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Wendy Williams
Her Majesty's Inspector of Constabulary
Her Majesty's Inspector of Fire & Rescue Services

Chief Fire Officer Paul Walker
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20 December 2018

Dear Paul,

CORNWALL FIRE AND RESCUE SERVICE REVISIT

We inspected Cornwall Fire, Rescue and Community Safety Service the week of 16 July 2018. During the inspection we identified several areas of concern. We shared the following cause of concern with the service:

Cause of concern
We have serious concerns about Cornwall FRS's response to incidents. The service consistently doesn't meet target response times for fires, especially in remote areas served by on-call stations.

It is sometimes slow to update mobile data terminals with risk information. Staff often rely on paper records. Staff in the critical control centre aren't confident in the ICT systems which show availability of staff and fire engines. This leads to increased resources being mobilised or delays in attending incidents.

Operational crews don't regularly record information because they aren't all completing risk assessments or decision logs, in line with national guidance. Frontline staff don't all understand how to identify vulnerable people or how to use the referral process for vulnerable people and safeguarding. The service doesn't consistently gather essential learning from operational incidents or pass this on to all staff.

Recommendations

(a) the service should regularly update risk information on mobile data terminals so that firefighters responding to incidents can see the most up-to-date information;

(b) the service should improve the information available to staff in the critical control centre, so that they can make effective decisions about the mobilisation of fire engines;

(c) the service should implement national operational guidance, specifically in relation to the completion of analytical risk assessments and decision logs;

(d) the service should train staff better in how to identify vulnerable people and use safeguarding referral procedures, and should ensure staff use these consistently;

(e) the service should improve how it monitors operational incident command and feedback processes; and

(f) the service should improve its operational assurance by debriefing firefighters effectively and passing on any learning to all staff.

2. You submitted an action plan setting out how you plan to address the areas of concern.

3. We revisited your service between the 8 and 10 October 2018 to review progress against the action plan. We didn't expect to see all the remedial work completed, we were looking for evidence of progress. We explored the following areas of the action plan:

(a) sharing of risk information with operational crews;

(b) operational assurance;

(c) use of analytical risk assessments

(d) fire control; and

(e) training of staff on safeguarding.

4. During the revisit we interviewed a range of operational staff, including the lead councillor with the Portfolio for Fire Service as well as the Strategic Director for neighbourhoods. We concluded the revisit by feeding back our findings to the Chief Fire Officer and the senior management team.

5. We were encouraged by the progress you have made. A summary of our findings is set out below.

Governance

6. We found strong governance arrangements in place to support the action plan, with a high level of knowledge and involvement from Cllr Sue James (Portfolio Holder) and Director Paul Masters. We were also encouraged that there are several independent members that sit on the improvement board to provide support and critical challenge to the service. The service has established regular meetings, chaired by a member of the senior management team, to monitor progress against the action plan. The service has also indicated when it will know that sufficient progress has been made and the work can return to business as usual.

7. We are aware that the service and council were waiting for the draft inspection report before deciding on additional posts to support improvement. We recognise this needs to be part of a budget setting and IRMP process.

Action plan

(a) Risk information is not shared across the service, as there is limited capacity to enter paper-based details onto the mobile data terminals. Crews rely on paper-based systems as they do not have faith in the terminals.

8. We found that the service has reviewed the purchase of mobile data terminals, has accelerated the process of procurement and has been able to build in a process for upgrades when technology changes, i.e. the emergency services network. The service has started a process to compare the risks held centrally against the information held on mobile data terminals and station-based paper records. This process was more advanced on wholetime stations than the on-call stations we visited.

(b) The service has not embedded operational assurance across the service, which means that essential learning from operational incidents is not gathered and shared with all staff.

9. We found that the service has introduced documentation to improve operational assurance. These include the officer operational assurance pack and hot debrief forms. Officers are being deployed to carry out operational assurance activities, and this has been welcomed by staff we spoke to at all levels. Operational staff see this as a positive change and an improvement.

10. The service has introduced a thematic operational assurance process. It was focused on road traffic collisions when we revisited the service. We also found an operational preparedness timetable for officers to undertake station audits. We were pleased to learn that staff welcome the new and improved feedback they receive from operational assurance processes.

(c) Analytical risk assessments are not regularly used at operational incidents and decisions are not regularly recorded.

11. We found that the service is undertaking a review of policies and processes to ensure it is in line with national operational guidance. The service is planning to provide more training around national operational guidance, such as operational discretion. The use of analytical risk assessments has increased and once completed, are now being sent back to a central team for review and feedback. The critical control centre is prompting operational crews to consider analytical risk assessments as a matter of course. This is positive progress.

(d) Fire control are not able to confidently mobilise appliances and guarantee a crew. This means that those geographical areas covered by on-call staff may not be receiving the response that they expect from the service; this is evidenced by the service having the longest response time.

12. We found that the service has conducted work in relation to critical control centre staff, and they are now confident in most of their functions. This is following an internal review, which found that the service lack confidence with the electronic Rappell system for on-call availability as well as using a range of other systems. The service has since introduced a process where Rappell is used as the one and only point of information which will influence mobilisation; on-call staff have been briefed in relation to this.

13. The service has introduced a new paper-based system to forecast availability of on-call staff. We found that this is not yet being used consistently as a management tool to manage gaps in cover. The service has also started work with on-call staff to review contractual arrangements, and this work is still in progress.

14. We found that the service has bought new mobilising equipment for 11 stations which is yet to be installed. However, staff fed back concerns about existing equipment and the speed of the mobilisation by control reaching station end, which may have a potential impact on mobilisation times. Due to the link with response times, the service may need to do some more work to understand this.

15. The service has been unable to show us the latest data in relation to response performance as it was in the process of being updated. The service may want to consider how it uses data to understand and inform its response, and to target improvement.

(e) We found an inconsistent approach to the training of staff on safeguarding. We could not confirm that staff were fully aware of the process and procedure for reporting safeguarding concerns.

16. We found that the service has made steps to improve staff understanding of safeguarding. The service has sent communications to all staff. Staff told us they knew they needed to improve their understanding of safeguarding. A new safeguarding flowchart is being used by staff to improve their ability to make referrals and identify people with vulnerabilities.

17. We found that the service has taken other additional steps to improve safeguarding. The service has updated web-based information relating to safeguarding. All flexi-duty officers and some support staff will become safeguarding advocates. We were shown several case studies that will form part of new training material. Staff have also welcomed the clarity around the single process for referrals.

Outcome

18. Overall, we were encouraged by what the inspection team found on the revisit. All staff we spoke to proactively told us that the areas identified for improvement in the first inspection were areas that they knew they needed to improve upon. They said the inspection had allowed them to refocus on their priority of serving the public.

19. I am pleased to say that we found that the service had made a very good start to improving the outcomes to the communities against the areas raised.

Yours sincerely,

Wendy Williams

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