

1. What do

**you think?**

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# QUESTIONS

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To help us analyse all feedback, please tell us if you are responding as a:

member of the public

member of SFRS wholetime & support staff RVDS staff

retained employer community group voluntary organisation local authority

emergency service organisation

public sector body

If you are responding on behalf of an organisation, or as a

retained employer, please state the name of your organisation:

If you are responding as an individual, please provide

the first part of your postcode e.g G77, EH1:

Please choose your **rating scale** for these statements:

strongly disagree

disagree neutral agree strongly

agree

1. The number of UFAS we attend in Scotland is a problem that needs to be addressed now.

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1. To reduce the impact of UFAS, we should stop sending fire appliances to AFAs unless it is for a confirmed fire or to premises on the exemption list.
2. The exemptions proposed for **OPTION A** and **OPTION C** provide a proportionate response to AFA calls based on risk.
3. Did you feel the consultation document provided you with enough information to enable you to give an informed response?
4. Please rank each **OPTION** from most preferred **(1)** to least preferred **(3)**

Call challenge all AFAs. No response is mobilised if questioning confirms no fire or no signs of fire. Sleeping risk premises are exempt and will receive a PDA based on premises type and time of day.

**A**

Call challenge all AFAs. No response is mobilised if questioning confirms no fire or no signs of fire. No exemptions to call challenging apply.

**B**

Non-attendance to all AFA’s, unless back-up 999 call confirming fire or signs of fire is received. Sleeping risk premises are exempt and will receive a PDA based on premises type and time of day.

**C**

1. Would you like to suggest any other options to put forward for consideration?
2. What else could we have provided or done to ensure it was easy for you to respond to the consultation?
3. Do you have any further comments?

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**EQUALITIES MONITORING FORM**

We would like to ask a few more questions about you. Because we have a duty to meet the needs of people across our diverse communities, it would help us to know the range of people who gave us feedback.

We can also use monitoring to determine whether our services are accessible, whether our policies have a disproportionate, unfair or positive impact on particular groups and whether members of those groups are satisfied with the service they receive. This section is optional. Any responses you do provide will be anonymised.

1. **Your Age**

Under 16

16-25

26-40

41-55

56-70

Over 70

Prefer not to say

1. **Your Sex**

Female Male

Prefer not to say

1. **Trans - Do you consider yourself to be trans, or have a trans history?**

Yes No

Prefer not to say

1. **Your sexual orientation** Heterosexual Gay/Lesbian Bisexual

Prefer not to say

1. **Disability**

Do you have any of the following, which have lasted, or are expected to last, at least 12 months?

Deafness or partial hearing loss Blindness or partial sight loss

Full or partial loss of voice or difficulty speaking (a condition that requires you to use equipment to speak)

Learning disability (a condition that you have had since childhood that affects the way you learn, understand information and communicate)

Learning difficulty (a specific learning condition that affects the way you learn and process information)

Developmental disorder (a condition that you have had since childhood which affects motor, cognitive, social and emotional skills, and speech and language)

Physical disability (a condition that substantially limits one or more basic physical activities such as walking, climbing stairs, lifting or carrying)

Mental health condition (a condition that affects your emotional, physical and mental wellbeing)

Long-term illness, disease or condition (a condition, not listed above, that you may have for life, which may be managed with treatment or medication)

Other condition No Condition Prefer not to say

5 **Caring Responsibilities**

Do you look after, or give any help or support to family members, friends, neighbours or others because

of either: long-term physical / mental ill-health / disability; or problems related to old age?

Yes – unpaid care provider full-time Yes – unpaid care provider part-time No

Prefer not to say

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1. **Care Experienced**

Care experienced means you are or were formally looked after by a local authority, in the family home (with support from social services or a social worker) or elsewhere, for example, in foster care, residential/secure care, or kinship care (with family friends or relatives) and you have not yet reached your 26th birthday.

Yes No

Prefer not to say

1. **Ethnicity – what is your Ethnic Group?**

Please select only one item:

* 1. White

Scottish Other British Irish

Gypsy/Traveller Polish

Roma Showman/Showwoman

Other white ethnic group (Please write below)

* 1. Mixed or multiple ethnic groups

Any mixed or multiple ethnic groups (Please write below)

* 1. Asian, Asian Scottish or British Asian Pakistani, Scottish Pakistani or British Pakistani Indian, Scottish Indian or British Indian Bangladeshi, Scottish Bangladeshi or

British Bangladeshi

Chinese, Scottish Chinese or British Chinese Other white ethnic group (Please write below)

* 1. African, Scottish African or British African African, Scottish African or British African (please write below - for example, NIGERIAN, SOMALI):
  2. Caribbean or Black

Caribbean or Black

(please write in below - for example, SCOTTISH CARIBBEAN, BLACK SCOTTISH)

* 1. Other Ethnic Group

Arab, Scottish Arab or British Arab

Other, please write below (for example, SIKH, JEWISH

* 1. Prefer not to say

1. **Religion or Belief**

None

Prefer not to say Church of Scotland Roman Catholic Other Christian

(please write in denomination or school below)

Muslim

(please write in denomination or school below) Sikh

Hindu Jewish Buddhist

Another religion or body

(please write in denomination or school below)

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