



# National Operational Learning

**National Operational Learning:**

**Good practice guide for fire and rescue services**

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## Introduction

National Operational Learning is an integral part of National Operational Guidance, which exists to facilitate continuous improvement in the sector. It provides a vehicle to identify new or emerging risks, monitor trends within the sector, recommends remedial actions, promotes best practice and shares learning across all UK fire and rescue services.

This user guide focuses on presenting good practice methods for gathering and assessing learning from operational activity within individual fire and rescue services. It also provides a route by which that learning can be shared with other fire and rescue services and the wider fire community.

**Incidents; should be taken to mean both preparing for and resolving operational incidents.**

The guide has been developed by the National Operational Learning secretariat and has brought together information from across the fire sector and from other high hazard industries. It has been subject to wide consultation and engagement and has been endorsed by:

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

It represents current 'good practice' within the UK's fire and rescue services. It is not however exhaustive, the Secretariat welcomes feedback and new ideas, on emerging best practices.

The guide builds on the framework set out in the Department for Communities and Local Government document: [Fire and Rescue Authorities – Health, safety and welfare for the operational environment](#).

Principles For Learning Lessons From Incidents - Ensuring that lessons are learned from previous incidents so that identical or similar accidents arising from work activities can be prevented in the future is central to the Health and Safety and welfare of the UK fire and rescue service.

If learning from incidents can be carried out consistently and the lessons acted on effectively and shared more widely, the service can continue to improve its operational performance and safety. This is particularly important in an environment where falling incidents mean a reduction in operational exposure for operational staff.

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 could be done in future, learning has only truly been achieved when some form of change is actually implemented that ensures actions will be different in future.

It will also involve people having the opportunity to reflect and make sense of the learning information and take action to reduce risk. It involves the organisation embedding changes so that even if people leave, measures to prevent incident re-occurrence stay in place.

Fire and rescue services will be able to use the guide as a benchmark in the form of good practice against which they can measure their existing systems and arrangements.

## **The importance of learning**

Fire and rescue service operations can be hazardous. If hazards are managed and controlled, the risks to firefighters and the public can be minimised. It is not possible to eliminate all risk, but it can (and must, legally) be reduced to a level that is as low as reasonably practicable. What defines what is practicable is subjective and should be based on a risk versus benefit analysis for each given situation.

Knowledge learned from these situations and other operational activity should be shared with all fire and rescue services, and the wider sector where appropriate, to help reduce risk. This consistent and shareable learning process will enable fire and rescue services to improve performance at incidents, cope with future changes in the operational environment, develop and innovate to provide the best service to the public and improve the safety of firefighters.

The document published by the Department for Communities and Local Government Fire and Rescue Authorities – Health, safety and welfare for the operational environment gives a practical guide to the issues that chief fire officers or chief executives should consider in planning the delivery of their health and safety duties and responsibilities.

These responsibilities are further reflected in legislation and industry standards and are set out in the following:

- Health, Safety and Welfare etc. Act 1974
- Management of Health and Safety Regulations 1999
- National Framework document – Operational Assurance
- National Operational Guidance – Operations
- National Occupational Standards – Role maps, debriefs
- Skills for Justice Command Competence standards
- National Operational Guidance – Operational Discretion process and protocol

Developing a culture where lessons are learned from operational activity and those lessons are shared with others to the widest extent will help to shape normal practice across the sector.

An active culture will generate the raw material for learning from incidents. If actions leading to effective change are taken, that will encourage additional reporting. If change is not effective and, in the worst case, individuals simply blamed, any reporting that has been happening is likely to decline and formal learning from incidents will cease.

## **Governance and corporate ownership**

Fire and rescue authorities have a statutory duty to deliver a fire and rescue service to the public. Learning should be fully embedded in its management structures and processes, Chief fire officers should nominate an individual to take responsibility and be the subject of appropriate scrutiny to ensure they are operating as intended. They should also determine the appropriate level of support and that individual's specific responsibilities.

The nominated person should have appropriate seniority and influence to ensure that actions to support learning can be implemented. The nominated person should either be a member of the

senior management board or have regular access to it and be able to influence its decision making. They should emphasise, that only through open and honest reporting of incidents can real learning be achieved. (See Appendix A for suggested responsibilities).

### **Single Point of Contact**

The nominated individual should take the role of a Single Point of Contact (SPoC) inside the service. They should manage information received from the wider sector and determine what further action should be taken. They should also determine the information that their service shares with the wider sector. The escalation of issues, learning or good practice into the National Operational Learning (NOL) process, described later in this document, should also be responsibility of the SPoC.

The SPoC's decision making should be supported by a board with members representing parts of the organisation that may be most affected, for example:

- Operational policy and procedures
- Fire Control policy and procedures
- Training
- Health and safety
- Equipment (procurement)

Other areas of the organisation should be involved in the operational learning process if it affects their service delivery or safety.

### **Change team**

The SPoC should lead a team of appropriate people as an integrated part of the decision-making process. This team may already exist or will be a part of the functions of other operational management activities or processes. This 'change team' should allocate and prioritise the tasks, actions and work from learning events and identify the appropriate departments, teams or individuals to address them. Matters affecting resources, risk management plans or the way an individual service manages its service delivery should be referred to the appropriate senior management team as necessary.

The change team should also ensure that any changes resulting from the lessons learned or good practice are implemented and that the changes are reviewed at an appropriate frequency. This will be informed by personnel carrying out operational assurance and audit roles within the service and could come from the following areas:

- Operational assurance
- Operational risk management
- Risk management
- Fire Control management

See Appendix B for further information on how to obtain and provide assurance that changes have been implemented successfully.

The change team should have appropriate processes that enable them to gather information, data and intelligence about operational performance. Any system used should be suitable for collecting

the quantity and range of information that an individual service considers necessary to meet its statutory responsibilities and identify notable practice and lessons learned.

The individual or team responsible for these systems and subsequent reporting should have sufficient skills, knowledge and experience to analyse the information received, determine where and how it may affect their fire and rescue service and how it might have implications for other UK fire and rescue services.

### **Arrangements for consulting with employees**

Fire and rescue services should use existing joint safety committees established under The Safety Representatives and Safety Committees Regulations 1977. This will help to promote a positive health and safety culture, assist in internal policy development and enable consultation with safety representatives and staff.

### **Capturing learning at incidents**

From the initial call to Control and while incidents are in progress, steps should be taken to ensure information can be captured to inform learning. Learning can be captured from:

- **Initial Information gathering and mobilisation**  
Undertaken by the Control room to ensure all relevant information relating to the incident is captured and risk critical information is shared with the initial Incident Commander and all subsequent updates and provided. Control rooms are able to provide details of attendances, initial actions and are a source of information as to how the incident commenced and was subsequently resourced.
- **Incident monitoring**  
Carried out at the scene or remotely by peer officers or specialists and providing immediate feedback to help incident commanders deliver effective and consistent operational performance. They act as an adviser to officers who are in command as well as gathering information about the tactics being deployed at the incident for use in later learning. It is recommended that all services provide officers responsible for incident monitoring at incidents.
- **Operational assurance**  
These officers are usually separate from normal command duties and carry out assurance of specific themed activities, processes and policy adherence. They gather information about operational performance, but the assurance process should not be limited to operational incidents; useful learning can also be gathered from exercises and training. They input data and information gathered from the incident, exercise or training into the internal operational learning process. In the absence of specialist officers, other peer officers may be trained to gather and capture this information.
- **Recording**  
Fire and rescue services should have procedures to ensure a comprehensive record of command decisions and operational practices is captured at the scene (See National Operational Guidance: Incident command\_for more detail).

These records will help identify effective and less effective processes and practices, provide information for debriefing processes and provide evidence of performance for later evaluation.

**Everyone has a role in identifying and reporting learning that could improve public and firefighter safety.** All staff should consider matters where there may be an impact on firefighter safety or where there is potential for operational improvement and report them to the relevant SPoC and their team. Managers should also ensure an open and active reporting culture so that the mechanisms described in this guidance are used to their full potential.

See supporting appendices for further information

## Post-incident learning

Fire and rescue services should have sufficient personnel with the skills and expertise to carry out debriefing post-incident or exercise. This will ensure that relevant lessons and opportunities for learning can be identified as well as identifying good practice.

After an incident has ended, the following approaches can be taken:

- **Hot debriefing**  
Debriefing staff at the scene when their operational involvement finishes and recording the key outcomes and issues. Some form of hot debriefing should take place after any incident where learning can be identified and is usually be conducted by officers in attendance at the incident. Some of this learning might be about teams and individuals and may not have organisational implications. See Appendix D for a set of good practice points when carrying out a hot debrief.
- **Post-incident reporting**  
Many services have IT systems that allow staff attending an incident or training event to provide feedback on the individual activities they carried out and comment on the effectiveness of the operation from their perspective. This information is often used to form the agenda for more structured group debriefing.
- **Structured debriefing**  
There should be a formal process for debriefing key staff who took part in an incident. These debriefs take place around specific incident or event types, or when the fire and rescue service identify the need for a debrief to take place. The lead officer for learning within the service should determine how the structured debrief should take place. See Appendix E for a set of good practice points to conduct structured debriefing.
- **Incident command reviews**  
One particularly helpful form of post-incident debriefing is to review the command of an incident through its various stages. This brings all of the officers who had a significant command role together to walk through the decisions taken throughout the incident. See Appendix F for a set of good practice points to conduct incident command reviews.
- **Operational discretion**  
At incidents or exercises where operational discretion is used to safely, efficiently and effectively resolve an operational incident, the reason and rationale behind its application and the resultant operational decision should be recorded to inform potential internal policy

review and National Operational Guidance development. This can be captured at either a hot or formal debrief and then shared as operational learning with the Secretariat through the National Operational Learning process.

- **Exercises and training**

The debriefing and review processes outlined above should be used in training exercises and learning events so that their use becomes common practice.

- **Accidents and near misses**

Debriefing should always be carried out following accidents and near misses as valuable lessons can be learned.

Learning is not only derived from operational incidents. There will also be other sources of information, including:

- Corporate reviews
- Workplace audits
- Performance audits
- Fire investigation reports
- Periodic policy or procedure reviews
- Health and safety
- Accident reports
- Near miss reports

When investigating accidents and near miss reports it is important that a timeline is created to identify the chain of events and determine the exact circumstances attributing to the safety event occurring and the potential operational learning identified.

- Health monitoring
- Workplace inspections
- Audits
- Risk assessment, including analytic and dynamic risk assessments
- Training
  - Individual training records and personal development plans
  - Exercise or simulation feedback
- Equipment or procurement
- Equipment testing record
  - Defect reports
  - Supplier documents and reports
- Customer complaints or compliments
- Post incident performance reports

## **Evaluating learning**

The SPoC should consider the size and scope of the issues reported and make recommendations for local action.

In completing their evaluation, they 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

The decision making that results from considering the issues is frequently carried out through a multidisciplinary working group or board. Many fire and rescue services already have these systems and organisational arrangements in place; the key features of the process are:

- Collation
- Categorisation
- Prioritisation
- Reporting
- Decision-making
- Communication
- Review

The volume of material that can be produced could potentially hamper the change team's processes or distract them from key issues buried within the detail. Fire and rescue services should therefore ensure that appropriate resources are made available and that there are systems for risk-based prioritisation of actions.

The actions that could result when learning is evaluated include:

- Referring back to an individual, manager or team, the issue is about local implementation of existing organisational policies, procedures or training
- Agreeing an internal change in policy, procedure, training content, equipment provision or any other relevant matter, the issue relates to local matters without any wider implications
- Agreeing an internal change but recognising that the learning has wider implications for the service as a whole, or the fire sector, the issue has national implications

Referring a matter back to a team, manager or individual, or making a change to a policy or procedure does not necessarily change the way the service is delivered. **Change Teams must have appropriate review methods to ensure that change has been communicated and is actually happening in service or on the incident ground.**

## Sharing learning

It is important that relevant learning is shared between fire and rescue services and with other emergency services and agencies. It enables all services to:

- Identify good operational practice, using it to improve safety and efficiency
- Recognise the implications of significant single high consequence events or high potential events that could impact their own service delivery or safety

- Recognise trends and multiple events that identify potential issues that should be addressed.

To make this possible, three key issues need to be addressed:

•**Common framework**

In a field as wide as operational service delivery, a common reference point or framework is needed to identify the areas of operational activity where change may be required. It is recommended that the activity structure used to develop National Operational Guidance is used for this purpose. See Appendix G for further explanation of the use of the framework to categorise learning.

•**Consistent analysis**

A structured approach is required that objectively measures the root cause of potential failure against the agreed good practices associated with that task. This allows what has actually happened to be compared against what good practice sets out. The good practice in operational guidance is presented as tactical actions that should be used to mitigate hazards that arise from operational activities. Reporting actual operational performance in respect of the tactical actions associated with an activity allows a direct comparison of what could have been done and what was done to control a hazard. There are many methods for reporting the findings of this type of comparison. One approach is to use a 'BowTie' model to provide a visual representation of the hazards and control measures. This allows for the tactics that represent good practice to be examined and for a comparison to be made.

•**Open reporting culture**

There may be significant caution in fire and rescue services around sharing information, particularly when it may evidence performance that may not reflect good practice and may have led to an accident, injury or death. Such information could be considered too sensitive to release and may be considered to have legal implications. It could also result in the identification of individuals who are involved. National Operational Learning does not focus upon the "who" but concentrates on the "how" and "why" of the learning.

Using control measures and reporting on whether they were successful, partially successful, unsuccessful or not used, can allow information to be shared quickly following an event without attributing responsibility. Further analysis conducted over time can subsequently be used to inform more detailed consideration of the incident and its implications for operational practice and the update of guidance.

**Sharing information with other services**

The SPoC is responsible for ensuring individual services make recommendations on whether an issue is considered as relevant to other fire and rescue services and whether those issues should be reported through the National Operational Learning process.

National Operational Learning process

The online NOL tool creates a central repository to improve the exchange of good practice and lessons learned across fire and rescue services. It enables the sharing of operational learning. The information generated from services is then collated centrally by the NOL Secretariat, this enables:

- The dynamic review of National Operational Guidance
- Identification of emerging issues and take any necessary action, including warning and informing other services
- Sharing of learning across the fire and rescue service
- Guides investment in equipment research and development and training functions
- Ensuring that national operational guidance always reflects current good practice

It is expected that the interaction between individual services and the Secretariat should be through their SPoC. The Secretariat will also interact with the wider fire and rescue sector to ensure that lessons learned through international experience or industry innovation, are available for consideration by each service.

### **Notification triggers**

When deciding on the need to share data and information on lessons identified, good practice or organisational learning into the National Operational Learning process, it is suggested that fire and rescue services use a methodology based on red, amber and green (RAG) ratings.

It is suggested that an additional blue rating is used where the organisational learning and resulting actions are considered minor, very limited and only affect the fire and rescue service involved. This will allow fire and rescue services to identify which issues, lessons or good practices should be shared nationally or remain within the local fire and rescue service.

Should any doubt exist, consultation with the National Operational Learning team is always the recommended course of action, the team can provide support and guidance at any time.

See Appendix H for further details.

## **Appendix A: Fire and rescue service: Single Point of Contact**

Fire and rescue services should nominate an individual to take responsibility for operational learning. They should also determine the support that will be provided to the individual, who will take the role of a Single Point of Contact (SPoC) inside the service for receiving external learning and informing the wider fire sector of internal operational learning.

### **Responsibilities and requirements**

- Have appropriate seniority and influence to ensure that activities to support learning can be effectively implemented
- Either be a member of the senior management board or have regular access to it and be able to influence its decision making
- Lead a team of appropriate staff to manage and analyse information on operational learning for the fire and rescue service
- Ensure the team has sufficient skills, knowledge and experience to analyse the information received and make decision as part of an integrated process
- Lead the team to allocate and prioritise tasks, actions and work from operational learning and identify the appropriate departments, teams or individuals to address any internal actions
- Ensure that any changes resulting from the operational learning process are implemented within their fire and rescue service
- Ensure that a review of these changes takes place at an appropriate interval or frequency to assure that changes are embedded in the fire and rescue service's operational policies and practices
- Ensure the team is able-to, risk assess internal information to decide on escalation of the issue to the National Operational Learning process
- Determine information to be communicated from their fire and rescue service to inform the wider sector
- Ensure information provided to the National Operational Learning process is provided in a timely manner 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 own service using identified structures and processes
- Refer resource implications or issues to the appropriate senior management team as necessary

## Appendix B: Assuring the implementation of changes identified through operational learning

Once operational learning has been identified and the appropriate steps taken to change operational policies and practices, fire and rescue services should provide robust processes to ensure changes are embedded into daily working practices and procedures at operational incidents. Assurance of this can be provided in a number of ways as set out below.

- **Incident monitoring**  
Specific or targeted operational monitoring should be carried out to constantly monitor the performance of staff or crews and the correct application of existing and amended operational procedures. This can be carried out at the scene or remotely by peer officers or specialists. Immediate feedback should be provided to assist incident commanders in improving operational performance.
- **Operational assurance**  
Officers independent of command duties can assure themed activities, processes and policy adherence activities. This assurance can be specifically related to the implementation of policy change following operational learning identification.
- **Observation**  
Direct observation of training, drills and exercises should take place to monitor adherence to performance standards, including safe systems of work and operational procedures.
- **Station/ Control room inspections and audit**  
A station inspection and audit process should be used to ensure operational competency, technical knowledge and adherence to operational policies and procedures. This process should ensure that work is being completed and achieving the required standard. Inspections can be programmed on a published frequency or conducted on an ad hoc, no notice basis. Specifically, there should be audits scheduled post incidents to check how recommendations and actions have been implemented.
- **Debriefs**  
Hot, structured and incident command debriefs should take place at a suitable time following an incident to identify learning points and examine the delivery of operations in accordance with existing and recently updated policies and procedures.
- **Monitoring**  
The monitoring and trend analysis of statistical data such as accident and incident investigations, near misses and hazards, equipment failures provide the opportunity to identify whether existing and changed operational policies and procedures are being adhered to at operational incidents.
- **Recording**  
A system to record when personnel have read, received and understood an amended or new policy will provide fire and rescue services with an audit or sample process and additional assurance that the policy change has been received and understood by staff.
- **E-learning**  
A web-based learning system can be used to test and assure the technical knowledge and understanding of staff when introducing new or amended policies. This could be used on one-off occasions or as an ongoing process.

The assurance methods above may need to assess whether required organisational or cultural changes have occurred as part of operational learning. Assurance should be sought that sufficient time is being allowed for personnel to reflect on operational learning so that they embed changes in their ways of working.

## **Appendix C: Operational debriefing**

Formal operational debriefs are a review process which support the aim of continual improvement and are conducted by members of the service after an incident or training exercise. The debrief process creates a link between the performance of individuals, the performance of teams and the performance of the fire and rescue service in meeting its objectives.

Debriefing an event will form an additional strand linked to the monitoring, audit and review process of the service and should:

- Identify and confirm good practice
- Promote continued learning and assist in developing the experience of individuals and teams
- Identify both team and individual training and development needs
- Assess competence through workplace assessment and a means of quality assurance
- Confirm if current policies and practices are effective and fit for purpose
- Identify operational learning.

The debriefing process allows individuals and teams to systematically analyse and evaluate the operational tactics employed during specific workplace activities with their colleagues and line managers. It is a mechanism to identify and discuss the hazards and risks present at the incident and evaluate the control measures used to manage them.

Debriefs should be conducted in an open, constructive manner and assess standards against a number of predetermined areas.

The outcomes of the debrief process should be collated, analysed, actioned and shared throughout the service. This should be carried out by the operational learning officer through existing governance arrangements to promote experiential and organisational learning and ensuring staff and public are afforded the highest levels of service, health, safety and welfare.

## **Appendix D: Hot-debriefing**

A hot debrief should be conducted, as soon as reasonable practicable, at the conclusion of all incidents and exercises, preferably on scene and involving all personnel. Other agencies e.g. police, ambulance, or any other responding agency, can also be included in the hot debrief to establish their perspective on the resolution of the incident and also promote collaborative working. A hot debrief should be considered normal for all incidents and exercises irrespective of whether a higher level debrief is expected to take place.

The incident commander should make notes of discussion points for future reference and to inform a structured debrief, if required. It is important to help reinforce the reflection of individuals on what happened during the event, particularly to focus on the areas of:

- Individual performance
- Task performance
- Team performance
- Tactics employed and their effectiveness in dealing with the incident
- Hazard and risk identification and control measure evaluation
- Organisational learning – procedures and equipment performance

If any aspect of the event is identified that could have had a risk critical impact on the health, safety and welfare of the people involved, or there are learning points for the organisation in relation to equipment and or procedures, then a structured debrief should be carried out.

## Appendix E: Formal debriefing

If there are organisational learning points on procedures, equipment, and health and safety, a formal debrief should be carried out.

Adequate time and preparation should be allocated to the debrief process. This means that it may be necessary for it to be conducted on a different day to which the event took place. But wherever possible, a formal debrief should be conducted as soon as is reasonably practicable after the event and ideally within four weeks.

At a formal debrief, the incident commander should consider whether they require the support of their line manager or a senior officer to complete the report. In some circumstances it may be advisable for the debrief to be carried out by an officer who was not part of the event.

To conduct an affective debrief, people may need to be assigned a specific role.

A debrief organiser is responsible for making the necessary arrangements for a debrief and assists in collating relevant information for the debrief facilitator.

The organiser is responsible for making all of the necessary arrangements, including identifying suitable facilities, ensuring relevant personnel are present and allocating sufficient time for the debrief to be conducted properly.

The people who could be invited to attend a debrief include:

- Operational personnel who attended the incident
- Service trainers
- NILOs
- Fire control officer or operators
- Fire safety officers
- Fire investigation officers
- Police or ambulance service officers
- Health and safety advisers
- Neighbouring fire and rescue service(s) at cross border incidents or exercises
- Environmental Agencies
- Resilience or emergency planning officers

A debrief facilitator chairs the discussions and is responsible for ensuring that feedback is collated and a report completed for publication and forwarding to the operational learning officer. The facilitator should:

- Officially commence debrief proceedings
- Explain its purpose
- Set the scene
- Highlight decision points and identify the performance requirements of the fire and rescue service in resolving the event
- Progress the debrief
- Identify any action points before forwarding the report to the operational learning officer

- Close proceedings and thank all participants, especially where contributions have been made by individuals external to the service

The debrief facilitator should remain objective and seek to be constructive and encourage an open and honest environment

To prepare for a formal debrief, all of the relevant information should be collated to enable an understanding of the sequence of actions from start to finish. To save time information this can be sent electronically and may negate the need to get people together for a face to face debrief.

Areas for consideration during the debrief are:

- **Sequence of events**  
A timeline of the incident pieced together using all of the available information
- **Incident command**  
Whether overall command and control was effective and whether the resources available were used to their best advantage

**Command and Control**

If the appropriate information was gathered and relayed to the Incident Commander. If the initial weight of attack was proportionate and the nearest, most appropriate resources were sent.

- **Operational practices and procedures.**  
Comparing operational delivery against existing local fire and rescue service guidance, policy and procedures, other fire service publications and health and safety guidance. This should involve the identification of hazards and risks at the incident and evaluation of whether the available control measures were used effectively and managed the hazard safely. Good practice should be highlighted, and poor practice identified.
- **Equipment usage**  
failure and inadequacies. Consider whether and how equipment was used. Was it adequate for the task? Did any equipment fail in use? Would other equipment have been more appropriate?
- **Communications**  
Were appropriate equipment and procedures rapidly established for both command and control information purposes?
- **Service liaison**  
How early were JESIP protocols established and were they effective? Was liaison with supporting agencies (EA, Voluntary, Gas, Water etc.) effective? Consider reporting any multi-agency findings through the JESIP Joint Organisational Learning (JOL) process
- **Public relations**  
Were media briefings well organised and regular? How did the media respond? Were owners, occupiers and neighbours kept informed?

It is the debrief facilitator's responsibility to ensure that the formal debrief is reported to the operational learning officer for further consideration and action.

If it is identified during the formal debrief that any aspect of the event could have had a risk critical

## Appendix F: Command reviews

To conduct an effective command review and promote individual and organisational learning the points below should be taken into consideration. As with a formal debrief the use and roles of a debrief organiser and facilitator would assist in delivering the command review.

- The command review should be carried out by an officer of a higher or equivalent rank than the incident commander
- Suitable facilities should be provided to accommodate the review
- All information should be collated to allow a review of the sequence of events and the command decisions made
- All officers with a significant command role at the event should be invited to attend the review
- The review's purpose is to capture potential operational learning from a command perspective and should therefore be conducted in an open, 'no blame' and constructive manner
- A walk-through of the decisions made throughout the duration of the event should be completed. At each decision point, an evaluation should be made, taking into consideration the information available, the respective commander's rationale and any potential decision alternatives
- The command review process should include an identification of the hazards and risks at the incident and the command team's perspective of the effectiveness and rationale of the control measures used
- Any identified operational learning should be captured and forwarded to the operational learning officer for consideration and potential action

## Appendix G: Categorising learning

The framework on which National Operational Guidance is based provides the structure for allocating data and information into categories for central analysis. Using a consistent approach for information collection and terminology will improve the sharing of operational learning and notable practice with other fire and rescue services while also enhancing the quality and timeliness of the National Operational Learning process. Using three key activity categories will help in the initial filtering of data and information; fire and rescue services should consider these categories when collating information and data through their own internal processes for subsequent sharing through the National Operational Learning process.

The categories are:

- Fires and firefighting
- Performing rescues
- Hazardous materials

To enable further information capture, these initial categories can be sub-divided into more specific activities based on the National Operational Guidance Framework. Fire and rescue services should also have procedures and system to identify data and information that could be assigned to other categories, including:

- Training.
- Health and safety
- Equipment

To consider and address future potential fire and rescue service delivery and activities, information should also be gathered about activities conducted by fire and rescue services where information and guidance is not currently planned, published or identified within the National Operational Guidance Framework. Examples are the co-responder schemes operated by some fire and rescue services.

The central National Operational Learning online tool will allow contributors to provide information about activities that are not part of current National Operational Guidance. Fire and rescue services should make sure they identify events that are not covered in published guidance but still have implications for the wider fire sector.

## Appendix H: Red, amber, green (RAG) and blue rating of learning

When deciding on the need to share data and information on lessons identified, notable practice or organisational learning into the National Operational Learning process, fire and rescue services can use a suite of triggers based on **red**, **amber** and **green** (RAG) ratings. An additional rating will also need to be identified and included – **blue** – where the organisational learning and resultant actions are minor, very limited and only affect the fire and rescue service involved. This will allow 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.

When reporting incidents into the National Operational Learning process, the process or trigger to be identified and followed will depend on the risk criticalness and potential impact on personnel, environment, finances and organisational reputation of the event. This will therefore determine whether the incident is reported as **red**, **amber** or **green** and the timeliness and pace of any resultant information, implementation or action by the fire sector.

- **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 injury or harm to 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 have limited interest to other fire and rescue services
  
- **Amber: Events that may be of interest to other fire and rescue services**
  - Can cause change or action within an organisation to policy or procedures
  - Where it is necessary to include additional information, instructions or amendments to training requirements or delivery
  - Modifications to equipment or their usage.
  
- **Red: Events that will be of interest to other fire and rescue services, nationally**
  - Can cause change or action within an organisation including intervention to cease activity
  - High risk to firefighter or public safety
  - Potential enforcement or legal action
  - Necessity to apply operational discretion
  - Any other special case or significant event

**Issues rated red or amber would normally be shared immediately with the National Operational Learning process** before any major changes had taken place within the contributing fire and rescue service.

Those rated green would normally instigate a change within the fire and rescue service before any involvement with the National Operational Learning process.