Appendix A

Review of Operational Arrangements

Buckinghamshire
Fire and Rescue Service
November 2018

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Executive Summary

The BFRS Management team is committed to ensuring independent scrutiny of the Service's risk critical functions, to fully explore any improvement opportunities and help drive continual service improvement. To this end they commissioned an independent audit of the service from Operational Assurance Ltd (OAL) in May 2016, with a smaller checkpoint audit in November 2017 to assess implementation of actions identified.

This document details a further review, the first of a rolling programme, carried out in November 2018 with a focus on key topic areas:

- Management of site-specific risk information
- Operational discretion
- The refined Operational Assurance model

The BFRS Senior Management Team (SMT) instructed OAL to explore all related improvement opportunities, to consolidate current practices and inform future development for the safety and benefit of the Services' operational staff.

As with previous reviews, the audit methodology consisted of structured interviews with a wide range of BFRS uniformed and non-uniformed staff at all levels, supplemented with detailed inspection of relevant databases and records.

OAL, as with previous audits, found BFRS to be a forward thinking, well managed and effective FRS, with a commendable commitment to continuous improvement.

OAL has however identified a several areas for improvement, arising from which are 26 recommendations.

OAL notes that some of these recommendations are already the subject of internal improvement activities generated by the SMT, including investment in new processes and systems. OAL expects therefore, that the majority will be fully addressed when such investment is complete. The recommendations have, nonetheless, been included to provide a snapshot of any consistency or inconsistency to legislation, regulation or best-practice thereby encouraging continued focus on the timeliness of existing improvement actions, rather than necessarily generating additional strands of activity.

Management of Site-Specific Risk Information (SSRI)

The review of the management and storage of SSRI confirmed management decisions to replace the current system with a newly designed and modernised system which will benefit from advances in technology which are not insignificant since the original system was introduced.

BFRS management of SSRI was found to be consistent with the legislation, regulation and most national guidance. Inconsistencies to national guidance were found in 3 areas relating to managerial

roles, staff competencies and the communication of risk information, primarily via the existing BFRS SSRI database which, due to its age, confirmed the BFRS decision to replace it with a new, significantly more robust system with more advanced functionality. 11 recommendations for BFRS consideration were identified, with those relating to the database expected to be fully met once a new system is implemented.

Operational Discretion

OAL evidenced that BFRS is managing OD consistent with national guidance regarding the existence of an Operational Discretion statement, and that staff were widely aware of it. Staff exhibited widespread confidence that they would be supported by service leadership in the exercise of Operational Discretion where warranted. Inconsistencies with national guidance were identified with regard the availability of the statement and the frequency of staff training with other observations included, for instance, regarding the detailed make-up of the training. Six actions for BFRS consideration were identified.

The Refined Operational Assurance Model

The OAL audit in May 2016 identified a number of potential improvements to the BFRS internal operational assurance model, and the November 2017 checkpoint audit showed good progress in implementation. This, November 2018, review has identified that progress has slowed or stalled in several areas, particularly with regard to publication of a revised an up-to-date OA policy, and the introduction of an Active Monitoring System (AMS), possibly due to combination of technical problems and staff turnover. 9 actions for BFRS consideration were identified, however many of these will be considered as fully addressed as the planned policy and procedures are completed.

Background

OAL is a company that is comprised of former senior Fire and Rescue Service (FRS) professionals, specialising and trained in providing the commissioning client with a professional, focused and fully independent audit of agreed risk critical functions. Each team member has wide ranging FRS experience across a number of disciplines, which is used to inform audit outcomes and recommendations[1].

OAL has committed to conduct two assurance visits/audits per annum that focus upon specified, pre-agreed aspects of the BFRS sphere of operations. In November 2018 three representatives from OAL undertook an independent review of the following areas of operations within BFRS:

Site Specific Risk Information (SSRI): This element of the audit tested the management of SSRI in BFRS to determine if the gathering of operational risk information is valid, timely and relevant. Specifically, OAL sought to establish how effectively the service identifies, gathers, develops and communicates site specific risk information to its operational staff. This included technical aspects related to the database application and the use of Mobile Data Terminals (MDTs).

Additionally, the audit sought to determine the level of consistency with BFRS policy and procedural document as well as National Operational Guidance on this topic.

The Management of Operational Discretion: Operational Discretion (OD) relates to rare or exceptional circumstances where strictly following a defined operational procedure could be a barrier to an effective resolution of an incident, or where no established procedure exists to adequately address the immediate situation.

In undertaking this element of review, OAL sought to establish how effectively Operational Discretion is currently managed within BFRS, including the levels of confidence that staff have in its implementation of OD and how effectively it is applied at operational incidents.

The Revised Operational Assurance Model: This element of the audit sought to establish how effectively the Operational Assurance Model is functioning within BFRS. Specifically, OAL were tasked with determining how well the current model has become embedded within the Service and how successfully its principles are being applied.

During the course of the review, the OAL team conducted a range of structured interviews involving a cross-section of BFRS staff and employing a multi-layered approach to include strategic managers, department heads, systems managers, operational officers and firefighters. This approach ensured the OAL team had sufficient opportunity to triangulate evidence and thereby inform and strengthen the findings and recommendations offered within this report.

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[1] *Short biographies of the attending OAL team are provided at Appendix 'A'.*

Consequential Findings

Although not strictly falling within the scope of the review, any matters arising as 'Consequential Findings' have also been included within the body of this report, so as to maximise the potential value of the audit to BFRS and its key stakeholders.

1. Management of Site Specific Risk Information

During the course of the audit the OAL team were afforded the opportunity to interview a newly appointed Area Commander (AC). This officer has been allocated the strategic references for Prevention, Protection and Response, as well as Performance Management.

During the audit, several areas of improvement were identified for the management of site specific risk information. These areas of improvement were discussed in detail with the AC, which provided assurance that BFRS management has a full understanding of the shortcomings related to the management of risk information in BFRS and evidenced that a number of improvements were already underway. Although many of these disclosures were in accord with findings made by OAL during the course of this audit, it would be considered a missed opportunity not to fully identify all improvement opportunities identified within the body of this report.

For the benefit of the reader, the following definitions are provided:

Site Specific Risk Assessment (SSRA) - A risk assessment carried out at a specific location for the purpose of gaining information and knowledge to inform operations. This activity is conducted primarily in satisfaction of the requirements contained in Section 7(2) d of The Fire and Rescue Services Act 2004. For the purpose of this report, this will be known as the I**nspection Process**.

Site Specific Risk Information (SSRI) - Knowledge and information gained from undertaking SSRA activities.

The Database – The electronic application used in BFRS to store and manage SSRI

1.1 BFRS SSRA Procedural Guidance

Buckinghamshire Fire and Rescue Service (BFRS) seek to be wholly compliant with the requirements set out in The Fire and Rescue Services Act 2004 and provides a policy statement for clarity and purpose.

The BFRS Policy Statement:

'The Fire and Rescue Services Act 2004 requires Fire Authorities to make arrangements for the inspection of premises to obtain information for firefighting.

It is the policy of Buckinghamshire Fire & Rescue Service (BFRS) that the procedure for gathering, recording and disseminating the information is based on the principles of risk assessment laid out in the Management of Health, Safety and Welfare at Work Regulations 1992.

The procedure forms an integral part of BFRS risk control strategy by ensuring, as far as is reasonably practicable, that suitable and sufficient information is available to all operational personnel whilst attending emergency incidents.'

In order to audit and review fulfilment of the BFRS Policy Statement for managing risk information, OAL employed an 'end to end' process that gave consideration to the numerous component parts.

The findings from this work stream are set out below and for each component part, consideration is given to the requirement of the policy or procedure and how these are realised at the point of service delivery. Where applicable OAL has made recommendation for improvement based upon end user requirements and evidence from senior managers/implementers.

As has been stated earlier in this report, the existing system for the management and storage of SSRI is under review by BFRS with a view to replacing it with a more modernised and technologically advanced system. It was evidenced that the newly designed system will be more responsive, stable, and user friendly. The findings set out below will briefly identify the areas of improvement in the existing system in order to assist in the development of' the newly designed desired elements.

1.2 Procedural Compliance

In the interests of ensuring guidance, contained within the SSRA policy, was in accord with that provided at national level, OAL consulted the following:

- The Chief Fire and Rescue Advisor 'Fire and Rescue Service Operational guidance – Operational Risk Information'
- The National Operational Guidance Programme
- The Fire and Rescue Services Act 2004
- Management of Health, Safety and Welfare at Work Regulations 2006

Findings:

The BFRS SSRA policy was found to be **consistent** with the following core aims and objectives:

i. The Prevention of injury and ill health of firefighters and other emergency responders.
ii. The Management and mitigation of risks in the community.
iii. Compliance with the legal duties on Fire and Rescue Authorities in relation to operational risk information.
iv. Compliance with formal guidance and "best practice" models.
v. Ensuring clear documentation, document control and security measures are in place.
vi. Ensuring the continuing monitoring of the performance of relevant personnel, including assessments of their competency and use of the system.
vii. That any gaps in the effective management of the system are identified.

The current policy document is a combined document and is provided alongside the operational guidance and instruction manual. During interview with end users it was evidenced that the current guidance does not fully meet with current practical use. The root cause of this inconsistency would appear to be that the advances and development of the SSRI system has not been followed by a change in the policy and guidance. Additionally, no change log could be identified to enable users to track the changes in the policy so as to allow understanding of what has changed and why.

The significant increases in the quality and quantity of information held and information continually added has identified inherent gaps in the current policy. These gaps have, in some cases, brought elements of the policy into areas inconstant with the above aims and objectives. OAL consider some of these gaps as unavoidable until the newly designed system is fully implemented and the accompanying policy document has been revised accordingly. These inconsistent elements are listed below:

i. Ensuring that the allocation of the roles and responsibilities take account of the competency, level of authority and capacity of individual employees. See section 1.5

ii. Ensuring there are effective communication and data sharing protocols within the organisation, and between the partner organisations involved in supplying and receiving operational risk information and intelligence. See section 1.6

iii. Continual improvement in the provision of accurate, relevant and timely operational information. Audit and review mechanisms set out in the Health and Safety Guidance 65 (HSG65). See section 1.10

Recommendation:

1. For the purposes of clarity, BFRS management should consider separating the policy and user manual to enable the effective auditing of change management (version control).

1.3 The Existing SSRI Database

As previously discussed, BFRS stores SSRI on a database provided through the Microsoft Access application. The database was created by a (now retired) Senior Manager and has worked towards making firefighters safe for some 15 years.

During the audit process OAL interviewed a number of key personnel to determine where improvement opportunities exist, these included:

- The BFRS I.T. Technician
- The BFRS Computer Aided Design (CAD) team
- End Users (Station Personnel)
- Station Commanders
- Command Unit Operatives

1.4 Identification and Grading of Risk

The SSRA policy and guidance was found to provide some guidance and support with regard to the identification and grading of risk. However, discussion with end users confirmed that many found the guidance somewhat confusing and often limited in its application, particularly where this concerned gathering information related to more modern construction techniques and their associated risks.

Examples were offered where more prevalent construction methods were unavailable in the system when constructing a new risk record or amending an existing record. Discussion with the I.T. Technician confirmed that the lack of a technical manual for the system provided difficulties in making software changes to meet desired changes.

Recommendation:

2. Ensure all modern elements of building construction are included in the new system as an option for the end user. Such a system should also be sufficiently flexible as to allow the inclusion of new forms of building construction and materials as they become introduced to industry.

A further improvement opportunity for the electronic database relates to the methodology by which sites are allocated a risk scoring. Currently the system allocates a risk score to a site based upon the size of the floor area. For example, a premises with a large floor area, such as a warehouse would automatically attract a score of 4 (high), regardless of its contents, or indeed if it were empty. OAL are of the opinion that this form of risk scoring has the potential to impact the manner in which the location is treated by BFRS for operational purposes. OAL were offered an example of a level 4 warehouse which stands empty yet is subject to a higher level of exercising (10+ pumps) and inspection frequency. This would appear to be disproportionate with the actual risk which is quite low.

Recommendations:

3. Ensure the end user has sufficient competence and privileges to allocate a risk score conducive to the reviewed property.

4. BFRS Management should confirm that any new database system includes a requirement for the end user to record the rationale applied to any risk score. This rationale will provide an audit trail for the purpose of review and provide assurance that this rationale is quality assured.

1.5 Allocation of Risk Work

The SSRI policy and guidance provides information on how risk work is allocated to individual stations. Although the document does not explain how the work is to be delegated beyond the station reference holder, it is accepted that this would be for the appropriate manager to determine.

It is common practice for fire service managers to delegate responsibility for many aspects of station work such as the management of risk information. In the fire sector this is widely accepted as a good method of developing staff and provides a consistent approach to undertaking a particular role. However, in order to perform the role competently and to the required standard, it would follow that the responsible person (the reference holder) should be provided an appropriate level of training, guidance and support.

Findings:
All reference holders interviewed stated that they had received no formal training or guidance on the identification of risk, the use of the database, audit and review of recorded risks, or risk control measures. All those questioned, stated that any competence they have achieved was as a result of cascade training from colleagues on station.

Whilst it is accepted that this apparent lack of training does not necessarily translate to the risk information database being incorrect or deficient, OAL would suggest that this situation does expose BFRS to some risk, insomuch that in the case of a significant event at a risk site, it could be argued that risk information has been included in the database by a person without:

- Adequate training in risk management.
- Any assurance of competence.
- Any quality assurance controls.
- Any meaningful supporting policy or guidance.

Recommendations:

5. BFRS Management should consider providing SSRA reference holders with suitable training in risk identification, risk management/scoring, etc. and all reference holders should be subject to an assessment of competence in the same. This confirmation of competence should be recorded against that persons training records.

1.6 Risk Sites in On Call Station Areas

In order to meet the significant challenge of providing adequate fire cover throughout the region, BFRS employs a range of crewing systems, pivotal to which is the provision of a flexible workforce both from Wholetime and On Call operational staff.

Ordinarily, as the 'On Call' stations are essentially on standby during normal working hours, the crews from these stations are unavailable to undertake core fire service work activities, such as gathering and processing Site Specific Risk Information.

In order to address this situation, BFRS has determined that crews from the adjacent whole-time fire stations will take responsibility for gathering and processing all information for risks occurring within the neighbouring On Call fire station ground(s).

An example of how this works, Aylesbury fire station is encompassed by On Call stations and it falls upon the crews from Aylesbury to inspect and process the outcomes from all risk premises located within the station grounds of the surrounding On Call stations, in addition to the risks occurring within their own station area.

Findings:

It was evidenced that established procedures for undertaking site specific risk assessments make no requirement for the communication of significant findings directly between the inspecting watch/officer/station, and the On Call fire station whose area the risk premises are actually located. It is widely accepted that the provision of risk information prior to any incident taking place allows for the pre-planning, exercising and problem solving of most potential scenarios. In order to triangulate these findings OAL asked watch officers to provide any examples of the outcomes of an SSRA but none were offered.

OAL are of the opinion that a risk exists, in that:

The identified weakness in the electronic database regarding search functionality and auto notification, combined with a policy and guidance document that does not impose a requirement to notify the local fire stations, provides an avoidable risk. This risk is that the local station may be unaware of new risks in their station area even though it has been visited by the nearest whole time station.

Recommendation:

6. The BFRS SSRA policy and procedure should be revised to ensure that, following any SSRA, significant findings should be communicated to relevant stations. In particular on call stations should be notified of SSRA activities and findings carried out on their behalf.[2]

[2] It was evidenced that the new database system will have auto-emailing functionality which should address the communications issue currently being experienced between stations.

1.7 Validity and Accuracy of Stored Risk Information

The BFRS I.T. Technician was interviewed to determine the performance, stability and general levels of confidence with the current electronic database and the following findings were revealed:

It was confirmed that there was no technical manual available to support the current electronic database. Such documentation would usually be required for maintenance and development, such as confirmation of data paths for information and other such technical operations, so as to advise potential improvements.

During the course of the audit, OAL became aware of the signs of system instability evidenced at various locations and these included:

- Different versions of a risk with different hazard observations.
- Repeated failures of the system at station level.
- Difficulty in recalling SSRI on the MDT.
- Duplicate records with differing risk information.

The I.T. Technician also confirmed that the current method of wireless update employed at fire stations has potential to create situations where risk information could be 'out of sync' with that information held centrally. It was also confirmed that this potential is due to a lack of incremental updates to the information rather than the all or nothing updates currently in place. The lack of a technical manual meant that OAL were unable to establish whether an uncompleted upload would recommence from the point of interruption, or if the update begins again from the start.

Observations:

Due to the nuances in the current electronic database, a risk exists that some fire engines could mobilise to operational incidents with risk information that varies, or is deficient to that held centrally. Examples of this were demonstrated by viewing the contents of a risk record for a residential care home. The demonstration showed that there were differences in the record on the station desktop computer compared against that on the MDT. The I.T. Technician confirmed that there is a high probability of other such inconsistencies between desktop based records and those on MDT.

Recommendations:

7. The new database system should allow incremental updates as and when new risk information is added.

1.8 Removal of Risk Information

Other key lines of enquiry for OAL involved determining the standard of audit and review in place for the electronic database. This involved discussions with end users as well as managers concerning reviewing the quality of the information added to the electronic database and determining what information had since been removed to ensure accuracy and validity of information.

Finding:

It was evidenced that at each time of asking, no examples could be provided of risk information having been removed from the database. Obvious examples of where removal of information may be required could be acetylene cylinders in businesses that are no longer trading, medical oxygen cylinders showing in premises where the patient has passed away or no longer needs them, premises that have since been demolished, or changed use, such as previous night clubs, etc.

The I.T. Technician confirmed the removal of such invalid information should relieve the stress currently being experienced by the database. Additionally, the removal of superfluous information would reduce the time taken to update each MDT in BFRS every 24 hours and also help to ensure the information is as valid as reasonably practicable pending the introduction of the new database.

Recommendations:

8. BFRS Management should ensure any future electronic database incorporates a process to periodically review the existing risk information and where appropriate, to have this amended for correctness or removed from the database entirely.

9. BFRS Management should provide for an audit of the current SSRA database, so as to identify any redundant risk information that can be safely removed prior to transfer to the new database.

1.9 Provision of Information to Thames Valley Fire Control Service (TVFCS)

During the audit, it was confirmed that on occasions, operational risk information becomes available that is not on the SSRA system. If an immediate change is required to the mobilising data, an officer can submit form 17.2 to TVFCS. This form will contain any information required for inclusion on the mobilising message or ‘tip sheet’. The control staff will amend the mobilising information for the identified risk, which will then be immediately available to the attending crews.

Indeed, during the audit such an occurrence took place when many illegal sleepers were located on a building site. The numbers and location of these sleepers were determined to be a life risk by the Station Commander at the incident. This information was passed to TVFCS in the interim period until it could be formally added to the SSRA system. This was evidenced to be an effective way of communicating newly gained risk information.

This process does not however, make any changes to the existing electronic database, therefore cannot be considered as a replacement for this. Also, further questions exist as to how effectively this information is subsequently removed, once the hazard has been controlled or removed.

Recommendation:

10. Where possible, any submission to TVFCS should be synchronised with the new database to ensure conflicts of risk information are minimised so far as is reasonably practicable.

1.10 Quality Assurance of SSRI

In order to confirm the quality of the SSRI used by BFRS, OAL interviewed the following staff:

- Station Commanders
- Watch Officers
- Station Reference Holders (SSRA/SSRI)
- I.T. Technician
- CAD Technician

It has been established that improvement opportunities exist in the quality assurance processes applied to the management of SSRI. All interviewed key personnel involved with this process confirmed that they considered quality assurance of SSRI to be important and something that 'should happen' or that they 'expected to happen'.

Audit evidence gathered by OAL has revealed that the quality assurance of SSRI is somewhat ad hoc and often down to individual competence or diligence, rather than a result of established and embedded procedure.

Clearly the risk to the BFRS is that without an established and auditable quality assurance process for SSRI there is the potential for lack of consistency in the management of risks, additionally any embedded quality assurance process will assist in ensuring relevant information will support any related tactical plan.

Examples are:

It was evidenced that Station Commanders do not routinely evaluate the quality of information contained on risk cards for their own station areas. A review of recent submissions to the SSRA database confirmed that the examples provided to Station Commanders by OAL, would have been rejected by them as 'unsuitable for the submission to the database' had they been reviewed as part of a quality assurance process.

It was evidenced that following submission of many of the SSRAs, the CAD technician has found it necessary to personally visit the risk sites in question, so as to ensure the accuracy of the submitted mapping information provided by the inspecting crews. It was further established that this colleague applies his own quality controls to ensure adequate standards are met.

It was evidenced that Station Commanders do maintain an overview of progress made by their crews in addressing the SSRA workload. However, this activity is primarily quantitative, rather than qualitative in nature and OAL were unable to identify any real quality assurance of the SSRA/SSRI process, other than that applied by the CAD Technician for mapping purposes.

Examples of improvement opportunities evidenced on live risk cards included:

- Photographs with no direct bearing on the risk. For example, photographs elements of structure or operation but no explanation of their relevance or importance.

- Identification of risks, but without the required control measures. For example, identification of a main gas intake, but with no indication of where the control valve is located, or indeed how it is operated.

- Insufficient information relating to fixed installations. For example, how the fixed installation could assist a firefighting strategy.

Recommendations:

11. BFRS management should consider if the requisite level of quality assurance processes are in place to ensure that the information being collated is Accurate, Relevant and Valid/Timely.

2. Operational Discretion

OAL understands that where there is an operational imperative, an Incident Commander (IC) may need to adapt Operational Procedures and develop a tactical plan which balances the need to protect life and property against the risk of inertia. In doing so, the IC will:

- Understand the actions which are normally required as part of the relevant SOP to conduct a suitable dynamic and analytical risk assessment.
- Ensure any variance/adaptation from standard procedures is the minimum necessary to achieve the objective(s).
- Ensure any variance/adaptation from standard procedures is communicated and recorded appropriately (in very dynamic situations this may be a verbal briefing of the tactical plan, which can be formally recorded later).
- Minimise exposure to any increased levels of individual or corporate risk by reverting to the relevant SOP as soon as practicable.

The National Operational Guidance document for Incident Command provides a description of Operational discretion and how it might be used:

'Most situations that incident Commanders are faced with are not unique and are foreseeable. In resolving an incident, Commanders use their own experience and knowledge of guidance, together with that of the command team and crew members.

However, Incident Commanders may occasionally be presented with a situation that is extremely unusual and not reasonably foreseeable. In this circumstance they may have to make decisions using their professional judgement.

Operational discretion relates to rare or exceptional circumstances where strictly following an operational procedure would be a barrier to resolving an incident, or where there is no procedure that adequately deals with the incident. Commanders need to be sufficiently aware of procedures, the skills and qualities of crew members, and the capability of resources available. Outcomes which would justify applying operational discretion include:

- ***Saving human life***
- ***Taking decisive action to prevent an incident escalating***
- ***Incidents where taking no action may lead others to put themselves in danger***

The overarching principle should be that in the opinion of the incident Commander the benefit of taking unusual, unorthodox or innovative action justifies the risk. Any decision to apply operational discretion should be the minimum necessary and only until the objective is achieved.

To support the post-incident learning process, fire and rescue services should have procedures for incident Commanders to record the reasons that support their decision. The extent of the record should match the severity and/or complexity of the incident.

On occasion, crew members and/or members of the public might apply pressure on an incident Commander to act. An incident Commander can apply operational discretion; therefore, it is unlikely that a crew member would intervene entirely of their own volition without putting colleagues or members of the public at additional serious risk.

Also;

The Health and Safety executive provides clarification of their stance in the published document 'Heroism in the Fire Service';

HSE fully endorses the recommendation in* Common Sense, Common Safety *that individual firefighters should not be at risk of investigation or prosecution, under health and safety law, if they have put themselves at risk as a result of a heroic act.

And;

HSE views the actions of firefighters as truly heroic when it is clear that they have decided to act entirely of their own volition in putting themselves at risk to protect the public or colleagues and there have been no orders or other directions from senior officers to do so and when their actions have not put other firefighters at similar high risk

It can be seen from the above statements that key stakeholders within the fire sector support the use of operational discretion when appropriate and offers expectations that FRS Commanders do likewise.

In light of these statements all FRS have provided clarification of their policy in what is often known as

'The Operational Discretion Statement'.

2.1 Applicable Guidance

The audit scope sets out an agreement between OAL and BFRS that the management of Operational Discretion will be reviewed against national and local standards (applicable Guidance). These are:

- Foundation for Incident Command
- Foundation for Breathing Apparatus
- BFRS Operational Article (Operational discretion)
- BFRS Standard Operating Procedure (Incident Command)
- HEAT Training packages
- BFRS Training, Learning and Development policy

The auditing officer conducted 11 detailed interviews specifically targeted at the management of Operational Discretion. In order to supplement and evidence the OD findings the remaining two auditors adopted an opportunistic approach by including specific lines of enquiry within their own interviews which provided further evidence from over 30 candidates.

The 11 detailed interview candidates have been operational commanders for between 3 years and 20 years and included:

- 2 Crew Commanders
- 7 Watch Commanders
- 1 Station Commander
- 1 Group Commander

Other Ad Hoc questioning included 7 Watch Commanders 4 Station Commanders, 1 Group Commander and Firefighters from various operational stations.

For the purposes of this report the evidence will be drawn together into concise feedback with recommendations where applicable. Each item of evidence was confirmed and triangulated to ensure accuracy. This was also covered by the time of the closing meeting with BFRS Senior Management Team (SMT).

2.2 Staff Confidence

It should be noted during the reading of this element of the report that all personnel without exception confirmed their confidence that BFRS management would support them should they need to implement operational discretion at an incident. They also confirmed that this confidence would prevent any operational inertia which could result in a delay in command decision making.

2.3 OD Policy

During the audit all personnel were aware that an operational discretion statement exists and it was clear from the knowledge demonstrated that training in OD has been delivered, albeit, for the general workforce some time ago. OAL is confident that following confirmation from all levels of staff, a policy exists and that it was communicated at the time of implementation.

Findings:

- During interview each candidate was asked to provide a copy of the OD statement. No candidate could do so.
- During interview each candidate was asked to access the statement online via the service intranet, no candidate could do so.
- During interview each candidate was asked to provide any evidence that they had received training in any capacity regarding operational discretion, no candidate could do so.

Observations:

OAL would offer the opinion that any operational discretion decision would be difficult to assess for compliance against the policy if the policy cannot be found by staff. Later feedback from SMT confirmed that they were able to access the policy and were confused why staff could not? This may indicate some level of disconnect either through access or competence in the use of the storage media?

It should also be noted that due to the amount of time that has passed since the initial implementation of the OD statement, several staff have left the service and have been replaced with newly promoted Operational Commanders. These new Commanders without exception expressed an opinion that they feel they would benefit from a refresh of the OD input so as to support their own operational development.

Recommendations:

12. OAL recommend that the OD statement is reviewed for republishing so as to ensure it is readily accessible to all staff.

13. OAL recommend that the OD statement is included in the process of command competence acquisition and maintenance.

2.4 Training in Operational Discretion

OAL cannot offer feedback or recommendations concerning the initial implementation of OD in BFRS, as the evidence gained was purely anecdotal and as such cannot be fully relied on. However, OAL can offer feedback on the current OD training package.

During the audit an opportunity arose where the OD training package was delivered to a watch and this training was directly observed by the OAL auditor. The training package was in the form of a PowerPoint lecture and delivered at a fire station.

Observations:

The OD lecture was delivered and discussed among the crews and lasted approximately one hour. It was interesting to note that all the scenarios in the lecture, as well as all the potential usage examples, were of a water incident nature. Additionally, during the interviews all candidates were asked for examples of an operational discretion decision and again, all these examples were of a water incident type.

To confirm:

- No staff member offered an example that was not water based in nature.
- All OD training was water based in nature.
- No staff member during any interview carried out by each OAL team member offered examples of a fire related OD use.
- No examples were offered either by a person or in the training package of when OD cannot or should not be used.

Recommendations:

14. The OD training package should be reviewed to ensure it offers a broader application range and does not overly focus on one specific type of incident.

15. The OD training package should be placed as a priority across all operational staff to ensure they have an appreciation of OD and the responsibilities it holds.

2.5 Recent use of Operational Discretion

During a recent incident in BFRS (April 2018) an operational decision was made which OAL consider a prime example of when OD should have been declared and consequently when OD should have been rescinded once the crisis was over. This incident is currently being processed through the OA team for wider circulation and training, but is currently unpublished.

The incident transcript confirmed that OD was not declared, nor was it rescinded later as per OD guidance. This scenario was discussed during all the interviews as well as a tabletop exercise with groups of firefighters. On each occasion the groups and candidates came to a similar outcome that OD should have been declared and rescinded (with prompting) yet all were confident such a situation was unlikely. The groups and candidates universally expressed surprise that not only did this situation take place but also that it was so recent, and crucially that they had little or no awareness of any learning outcomes arising from it.

Other observations:

- When giving examples of OD, several candidates offered the opinion that the use of OD only applied to fire service personnel and equipment.

- No candidate was able to describe the link between the OD statement and the Joint Decision Making Process.

2.6 Audit and Review

During the review of the incident in April 2018 (see section 2.5), it has been stated in this report that OAL regard this as a prime candidate for OD, but it was not used. OAL attempted to find a record of the review of why the OD statement was not used, but no review was offered or provided. OAL would ask BFRS management to consider this feedback and determine their own incident audit approach so as to ensure OD is reported on if used. This material can then be used to develop Managers in crisis management (WM.7 Skills for Justice).

2.7 Understanding of Hierarchy of Risk Control

It has been confirmed that new Managers are educated on the management of risk controls i.e.:

Eliminate **R**educe **I**solate **C**ontrol **P**olicy and **D**iscipline (ERICPD).

During interview, feedback from candidates indicated a desire to receive further and more detailed input about risk management so as to assist them when making command decisions and installing control measures.

It has been confirmed that all commanders in BFRS hold (as a minimum standard) Institution of Occupational Safety and Health qualifications (IOSH). The course content of IOSH includes the hierarchy of risk control and so OAL consider the maintenance of understanding this risk management process as an on-going process and continual professional development.

2.8 Authority on the Incident Ground

Interviews with some junior commanders confirmed they did not fully understand the line management structure when applying OD. Conversely OA Team members reported that firefighters have failed to comply with some safety instruction on the basis of applying OD, one example offered is a firefighter not wearing a seatbelt when travelling in a fire engine and stating they were not doing so under OD. This would clearly conflict with the ethos of OD.

OAL raise this point not as evidence of a general attitudinal failure, but rather as an example of the level of understanding of the line management structure when applying OD. National Operational Guidance sets a clear responsibility of the incident Commander in applying OD and states:

'The overarching principle should be that in the opinion of the Incident Manager the benefit of taking unusual, unorthodox or innovative action justifies the risk.'

Recommendation:

16. BFRS management should ensure the policy for OD clearly sets out the line management responsibilities when OD is declared at an operational incident.

2.9 Message Procedures

During interviews OAL sought to determine the understanding of standard messaging procedures when implementing and rescinding OD. It was evidenced that the understanding of message procedure for long standing and experienced officers is in accordance with expected standards. However, newly appointed commanders demonstrated a poorer understanding of the required message procedure and required prompting to build a message they could transmit to control when required.

Recommendation:

17. Provide an updated message procedure guidance to include the operational discretion message procedure.

3. The Refined Operational Assurance Model

Operational Assurance (OA) and Resilience in BFRS is largely dependent upon two key factors; the implementation of the revised BFRS Operational Assurance Model and the role of the BFRS OA Team (OAT).

The revised BFRS Assurance Model sets out the methodology by which the service will maintain OA and incorporates a wide array of inputs and outputs to achieve this.

OA Model - Background

In October 2016, Operational Assurance Limited undertook an independent review of Operational Assurance (OA) within BFRS. The review considered the application of a newly developed Assurance Model, and made some 30 recommendations for improvement, of which 26 were accepted by the BFRS management team. Of these 26 accepted recommendations, three themes were considered to be of particular priority:

1. That BFRS should continue to develop and resource effective internal processes through which, matters arising from significant external and internal events are captured, communicated and effectively managed through to a conclusion that is acceptable to the service. This should include (for example) processes for undertaking gap analysis, communicating findings to operational staff and informing any resultant training delivery.

2. That in support of recommendation no. 1 (above), BFRS should develop the use of an Active Monitoring System (AMS) to act as a comprehensive, service-wide tool. This system should incorporate a user-friendly database that is capable of providing auditable records and is easily accessible to all staff.

3. That BFRS should consider re-establishing an effective Operational Assurance forum, with the necessary direction and authority to assist in the formal management and progression of issues arising, through to meaningful resolution.

In November 2017, OAL were invited to revisit BFRS to provide an independent check on the Service's progress on implementation of those recommendations.

OAL's conclusions from this checkpoint audit were extremely positive, with BFRS being found to have made considerable progress against all the accepted recommendations and in particular, the three areas previously identified as being 'Priority'. However, whilst some recommendations were confirmed as having been completed, a number were found to be still in progress, primarily due to interdependencies with other competing work-streams, such as the introduction of an AMS and its attendant operational debriefing repository. Service managers were considered to be committed to ensuring that all work-streams still in progress would be pursued through to completion, in order to ensure that the considerable work undertaken to that point, would not be lost to competing priorities.

As an element of this November 2018 audit, OAL sought to establish how effectively the Operational Assurance Model is now functioning within BFRS. Specifically, OAL were tasked with establishing how well the model has become embedded within the Service and how successfully its principles are being applied.

3.1 BFRS Policy and Procedure

The 2016 review of Operational Assurance made a number of recommendations with regards to policy and guidance. These included:

'Recommendation 5.4.1 - It is recommended that the Operational Assurance model is clearly published and communicated, that roles and responsibilities are clearly identified and finally, that understanding is confirmed.

Recommendation 6.4.1 - BFRS should review its Procedure Note: 'Operational Assurance; Incident Monitoring and Improvement' at the earliest opportunity to ensure it aligns more closely with the service's new ways of working. Any revised guidance issued should clearly set out the Monitoring Officer role and re-establish the 'Thematic Reviews' process.'

Upon revisiting the Service in November 2017, OAL considered the provision of adequate OA policy and guidance to be 'In Progress' and offered the following observations:

'Whilst the revised version appears more holistic (and comprehensive), service managers confirmed the model will require explanatory documents to explain the specific roles and responsibilities to key stakeholders. Although there is clear sight and knowledge of the revised OA model at strategic level, this has yet to be shared with operational staff, or their understanding confirmed.

A Procedural Note to capture the revised model for delivering Operational Assurance in BFRS is currently under development. It is intended that once completed and communicated, this Procedural Note will address the above issues with the result that this recommendation will be fully addressed.'

As an element of this November 2018 audit, OAL reviewed the BFRS *'Service Document Procedure: Operational Assurance, Active Monitoring and Review Procedure'.* Primarily this document sets out the expectation for an Operational Assurance framework and details the role and terms of reference for the Operational Assurance Group (OAG) and the Operational Assurance team (OAT).

Findings:

The Service Document related to Operational Assurance was found to be still in its draft format.

It should be noted that this document was considered to be nearing completion in November 2017.

Upon close examination it was noted that aspects of the 'new' document were inaccurate, this included the following:

3.1.1 Development Plans

The Service Document Procedure states: *"the OAT will maintain an oversight of all development plans relating to BFRS operational personnel."*

It was established that the OAT only oversee development plans that come through the 'Maintenance of Competency' system (MoC) and therefore only relate to staff not being competent in training. For example, the OAT would be unsighted on any development plans issued in relation to breathing apparatus or validation assessments undertaken at the Fire Service Collage[3].

The current approach to managing development plans is considered to be fragmented and without central collation (a repository), or oversight. Instead development plans were found to be held in a variety of locations including on fire stations, held by OAT, held by Training Development, etc.

The current practice is considered to prevent sufficient information from being gathered in any one place, so as to allow for the identification of trends or themes to help inform future training development, training needs analysis and continuous service improvement.

3.1.2 OAT Terms of Reference

The terms of reference for the OAT offers a challenging array of expectations, given the current composition of the team. Therefore, BFRS will need to ensure that all team members, regardless of being temporary or substantive, possess the necessary competences to fulfil their role at operational incidents.

3.1.3 Reference to the Active Monitoring System (AMS)

The Service Document makes continual reference to an AMS that is unlikely to come into Service for the foreseeable future (see Section 3.7.1 below).

3.1.4 Other Items

The BFRS *'Service Document Procedure: Operational Assurance, Active Monitoring and Review Procedure'* also contained a number of inconsistencies, which although less significant in nature than those cover above, were still considered to distract from the accuracy and validity of the document. These included:

- Use of an OAT Response Car - OAL were informed that this support vehicle had not yet been provided.
- OAT utilising available Pool Cars - OAL were informed that this mobilisation option was currently 'on hold'.
- Upon arrival at an incident the OAT are to deposit their nominal role board or 'tally' at the Command Support point - The OAT have not been provided with tallies.

[3] Validation usually involves realistic scenarios and this is where the majority of development plans are issued. Development Plans issued in relation to validation should be considered to present a risk, as the situations involved are more likely to be repeated at operational incidents, if they are not effectively addressed.

Observations:

The service would benefit from the provision of a procedural document relating to Operational Assurance, Active Monitoring and Review that relates directly to actual/practical application. Until the existing document is amended and progressed through Governance, the only enacted policy applicable to the workings of the Operational Assurance function in BFRS dates back to the previous 'Performance and Evaluation team' circa 2005[4].

Recommendations:

18. The Service Document Procedure for 'Operational Assurance, Active Monitoring and Review Procedure' should be reviewed to ensure it contains only current and accurate information and the revised document communicated to all staff at the earliest opportunity.

19. BFRS should review its current procedures for managing development plans. Specifically, all related information should be collated in a central repository, such as the MoC database and the responsibility for maintaining and managing this work stream should be devolved to a single function, with consideration given to this being the Training Assurance department.

3.2 Structure of the Operational Assurance Team (OAT)

The Service Document Procedure defined the structure for the OAT as being comprised of one Station Commander, one Watch Commander and two Crew Commanders.

This document also establishes challenging 'terms of reference' for the OAT, which include the requirement to:

- ***Contribute to the tactical decision making process***, and,
- ***Perform a mentoring/support role as and when required***

Additionally, OAT members are expected to report against a wide range of incident types including hazardous materials, wild fires, large animal rescues, etc.

It was noted that some members of the current OAT were performing in a temporary role. This included a temporary Crew Manager who only recently left his watch as a firefighter.

Observations:

OAL consider the current structure of the OAT to be inconsistent with some expectations set out within the BFRS draft Service Document Procedure. It was established that some members of OAT have only limited experience in taking command and control of an operational incident and only limited training in performing the OA role.

Specifically, Appendix 'C' of the Service Document Procedure sets out the following Terms of Reference for the OAT incident monitoring role:

[4] It has been previously reported by OAL that this document is undeliverable due to significant changes in staffing levels due to restructuring post 2008, and considerable changes in working practices.

- Support the Incident Commander in implementing their plan safely, act as a 'critical friend', contribute to the tactical decision making process and perform a mentoring and/or support role 'as and when' required/appropriate.
- Take command of the incident if it is felt that the situation warrants it and the current IC does not appear to have full command and control.

While it is accepted that all Crew and Watch Commanders will attain the same Incident Command (Level 1) qualification, it could be considered challenging for a temporary OAT Crew Commander to effectively peer review the performance of an established Watch Commander, particularly should the OAT member have only limited practical experience in taking charge of such events themselves.

Examples evidenced in other Fire and Rescue Services have included utilising experienced Station Commanders to undertake this role, or to develop (and assess) monitoring officers to perform at one level above that which they are required to operate i.e. Level 2 Incident Command, thereby providing the necessary skillset to and credibility.

In BFRS the OAT members currently attend operational incidents on a fire engine and primarily act in an observational/monitoring capacity. Clearly the team would benefit from the use of a dedicated vehicle to provide flexibility in attending and leaving incidents. Furthermore, access to such a vehicle would provide increased benefit to the organisation through enabling OAT members to attend incidents outside normal working hours, something that currently does not happen.

Recommendations:

20. BFRS should consider providing OAT members with Level 2 training and assessment in Incident Command. Such training would:
    i. Improve the ability (and credibility) of team members to review and support the Incident Command function at operational incidents.
    ii. Assist the Service with providing more effective Command Support.

21. The OAT should be afforded access to a dedicated vehicle to provide flexibility in attending and leaving incidents and facilitate attending incidents outside normal working hours.

3.3 Embedding the OA Model

Managers confirmed that embedding the Operational Assurance Model within BFRS has been a challenge.

It is apparent that following the initial 2016 review of Operational Assurance in BFRS, there was a high level of activity that saw implementation of the new OAT and the establishment of the Operational Assurance Group (OAG) as an effective forum to manage and progress OA issues arising, through to meaningful resolution.

During the 2017 Checkpoint review, OAL were provided with strong evidence to demonstrate progress made during the preceding 12 month period. Of particular note was the work undertaken to ensure the organisation could effectively capture, analyse and embed the lessons learnt from significant external events.

This included an impressive presentation concerning the Balmoral bar incident. A piece of work that was considered ‘best practice’ and the service were advised that the work should be shared for the benefit of the wider Fire and Rescue Service. In addition to this, the operationally focused ‘Monthly Newsletter’ was found to be of a standard similar to periodicals available on the high street.

Findings:

Discussions held with a cross-section of staff involved in the OA process identified that the quality and detail applied to the early OAT publications was difficult to sustain, insomuch that team members found themselves spending disproportionate amounts of time producing 'glossy documents', as opposed to assuring operations. The situation is reported to have been compounded by a turnover of staff within the OAT, and the loss of some key individuals is said to have initially impacted upon team performance and the quality of its outputs.

It was established through audit that BFRS harnessed the above changes to refocus the efforts of the OAT, so as to strike a better balance between input (undertaking OA) and output (producing reports and newsletters). As an example of this, the new team has moved the newsletter and quiz publications from monthly, to a more achievable bi-monthly publication and having reviewed recent examples, OAL can confirm that the relevance and quality of the current publications remains high, with feedback from station level still very positive.

Although considerable work has been completed, OAL discovered that a number of key elements required to support the mainstreaming of 'Operational Assurance' have yet to reach completion. These include:

- The OA Service Document Procedure (see Section 3.2 above)
- The Progression of Presentations (see above)
- The provision of an effective AMS (see sect. 3.7.1 below)

Whilst visiting BFRS, OAL were unable to identify any member of operational staff who did not speak highly of the Balmoral Bar publication and the learning they derived from this. However, it was also evidenced that the outcomes, findings and recommendations from more recently produced reports was taking significant time to reach staff at the fire stations. This included:

a) OAL identified that a substantial amount of effort had been placed into producing a presentation that was intended to replicate the learning achieved from the Balmoral bar incident. This work related to a thatched roof fire that occurred in Wavendon during late 2017. However, OAL were unable to evidence anything to suggest this report/presentation had made it to full publication and certainly awareness of this incident and any resultant learning outcomes was extremely sparse at station level. Furthermore, given that the Wavendon incident is now over 12 months old, the potential impact of this work is likely to be diminished with each passing month.

b) In July 2018 the OAT undertook a Gap Analysis of recommendations made within the Kerslake Report. At the time of the review the findings from this work had not been effectively progressed to inform operational staff.

c) In April 2018 a significant incident occurred at a lower tier COMAH site near Aylesbury, from which a number of improvement opportunities were identified at the subsequent Learning Review of Command debrief (LRC).

   As an outcome of the LRC, OAT produced a report containing six recommendations for improvement, which was presented to the OAG on 27 September 2018. These recommendations related to:

   - Analytical Risk Assessment
   - Training with foam
   - Conducting Multi Agency Meetings
   - Sharing SSRI with neighbouring FRS
   - Welfare Packs
   - Improving information for crews re. Anaerobic Digestion (AD)

At the time of undertaking the November 2018 audit, OAL were unable to evidence any progress made in addressing these recommendations, or any knowledge of the incident or its associated issues, at station level. Furthermore, outcomes from the LRC do not appear to have been communicated to representatives from the site itself.

More significantly, and in direct relation to the topic areas covered during this November 2018 audit, OAL's review of the actions undertaken before, during and after the above incident clearly demonstrate that:

The process for gathering **Site Specific Risk Information** with regards to this incident were ineffective. For example:

- Fire crews had difficulty locating the incident
- There was confusion over the hazardous nature of the products involved
- Fire hydrants were not correctly identified on the risk plan
- There were no details for controlling the pollution of local water courses

There was a failure in the use of **Operational Discretion** at this incident, with the supporting 'incident log' confirming the use of operational discretion was not communicated to TVFCS.

OA Procedures failed to effectively capture and communicate these significant findings to OAG, or indeed to the wider operational staff. At the time of the audit, the issues that had been identified (and recommendations accepted by OAG), were not adequately reflected on the OAIP, or shown to have been progressed.

The horizon scanning aspects of the OA Model had failed to identify that the type of premises involved in the above incident (waste processing and recycling centres), represent a significant risk, insomuch that they are involved in approximately 300 serious fires per year in the UK. It was noted that the SSRA Plan for the above incident made no reference to controlling pollution. This should be an important initial intervention for the Fire and Rescue Service at all such incidents.

Recommendations:

22. Management should review the application of the OA Model. Specifically, consideration should be given to ensuring that learning outcomes are progressed towards operational staff in a timely manner, so as to maximise the relevance and impact.

3.4 OA Model - Inputs and Outputs

The application of OA in BFRS is based on a theoretical model that depicts an aspirational 'catch all' for its inputs. Although OAL were able to confirm the service has vastly improved its arrangements for ensuring such information is captured and progressed, the range of topics progressed via the OAG (the outputs) was found to differ significantly from those depicted.

The OAT were considered to be working well in capturing external information emanating from collaborative learning sites, such as National Operational Learning and Joint Operational Learning databases, etc. However, the ability of OAT to access potentially rich seams of information arising from internal sources could be further strengthened. This includes information from the incident report and feedback forms (17.2 & 17.3), information from the ARA process, and general feedback from operational crews.

Indeed, it was reported that the OAT are themselves responsible for the production of around seventy per cent of all completed 17.2 forms, despite there being an expectation for all operational officers to contribute towards this.

A number of operational fire crew reported that feedback on submissions previously contributed (including 17.2 forms, ARAs, etc.) was limited and OAL consider this a potential demotivating factor that may be contributing towards the low return rates currently experienced.

Given that members of OAT are station based for the majority of the working week, a clear opportunity exists to improve the flow of information and feedback loop that BFRS should look to exploit.

It is the opinion of OAL that establishing the OA Model within BFRS is a journey to which the organisation is fully committed and indeed a considerable amount of has already been achieved. However, there is still some work still to be done, before the model can be considered as being 'fully embedded'.

Recommendations:

23. It is recommended that BFRS review the processes for gathering information from internal sources, such as ARA data. This should include ensuring operational staff are in compliance with the BFRS incident reporting procedures, and providing adequate feedback to crews on the same.

3.5 Active Monitoring System (AMS)

The implementation of an affective AMS is a key element for supporting and embedding the Operational Assurance Model in BFRS and is cited in the draft Service Document Procedure as follows:

The AMS has been developed to assist the OAT in providing assurance that the operational front-line capabilities with BFRS are both effective and efficient. The OAT will continually review the AMS ensuring that identified areas of operational improvement are being managed appropriately.

At the time of the November 2017 audit the tranche of work to introduce the AMS was considered to be nearing completion.

Unfortunately however, the introduction of the AMS would appear to have stalled due to technical difficulties and therefore the AMS related activities set out within the draft Service Document Procedure cannot currently take effect.

This includes the requirement for incident monitoring and incident feedback forms (17.2 & 17.3), to be completed directly into the AMS and instead the OAT has reverted to utilising Excel Spread sheets. to gather and review such data.

The practice of employing Excel Spread sheets to gather and review such data provides poor information security and integrity is not considered conducive to effective audit and review.

Recommendation:

24. BFRS should revisit its options for providing an effective AMS in consideration to providing a workable, secure and user-friendly application at the earliest opportunity.

3.6 Training and Exercising

A challenging exercise programme has been developed to commence in January 2019, which places an expectation on each area of the Service undertaking four large-scale operational exercises, per annum.

Training exercises are also undertaken twice a year at the Fire Services College, with an aspiration for each to incorporate multi agency working.

It was identified that the OAT has some difficulty in completing all the required post-exercise activities, such as completing debriefs, especially where this involves On-Call staff. This process is further frustrated due to the lack of an effective AMS in which to upload and analyse the outcomes.

3.7 Optimising the OAT

Notwithstanding the comments offered above, it is the opinion of OAL that much could be done to ensure the Service achieves maximum impact from the resources it has allocated to the OAT.

In particular, it was noted that the Station Commander in charge of the OAT did not attend operational incidents specifically in an OA capacity, such as to:

- Offer credibility to the role
- Undertake Quality Assurance and ensure consistency of approach
- Support and mentor new/junior members of the OAT
- Provide 'on the job' training

Furthermore, when reviewing the working practices of the OAT it was established the team work from fire stations on four out of five days each week, (with the remaining day spent working from Service Headquarters (SHQ).

The OAT are given the freedom to choose where they will work, and also to determine which incidents they will respond to with the crews.

It was further identified that multiple OAT members often work from the same fire station location and that the same location could be repeatedly used, whilst other stations may not be visited.

OAL were unable to identify if any meaningful interaction took place between the OAT and the duty watch, other than when the OAT undertook their observational role at an incident. OAL were unable to determine how the team were supporting any work routine, structured delivery or rotational programme. This lack of clear guidance was considered to also extend to the team's operational roles and responsibilities.

Recommendations:

BFRS Management should consider reviewing the OAT work routine so as to ensure the team provides maximum benefit and optimal impact. In particular:

25. Consideration should be given to developing an OAT rota to formalise the current working practices and to ensure all fire stations are visited on a regularised basis.

26. Consideration should be given to formalising the interaction between OAT members and the duty watch so as to provide maximum benefit from the visit. This interaction may include:

i. Reviewing the previous evening work routines and discussing any incidents attended.

ii. Observing the station handover and routine tests.

iii. Leading discussions, providing further information/feedback regarding recent newsletters, quizzes, or other reports produced by OAT.

iv. Reviewing previous incidents and debriefs.

v. Reviewing new/trial equipment.

vi. Canvasing the watch for concerns or suggestions, and acting as a conduit between them and the appropriate departments at SHQ.

Table of Recommendations

Section 1. SSRI Policy	
1	For the purpose of clarity, BFRS management should consider separating the policy and user manual to enable the effective auditing of change management (version control).
2	Ensure all modern elements of building construction are included in the new system as an option for the end user. Such a system should also be sufficiently flexible as to allow the inclusion of new forms of building construction and materials as they become introduced to industry.
3	Ensure the end user has sufficient competence and privileges to allocate a risk score conducive to the reviewed property
4	BFRS Management should confirm that any new database system includes a requirement for the end user to record the rationale applied to any risk score.
5	BFRS Management should consider providing SSRA reference holders with suitable training in risk identification, risk management/scoring, etc. and all reference holders should be subject to an assessment of competence in the same. This confirmation of competence should be recorded against that persons training records.
6	The BFRS SSRA policy and procedure should be revised to ensure that, following any SSRA, significant findings should be communicated to relevant stations. In particular on call stations should be notified of SSRA activities and findings carried out on their behalf.
7	BFRS Management should consider utilising watch-based reference holders to assist in maintaining the SSRA database and related procedures and processes. These reference holders can provide a quality assurance role with associated consistency benefits. The rationale for this recommendation is that watch based reference holders will have ownership of specific risks with a consequent attainment of consistency in the management of the database.
8	BFRS Management should ensure any future electronic database incorporates a process to periodically review the existing risk information and where appropriate, to have this amended for correctness or removed from the database entirely.
9	The new database system should allow incremental updates as and when new risk information is added. BFRS Management should provide for an audit of the current SSRA database, so as to identify any redundant risk information that can be safely removed prior to transfer to the new database.

10	Where possible, any submission to TVFCS should be synchronised with the new database to ensure conflicts of risk information are minimised so far as is reasonably practicable.
11	BFRS management should consider if the requisite level of quality assurance processes are in place to ensure that the information being collated is Accurate, Relevant and Valid/Timely.
Section 2. Operational Discretion	
12	OAL recommend that the OD statement is reviewed for republishing so as to ensure it is readily accessible to all staff.
13	OAL recommend that the OD statement is included in the process of command competence acquisition and maintenance.
14	The OD training package should be reviewed to ensure it offers a broader application range and does not overly focus on one specific type of incident.
15	The OD training package should be placed as a priority across all operational staff to ensure they have an appreciation of OD and the responsibilities it holds.
16	BFRS management should ensure the policy for OD clearly sets out the line management responsibilities when OD is declared at an operational incident.
17	Provide an updated message procedure guidance to include the operational discretion message procedure.
Section 3. The Refined Operational Assurance Model	
18	BFRS should review the Service Document Procedure for 'Operational Assurance, Active Monitoring and Review Procedure' to ensure it contains only current and accurate information.
19	BFRS should review its procedures for managing development plans. Specifically, all related information should be collated in a central repository and managed by a single function.
20	BFRS should consider providing OAT members with Level 2 training and assessment in Incident Command.
21	The OAT should be afforded access to a dedicated vehicle to provide flexibility in attending/leaving incidents and responding outside normal working hours.
22	BFRS should review the application of the OA Model to ensure that learning outcomes are progressed towards operational staff in a timely manner.
23	BFRS should review the processes for gathering information from internal sources. This should include ensuring operational staff are in compliance with the BFRS incident reporting procedures, and providing feedback to crews on the same.
24	BFRS should revisit its options for providing a workable, secure and user-friendly AMS at the earliest opportunity.
25	Consideration should be given to developing an OAT rota to formalise current working practices and to ensure all fire stations are visited on regularised basis.
26	Consideration should be given to formalising the interaction between OAT members and the duty watch so as to provide maximum benefit from the visit.

Garry Jones – Team Leader

Garry retired from Greater Manchester Fire and Rescue Service in October 2014, having served 27 years at some of Greater Manchester's most operationally challenging inner city fire stations. For the last ten years of his career Garry served as a Group Commander, with responsibility for Performance Review and Operational Assurance. Since retirement from the FRS, Garry has specialised in audit, review of risk critical activities and risk management of Lower Tier COMAH sites.

Garry Geoghegan

Gary joined the London Fire Brigade in 1981. Gary served at some of the busiest stations as an operational firefighter and Watch Officer. Gary served at London Fire Service HQ and London Eastern Command and held responsibilities which included managing London's Arson Reduction Teams and Community Engagement Manager for London. Gary also worked directly for the Commissioner for London, performing the role of London's link Officer to the Office of the Deputy Prime Minister (ODPM) and Department for Communities and Local Government (DCLG). Gary has extensive experience in writing operational policy and standard operating procedures for Fire Services.

Kevin O'Connor

Kevin has wide ranging operational experience having served at some of Greater Manchester's most operationally challenging locations as a firefighter and Watch Officer. Kevin also spent 5 years at Fire Service Headquarters within the Operational Assurance Department. In his role as Head of the Greater Manchester Incident Command Academy, Kevin was instrumental in the development of command competence development and assessment. Kevin was the subject matter lead officer in enabling GMFRS to become an approved 'Skills for Justice' Centre for incident command, providing accreditation to the level of Strategic Manager. Additionally, he was GMFRS lead coordinator for the JESIP rollout in 2013.

Kevin was singularly responsible for assuring and maintaining the command competence of all GMFRS Officers up to the role of Assistant Principal Officer. Kevin retired from the service in July 2016.

Glossary

AM	Area Manager
ARA	Analytical Risk Assessment
BFRS	Buckinghamshire Fire & Rescue Service
CAD	Computer Aided Design
CC	Crew Commander
FDO	Flexible Duty Officer
IC	Incident Commander
ICU	Incident Command Unit
JESIP	Joint Emergency Service's Interoperability Principles
KLOE	Key Line of Enquiry
MDT	Mobile Data Terminal
NOGIC	National Operational Guidance Incident Command
OA	Operational Assurance
OAL	Operational Assurance Ltd.
OAG	Operational Assurance Group
OAT	Operational Assurance Team
OD	Operational Discretion
OIG	Organisational Improvement Group
SMT	Service Management Team
SSRA	Site Specific Risk Assessment
SSRI	Site Specific Risk Information
SFJ	Skills for Justice (an accrediting body)
SC	Station Commander
SOP	Standard Operating Policy
WM	Watch Commander