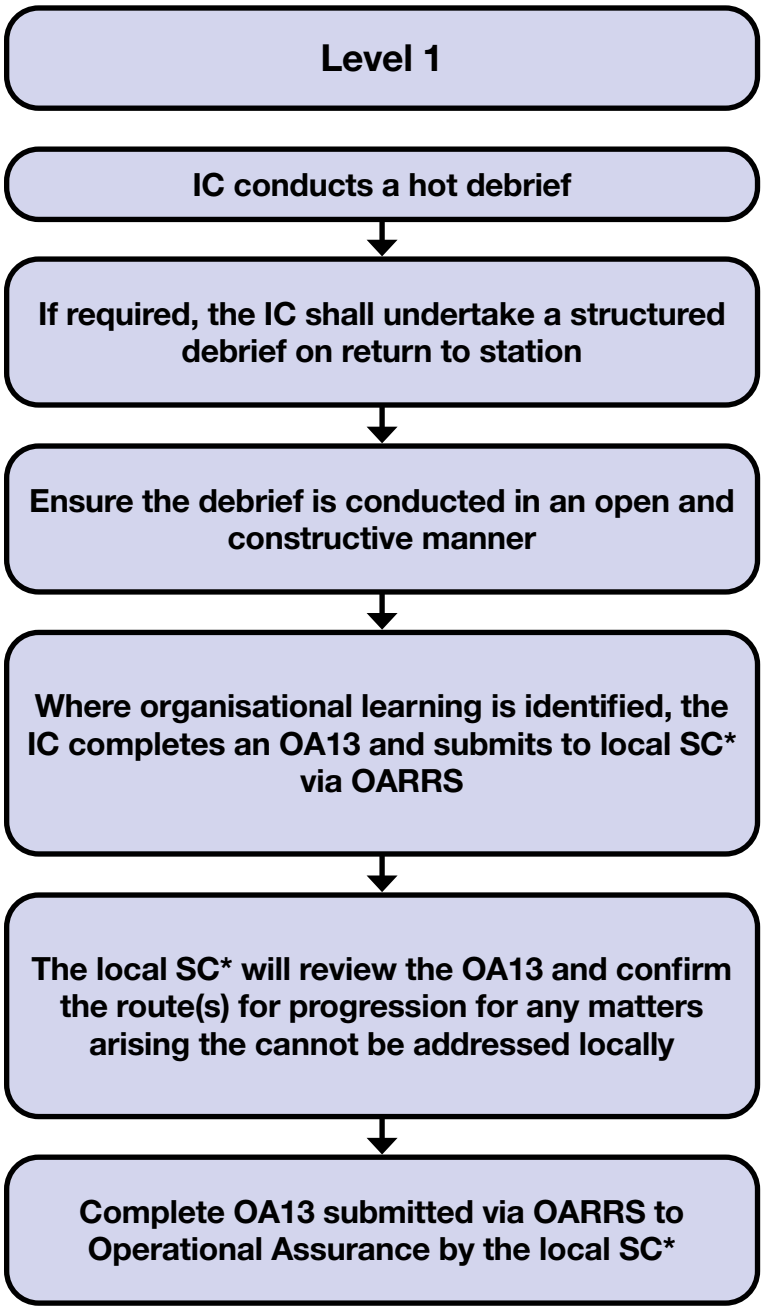


Figure 4 – Level 1 debrief process

143. We reported in our WSDA inspection that in relation to OA, staff were routinely frustrated that the Service did not seem to be learning from certain types of incidents and that there was, in their opinion, gaps in operational preparedness. Specifically, we recorded that *'given the rise in forced entry incidents, bespoke equipment to assist this type of incident such as a power drill, reciprocating saw and door opener had not been provided, after repeated requests'*. Whilst speaking to staff, during this inspection, our understanding of this issue was further reinforced. We found similar types of incidents to be those involving assistance to Scottish Ambulance Service with bariatric patients, large animal incidents, electric vehicles and solar panels. Frustrations surrounded limited training, equipment and procedures for these incident types, that staff believed could be anticipated and foreseeable. Many of these incidents form day to day operational work and are not new to the organisation. It is therefore important to attempt to understand why there is an apparent disconnect between the perceived, expected and actual operational preparedness.

144. It is apparent that many of these incident types detailed above would normally be categorised as L1A – L1D within the ICS. As such, there is no automatic requirement within the guidance to carry out a structured debrief or complete a OA13 to formalise learning. For this level of incident, we found that staff overwhelmingly use hot debriefing as the means of learning with awareness of the need or ability to use the OA13 formal report limited. To resolve issues for this type of incident many staff believed the correct action was to report concerns informally to their line management, with the expectation that they would escalate these up through the Service structure. Most reported that this approach seldom resulted in a satisfactory resolution, and just increased frustration and disengagement.

145. We surmised that this expectation may be over ambitious, given the hierarchical nature of the organisational governance and structure of the SFRS linked to the Service-wide nature of some of the issues. As such, there may be a high degree of under-reporting for smaller incident types, and therefore potentially no body of evidence being developed to initiate sustained actions for improvement at the correct level or place within the organisation. This issue is probably exacerbated by the functionality and data analysis limitations of OARRS. Given that L1 incidents form the bulk of incidents and the potential challenges with analysis and reporting, there is a concern that the Service is not effectively and efficiently learning from its high-frequency operational activity.

Recommendation 6

We recommend that the Service review how it gathers debrief information from L1 incidents and analyses this, to ensure that ORL encompasses issues generated from all incident types.

146. Following a L2 or L3 incident, OAD will issue an email via OARRS to the most senior IC who attended over the duration of the incident, informing them that a structured debrief is required and that they are the nominated debrief lead (Figure 5). It is then the responsibility of the IC to undertake the debrief. The IC may choose to conduct the debrief by issuing an OA13 via OARRS to all attending appliance OiCs, FDOs, OC, etc., organising a face-to-face group debrief or by utilising video conference (VC), telephone, etc. Where the IC chooses to issue OA13s via OARRS, all the OA13 returns are automatically collated on to a single OA13 debrief report for the IC on OARRS. Wherever possible, ICs address any local matters arising.

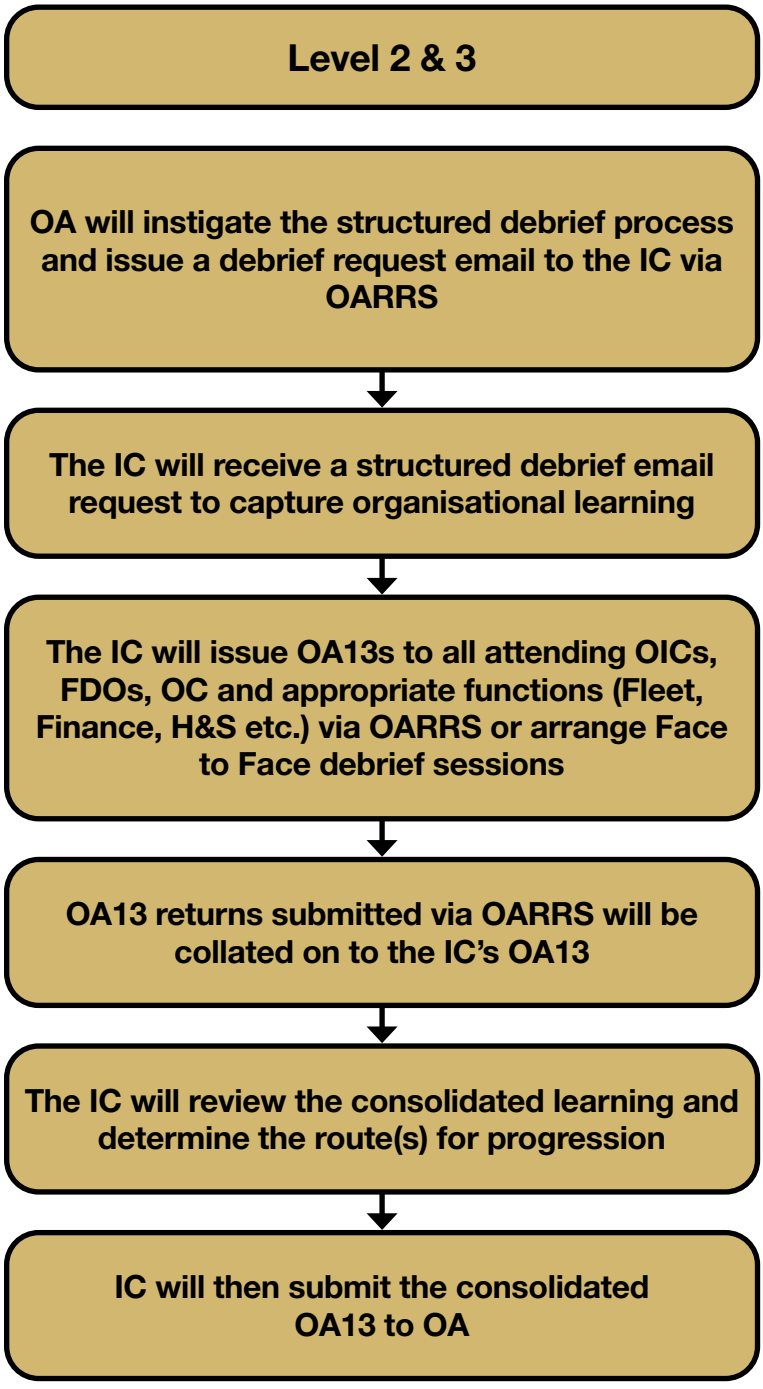


Figure 5 – Level 2 and 3 debrief process

147. The OA Policy allows commanders to opt for a face-to-face/VC process or to issue an electronic OA13 information gathering process on the OARRS as detailed previously. Both systems have their merits as face to face allows for positive human interaction and the opportunity to verbalise and contextualise issues, whilst the OA13 process is automated and much more efficient when managerial capacity is limited. As such, there is an expectation that both may be used in a blended approach to ensure good ORL.

148. We found convincing evidence that the electronic consolidated OA13 process was being utilised and limited evidence that face-to-face/VC debriefs are used routinely. Where we did observe, or were provided evidence of, face-to-face/VC structured debriefs, these had normally been supported and/or facilitated by the OAD and were incredibly positive experiences for those involved. In our WSDA inspection, we found limited evidence of managers conducting face-to-face/VC debriefs and almost universally, the standard approach was to use the consolidated OA13 electronic system. Our fieldwork for this inspection confirmed this to be the case throughout the Service.

149. In themselves, the consolidated OA13 forms are not the issue as they capture all the necessary feedback in an efficient automated manner. The issue with this aspect of the process is the fact that the consolidated form is being accepted as a structured debrief of the incident, rather than it being just a consolidated list of feedback. Staff confirmed that the consolidated lists are rarely discussed with those that submitted them and as such, issues are not filtered, clarified, learned from or given context as they would normally be in a face-to-face/VC process. Therefore, consolidated OA13s are being submitted into OARRS where the previously documented limitations on functionality, OAD capacity and manual nature of analysis find the identification of ORL challenging.

150. It is not clear why there is a prevalence of using the consolidated OA13 process. In our WSDA report we detailed that some reasons may be the convenience of the electronic system, the capacity needed to conduct a face-to-face/VC process and a lack of development and resulting confidence in debrief skills. Throughout our inspection, we observed that these reasons were still valid, as well as issues regarding the limitations of support provided by the OAD, coupled with limited training and awareness of the OA system.

Area for Consideration 12

The Service should review the OA13 process to ensure that effective and appropriate debriefing of consolidated OA13 is being conducted.

151. The Service details that all L4+ incidents require a formal structured debrief process and that they shall be coordinated and managed by the OAD (Figure 6). On conclusion of a L4+ incident, OAD issue an OA13 via OARRS to all attending OiCs, FDOs, OCs and appropriate support functions, where applicable (e.g. Fleet and Equipment Workshops, Finance, etc.). OAD also arrange for debrief submissions from partner agencies if applicable. OAD collate all OA13 returns, consolidate the learning and create a case study (CS) presentation to share information on the positive aspects, the challenging aspects and action(s) that have been taken or are required to be taken to improve performance. If required, the key aspects are presented at a strategic debrief, and shared throughout the Service at a later time via a CS presentation, FLU, or UI etc.

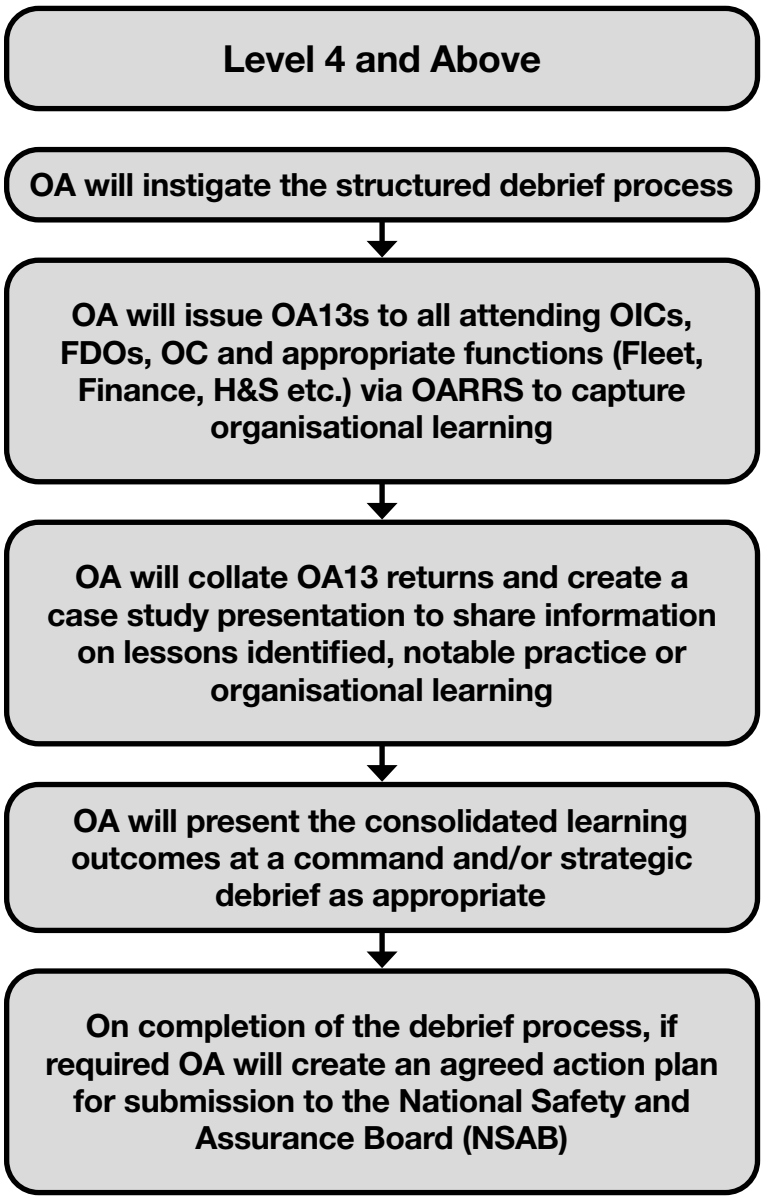


Figure 6 – Level 4+ debrief process

152. We found evidence that the Service is conducting structured incident debriefs for L4+ incidents which were facilitated by OAD. These were generally very memorable to staff and included recent examples such as, Breadalbane Street in Edinburgh, Katherine Street in Livingston and High Camilty in West Lothian. Due to the scale, and therefore infrequency of these types of incidents, there were limited instances recounted by staff of being involved. In addition to these debriefs, we also found that the OAD had facilitated structured debriefs recently for other significant events and lower-level incidents such as Cannich Moor in Highland, New County Hotel in Perth, Linwood Recycling Centre in Renfrewshire, MV Ultra Virtue in CoG and Storm Babet. The Governance system was utilised to manage all these processes, ultimately ending at the TSAB in an action plan for completion.

153. It is clear that the Service is very sensitised to learning from high-impact, low-frequency incidents and has good process in place to capture this Service-wide learning. Consequently, the majority of the OLG workload derives from these types of debriefs. Staff who had been involved in these debriefs were very complimentary of

the processes and overall found it a good engagement process. Negative feedback generally centred around the bureaucracy involved in making change, silo working, the lack of personal feedback, the timescale for learning outputs to be published and the unclear link to improved outcomes.

154. HMFSI had the opportunity to observe an L3 facilitated debrief, via a VC meeting, and found the process to be very constructive, engaging and a positive forum for potential learning and development. It occurred to us that as an observer, the occasion for learning could be very profound and that the Service may be missing an opportunity by not allowing general observation as a development tool. It is understood that there would need to be controls to this, however, these issues would not seem insurmountable and in our opinion the potential benefits would far outweigh any downside.

Area for Consideration 13

The Service should consider expanding the audience of structured debriefs and allow observation as a tool for learning and development.

155. There was robust evidence of ICs submitting a completed OA13 form when requested and we were convinced of routine normalised use. The Service provided partial data for completed OA13 forms for the period of 2018 to 2023 which indicated that this process is being completed to a degree. However, it was unable to provide completion rate data for the same period, or evidence to support the ongoing use of OA13 information for debriefing, and/or trend analysis toward ORL. In addition, it could not provide statistical information as to the number of L1 to L3 incidents that had been debriefed independently by the attending IC.

156. As detailed, the trigger for structured debriefs within the Service is predominantly derived from the incident levels. The Service also has the flexibility to be able to debrief any incident and has done so in the past. The incident level system is very much a blanket approach, and due to the restrictions in monitoring and analysis detailed previously, there is potential to miss learning opportunities at smaller incidents. The C&C benchmark process detailed the NFCC NOL triggers, which are more aligned to specific incident types and events and provide potential additions or alternatives for consideration. As such, the OAD has undertaken to review these triggers throughout 2025 with a view to making recommendation for improvement thereafter. We believe that this review would be appropriate and may identify opportunity for improvement.

Area for Consideration 14

The Service should consider reviewing the current debrief triggers as recommended within the benchmark process to identify if improvements can be made.

157. We found that the concept of hot debriefing within OC was well understood and instances of practising it were reported. However, staff were acutely aware that the working environment within OC was slightly different, in that they would normally be dealing with numerous incidents at one time, whilst incident command attendance was normally singular. As such, staff accepted that the opportunity to debrief an incident could routinely be inhibited by other ongoing workload, and that a pragmatic approach was required. This understanding and pragmatism normally led staff to debriefing incidents more structurally when time, capacity and workload allowed, which seemed to produce more tangible learning for OC.

158. As detailed previously OC are a vital component within OA and as such are included within the ethos of the OA Policy. The nature of the role within the Service, whilst operational, does not normally include attendance on the incident ground and, many of the aspect of the Post-incident GIN do not apply. However, their role within the operational cycle, out with attendance on the incident ground, is just as, if not, more important. Consequently, there is a requirement that they complete a structured OA13 form as and when requested. Like the OA06, many of the cells within the existing OA13 form are specific to incident ground attendance and do not apply directly to OC operational procedure or systems. Similar to the OA06, we were pleased to note that OC have developed their own version of the OA13 form (OA13OC) in order that they can formally capture learning specific to OC procedures. It is also understood that this form is not accommodated within the OARRS, and the input and output is administered by the OC management team.

Good Practice 8

The development of the OC-specific forms was pleasing to observe and staff should be commended for the innovation.

159. OC provided instances of contributing to structured debriefs utilising the OA system as well as being involved in face-to-face/VC debriefs for larger incidents. They also noted that they routinely completed the OA13OC form, which captured specific and bespoke learning for the OC. Staff reported that the perception seemed to be that historically OC were overlooked from many of the formal debrief processes and that this was indicative of their pervasive feeling of being an afterthought. In support of this, we are aware that the C&C benchmark process highlighted potential gaps in their attendance at debriefs, which had now been remedied. This was supported by OC staff reporting inclusion in a number of recent prominent level debrief processes. However, it is disappointing to note that OC and their part in operations is not considered within the holistic OA systems, and as such ORL may be less efficient and effective.

Area for Consideration 15

The Service should consider how integrated OC is within the current OA processes and ensure that they are fully involved in the development and review of future ‘post-incident’ process change.

Training and Exercising

160. The operational event and debriefing GIN details it is designed to support the debriefing of operational incidents, training events and exercises. In this instance and putting operational incidents aside we understand that simply, training is the acquisition and maintenance of skills and knowledge, whilst exercising is the testing of the skills and knowledge. Debriefing operational incidents and significant events is a reactive process born from the need to learn from how the Service *has* responded.

161. However, debriefing training and exercising would seem to be a proactive process born from the need to learn from how the Service is designed to respond to known incident types. In essence, training and exercising will stress test the equipment, procedures and training prior to attending incidents and is equally, if not more, important to the reactive process, as it may identify learning opportunity before a problem occurs. It is understood that the Service has a statutory 'near miss' H&S reporting process, which may act as a proactive circuit breaker for learning. This system is imperfect, however, as it is prone to documented under-reporting.

162. We found almost no evidence of training being debriefed in a format that would formally assist in OA. We were provided with limited examples of large-scale and multi-agency exercises being debriefed, and where this did happen positive learning outputs were developed. However, in general we found limited evidence that internal exercising was being debriefed, with most staff openly reporting that exercising was not something they would consider formally debriefing for OA.

163. Staff were unable to explain why exercising was not routinely debriefed, as there was general acknowledgement that learning prior to an operational incident would be more effective and safer. Issues such as, unclear policy and process, limited management learning and development, limited communication and engagement, unclear values etc. were all potential reasons provided. The requirement to debrief training and exercising is part of the 'post-incident' process, that staff routinely connected with operational incident attendance and may also be a reason why it is overlooked. We observed that training and exercising debriefing may therefore be better aligned to the 'pre-incident' process which is more associated to securing operational preparedness prior to attending incidents.

Recommendation 7

We recommend that the Service review how and when it debriefs training and exercising to ensure that there is suitable proactive learning to enhance ORL outcomes.

Operational Discretion

164. The Incident Command Policy and Operational Guidance (ICPOG)[31] details that most incidents will be brought to a safe and successful conclusion by the formulation of a tactical plan based on a framework of relevant SOPs, incident risk assessment and OI available. It is recognised that it is impossible to anticipate every incident which may occur and provide a SOP for every situation. In circumstances where the relevant SOPs do not provide adequate guidance to formulate an effective tactical plan, the IC should consider exercising professional judgement to adapt procedures, this process is termed OD. It is emphasised by the Service that OD is not an instruction for personnel to routinely deviate from SOPs. The purpose of OD is to provide ICs with guidance to make calculated risk-based decisions when faced with unforeseen circumstances. Tactical outcomes that may justify OD include:

a. saving human life;

b. taking decisive action to prevent an incident escalating; and

c. incidents where crews taking no action may lead others to put themselves in danger.

165. OD should only be applied when the benefit of taking action outweighs the inherent risk to achieve the objectives of the tactical plan. In all cases, the IC should be able to explain and justify the rationale behind the decision to apply OD. The IC's decision-making process should not be judged on the outcome of the incident but on the decision-making rationale. The Service states that ICs will receive their full support in all instances where it can be demonstrated that decisions were assessed and managed reasonably in the circumstances existing at the time and taken in compliance with this policy. The ICPOG states that *'all instances where OD is applied will be subject to review under the operational assurance policy to ensure the Service is able to learn from the experience'.*

166. We were provided evidence that the declaration of OD is a relatively uncommon event, and when used there is an investigation process conducted by the OAD. The reported output of these investigations often concluded the misapplication of the OD process, the reasonably foreseeable nature of incidents, and the subsequent need for further personal development. However, there were occasions where the need for ORL was identified and subsequent recommendations for change made from this process, which was an important aspect.

OA21 Process

167. The post OA process is supplemented by a GIN titled OA21 – 21 Day Investigation Procedure[32]. The aim of this procedure is to *'provide interim recommendations to the National Safety and Assurance Board (NSAB) within 21 days of the activation of the OA21 process for any relevant health and safety event, whilst the full investigation process is ongoing'*. The OA21 investigation procedure captures short-term risk-critical recommendations that require specific actions or interventions to prevent reoccurrence of the safety event under investigation. Due to the nature of the OA21

31 SFRS, Operations Delivery, Operations, Incident Command policy and Operational Guidance, Version 14, 23/09/2024

32 SFRS Training Safety and Assurance, Operational Assurance, GIN OA21 Procedure, Version 4, 31/08/2023

investigation process and the limited time available to capture all presentable evidence, there may be circumstances when the outcomes from the OA21 investigation are superseded by the findings from a full investigation. The 21-day turnaround period is aimed at mitigation of risk as well as reoccurrence of H&S events and is also believed to be reflective of industry best practice. The instigation of the OA21 procedure shall not delay the commencement of a full H&S investigation.

168. The OA21 procedure may be activated in the following circumstances:

a. reaction to H&S events that require a significant level of investigation;

b. a near miss event with the potential to cause significant injury;

c. an injury to SFRS personnel that results in hospital treatment;

d. significant safety events involving other FRS both nationally and internationally; and

e. any incident / event of interest to the TSAB.

169. Staff reported that this process was generally considered to be positive and allowed for a quick identification of safety improvements. However, there was a perception that the process may have become obsolete and consequently concern that it had not been used for recent significant and high-profile safety events within the Service. We found that between the five-year period of 2019 to 2024 the process was used eight times for incidents of varying nature, size and scale. The trend across the reporting period was that there was less use of the system recently, which may account for some comments. The decreased use may be due to many differing factors, however, there was no conclusive evidence to point at a decision not to use it. The Service provided assurance that the process is active but that it is being reviewed and developed into an amalgamated SA process, being renamed SA21. The Service also detailed other investigative processes that had been used for recent significant incidents due to their nature and risk to the organisation.

8. Outcomes

170. The OA Policy details '*the outcomes from the OA process support the continual review of SFRS policy & procedure, training standards and assets & equipment with a focus to continually improve firefighter safety*'. Of particular note, outcomes such as CI, culture, communication and engagement featured heavily in our inspection.

Continuous Improvement

171. CI from an operational aspect has three main outcomes, which are reviewed training, policy and equipment. Objective evidence provided in the form of the OLG Tracker, TSAB papers, SA Quarterly and APR, PC and SDC papers, OA reports etc. detailed actions and improvements. Subjective evidence from staff such as awareness of increased PPE stock for decontamination, the introduction of wildfire equipment, the introduction of new digital fireground radios, changes to initial BA training also demonstrated that there was palpable change that staff could recognise as improvement. Consequently, it was easy to observe there are numerous actions being completed that illustrate improvement which directly or indirectly support the three aspirational outcomes.

172. Conversely, it was also apparent from staff feedback there were issues that were a continuous source of frustration and concern that seemed challenging for the Service to resolve. As well as those incident types previously detailed in the structured debrief section there were additional concerns raised around welfare and relief provision at large-scale or protracted incidents, under provision of wildfire PPE, new pumping appliance design and equipment, the implementation of high-rise building evacuation procedure, command support vehicle provision, the standard of hot wear BA training etc. It is understood that the Service has uniformed staff within the research and development department and also has engagement fora such as a User Intelligence Group (UIG) and the New Appliance Working Group (NAWG) to give staff a voice over and above normal engagement process.

173. However, many of these unresolved issues were reported as being protracted, having been repeatedly reported over many years so it would seem there is a disconnect somewhere within the processes. As detailed previously, the functionality of OARRS makes it difficult to determine whether this subjective feedback from staff aligns to objective debrief data that may be used to compel change. Additionally, staff that reported these issues did not sometimes appreciate that they could be a direct OA matter and as such, some had not contemplated utilising the OA process to highlight them.

174. It can therefore be observed that the Service is making improvement continuously from significant incidents, thematic audits, case studies, NOL and OD outputs, which may have a more acute high impact risk to the organisation due to their nature. However, there remains a question regarding whether the Service is making improvement from more protracted issues that are less visible, and are not highlighted due to issues such as challenging data analysis, limited audit, under-reporting, misreporting, poor OA process awareness etc. As such, there may potentially be a bias to identifying improvement from high-impact, acute-risk issues as opposed to those that are of a more protracted nature.

Area for Consideration 16

The Service should consider reviewing whether there is a bias in the OA process towards predominantly developing improvements from high-profile, acute-risk issues that are more visible and easily identifiable.

Communication and Engagement

175. When asking staff about OA and outcomes, very few could articulate how effective it was and had no clear reference for its performance. This was compounded by the KPI measuring issue previously detailed and the lack of any visible dashboard or register of issues tool where input, outputs and outcomes could be easily linked and communicated. This issue was exacerbated by the large nature of input from operational staff and the OADs limited capacity to administer it and feedback directly to staff.

176. In addition, there would appear to be no process for 'celebrating success', where the links to change from staff feedback could be easily illustrated. As such, most staff found it difficult to 'join the dots' from their incident attendance feedback to actual improvement in the Service. Many of those we interviewed were left frustrated by the inability of the organisation to 'close the loop'. An SA strategic priority action was, to develop feedback arrangements to inform staff involved in changes following lesson learned and to develop business partner engagement feedback processes. We have found no evidence to support that these actions are complete, and that tangible arrangement for change are in place.

Recommendation 8

We recommend that the Service develop a system to easily demonstrate the link between inputs, outputs and ORL outcomes to help maintain staff engagement.

177. There are several communications documents the Service uses that are the embodiment of OA process and ORL output. These include UI, AB, FLU and CS. As the name suggests UIs (Figure 7) are designed to inform staff of an urgent operational issue and to provide remedial instruction. ABs are used similarly but for issues that are deemed to be of a less urgent nature. Both are issued in PDF format by email to all staff, are available on the OA intranet page and form part of a gateway process within Personal Development Recording (PDR) system, where understanding and awareness must be agreed whilst logging on.

OFFICIAL

Operational Delivery

SCOTTISH FIRE AND RESCUE SERVICE

URGENT INSTRUCTION

TITLE:	Edelrid 11mm LSK 50m Rope

FOR THE ATTENTION OF: Operational Personnel

BACKGROUND

Following the national rollout of SWAH replacement kits, Edelrid have supplied SFRS with approximately 270, 50m LSK 11mm Ropes. These ropes meet current EN standards. However, it has been brought to the attention of the Operations Function that these ropes have a different protective covering over the sewn termination ends than legacy ropes (Figure 1):

Figure 1

A risk of serious injury has been identified. It is possible that a Karabiner can be inserted through the protective sleeve whilst not passing through the sewn textile rope termination.

Operational Delivery	SFRS.OperationsFrontlineSupport@firescotland.gov.uk

OpDel/Ops/UI/Edelrid11mmLSK50mRopes Page 1 of 3 Version 1.0 (Date: 04/06/2025)

Figure 7 – Urgent Instruction

178. Staff were generally positive in regard to these documents and felt that they helped improve safety. Support functions also found them helpful for supporting and communicating issues. Criticisms were, that sometimes far too many are published, which led to a degree of audience desensitisation. Sending UIs by email did not seem to fit the nature of the risk, particularly for on-call staff who find receipt of emails out with the workplace challenging and can therefore struggle to respond in a timeous manner. Other criticisms focussed on the lack of retraction of the instruction or brief from the primary document and that there did not appear to be a formal sign off process of UIs actions being completed. This issue was highlighted within a couple of LSO areas, where management of actions and accountability had been problematic.

179. FLUs (Figure 8) are used more as a learning tool and are developed with a specific theme that has been identified internally or externally from NOL. These are issued in PDF format by email to all staff and are available on the OA intranet page. We found a lot of examples of this tool being used to communicate information and learning to operational staff. Some criticisms centre on the fact that they could be too generic with lack of specific incident detail making them too sanitised. However, feedback from staff regarding these documents was overwhelmingly positive with many reporting that there was not enough of them (4 issued in 2023/24) and that they would welcome more.

Figure 8 – Frontline Update

180. These methods of communication are, to a lesser or greater degree, effective. Those that are consigned solely to learning are far more popular as they are viewed by staff as a development tool and can therefore help them to improve effectiveness and safety. We found many examples of these documents being used for staff briefing and prominently displayed within the workplace (Image 1), which is reflective of a positive safety culture.

Image 1 – Dumbarton Fire Station Notice Board

181. CS tend to be focussed on a particular high-profile incident and detail the learning from that incident, which is based upon the structured debrief process. They are developed in a video modular format, which allows for a much more interactive experience for the user with videos, diagrams and schematics forming part of the tool. The document is available on the OA intranet page and also forms part of the TFoC/PDR system. We found two examples of this tool being used to communicate information and learning to operational staff, George IV Bridge (Figure 9) in City of Edinburgh (CoE) and Albert Drive in CoG. Feedback from staff regarding these documents was overwhelmingly positive with many staff reporting that there was not enough of them and that they wished there were more. The only criticism of this tool was the time taken to publish the learning, for example, the CoE incident happening in the Summer 2022 with the CS being published Autumn 2024, over two years later.

Figure 9 – Case Study of George IV Bridge

Good Practice 9

The development of CS is considered good practice and is supported by most staff. This practice supports the ORL and LO concepts.

Culture

182. According to the Cambridge dictionary[33] culture is *'the attitudes, behaviour, opinions, etc. of a particular group of people'* and is commonly described in an organisation as the way we do things about here. As such, it is difficult to provide quantitative evidence in relation to this section with heavier reliance on qualitative evidence. There was comment regarding the concern that OA is still viewed as a punitive process in some workplaces and that the Service had not quite achieved a culture where staff are entirely comfortable or open to constructive criticism. However, our overriding impression during this inspection was that the OA culture within the Service is relatively healthy with most staff believing in the ethos, understanding the need for the process, and eager to identify improvement opportunities. That said, there are a number of themes that we repeatedly observed that may highlight where the culture could be improved.

183. We were provided examples of the Service's operational preparedness and response, specifically with regard to IC and staff decision making, which in some instances potentially contributed to accidents or near misses occurring. Staff appeared frustrated by this situation and could not fully articulate why they felt the Service

33 Cambridge Dictionary CULTURE | English meaning

seemed unable to preserve previous critical learning within systems and process. One person told us that previous learning should 'be tattooed into the DNA' of the organisation but could not explain why it sometimes struggled to do so.

184. Some of those interviewed pointed to the high turnover rate of staff in the last few years as a probable reason for challenges in preserving learning. However, we noted previously the NFCC state[34] that OL *'involves the organisation embedding changes so that, even if there are staffing changes, measures to prevent reoccurrence stay in place'* and as such, there is an expectation that learning should endure within process, beyond the current muscle memory of its staff. Other staff detailed concern about the lack of focus on the operational mission and lack of engagement with end users in management decision making. This was underlined by the frequently reported perception of the Service routinely passing off genuine frustrations of staff regarding operational effective and efficiency as 'moans'.

185. It is understood that learning from significant incidents should be embedded into the everyday business of the Service. However, by doing this there is the potential that the significance and importance of the learning may diminish over what can be a short or longer period as it becomes more routine. As such, there is always the risk that similar issues will repeat with similar consequences. There is therefore a need for the Service to consider how it maintains long-term focus on previous ORL in its decision-making processes. SA strategic priority actions were, to develop an OA campaign to embed and enhance the outcomes of robust OA on the incident ground and the development of a lessons learned programme for OL. We have found no evidence to assure us that these actions are complete, and that tangible arrangement are in place.

Recommendation 9

We recommend that the Service develop a system to record change, or significant ORL, which can be referenced and utilised for long-term strategic management and decision making.

186. Whilst speaking to staff about the OA we became aware that many managers would do the minimum administration required to satisfy the requirements of the process and then move it on. Some were not wholly bought in to the process and it became apparent that OA was viewed as a sacrificial piece of work in comparison to other competing priorities. There could be many reasons for the prevalence of this attitude but there was definitely a sense that OA was a function of command, and that the administrative process after any incident was more of an encumbrance than a real opportunity to improve operational performance.

187. There also appeared to be an urgency from some managers to discard the incident-related workload to get back to the priorities within their management role. Some staff felt that the Service was trying to do too much and inevitably there was not enough focus on things like OA. As such, this aspect of the culture would seem to favour focus on the completion of management tasks over operational improvement, which appears at odds with the value of safety and the Service's overall mission.

34 NFCC National Operational Learning: Good Practice Guide

188. OA involves most functions of the Service and encompasses both the levels of command and structure of management. Managerial roles and responsibilities are clearly defined in the OA Policy and supporting documents. The directorates of TSA and Operations have the responsibility for the assurance and delivery of operations, respectively. The command groups have the responsibility for incident command as well as operational preparedness and response. Specifically, the OAD has a clear remit of acting as the conduit and administration for OA information, but reaction can be limited due to challenges with analysis.

189. We found that OAD has no overt remit for policing standards. OA processes and governance is structured to manage significant incident trends, whereas command groups are very reactive and implement current procedures as opposed to having a strong learning remit. Whilst the OAO is a function of incident command and it is limited in its application as per our feedback detailed previously. Additionally, we also experienced the obtuse situation where LSOs who are responsible operationally and managerially for the performance of their area may not to be included in, or aware of, the wider OA processes initiated for that area, particularly if they were not part of the attending incident command team. We found this aspect of the OA culture confusing as it is unclear who has the responsibility for monitoring and reporting on flawed operational standards on a routine basis as well as learning and reporting quickly. As such, we observed the learning culture to be very bureaucratic, cumbersome and slow with potential gaps.

190. We interviewed staff throughout the Service area and became aware of a prevalent culture in remote rural communities. Whilst discussing operational issues we found many instances where there were challenges in delivering the standards expected in policy, operational guidance and procedures. It is understood that many of these documents were historically developed for consistency and continuity whilst the Service was completing the amalgamation process. The challenges cited, normally resulted in the restriction of incident support and attendance of additional resources.

191. Staff in these areas freely accepted these challenges and routinely fed back that they would normally just ‘make do and mend’ as the perception was that nothing would change. There was limited evidence that these staff ever formally raised concerns regarding the problematic application of policy and the consequential risk to their community and the organisation. There was an acceptance that many of the standards applied better to urban or less remote areas and could never be achieved locally in the current format or set up. Whilst commendable, it was disappointing to observe this resignation regarding the desire to urge for improvement via the OA system as well as development of policy that is fit for purpose and related to geographical restrictions.

192. We found that whilst there was an issue with under-reporting, linked to the previous section, the problem seemed to be greater than just that of a geographic nature. A culture of under-reporting also seemed to stem from issues such as lack of awareness of the OA process, reluctance to evaluate colleagues to a standard, limited knowledge of operational standards, ongoing perception of being a punitive process, disengagement due to lack of feedback and tangible outcomes as well as conflicting capacity and work priorities etc.

193. In addition, there was also an element of misreporting where staff routinely had confidence that because they had raised an issue with a line manager then it would be dealt with. This process normally resulted in disappointment as the line management process often failed to provide the result expected, particularly if the issue was of a regional or Service-wide nature. Thankfully, we found examples of line managers urging staff to formalise their issue within the OA system, which was pleasing to hear. However, there is still concern that this is not consistent across the Service and that many issues are under or misreported. This may be creating a culture of disengagement with the OA process with the possible loss of valuable learning for the organisation.

Area for Consideration 17

The overall culture towards OA was positive but the Service should consider these specific cultural issues in any review and further development of OA.

9. Conclusion

194. The Service details that it is a learning organisation and there is a clear link between this aspiration and its OA process as an ORL tool. Its OA management is mature and has been developed in line with UK national statute and UKFRS guidance. OA is embedded within the organisation, it understands that ORL is about process improvement and that learning is achieved when change is implemented. The Service plays an active part in inter- and intra-agency learning locally, regionally and nationally. There is a functional strategy which incorporates actions for OA improvement over a five-year period and demonstrated a desire to evolve.

195. A bespoke OA policy has been developed and reviewed, which incorporates a model and governance process based on industry standards. The governance structure suffers from being overly bureaucratic, with some staff awareness of communication lines being limited. The Service has recognised some of these issues and made improvement with a simplified clearing house called the OLG, and workplace tasking cards. However, limitations to the OARRS, as well as OAD responsibilities and its capacity, inhibit data analysis and output development, as well as engagement with the wider organisation.

196. There is a structured data review, analysis and scrutiny process linked to OA. There are large volumes of OA-related data being generated, some of which is related to H&S KPIs which are an indication of safety improvement that could be attributed to OA. On the other hand, there was limited specific OA data to provide meaningful metrics and indicators, including the dedicated KPI, to demonstrate the actual performance of OA. Consequently, we found that the Service was unable to demonstrate or articulate effective measurement of OA performance.

197. There is a structured system for monitoring and auditing improvement within both Service-wide and local OA governance structure. We believe this could be improved to provide better oversight. Scrutiny is provided utilising the existing structures of the TSAB, SLT, Sub Committees and the Board, which is a robust system. However, the concern regarding the provision of good measurement of performance must inhibit the ability of these bodies to scrutinise effectively. The Service completed an effective benchmark assessment of OA with several recommendations identified and discharged. This self-assessment process is a notable example of proactive continuous improvement and those involved should be commended for it.

198. Pre-incident OA process encompassing station audits, thematic audits and training provides a structure for good operational preparedness. The station audit process is mature and well established within the local areas with the parameters of the audit reviewed on a regular basis. There are areas where the communication of improvements and reporting could be improved but also areas where innovative changes were piloted, which we believed had the potential to enhance the process further. It was disappointing to note that OC had been omitted from the development of the station audit process, and we believe that this should be remedied in order that their workplaces are supported in the same way as a CFS.

199. The thematic audit process is a particularly valuable tool and provides extremely useful analysis and recommendations for improvement in a particular aspect of operations when conducted. It was therefore disappointing to observe that the frequency of this process does not always meet the aspirational target set, and the opportunity to identify improvement proactively is thus limited. There were aspects of OA being included within training and development material, which provided a measure of increased awareness for staff. However, in general we found that there was a lack of OA training and development of most staff groupings, with some having none. This resulted in a general sliding scale of awareness of the process, from strategic management down, with the ensuing negative impact on OA as an ORL tool.

200. During-incident OA encompassing AM, mentoring and the OAO role provides a structure for identifying improvement whilst incidents are developing. AM is a particularly good system, as it allows FDOs to assess operational standards as well as prepare for potential mobilisation to an incident. There are aspects that could be reviewed, but in general it is a positive feature of OA. Similarly, FDOs attendance at incident grounds to provide OA or mentoring is a particularly good facet of the system, which could also be reviewed to make improvements. The OAO role has the potential to be an especially useful attribute of OA and the identification of improvement. There are negative aspects related to the deployment, which are definitely inhibiting that potential, and as such, the role should be reviewed to ensure support for ORL and IC can be maximised. Once again, it was disappointing to note that OC had not been fully integrated into this aspect of the system and as such there must be a detriment to ORL.

201. The post-incident OA process, encompassing hot and structured debriefing, provides a good structure for identifying improvements after an incident. Hot debriefing is a good informal debriefing tool that is evolving to provide additional mental health support for staff as well as identifying learning. There are aspects of hot debriefing that could be improved, with over reliance on the system for smaller incidents and subsequently not sharing learning outside a small community being the main ones.

202. The application of structured debriefs and subsequent reporting for L1 incidents is limited and is therefore not producing tangible outputs for the Service. Structured debriefs for L2 and L3 incidents are being conducted to a degree but the overreliance of the OARRS automated consolidation tool is also limiting tangible outputs for the Service. Whereas, structured debriefs for L4+ incidents are routinely conducted to a high standard with learning identified and fed into the governance system. There are potential improvements identified, but overall, this aspect of the debriefing process was positive. Structured debriefing of training and exercising was extremely limited with only some examples provided by the Service but little from staff. As such, the OA system is predominantly learning reactively and as such, proactive learning could be improved.

203. From an outcome perspective, there is compelling evidence to suggest that the Service is learning from incidents and that there are continuous improvements in training, equipment and procedure. However, there are many other issues repeatedly reported, that seem an ongoing frustration to staff. We observed that the system is structured to identify and make improvement from incidents that are more significant to the Service due to their nature, risk or genesis. Change and improvement within the Service would appear biased towards high-impact, low-frequency incidents and

not those that are more frequent and low-impact. It is therefore understandable and symptomatic that many OA-related frustrations from staff predominantly tend to emanate from these smaller more frequent incident types.

204. The communication methods published for OA were highly praised with minor complaints regarding frequency and time to develop them being too long. Overall, they were universally popular with the learning tools such as the FLU and CS of particular note. Conversely, two-way engagement with staff was limited. This had a striking effect on the lack of OA awareness of processes and successes, as well as people feeling disenfranchised from inadequate feedback to close the loop. The lack of an engagement tool to help illustrate the successes of the Service and OA system is a real gap in provision as it would support the OAD.

205. In general, the OL culture within the Service is healthy with the majority of staff engaged to a greater or lesser degree in the OA process. Most staff believed that it is a good system, and that if used properly would make their job safer. We identified a number of cultural issues affecting the OA system, such as underreporting, misreporting, resignation and unclear managerial priorities. However, the Service's perceived inability to lock in change from previous learning and embed it into the systems of the organisation seemed to be the biggest issue with many staff. It seemed appropriate to us that the Service would benefit from the development of a register of ORL that could be referenced for future management decision making processes.

10. Recommendations, Areas for Consideration and Areas of Good Practice

Areas of Good Practice

Area of Good Practice 1: Staff involved in the processing and management of OA provided positive feedback on the OLG and its development as a 'clearing house' for actions. It has been a positive addition to the governance process.

Area of Good Practice 2: The Service has developed a positive connection within the UK OL community and is viewed as a productive partner. Having a GC as NOLUG chair and the Service SPoC is an extremely encouraging indicator of the success of this relationship and should be given ongoing support.

Area of Good Practice 3: The OA debrief tasks cards are a positive addition to the internal administrative procedures and the OAD should be commended for their innovation.

Area of Good Practice 4: The C&C benchmarking process is good management and performance practice and provided constructive recommendations for improvement. The OAD should be commended for undertaking this process and proactively identifying these actions.

Area of Good Practice 5: The station audit report process is good management and performance practice in line with the SA strategy and provides positive recommendations for improvement. The OAD should be commended for undertaking this process and should be encouraged to repeat it.

Area of Good Practice 6: We found that altering the core practical and technical skills element of the station audit to include practical operational preparedness testing to be a positive innovation. The Service should be commended for this and consider it for incorporation into any future review of OA process.

Area of Good Practice 7: We found examples of the changing culture to include PISP and MHW within the Hot Debriefs to be incredibly positive and that this good practice should be used to influence future IC development.

Area of Good Practice 8: The development of the OC-specific forms was pleasing to observe and staff should be commended for the innovation.

Area of Good Practice 9: The development of CS is considered good practice, supported by most staff. This practice supports the ORL and LO concepts.

Areas for Consideration

Areas for Consideration 1: The SAIG, SAC and SALO are an integral part of the OA management and governance process. There is scope to improve the understanding of these roles for middle and supervisory managers. The Service should consider this potential improvement for any future training, development or review in relation to OA.

Areas for Consideration 2: The Service should consider the prioritisation of the OARRS replacement to improve OA data analytics and output development.

Areas for Consideration 3: We are confident that the OAD is performing but within its limitations as detailed. The Service should consider a review of the team size and responsibilities as well as use of automation and analysis tools to help improve ORL outputs.

Areas for Consideration 4: Structural positioning of a department within the organisation is a management function and there is no intention to recommend this be reviewed. However, there is a need for the Service to consider whether the current structural position allows for OA to be given the appropriate focus, visibility and profile, whilst ensuring managers can resolve issues as efficiently and effectively as possible.

Areas for Consideration 5: The Service should consider reporting improved measurement data in order that performance management and improved outcomes are able to be scrutinised effectively.

Areas for Consideration 6: The Service should consider the different frequency standard being applied to the CFS audit process and review guidance to ensure consistency of application and most efficient use of managerial capacity.

Area for Consideration 7: The limited-notice station audit pilot was well received throughout the pilot area with most staff reporting that it would be a positive development. The Service should be commended for this innovation and consider the outcome of the pilot for incorporation into any future review of OA process.

Areas for Consideration 8: The station audit output and subsequent improvement action plan is an effective process; the Service should consider reviewing its local management systems to ensure continued understanding and engagement with improvement from all staff.

Areas for Consideration 9: The Service should consider conducting more thematic audits as the recommended changes from robust data analysis are tangible and can be aligned to continuous improvement.

Areas for Consideration 10: The Service should consider how integrated OC is within the current OA processes and ensure that OC staff are fully involved in the development and review of future 'during incident' process change.

Areas for Consideration 11: The Service should consider reviewing how local OL is informally transferred within its management structures and reinvigorate the need to ensure that learning is reported appropriately.

Areas for Consideration 12: The Service should review the OA13 process to ensure that effective and appropriate debriefing of consolidated OA13 is being conducted.

Areas for Consideration 13: The Service should consider expanding the audience of structured debriefs and allow observation as a tool for learning and development.

Areas for Consideration 14: The Service should consider reviewing the current debrief triggers as recommended within the benchmark process to identify if improvements can be made.

Areas for Consideration 15: The Service should consider how integrated OC is within the current OA processes and ensure that they are fully involved in the development and review of future 'post-incident' process change.

Areas for Consideration 16: The Service should consider reviewing whether there is a bias in the OA process towards predominantly developing improvements from high-profile, acute-risk issues that are more visible and easily identifiable.

Areas for Consideration 17: The overall culture towards OA was positive but the Service should consider these specific cultural issues in any review and further development of OA.

Recommendations

Recommendation 1: We recommend that measurement of OA be reviewed in order that appropriate indicators be developed for robust performance management and scrutiny.

Recommendation 2: We recommend that there be a review of the monitoring and audit processes to provide assurance that the Service has a complete understanding of OA trends and potential ORL throughout the organisation.

Recommendation 3: We recommend that the Station Audit GIN should be reviewed to include OC sites. In the interim period the Service should consider publishing the OC-specific procedure to complement the existing GIN.

Recommendation 4: We recommend that the Service review its leadership, managerial and command development processes to include generic OA training for all staff and that it further reviews its development of OAD staff or those with a specific OA remit to ensure they have suitable competency-based training for their role.

Recommendation 5: We recommend that the OAO role be reviewed to ensure development is provided, correct competence is assigned and involvement in the OA debrief process is ensured to appropriately support ORL and the IC.

Recommendation 6: We recommend that the Service review how it gathers debrief information from L1 incidents and analyses this, to ensure that ORL encompasses issues generated from all incident types.

Recommendation 7: We recommend that the Service review how and when it debriefs training and exercising to ensure that there is suitable proactive learning to enhance ORL outcomes.

Recommendation 8: We recommend that the Service develop a system to easily demonstrate the link between inputs, outputs and ORL outcomes to help maintain staff engagement.

Recommendation 9: We recommend that the Service develop a system to record change, or significant ORL, which can be referenced and utilised for long-term strategic management and decision making.

11. Methodology

About HMFSI

HMFSI is a body that operates within, but independently of, the Scottish Government. Inspectors have the scrutiny powers specified in section 43B of the Act. These include inquiring into the state and efficiency of the SFRS, its compliance with Best Value, and the way it is carrying out its functions.

HMFSI Inspectors may, in conducting inspections, assess whether the SFRS is complying with its duty to secure Best Value and continuous improvement. If necessary, Scottish Ministers can direct Inspectors to investigate anything relating to the SFRS as they consider appropriate.

We also have an established role in providing professional advice and guidance on the emergency response, legislation and education in relation to the FRS in Scotland.

Our powers give latitude to investigate areas we consider necessary or expedient for the purposes of, or in connection with, the conducting of our functions.

The SFRS must provide us with such assistance and co-operation as we may require enabling us to conduct our functions. When we publish a report, the SFRS must also have regard to what we have found and take such measures, if any, as it thinks fit.

Where our report identifies that the SFRS is not efficient or effective (or Best Value is not secured), or will, unless remedial measures are taken, cease to be efficient or effective, Scottish Ministers may direct the SFRS to take such measures as may be required. The SFRS must comply with any direction given.

We work with other inspectorates and agencies across the public sector and co-ordinate our activities to reduce the burden of inspection and avoid unnecessary duplication.

We aim to add value and strengthen public confidence in the SFRS and do this through independent scrutiny and evidence-led reporting about what we find. Where we make recommendations in a report, we will follow them up to assess the level of progress.

We aim to identify and promote good practice that can be applied across Scotland. Our approach is to support the SFRS to deliver services that are high quality, continually improving, effective and responsive to local and national needs. The terms of reference for inspections are consulted upon and agreed with parties that the Chief Inspector deems relevant.

How This Inspection Was Carried out

The purpose of this inspection was to examine the provision of OA within the SFRS as detailed within the policy. An inquiry by the Inspectorate can be self-directed or can be subject to direction by Scottish Ministers. This inquiry into the SFRS was self-directed by the Chief Inspector.

The following persons contributed to the Inspection and to the report:

Robert Scott QFSM, Chief Inspector

David Young, Assistant Inspector

John Joyce QFSM, Assistant Inspector

Brian McKenzie, Assistant Inspector

Graeme Fraser, Assistant Inspector

Calum Bruce, Inspection Support Manager

Lynne Gow, SFRS Secondee

Shirley Hartridge, SFRS Secondee

When undertaking this inspection, we followed established practice utilised in previous thematic inspections. This inspection outline framework provided a structure to our work, which was risk-based, proportionate and focussed on the SFRS OA Policy and procedures, which set out the SFRS position in relation to the information gathering and assurance of operational activities, including the application of those policies and procedures.

We conducted early engagement with the Service and established a SPoC who facilitated a number of different methods of evidence gathering and analysis. These being:

a. desk-top data review of documents and data supplied by the SFRS. We undertook a sense check and assessment of the content of procedural documents;

b. numerous face-to-face and virtual interviews with SFRS staff who are responsible for the provision of, management, and training necessary for service delivery;

c. observation of a Level 3 Incident debrief; and

d. observation and demonstration of the systems used for the management of OA.

12. Glossary of Terms

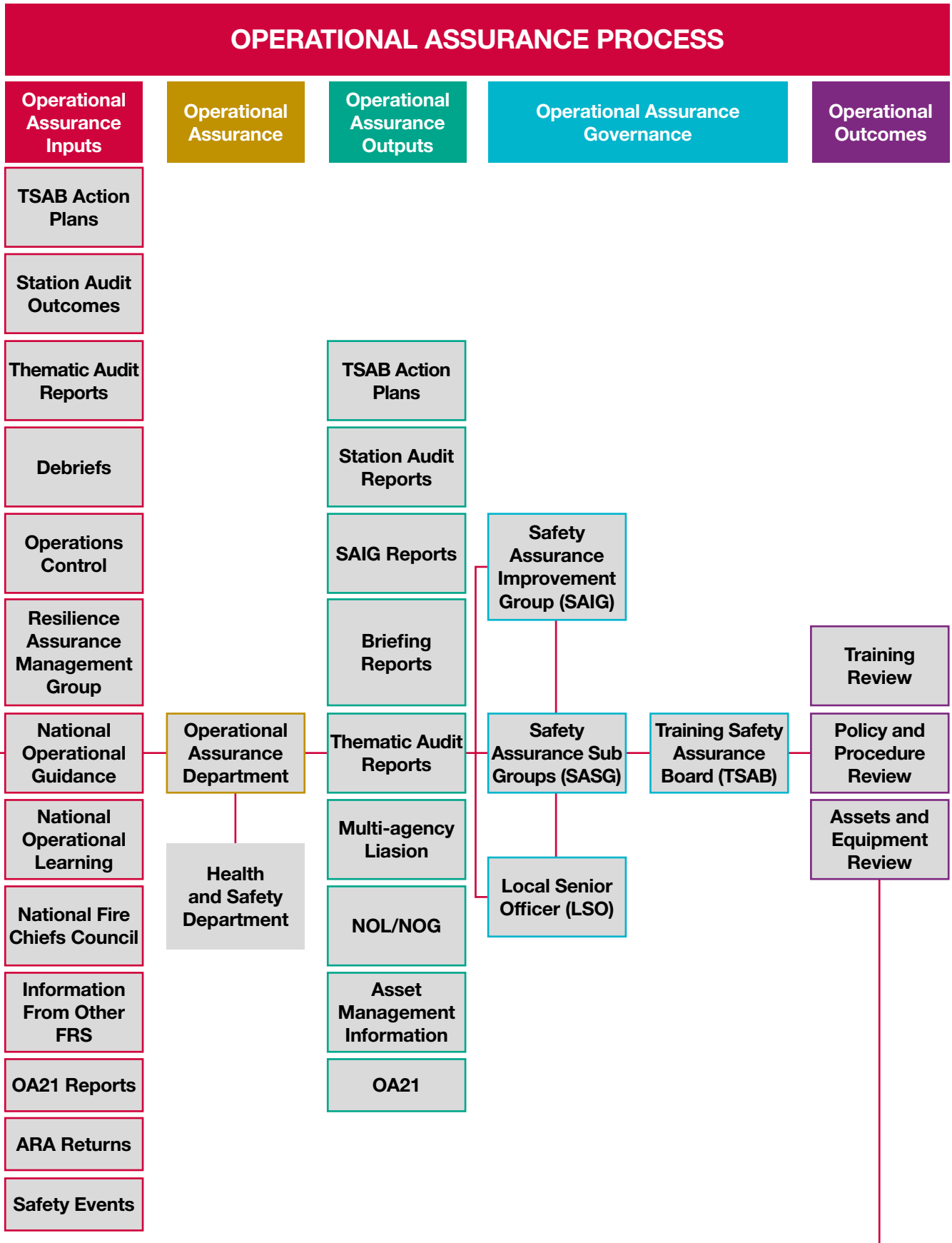
AB	Awareness Brief
AM	Active Monitoring
APR	Annual Performance Report
ARA	Analytical Risk Assessments
BA	Breathing Apparatus
Board	The Board of the Scottish Fire and Rescue Service
C&C	Compare and Contrast Benchmark Review
CC	Crew Commander
CDS	Continuous Duty System
CFS	Community Fire Station
CI	Continuous Improvement
CoE	City of Edinburgh
CoG	City of Glasgow
COP	Control Operating Procedure
CS	Case Study
DACO	Deputy Assistant Chief Officer
DOC	Dundee Operations Control
EOC	Edinburgh Operations Control
ESDA	East Service Delivery Area
FDO	Flexi Duty Officer
FDS	Flexi Duty System
FLU	Frontline Update
FRS	Fire and Rescue Service
FSA	Fire (Scotland) Act 2005
GC	Group Commander
GIN	General Information Note
HMFSI	His Majesty's Fire Service Inspectorate
HMI	His Majesty's Inspectorate
H&S	Health and Safety
HSE	Health and Safety Executive
IC	Incident Commander
ICL	Incident Command Level Training (Level 1, 2, 3 and 4)
ICPOG	Incident Command Policy and Operational Guidance

ICT	Information and Communication Technology
ICS	Incident Command System
JOC	Johnstone Operations Control
JOL	Joint Operational Learning
KPI	Key Performance Indicator
L1	Incident Level 1
L2	Incident Level 2
L3	Incident Level 3
L4	Incident Level 4
L5	Incident Level 5
LCMS	Learning Content Management System
LO	Learning Organisation
LSO	Local Senior Officer
MDF	Management Development Framework
MHW	Mental Health and Wellbeing
MPDP	Maintenance Phase Development Plan
NFCC	National Fire Chiefs Council
NOG	National Operational Guidance
NOL	National Operational Learning
NOLUG	National Operational Learning User Group
NSAB	National Safety and Assurance Board (Now TSAB)
NSDA	North Service Delivery Area
OA02	Pre-Incident Station Audit Form
OA06	During-Incident Review Form
OA07A	OAO Action Checklist
OA07B	OAO Aide Memoire
OA13	Post-incident Review Form
OA21	Operational Assurance 21 Day Procedure
OA	Operational Assurance
OAD	Operational Assurance Department
OAO	Operational Assurance Officer
OARRS	Operational Assurance Recording and Reporting System
OC	Operations Control
OD	Operational Discretion
OI	Operational Intelligence

OiC	Officer in Charge
OL	Operational Learning
OLG	Organisational Learning Group
Ops	Operations Directorate
ORL	Organisational Learning
PC	People Committee
PDR	Personal Development recording
PISP	Post-incident Support Process
PMF	Performance Management Framework
PO	Principal Officer
PPE	Personal Protective Equipment
QFSM	Queen's Fire Service Medal
RDS	Retained Duty System
SAC	Safety and Assurance Coordinator
SAIG	Safety and Assurance Improvement Group
SALO	Safety and Assurance Liaison Officer
SASG	Safety & Assurance Subgroup
SC	Station Commander
SD	Service Delivery
SDA	Service Delivery Area
SDC	Service Delivery Committee
SFRS	Scottish Fire and Rescue Service
SLT	Strategic Leadership Team
SMARTEU	Scottish Multi-Agency Resilience Training and Exercising Unit
SOP	Standard Operating Procedure
SPoC	Single Point of Contact
TFoC	Training for Competence
TSA	Training Safety and Assurance Directorate
TSAB	Training Safety and Assurance Board (historically referred to as NSAB)
TacAd	Tactical Advisor
UI	Urgent Instruction
UIG	User Intelligence Group
UK	United Kingdom
UKFRS	United Kingdom Fire and Rescue Services
VC	Video Conference

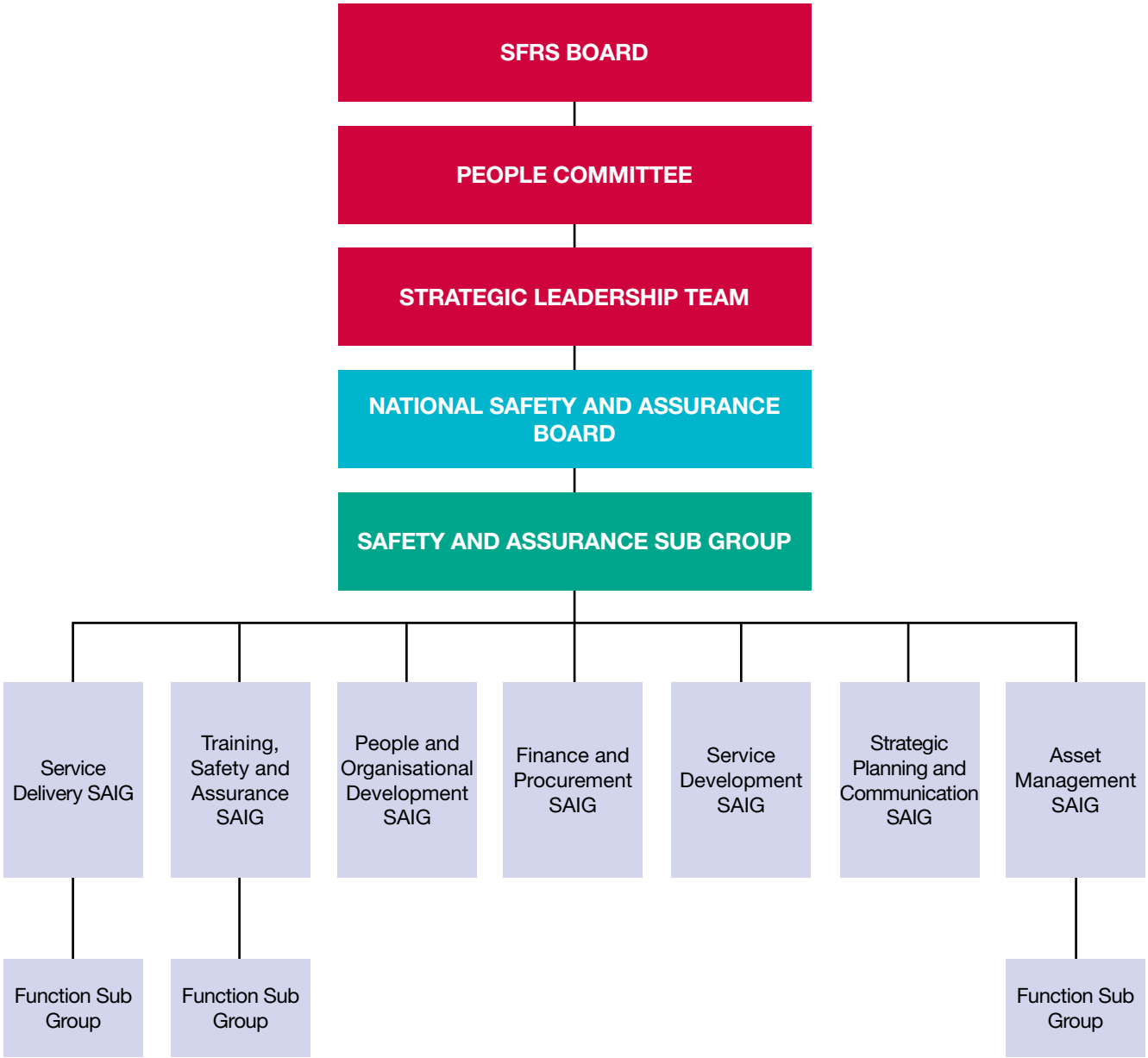
VDS	Volunteer Duty System
WC	Watch Commander
WSDA	West Service Delivery Area
WT	Wholetime Duty System

Appendix 1


OPERATIONAL ASSURANCE PROCESS
Operational Assurance Inputs
Operational Assurance
Operational Assurance Outputs
Operational Assurance Governance
Operational Outcomes
TSAB Action Plans
Station Audit Outcomes
Thematic Audit Reports
Debriefs
Operations Control
Resilience Assurance Management Group
National Operational Guidance
National Operational Learning
National Fire Chiefs Council
Information From Other FRS
OA21 Reports
ARA Returns
Safety Events
Operational Assurance Department
Health and Safety Department
TSAB Action Plans
Station Audit Reports
SAIG Reports
Briefing Reports
Thematic Audit Reports
Multi-agency Liasion
NOL/NOG
Asset Management Information
OA21
Safety Assurance Improvement Group (SAIG)
Safety Assurance Sub Groups (SASG)
Local Senior Officer (LSO)
Training Safety Assurance Board (TSAB)
Training Review
Policy and Procedure Review
Assets and Equipment Review

Appendix 2

NATIONAL SAFETY AND ASSURANCE BOARD (NSAB) WHICH MEETS 8 WEEKLY AND IS CHAIRED BY THE DIRECTOR OF TRAINING, SAFETY AND ASSURANCE

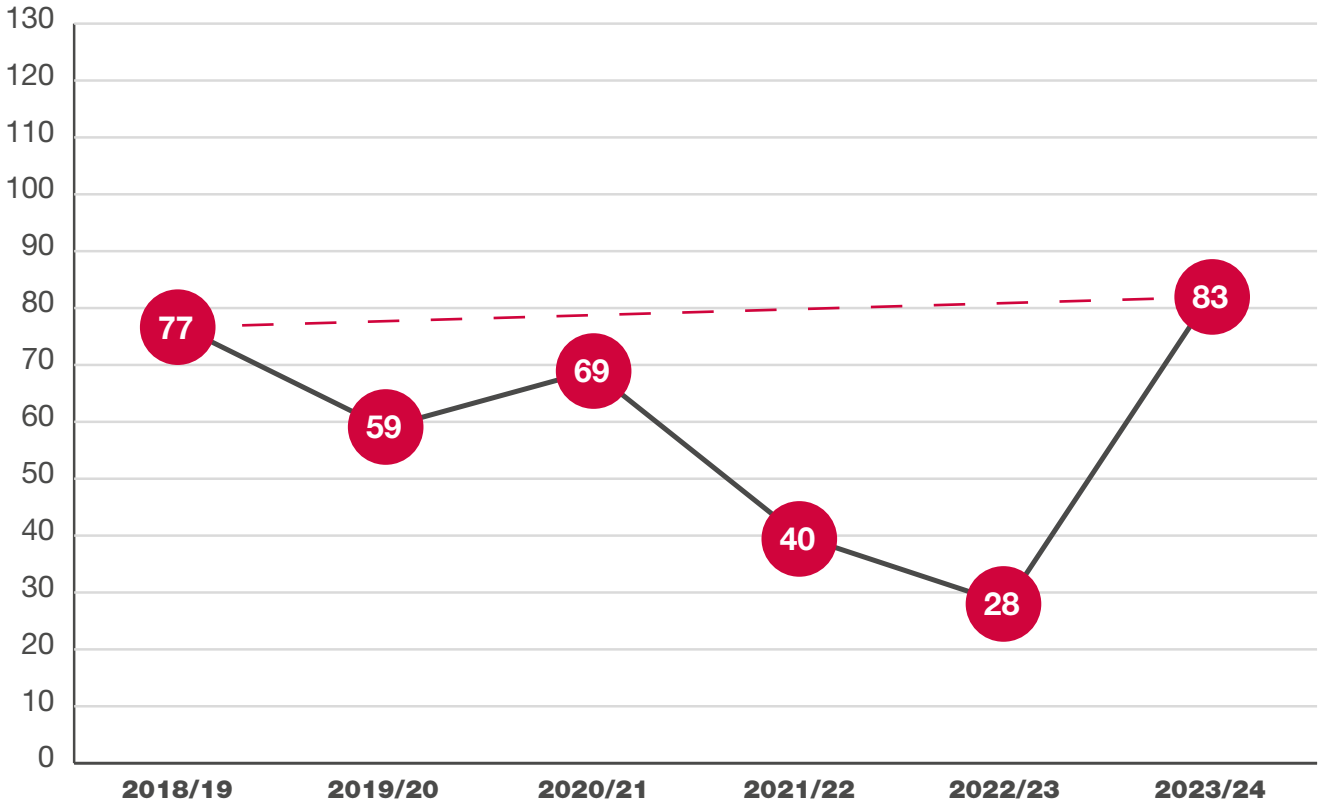


Appendix 3

KPI 19: Operational Assurance Audit Actions

Purpose: the KPI demonstrates the number of 'Significant' recommendations identified through OA Debrief Processes.

We will: continue to review significant events when required and continue to promote hot debriefs and the recording of what went well and what didn't through the Operational Assurance Recording and Reporting System (OARRS).



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