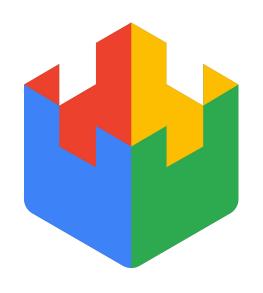


Reporting on Reliability

Improving stakeholder conversations



<u>sre.google</u> • <u>twitter.com/googlesre</u>

<Presenter Name>
<Presenter Role>
@<Twitter Handle>



principles



ncidents happen.



The goal is not 100% uptime.



Reliability matters.



Reliability takes work.



Reporting facilitates decision making

Decisions may include...

Resource allocation

- Human resources
- Capital investments

Prioritization

- Feature A vs. Feature B vs Reliability Project A vs. Reliability Project B

Communications

- External
- Internal





What was that??



What was that??

How's it going?



What was that??

How's it going?



What was that?? ← Postmortem

How's it going?



What was that?? ← Postmortem

How's it going? ← Periodic reviews



What was that?? ← Postmortem



★ How's it going? ← Periodic reviews



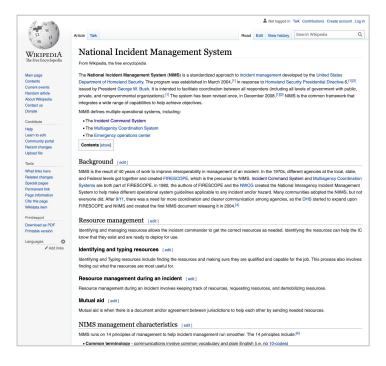
Real-time incident status



What the heck?!? Real-time incident management

Assign clear, specific roles

- Incident commander
- Communications manager
 - Internal
 - External





What the heck?!? Real-time incident management

Use appropriate communication channels

- Avoid conference calls
 - Noisy and lossy
 - Single threaded
- Chat/IM
 - Multi threaded
 - Allows multicast as well as small groups
 - History can be preserved
- Live docs and collaborative systems
 - Capture (but don't publish) in real time





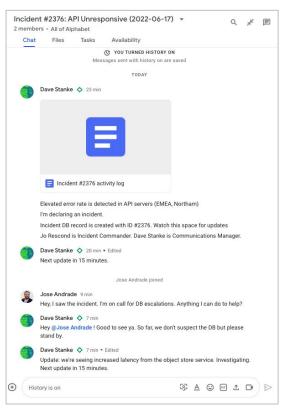
What the heck?!? Real-time incident management

Be predictable

- Regular updates with new information
- Each update includes "next update in {x} minutes"

Most people should mostly listen

- Core responders broadcast to stakeholders
- Others can offer to help
 - But wait until acknowledged to take action





What was that??

Postmortem



- Capture data and experiences
- Resolve ambiguities
- Complete the narrative
 - For consumption by others
- Plan next steps

Incidents are unplanned investments, and they are also opportunities. Your challenge is to maximize the ROI on the sunk cost. To do that, the organization has to invest in really exploring and understanding these events, and share that understanding broadly and over time.*

-John Allspaw



Blamelessness is key

- Criticize systems, not people
- Assume that everyone involved in an incident had good intentions
- "Human" errors are systems problems

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"Jamie shouldn't have done that" →
"The system shouldn't have allowed an engineer to do that"
```

- A culture of blame leads to hiding of problems and poor morale



Documenting the incident

- Participants are cross-functional stakeholders
 - The ones who were involved in the incident!
- Provide time and space for open communication
- Be Comprehensive
 - Status (e.g. "Complete, action items in progress")
 - Summary
 - Impact
 - Contributing factors
 - Trigger
 - Resolution
 - Action items
 - Timeline



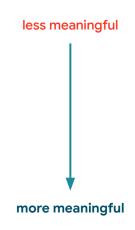
Action items (TODOs)

- There should probably be several
 - Is there really only one problem to fix?
 - Look beyond specific bugs, to find systemic contributing factors
- Seek opportunities to improve...
 - ...detection
 - ...mitigation
 - ...prevention
- Assign them, prioritize them, track them
 - The incident isn't really over until all the Als are completed



Assessing impact: How bad was it?

- It happened
- It lasted for {x} minutes
- It affected systems A, B, C
- It impacted users attempting to {do_thing}
- It caused \$X in lost revenue





Independent review

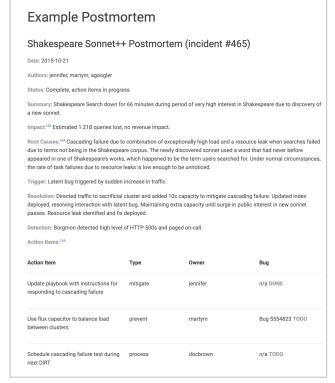
Before publishing a postmortem report to stakeholders, solicit peer review to ensure it's clear and comprehensive.

Make it easier by hosting regular office hours.



Publishing and distribution

- Executive Summary
 - TL;DR
- Push to known channels
- Publish to known locations
- Schedule a readout
- Invite questions





How's it going?

Periodic reviews



Where decisions are made!

- Learn from the past
- Plan for the future

Scheduled and templated

- Twice a year (or thereabouts; adjust as needed)

- Attendees:

- Decision makers (management; executives)
- Technical leads from the team
 - Not just SRE; all "owners," including Devs, Product, etc.
- SRE experts (from beyond the team)



Look back Look ahead Look all around



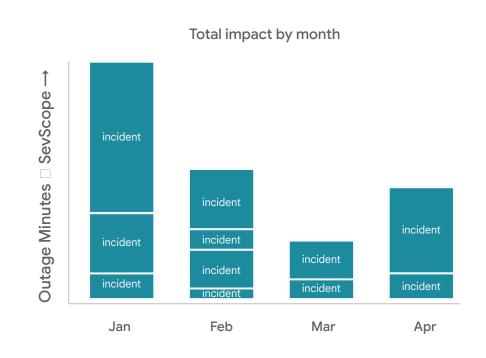
Look back: SLO rollup

- Restate SLO targets
 - Assess SLO compliance: targets hit/missed
- Analyze upstream and downstream dependencies
 - This service's impact to others; other services' impact to this
- Consider revising targets



Look back: Incident report

- Don't focus on incident counts
 - Each incident is unique
- Do focus on the aggregated impact of incidents
 - Revenue lost
 - Error budget burned
 - Blast radius
 - Teams/services affected
 - Look for patterns





Look back: Incident report

- Major incidents
 - Where did they happen?
 - Are there trends? Clusters?
 - Specific teams that struggle?
 - What was the impact?
 - Is it concentrated on particular regions? Customers? User types?
 - Action Items
 - Are they getting done?

Beware of recency bias





Look back: Team health

- People Does the team have the right mix of skills? What training can we offer?
- Cognitive Load Is the team at capacity, or can they onboard additional services?
- Toil Are we doing the right amount? Are we learning from it?
- Interrupts Consider a paging "budget" (e.g. max 2 per on-call shift)
- Morale A happy team is a reliable team



Look ahead

- Forecast: demand
 - What capacity will be needed?
 - What other factors will become relevant?
- Forecast: work to be done
 - What's in the reliability backlog? What might prevent it from getting prioritized?
- Plans
 - Are stakeholders expecting improved reliability? Can we achieve it?
 - What launches are coming, for this team or related teams?
 - What known future bottlenecks/deprecations/etc. can we prepare for?
 - How does the team's work align to (ongoing or emerging) organizational strategy?



Look all around

Dependencies

- Who is dependent on this team? Are we supporting them well?
- Who does this team depend on? Are they supporting us well?

Platforms and tools

- Does this team use common standards?
- Does this team contribute back to the ecosystem?
 - PRs to upstream projects; creating/maintaining tools; tech talks or consultation

Learning

- Who can learn from this team? Who can this team learn from?



Requests and proposals → decisions!

- Do we need to change our plans?
 - Product Roadmap
 - Communications
 - Protocols
 - Resourcing
 - Team structure
 - Engagement model
- Meeting outcome: updated plans
 - e.g. OKRs or other planning artifacts; staffing; budgets



Reliability is hard.



When we talk about reliability, it helps to...

- Respect the inevitable
 - Incidents will happen
- Practice blamelessness
 - Assume good intent
- Share insights broadly
 - Nurture a learning community
- Reflect and iterate



A "near miss:" silver lining?



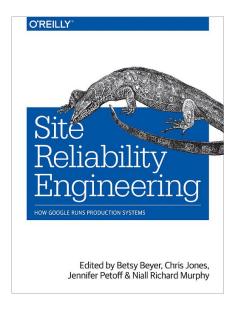
A "near miss:" solid gold.

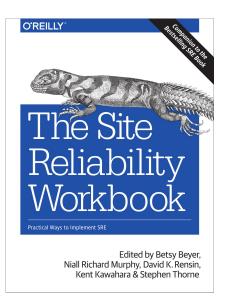


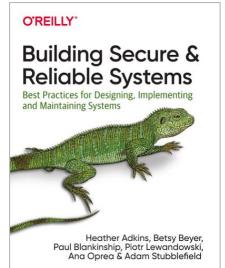
May all your incidents be interesting.

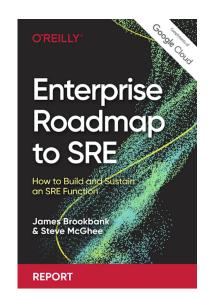


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Emergency Incident Response

Planet-Scale Distributed Systems

Service Level Objectives (SLOs)

Systems Engineering

Global Storage

Load Balancing

Monitoring

Availability

Embracing Risk

Blameless Failures

Software Engineering

Automation

"Hope Is Not A Strategy"

Site Reliability Engineering

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Extra bits



Calculus, anyone?

- Individual errors
 - ...are the domain of machines
- Incidents (1st derivative of errors)
 - ...are the domain of SREs
- Trends (2nd derivative of errors)
 - ...are the domain of leadership

