National Operational Guidance

Guidance

National Operational Learning: Good Practice Guide

Developed and maintained by the NFCC

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Introduction

Welcome to this revised National Operational Learning Good Practice Guide, designed to assist with capturing and sharing learning from operational activities.

As an integral assurance loop of National Operational Guidance, National Operational Learning facilitates continuous improvement in the fire and rescue service sector. It provides the methodology to:

- Identify new or emerging risks
- Monitor trends in the sector
- Recommend remedial actions
- Promote good practice
- Share learning across all UK fire and rescue services

This guide presents good practice methods for capturing, categorising, evaluating and allocating operational learning across all operational activities within individual fire and rescue services. It also provides a route by which learning can be shared with other fire and rescue services, and the wider fire and rescue service sector.

The National Operational Learning Secretariat has developed this guide, bringing together information from across the fire and rescue service sector and from other high-hazard industries. It has been subject to wide consultation and engagement. The first edition of the good practice guide was endorsed by:

- The Health and Safety Executive
- The Local Government Association
- The National Fire Chiefs Council
- The Home Office

The National Operational Learning Secretariat recognises that the good practice described in this guide is not exhaustive and welcomes feedback or new ideas on emerging good practices.

Please note that throughout this guide the term 'incidents' can be applied to training for, preparing for and responding to operational incidents, including all fire control room activity that supports this.

Principles of learning from incidents

Ensuring that lessons are learned from previous incidents, so that occurrences can be prevented in the future, is central to the health, safety and welfare of people working for the UK fire and rescue service.

The service can continue to improve its operational performance and improve safety if learning from incidents is continual, and the lessons are shared effectively and widely. This is particularly important in an environment where a decline in the number of operational incidents could lead to a decline in operational experience.

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.

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.

Fire and rescue services can use this good practice guide as a benchmark against which to measure their existing systems and arrangements.

More information on operational learning is available in the Corporate guidance for operational activity

The importance of learning

Fire and rescue service operations can be hazardous. If hazards are managed and controlled, the risks to personnel, public and the environment can be minimised. It is not possible to eliminate all risk, but it must be reduced to as low a level as is reasonably practicable. How 'practicable' is defined is subjective and should be based on a risk–benefit analysis for each situation.

To help reduce risk, knowledge learned from incidents should be shared with all fire and rescue

services and the wider sector, where appropriate. A continual and shared learning process will help fire and rescue services to resolve incidents, cope with future changes in the operational environment, develop, innovate and improve the safety of all personnel and, therefore, provide the best service to the public.

The National Operational Guidance for Corporate guidance for operational activity highlights the issues that chief fire officers or chief executives should consider when planning their health and safety duties and responsibilities.

An active learning culture will generate the raw material for learning from incidents. Taking action that leads to effective change encourages additional reporting. However, if action is not taken and change is ineffective, and in the worst case individuals are blamed, reporting is likely to decline and formal learning from incidents will be challenging.

The National Fire Chiefs Council Leadership Framework supports the development of learning cultures within fire and rescue services and sets out the behaviours expected from leaders in such environments.

The delivery of National Operational Learning activity is supported the standard. Governance and corporate ownership

Learning should be an integral component of management structures and processes. For an organisation to become a learning organisation, senior leadership teams should encourage and participate in learning, seek to understand the process in which true learning is achieved and actively promote it.

Chief fire officers should nominate an Operational Learning Strategic Lead.

The Operational Learning Strategic Lead

The Operational Learning Strategic Lead should have appropriate seniority and influence to lead an Evaluation Board and nominate a Single Point of Contact (SPoC).

The roles and responsibilities of the Operational Learning Strategic Lead are detailed in Appendix A.

The Single Point of Contact

The Single Point of Contact (SPoC) should have access to the appropriate seniority and influence to deliver the learning activities identified in this guide and manage the subsequent learning outcomes that arises from them, as well as outcomes received from and submitted to the wider sector.

The roles and responsibilities of the SPoC are detailed in Appendix A.

Defining operational learning

Operational learning is the responsibility of the Operational Learning Strategic Lead and the SPoC, who should use the learning activities identified in this guide to capture, categorise, evaluate, allocate and share outcomes arising before, during and after any incident in local, regional and national processes.

Learning activities

Fire and rescue services should provide robust processes to initially identify operational learning outcomes, or ensure outcomes from previous operational learning activities and the changes arising from them have been successfully implemented. This can be primarily delivered by carrying out the learning activities as set out below.

Incident assurance

Incident assurance should be a consideration for all incidents and be scaled to the nature of the incident. It can include:

- Observations and reflection from incident commanders
- Peer review of personnel involved
- Mobilisation of an officer to the incident to carry out a dedicated assurance role

The information gathered can contribute to on-scene or structured debriefs.

Refer to Appendix B for a set of good practice points when carrying out an incident assurance.

On-scene debriefing

Debriefing personnel at the scene or in the control room, when their operational involvement finishes, is recognised as good practice. It offers the opportunity of recording key outcomes, observations and issues, and is normally conducted by an officer in attendance. Some of this learning may be about the activities of teams and individuals, with the potential to contribute to one or more identified operational learning activities.

On-scene debriefing also allows for personnel to begin to rationalise the incident they have been involved in, and carrying out an on-scene debrief should be an integral part of starting the welfare process.

Refer to Appendix C for a set of good practice considerations for carrying out an On-scene debrief.

Post-incident reporting and feedback

Providing a process for personnel to submit their own observations and thoughts following an incident, or more general observations that may not be related to a specific incident is recognised as good practice.

Post-incident reporting and feedback submissions may typically be sought following changes identified from previous outcomes from operational learning activities, or where appropriate the learning outcomes from Post-incident reporting and feedback often will form discussion points in structured debriefing.

Structured debriefing

A structured debrief process allows key personnel to reflect on their involvement with an incident, from the initial contact with the fire control room through to post-incident actions.

The process allows individuals and teams to systematically analyse and evaluate the decisions taken and tactics used, with their colleagues and managers. It is a means to identify and discuss the hazards and risks that were present at the incident, evaluate the control measures used to manage them.

Refer to Appendix D for the principles of structured debriefing.

Triggers

Each fire and rescue service should establish when they will instigate their operational learning activities. This will rely on a number of factors within each individual fire and rescue service, and will be based on experiences and outcomes for communities' fire and rescue services serve, and not based soley on the level of response or resources sent to any incident.

Pre-determined triggers to initiate operational learning activities include:

- A fire-related fatality
- A declaration of operational discretion
- A recall to an incident
- A critical incident or incident of interest, for example a fatality following a rescue from water or unstable surface or following a technical rescue
- An incident identified as requiring further investigation or sampling by an individual fire and rescue service, or at the discretion of the incident commander, Operational Learning Strategic Lead or SPoC
- Where an incident falls into one of the nationally reportable incident categories, for example those detailed in The National Coordination and Advisory Framework (NCAF) England and the Fire & Rescue Service Supporting Guidance to NCAF
- When needing to understand the success or failure of:
    - Changes implemented following previous lessons learned
    - Adoption of new policies, procedures, tailored guidance or equipment
- Following:
    - Formal complaints
    - Accident and investigation outcomes
    - Outcomes from horizon scanning activities, including NOL and JOL action and information notes.
- Identification of specific premises types, risk types or locations of interest

Information sources

When identifying outcomes from operational learning activities, a range of information sources may support operational learning activities. They can also be used to determine whether previous learning outcomes have been successfully embedded.

The sources of information will include:

- Data for the recording of incidents
- Corporate reviews
- Performance audits
- Periodic reviews of policies, procedures or tailored guidance
- Complaints or compliments from members of the public
- Station or fire control room inspections and audits
- Call and radio communication recordings
- Video recordings, for example from CCTV or drones
- E-learning

- Incident monitoring
- NOL, JOL and other nationally published learning
- Fire investigation reports
- Fire Safety and Community Engagement interactions
- Health and safety investigations, accidents and near misses
- Analytical risk assessments (ARA), incident handover and other incident-related documentation
- Reports to prevent future deaths
- Horizon scanning activities

Capturing and categorising operational learning

Capturing operational learning

The SPoC should apply a method of capturing outcomes from all operational learning activities, this should include:

- Record of the date, activity and origin of the learning
- Categorisation
- Risk rating
- Allocated owner
- Evidence and rationale of changes made
- Completion and closed dates

A fire and rescue service may choose to make this method available to all staff, improving the transparent nature of learning submissions, and encouraging subsequent learning being identified and submitted.

Categorising operational learning

Using a consistent approach and terminology when collecting and categorising information relating to operational learning will improve the outcomes of trend analysis.

The Health and Safety Executive has analysed major incidents in high-hazard industries, with different technical causes and work contexts as part of their learning lessons process. This identified several common factors involved when things go wrong, which could be used for categorisation purposes.

These factors are related to:

- Leadership
- Attitudes and behaviours
- Risk management and oversight

To consider and address future potential fire and rescue service operational delivery and activities, information should also be gathered about activities where information and guidance does not currently exist in the National Operational Guidance framework.

An examples of this is the co-responder schemes that some fire and rescue services participate in. Gathering information about such activities may help to support the future development of guidance if it becomes a mainstream function of fire and rescue services.

Evaluating and allocating operational learning

Evaluation board

The Operational Learning Strategic Lead should lead a board of appropriate people, including the SPoC along with representation from personnel who have sufficient knowledge, skills and competence to analyse the outcomes from operational learning activities received, determining where and how it may affect their fire and rescue service and how it might affect other UK fire and rescue services.

This board may already exist or will already be a part of the functions of other Fire and Rescue Services management activities or processes.

In completing their evaluation, the evaluation board should consider the potential for:

- Serious, or multiple minor, injuries
- Immediate or long-term ill-health.
- Significant operational improvements, including in firefighter health and safety
- Impact on the service to the public
- Enforcement action, for example, by the Health and Safety Executive or the appropriate environmental agency
- Significant financial or reputational loss

Rating the risk

When deciding on the need to share information about the outcomes from operational learning activities, National Operational Learning use a methodology based on blue, red, amber and green (BRAG) ratings.

Using this methodology will allow the Evaluation Board to consistently identify the timeliness and pace of any resulting actions from learning activities. It will also determine if these should remain within their fire and rescue service, be shared regionally or be shared nationally.

Refer to Appendix E for further details on this methodology

Allocating

The Evaluation Board should allocate the outcomes from operational learning activities, and identify the appropriate departments, teams or individuals who will be assigned to address them.

The Evaluation Board should also ensure that changes resulting from previous operational learning activity outcomes have been implemented. The board should commission the review of the success of, and adherence to, changes at an appropriate frequency.

These reviews should take into account:

- Whether sufficient time has been allowed for personnel to reflect on the changes
- To what level the changes have been adopted
- Whether the changes have been appropriately embedded into working practices

Sharing operational learning

Sharing of operational learning internally

Following the evaluation and allocation of outcomes from operational learning activities, the SPoC should be supported and have access to colleagues and teams of the appropriate influence and seniority to ensure that actions to support learning are progressing and being implemented as the evaluation board suggested; these may include those responsible for:

- Operational policy and procedures; such as the strategic gap analysis
- Fire control policy and procedures
- Operational vehicles and equipment
- Training
- Health and safety

Sharing of operational learning externally

Following an Evaluation Board decision that learning is to be shared more widely, the SPoC will be responsible for ensuring that this is carried out via regional groups, National Operational Learning or Joint Organisational Learning.

Regional operational learning

The SPoC should participate in regional operational learning groups, which can identify lower-impact high-frequency trends when reviewing outcomes from induvial services Operational Learning activities. These may have been initially risk rated as blue or green, but when themes or trends are identified may be risk rated higher and shared externally through the NOL or JOL processes.

Regional operational learning groups also provide the opportunities to work collaboratively to implement changes arising from outcomes of operational learning activities.

National Operational Learning

The online National Operational Learning (NOL) tool creates a central repository to improve the exchange of good practice and lessons learned across fire and rescue services. The information generated from services SPoC is collated by the National Operational Learning Secretariat to:

- Enable the dynamic review of National Operational Guidance to ensure it always reflects current good practice
- Identify emerging issues and take any necessary action, including warning and informing other fire and rescue services
- Share learning across the fire and rescue service
- Influence fire and rescue service decisions about development and training

Joint Organisational Learning

The JESIP Joint Organisational Learning (JOL) process exists to encourage closer interoperability between responder organisations. It is good practice for any identified multi-agency learning to be submitted by the SPoC via the Joint Organisational Learning portal.

Appendix A: Responsibilities and requirements of the Operational Learning Strategic Lead and Single Point of Contact

Operational Learning Strategic Lead

Responsibilities and requirements:

- Either be a member of the senior management board or have regular access to it and be able to influence its decision-making
- Lead the Evaluation Board with the sufficient knowledge, skills and competence to evaluate and risk rate the outcomes from operational learning activities delivered by the SPoC
- Lead the Evaluation Board to allocate outcomes from operational learning activities, identifying the appropriate departments, teams or individuals to address them
- Lead the Evaluation Board to, risk assess internal information to decide on any escalation of the issue to the National Operational Learning (NOL) and JESIP Joint Organisational Learning (JOL) processes
- Ensure that any changes resulting from outcomes from operational learning activities are implemented within their fire and rescue service
- Ensure that a review of these changes takes place at an appropriate interval or frequency to ensure that changes are embedded in the fire and rescue service's policies, procedures and tailored guidance

Single Point of Contact

Responsibilities and requirements:

- Delivery of the operational learning activities outlined in this guide.
- Manage the capture, categorisation, evaluation and allocation of outcomes from operational learning activities.
- Have the sufficient resources, skills, knowledge and experience to analyse the information

received and make decisions and suggestions to the Operational Learning Strategic Lead and the Evaluation board.
- Ability to risk assess internal information to suggest the escalation of the issue to the National Operational Learning (NOL) and Joint Operational Learning (JOL) processes.
- Ensure the information provided to the National Operational Learning (NOL) and Joint Operational Learning (JOL) processes is delivered promptly and to a high and accurate standard.
- Manage the receipt of information into the service from the wider sector and arrange appropriate actions to be taken within their service using identified structures and processes.
- Refer resource implications or issues to the appropriate senior management team as necessary.
- Participate in regional operational learning forums and working groups
- Participate in SPoC CPD events hosted by National Operational Learning

Appendix B: Incident assurance

The areas where further assurance is identified as being required, and who will carry this out, will be specific to each fire and rescue service, and commissioned on a case-by-case basis. Considerations for areas on which to base any investigation, reality testing, sampling or observations can include:

Incident command

- Was overall command and control effective
- Were sufficient resources mobilised
- Were resources used to their best advantage
- Was a tactical adviser contacted or mobilised
- Was a National Inter-Agency Liaison Officer (NILO) contacted or mobilised
- Were specialist teams requested, and if so were they mobilised
- Were external specialists contacted for advice or assistance, and if not, should they have been
- Was BA rapid deployment used
- Was operational discretion applied, and if so, was it justifiable and appropriate

Risk information

- Did the site have risk information available, and if not, should it have been
- If the site did have risk information, was it suitable, sufficient and accurate
- Was the risk information used during the incident

Operational practices and procedures

- Did operational tactics match existing fire and rescue service policies, procedures, tailored guidance and training
- Were all hazards and risks at the incident identified and assessed
- Were available control measures used effectively, and did they manage the hazard safely

Equipment

- Consider whether and how equipment was used
- Was it adequate for the task
- Did any equipment fail in use
- What alternative or additional equipment might have been appropriate

Communications

- How effective was incident ground communication
- Were messages to and from the fire control room timely and effective
- Were messages between the fire control room and other control rooms timely and effective
- Was other Information used effectively for example information available on mobile data terminals

Stakeholder communications

- Were media briefings well organised and regular
- Were arrangements put in place and maintained to warn, inform and advise the public
- Were there adequate and accurate press office liaison activities

Community liaison

- Were the responsible person, owners, occupiers and neighbours kept informed
- Were post-incident welfare considerations appropriate and timely

Inter-agency liaison

- Were the JESIP principles applied and were they effective from the response phase through to the recovery phase
- Was liaison with partner organisations effective

Health and safety

- Was there the potential for any impacts on the health and safety of personnel involved in the incident
- Were there any impacts on the health and safety of personnel involved in the incident

- Are there ongoing or long-term impacts on the health and safety of personnel involved in the incident

Welfare

- Has the welfare of fire and rescue personnel been effectively managed
- Are there ongoing or long-term welfare issues still being managed

Appendix C: On-scene debrief

An on-scene debrief should be conducted, as soon as is reasonably practicable, after the conclusion of all incidents, preferably on scene and involving all personnel. Other Category 1 or Category 2 responders, for example police or ambulance, or any other responding organisation, can also participate in the debrief and share their perspective on the resolution of the incident.

An on-scene debrief should be considered normal for all incidents, irrespective of whether a further or higher-level debrief is expected to take place.

The incident commander should make notes of discussion points for future reference, which can inform a structured debrief if required. These points will help individuals to reflect on what happened during the incident, particularly in the areas of:

- Individual performance
- Task performance
- Team performance
- Tactics employed and their effectiveness in dealing with the incident
- Hazard and risk identification, and evaluation of the control measures applied
- Organisational learning, in relation to the:
    - Adherence to or application of procedures
    - Performance or deployment of equipment

When resources permit, control room personnel should conduct an incident debrief. If the actions of other agency control rooms affected the course of the incident, they should also be included in the debrief.

A structured debrief should be conducted if any aspect of an event is considered to have had an impact on the health, safety and welfare of the people involved.

Appendix D: Structured debriefing

Structured debriefs can inform the monitoring, audit and review process of the service to:

Identify and confirm good practice

Promote continued learning and assist in developing the experience of individuals and teams

Identify individual and team training and development needs

Assess competence through workplace assessment and a means of quality assurance

Confirm if current policies and procedures are effective and fit for purpose

Identify operational learning

Principles of structured debriefing

The structured debriefing process allows individuals and teams to systematically analyse and evaluate the operational tactics they employed during specific activities with other personnel. The process should help to identify, and support discussion about, the hazards and risks present at the incident, and evaluate the effectiveness of the control measures used to manage them.

Structured debriefs should be conducted in an open and constructive manner to assess standards against a number of predetermined areas.

Adequate time and preparation should be allocated to the process; it may not be possible to conduct it immediately after the incident. However, a structured debrief should be conducted as soon as is reasonably practicable afterwards, and ideally within four weeks.

In some circumstances it may be advisable for the structured debrief to be facilitated by an individual who was not part of the incident.

Participating in the structured debrief process should be considered as command activity, and added to the command continuous professional development hours of that individual. For further details please refer to Complementing incident command experience: A guide for fire and rescue.

Structured debrief attendees

By the very nature of fire and rescue service operations, there should be flexibility about who needs to attend a structured debrief. Some incidents may warrant only the incident command team being present, while others may need to involve those who have had a historical interaction with a site, premises or person.

Those who should be considered for attending a structured debrief include:

- All officers with a significant command role at the event
- Operational personnel who attended the incident
- Fire control personnel
- Fire safety officers
- Incident ground assurance officers
- Community safety officers
- Fire investigation officers
- External investigation teams, such as:
  - Air Accidents Investigation Branch
  - Rail Accident Investigation Branch
  - Marine Accident Investigation Branch
- Training team representatives
- Health and safety advisers
- Resilience or emergency planning officers
- Neighbouring fire and rescue services for cross border incidents or exercises
- Other emergency services
- Environmental agencies
- Local authorities
- Highways agencies
- National Inter-Agency Liaison Officers (NILOs)
- National Resilience Assurance Team (NRAT)

A**reas for consideration during a structured debrief**

In addition to the areas identified for incident assurance shown at Appendix C, a structured debrief should also consider:

Sequence of events

A timeline of the incident, pieced together using all available information, including a comprehensive record of command decisions and operational practices captured at the scene; for more detail refer to National Operational Guidance: Incident command

History

- Previous connected activity for:
  - Operations
  - Community safety
  - Fire protection
- Previous safeguarding referrals

The fire control room

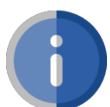
- Review of the initial call
- How did fire control personnel assess the severity of the incident
- Did fire control personnel gather as much information as possible during the call
- Review of initial resourcing decisions
- Review of prompts and information sharing
- Whether it was a critical incident

On-scene debrief

- Did an on-scene debrief take place
- Was any feedback from an on-scene debrief supplied

Post-incident

- Was all incident information completed and returned
- Fire investigation if applicable
- Post-incident fire protection actions if applicable
- Post-incident community safety intervention if applicable
- Post-incident community intervention by partner agencies if applicable
- Was any external feedback received
- Have any freedom of information requests been received



Appendix E: Blue, Red, Amber, Green (BRAG) rating of learning

When deciding whether to report information on lessons identified, good practice or organisational learning via the National Operational Learning process, fire and rescue services can apply the following methodology that uses triggers to provide a blue, red, amber or green rating.

When reporting incidents to the National Operational Learning process, the severity and potential impact on personnel, environment, finances and organisational reputation of the event will identify the process or trigger to follow. This will determine whether the incident is reported as red, amber or green and, in turn, the urgency with which the fire sector shares any resultant information or implements any changes.

An additional rating of **blue** is applied if the operational learning and resultant actions are minor, very limited and only affect the fire and rescue service involved. This allows fire and rescue services to identify which issues, lessons or notable practices should be elevated to National Operational Learning or resolved within the local fire and rescue service operational learning.

Contributing fire and rescue services should share details about red or amber rated events immediately via the National Operational Learning process, before implementing any changes within their service.

Blue: Events that do not need to be reported outside of the local fire and rescue service
Only cause change, reinforcement or action within the reporting fire and rescue service and are routine or very minor in nature
Do not have the potential to cause personal injury
Do not have the potential to harm the environment
Green: Events that are primarily limited to the reporting fire and rescue service
May cause change or action within an organisation; for example, a single occurrence in one service that may be replicated in other services
May be of limited interest to other fire and rescue services
May have the potential to harm the environment
Amber: Events that may be of interest to other fire and rescue services
Can cause change or action within an organisation to policies, procedures or tailored guidance
Where it is necessary to include additional information, instructions or amendments to training requirements or delivery
Require modifications to equipment or its usage
Red: Events that are of national interest to other fire and rescue services
Can require change or action within an organisation, including intervention to cease activity
High risk to personnel or public health and safety
Potential enforcement or legal action, including in relation to environmental harm
Required the application of operational discretion
Any other special case or significant event