

# Failing Well

Insights on dealing with failure and  
turnaround from four critical areas  
of public service delivery

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All views, along with any inaccuracies, errors or omissions, are those of the authors.

# Executive summary

Failure matters because failure happens. The system of organisations that deliver public services in the UK is complex and it is inevitable that failures will occur. But as recent high-profile cases have shown, when essential public services fail, citizens can be left without vital support or care.

Now more than ever, the risk of failure is increasing. Providers remain under pressure to cut costs and reconfigure the way services are delivered. In addition to squeezed finances, the way services are being delivered has been changing. Recent years have seen a push towards more autonomous models of public service provision, with ambitions to expand academisation, take over underperforming children's services departments and innovate in NHS 'vanguard' sites. While new models of service delivery present opportunities for improvement, the risk of failure is heightened during change and transition.

In this context, our research analyses the experiences of four different organisations that endured serious failures – often over substantial periods of time – but nonetheless managed to successfully turnaround and return to providing good services for citizens. We interviewed those involved in turnarounds at Doncaster Metropolitan Borough Council, Eltham Foundation School (now the Harris Academy Greenwich), Basildon and Thurrock University Hospitals NHS Foundation Trust and West Sussex children's services. Looking across these examples, we found eight things in particular stood out when thinking about what could be learned from these stories:

- 1. Peer-to-peer support provides opportunities for earlier intervention – but it needs a trigger.** Across our case studies, we saw that central government tends to intervene in failing services only when it has evidence that there are very serious problems afoot. Peers – other schools, hospitals or sector-based organisations – on the other hand, can provide scope for earlier and more consensual forms of intervention. But while peer support can be very effective, it is currently usually voluntary, raising questions about whether the most troubled organisations – which often have only weak connections to other bodies – are likely to seek support from their peers. Establishing a greater role for peer review as a form of sector-led, non-statutory intervention may therefore be necessary.
- 2. Interventions may not need to remain in place until the turnaround is complete.** In our research we encountered two competing descriptions of when an intervention should end. In some cases, this was once service standards had returned to normal – this is typical in schools and hospitals. In others, interventions were brought to a close once the organisation had been deemed capable of returning itself to the required level of performance, even if standards themselves were not there yet. The first approach may rightly be appealing for the most serious and sensitive issues (such as where lives are at stake), but there is also a risk that, in waiting for standards to return to normal, a culture of incapacity or dependency might arise. Earlier or tapered exit from intervention should be an option in the right circumstances.
- 3. Insularity is often a characteristic of failing organisations.** During our research we heard that failing organisations are also insular organisations; they have weak networks and connections to their peers. Their insularity makes it harder to use comparison to judge when standards have slipped and harder to rectify any slippages by learning from others. There appeared to be two main ways of overcoming this insularity – first through the firm designation of failure, usually by a regulator, which shocks the organisation into action.

The second was by finding mechanisms for reintroducing the perspectives of peers; in the local authority we looked at, the leader of a neighbouring council was invited to support the recovery effort.

- 4. Responses to failure can be over-reliant on structural reforms.** Structural change is one of the most common responses to failure; high-profile scandals are often followed by conspicuous changes to corporate governance or mechanisms for accountability. But there is a risk that too much faith is placed in structural changes that might not prevent failure unless in combination with other efforts. In our schools case study, it was not academy status alone that led to dramatic improvements at the school – success also depended on access to the resources and connections of an academy chain as well as the financial benefits that were, at the time, on offer to schools that converted to the academy system. Perhaps most crucially, it was also bringing in reinvigorated leadership at the top of the school.
- 5. Creating an open, no-blame culture helps to protect against future risk of failure.** Although the impulse to blame someone when things go wrong is instinctive, our research suggested that environments where people feel unable to be honest about problems allow even more serious failings to incubate. The inquiry into Mid Staffordshire NHS Foundation Trust revealed that the early warning signs from front-line staff were not recognised because the culture was one of fear and secrecy. In our case studies, we saw that creating a culture that valued honest reporting of problems was critical to turnaround. In the hospital we looked at, creating a culture of transparency, where all staff felt able to report incidents, was one of the first changes made.
- 6. There is scope for more sector-wide learning from failure.** The people involved in our research said that they think that opportunities to learn from failure are currently limited. Where learning and sharing do occur, this tends to happen on a localised level and is led by proactive organisations rather than being routine. There is an opportunity to capture and more widely disseminate lessons on effective turnaround, as well as guidance on how organisations can mitigate the risk of future failure. There is arguably a case for enabling institutions that already broker support within particular sectors to create more routine opportunities for learning and sharing.
- 7. Failure can (appear to) get worse before it gets better.** The attribution of failure is traumatic for an organisation and more needs to be done to mitigate its detrimental effect on services – the financial costs accrued, deteriorating staff morale and the damage done to retention and recruitment. But our research also suggested that the label of failure can be a pivotal moment in breaking an organisation's insularity, bringing problems into the open and galvanising it into action. In some cases what appears to be worsening performance after being designated as failing was in fact the beginnings of honest reporting. The ascription of failure often leads to a more rigorous examination of the issues underlying poor performance, in turn revealing the true extent of the problems being experienced. In the school we looked at, exclusion rates rose dramatically soon after it went into special measures, as the school leadership started to manage behavioural standards more assertively.
- 8. Turnarounds should set the foundation for long-term improvement, as well as dealing with immediate problems.** Recovery from failure is only half the journey; all of the people that took part in our research aspired to convert their turnarounds into lasting improvement. But the method of intervention had an impact on the organisations' ability to transition out of recovery and into enduring improvement. In some cases, organisations focus solely on achieving an 'adequate' rating – simply hiring new staff until ratings are

dragged up – without focusing on the underlying reasons for underperformance. Those organisations that do achieve lasting improvement tended to have their eyes on the horizon even when tackling immediate problems – for instance building deeper internal capacity by tapering the exit of an intervention team, or ensuring peers were on hand to provide ongoing support outside periods of formal intervention. A focus on continuous improvement is often the difference between falling back into sub-standard provision and maintaining lasting positive change.

While the focus of these case studies was on events several years past, all of the interviewees were acutely aware of the changing nature of the response to failure in their sector. The abolition of the Audit Commission, the introduction of regional school commissioners, the transfer of failing children's services to independent trusts and the new NHS Success Regime all represent major changes and are in the early stages of their implementation. So, in addition to the above insights, some broader conclusions emerged from the research that helped in understanding the nature of failure in the first place and should be borne in mind as current and future reforms are implemented.

First, the ownership of failure is shared and responses to failure should be as much about the system as organisations and individuals. In these case studies, collective responsibility frequently extended beyond the individual public service organisation in which failure was most acutely observed and incorporated a wider system, including the central government department, local government structures, the regulator and neighbouring services. Second, failure has fluid boundaries – organisations are likely to dip in and out of failure before making a full recovery. In some instances, things will get worse before they get better. Finally, in all of our case studies, organisational turnaround was to some extent predicated on the adoption of new cultures and ways of working. A culture of transparency, where staff are actively encouraged to flag risks or concerns about standards of provision, both allows organisations to prevent further failure and encourages reflection when failure does occur.

Failure is an ever-present threat in our public services – the aim of this report is to contribute to a conversation about how to best understand it, avert it, manage it and recover from it. We hope these stories and their lessons make some headway in achieving that.

# Chapter 1

## Why does failure matter?

When essential public services fail, citizens can be left without the support or care they need. In the very worst cases, they may be harmed. The well-publicised failure at Mid Staffordshire NHS Foundation Trust, for instance, led to very poor standards of care and even mistreatment for hundreds of patients.<sup>1</sup> At Rotherham children's services, failure allowed 1,400 children to be abused over a 16-year period.<sup>2</sup>

While these cases are remarkable for their extremity, other recent cases of sub-standard provision have raised questions about government's ability to avert, manage and overcome failure in essential public services.<sup>3</sup> Investigations into collapses of service provision at Haringey children's services, Doncaster Metropolitan Borough Council and the E-Act academy chain<sup>4</sup> found that cultures of denial, poor systems of accountability and dysfunctional mechanisms for identifying failure inhibited an effective response. In addition to these cases, there are many other instances of underperformance or failure that do not make national headlines, but negatively impact local populations nonetheless.<sup>5</sup>

Failure matters because failure happens. The constellation of organisations that constitute public services in the UK is inherently complex and therefore at permanent risk of failure.<sup>6</sup> This risk, while longstanding, is particularly acute at present. Service providers remain under pressure to cut costs and reconfigure the way services are delivered. For instance, the NHS must make efficiency savings of £22 billion by 2020<sup>7</sup> and the Local Government Association (LGA) estimates that local authorities will face a £13 billion funding gap by the end of the decade.<sup>8</sup>

In addition to squeezed finances, the way services are being delivered has been changing. Recent years have seen a push towards more decentralised and autonomous models of public service provision.<sup>9</sup> While new models of service delivery present opportunities, the risk of failure can be heightened during periods of transition, due in part to the inherent instability of change and the fact that new ways of working will create new forms of failure; forms that have not yet been identified through experience.<sup>10</sup> According to the Jay report into child sexual exploitation in Rotherham, one reason for Rotherham's poor children's services was its difficulty in successfully transitioning to the new rules set out by the Children Act 2004.<sup>11</sup> Similarly, a serious case review into the Isle of Wight's children's services, following the case of Baby T, concluded that the authority had rushed its transition to the whole-team approach introduced by the spread of the 'Hackney model' of care.<sup>12</sup>

Fiscal pressures and structural reforms to services are likely to increase the risk of failure. This increased risk makes it timely to consider what insights can be gleaned from recent experiences of failure and turnaround in the public sector.

# Chapter 2

## What do we mean by failure?

Failure is a broad term and means different things in different contexts. Despite its increasing importance to the delivery of public services,<sup>13</sup> this report is not about 'positive' definitions of failure commonly associated with innovation and entrepreneurship. In these 'positive' manifestations, 'failure' is embraced as part of an iterative learning process to discover better ways to deliver public services.<sup>14</sup> This type of failure is considered to be desirable and, in that it has been anticipated, containable.

In contrast, the focus of this report is on undesirable forms of failure. This is the type of failure that results in adverse impacts on essential public services. These impacts may include:

- unacceptable standards of service provision
- harm to service users
- disruption to service provision
- discontinuation of the service entirely.

Failure, in this sense, is a frequently contested term. Drawing on work from the National Audit Office<sup>15</sup> and PwC,<sup>16</sup> we have identified seven types of failure, which are summarised in Table 1.

**Table 1** Categorisations of failure

Type	Description
Financial	Organisations are unable to continue operation due to financial imbalance
Governance	There is a dysfunctional governance structure or senior leadership
Performance	There is an unacceptable standard of care or provision
Policy and politics	An inadequate framework for actions, strategy or stakeholder engagement is in place
External	There is insufficient preparation for both planned and unforeseen events
Commissioning	There are dysfunctional commissioning arrangements
Connection	Individual organisations focused on one aspect of the user's needs are successful, but they fail to co-ordinate and so lead to unacceptable outcomes

Importantly, these categories are not discrete – the much-publicised failings at Doncaster Metropolitan Borough Council were attributed to a chronic failure in governance, which in turn gave rise to deteriorating performance in the provision of services.<sup>17</sup> Nor are all of these forms of failure universally applicable across the public sector. For instance, local authorities have a statutory requirement to run a balanced budget, meaning that poor management of resources is likely to manifest as performance failure rather than financial collapse.

While each type of failure is worthy of investigation in its own right, the case studies and discussion featured in this report tend to focus on financial, governance and performance failure – the Institute for Government has already examined instances of commissioning and policy failure in previous research.<sup>18</sup>

# Chapter 3

## Managing failure: experience from four sectors

While much has been written about failure within individual sectors, less attention has been paid to what can be learnt from failure by looking across sectors. Much of the existing material is focused within sectors or on post-mortems of specific high-profile cases such as the Francis Inquiry into Mid Staffordshire NHS Foundation Trust and the Jay report into child sexual exploitation in Rotherham.

The core of this report presents case studies of failure and turnaround in four different sectors: local government, schools, hospitals and children's services. Each has a compelling story to tell of how systems and organisations identified, monitored and responded to failure with varying degrees of effectiveness. The case studies have been informed by 20 in-depth interviews with some of the key figures involved in the turnaround process. They have been supplemented with a wide-ranging desk review of literatures on public sector reform, risk management and organisational studies, and an analysis of current regimes and approaches for managing failure in each of the four sectors.

The case studies are:

- the commissioner-led intervention at **Doncaster Metropolitan Borough Council** following the Audit Commission's corporate governance inspection in 2010
- the turnaround at **Eltham Foundation School** (now the Harris Academy Greenwich) after Ofsted placed the school into special measures in 2010
- the turnaround at **Basildon and Thurrock University Hospitals NHS Foundation Trust**, which was placed into special measures in 2013
- the turnaround at **West Sussex children's services** after receiving a series of improvement notices and interventions between 2010 and 2015.

This cross-sectoral perspective is intended to offer broad insights into effective failure management, not only for service providers, but also for the systems that support those providers, including central government departments. Through this research, we hope to contribute to a much-needed debate about how services – and the systems that support them – can respond to the increased risk of failure in the context of austerity, major public service reforms and evolving regimes of oversight and accountability. This includes encouraging a more frank and open discussion about managing public service failure, as well as highlighting opportunities to improve the way the public sector identifies and responds to failure. This is a preliminary report, aimed at understanding more about effective failure management across a range of sectors. Given this, the sections that follow offer insights into managing failure rather than firm recommendations for change.

## Doncaster Metropolitan Borough Council

'Doncaster Metropolitan Borough Council (the Council) is failing.'<sup>19</sup> These were the first words in the Audit Commission's 2010 report on its corporate governance inspection of the council. The report described a council that 'does not do enough to meet the needs of its most vulnerable people, does not safeguard children, and has not been good at helping vulnerable people find a home'.<sup>20</sup> It also confirmed what those in the sector already knew: the council 'was a well-known failure'.<sup>21</sup>

### A failure of governance

The problems at Doncaster had a long history. In 2001, 21 councillors were convicted of fraud as part of South Yorkshire Police's 'Operation Danum'.<sup>22</sup> Problems persisted and, in 2009, the council received a 'red flag' in its Comprehensive Area Assessment and underwent an 'Ethical Governance Healthcheck' overseen by the LGA.<sup>23</sup> At the centre of the persistent failure at Doncaster was a breakdown in the relationships of those that governed the local authority. Many of the participants interviewed as part of the present research identified "a collapse ... of trust at the centre of the organisation between elected members and senior officers", or described a specific fall-out between the elected mayor and the authority: "The mayor refused to work with the new chief executive and the business of the council essentially ground to a halt."

In 2010, the Audit Commission found that this failure of governance had led to a situation in which the local authority was 'failing in its legal duty to make arrangements to secure continuous improvement in the exercise of its functions'.<sup>24</sup> The result was inadequate service provision. For instance, in 2009, two brothers aged 10 and 11, looked after by Doncaster Metropolitan Borough Council, assaulted two young victims (known as the 'Edlington case').<sup>25</sup> The resultant serious case review found that local agencies had failed to provide better outcomes for the looked-after children.<sup>26</sup> In February 2010, immediately before the Audit Commission's corporate governance inspection, councillors chose to ignore the budget proposed by the executive mayor, instead passing their own budget and so creating parallel and conflicting power structures within the organisation.<sup>27</sup>

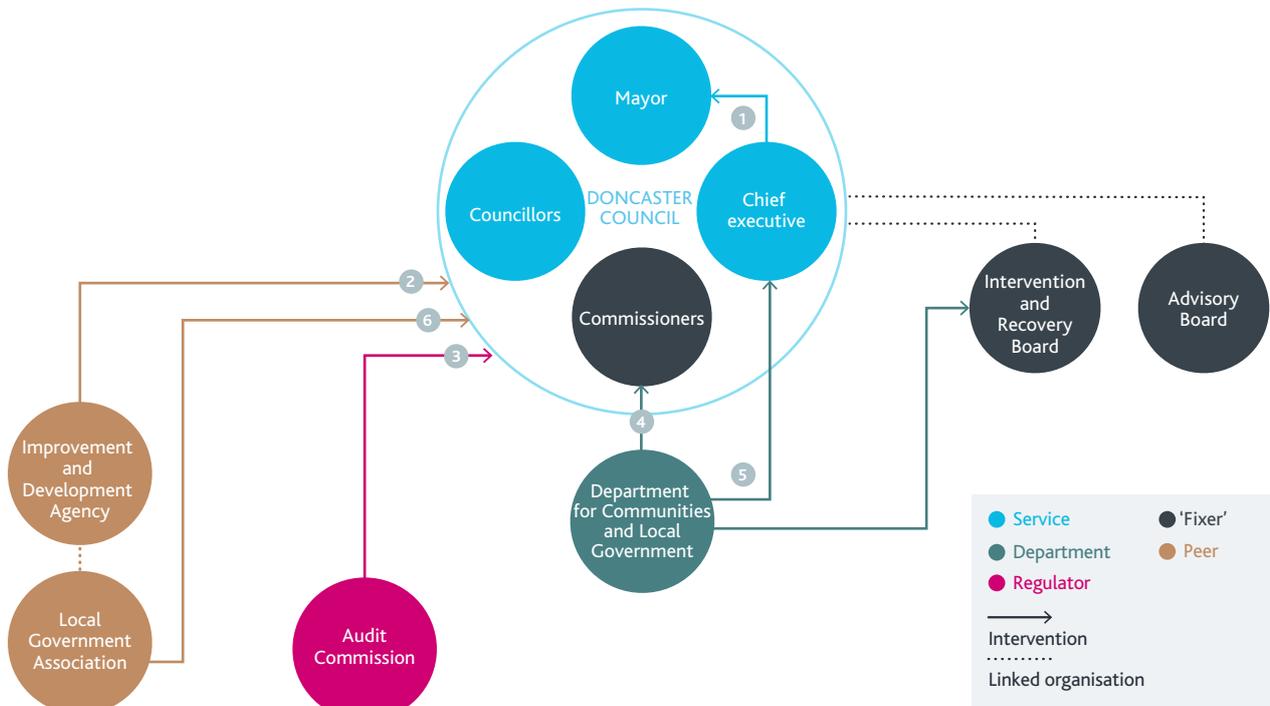
Unsurprisingly, in the council's climate of political antagonism, the Audit Commission's findings received a negative reception, with one group of councillors declaring that 'this report is the most biased, factually inaccurate gross misrepresentation that we have ever had the misfortune to read'.<sup>28</sup>

### An extraordinary step

The then Secretary of State, Eric Pickles, took a different view of the Audit Commission's findings. He responded by appointing a new chief executive, Rob Vincent, and a team of commissioners to oversee the turnaround at the council. Sir John Harman, a former leader of Kirklees Council, was asked to lead the team of commissioners who would have unprecedented powers, including the ability to intervene and direct activity within the local authority. This was an extraordinary step, with central government imposing its will on local government in direct opposition to the democratically elected councillors.

**Figure 1 Timeline of the turnaround at Doncaster Metropolitan Borough Council**

Failure in local authorities is managed through a mixture of peer support and direct intervention from the Department for Communities and Local Government (DCLG). The infographic below shows Doncaster’s experience of dysfunction, intervention and turnaround, as well as the key actors in this process



- 1 2001–2009**  
Doncaster experiences governance problems. Relationships between mayors, chief executives and councillors break down.
- 2 FEB 2009**  
The LGA’s Improvement and Development Agency (IDeA) raises concerns.
- 3 JUN 2009–APR 2010**  
In April 2010, the Audit Commission makes an inspection. Its damning report opens with a verdict that the council ‘is failing’.
- 4 APR 2010**  
John Denham, Secretary of State for Communities and Local Government, appoints an acting chief executive and Advisory Board.
- 5 JUNE 2010**  
Eric Pickles appoints a new chief executive, three commissioners, and an Intervention and Recovery Board. The LGA contributes to improvement.
- 6 2010–2014**  
Doncaster turns around. Following recommendations from the commissioners and the LGA, Pickles announces the end of the intervention in November 2014.

Sources: Audit Commission, *Corporate Governance Inspection: Doncaster Metropolitan Borough Council*, Audit Commission, London, 2010; Bennett, M., Allen, T., Grace, C. and Martin, S., *Self, Sector, or Centre? Approaches to turnaround*, Local Government Association, London, 2014.

One of the first steps for the new commissioners was to agree an improvement plan with the local authority. This set out seven broad themes for improvement (from 'corporate issues' to 'health and caring'), breaking each theme down into a number of specific actions, with a designated lead officer and a set of criteria for measuring success. Actions related to the failure of governance included:

- the production of a 'Mayor's Vision Paper'
- the linking of performance and financial information in annual reports
- a greater use of benchmarking information.<sup>29</sup>

The commissioners also focused on relationship-building. The problems at the council were driven in part by a breakdown in the personal relationships of those involved in running the organisation. Repairing these breaches placed a great emphasis on the commissioners' ability to form positive personal relationships with those involved. One interviewee said that this aspect of the intervention would make the experience at the council difficult to replicate – the need to accommodate the individual personalities involved meant that any local government intervention of this nature would need to be responsive to these personalities and so could not be expected to follow a fixed protocol.

### Could failure have been averted?

One interviewee described the appointment of commissioners as a sudden and dramatic increase in the level of intervention; rather than scaling up remedial action, central government had gone from "zero to 100". This characterisation was contested by some of the interviewees,<sup>30</sup> but for many, central government's hesitancy to intervene in local government affairs meant that the situation at the council was allowed to deteriorate to the stage where the appointment of commissioners appeared to be the only option. Things had become bad enough that only dramatic action was deemed appropriate. In its review of the intervention, the LGA identified 'a longstanding presumption against intervention on the part of central government,'<sup>31</sup> noting that this presumption held fast despite 15 years of self- and sector-led turnarounds at Doncaster that had had limited sustained impact.

However, almost all of the interviewees rejected the idea that commissioners might have been appointed earlier – in their opinions, the independence of local government means that this kind of powerful intervention from the centre should only be used as a last resort. Instead, what had been absent during the council's protracted slide into failure was a more comprehensive set of effective intermediary forms of intervention, forms that perhaps went beyond the inspection functions of the 2009 Ethical Governance Healthcheck or the 2008 Public Interest Report. When pressed on what form this might take, most participants described the potential for a greater use of peer-to-peer intervention and challenge.

## **INSIGHT 1: PEER-TO-PEER SUPPORT PROVIDES OPPORTUNITIES FOR EARLIER INTERVENTION – BUT IT NEEDS A TRIGGER**

Peers are able to operate in ways that are not available to central government. For good reason, central government is not able to intervene until it has sufficient formal evidence – such as a critical Ofsted report or, in the case of Doncaster, a damning corporate governance inspection report from the Audit Commission.

In contrast, given their grounding in the sector, peers are sometimes able to develop connections and establish legitimacy, which can allow them to offer earlier forms of support, guidance and intervention. Interviewees described this style of intervention as “a much more consensual process”, which potentially reduces the need for central government intervention and could reach local authorities before they deteriorate into serious failure. Examples of this type of work are well established; in the Institute’s upcoming research on local delivery, we identify over 100 different programmes and organisations to support local areas to learn from one another. The LGA runs a peer challenge tool whereby teams of experienced local government figures are deployed to inspect, review and make suggestions for improvement to local authorities in a specifically tailored process.<sup>32</sup> Interviewees who had seen this tool at work were positive about it. Wirral Metropolitan Borough Council was provided as a counterpoint to Doncaster. It too suffered from a failure of trust and high turnover of leaders, but this was picked up through an LGA peer review. An Improvement Board was set up and peer reviews monitored the council’s progress.<sup>33</sup> This was done without the need for central government involvement, which, as one interviewee noted, had advantages over Doncaster’s intervention led by the DCLG: “It was subtler and quicker than the intervention [in Doncaster] without the antibodies to intervention. So if you tell local government the Secretary of State is intervening, everybody gets a bit uppity really. It’s not welcome. But if it’s [led from within] a sector, there’s still tension, but it’s more acceptable.”

But while peer support is clearly extremely useful in averting failure, there is a challenge around how it should be triggered. The primary limitation of peer-led approaches is that they are currently voluntary, raising questions about whether the most troubled local authorities – which are often insular organisations with only very weak networks, as explored in a later insight in this report – are likely to seek support from peers. As one interviewee put it: “[T]he question mark in basket-case authorities is ‘are they going to invite in a peer review?’ They may, they may not.”

With this limitation in mind, strengthening the mandate of peer organisations or networks, – such as the LGA, The King’s Fund<sup>34</sup> or professional bodies – to establish a greater role for peer review as a form of “sector-led, determined, but non-statutory intervention”, as one interviewee put it, might be necessary. But what this looks like remains an open question. Juxtaposing the failure of the LGA Ethical Governance Healthcheck in Doncaster and the success of the LGA intervention on the Wirral, this may involve moving beyond using peers for inspection and towards a model of Improvement Boards and performance assurance that might more closely resemble commissioner-led interventions.

### The role of commissioners

While the commissioners in Doncaster had the ability to direct activity within the local authority, they viewed this as a reserve power. Rather than deploy it, they attempted to ensure that the council itself held ownership of the turnaround. One interviewee said: "I was very clear about that; it had to be Doncaster's recovery plan ... we have the guardianship of it, we have the monitoring of it. But we wanted it to be owned by the council."

The commissioners saw themselves in a monitoring role, measuring the progress of the council against the agreed improvement plan. This was a different use of commissioners from that pursued more recently in Rotherham, where the commissioners formed an Executive Board and replaced the council in the day-to-day running of services.<sup>35</sup> While superficially the two cases may appear similar, the differences in the behaviour of the commissioners in Doncaster and Rotherham demonstrate the extent to which intervention in local authorities is a bespoke activity.

The commissioners had to manage an apparent contradiction between their mission and the method of their appointment; despite being external appointees imposed on the council by the Secretary of State, one interviewee stated that their "ultimate aim" was "sustainable self-aware improvement at a local level, not improvement that is forced and driven by an external agent". In general, interviewees were in agreement that the commissioners succeeded in creating a genuine sense of partnership.

### Knowing when to leave

Rob Sykes replaced Sir John Harman as leader of the commissioners in April 2012.<sup>36</sup> The intervention was originally intended to conclude in July 2015, but in February 2013 Rob Sykes wrote to the Secretary of State to recommend that the commissioners remain in place for another year only.<sup>37</sup> The commissioners were withdrawn in July 2014.<sup>38</sup>

For one interviewee, the criteria for determining when to conclude the intervention were simple: "They'd got to the stage where it was by no means perfect and there was still a long way to go, but ... we were confident enough in the governance to think they could do the rest of the journey ... it didn't need commissioner intervention. And indeed commissioner intervention might well slow further progress."

This meant that it was possible for the intervention to wind down even before the turnaround was complete. Standards might still have been suboptimal – although the LGA found that the council was 'no longer an outlier in terms of the performance expected of a local authority'<sup>39</sup> – but so long as the commissioners were confident in the trajectory of improvement and the ability of the staff to maintain it, then it was appropriate to conclude the intervention. The commissioners clearly felt an imperative to wind down the intervention in good time. One of the interviewees described two "clear risks" in a commissioner-led intervention that overstayed its welcome or need: "You could end up with an organisation that either becomes frustrated because it feels it wants to run itself but thinks it's being imposed on, or you could run the risk of an organisation that becomes dependent and loses the ability to be sustaining and self-led and self-driven."

Once they were clear on when to exit, the commissioners had to decide how to exit. Some interviewees felt that the very nature of a centrally imposed intervention made it hard to exit in a manner that was conducive to continued improvement: "How do we exit as neatly and cleanly with continuing progress occurring? ... I don't think that's anything like as easy if its intervention is based on the statutory powers by the Secretary of State."

While the commissioners wanted to start the process of withdrawal early, the idea of disengaging entirely raised concerns. One participant held the view that "the commissioners should be asked about what should happen after the intervention. And if necessary, some of that should be agreed". Indeed, if the commissioners had confidence that they could play an ongoing but more remote role in improvement – perhaps checking in on a regular basis – it would "encourage people to end the intervention earlier, wouldn't it?". Others expressed concern that this 'tapered' approach to ending an intervention would have its own pitfalls; the ongoing presence of commissioners might inhibit the local authority's drive for self-reliant improvement.

## **INSIGHT 2: INTERVENTIONS MAY NOT NEED TO REMAIN IN PLACE UNTIL THE TURNAROUND IS COMPLETE**

In this research, two competing descriptions of the appropriate point for an intervention to conclude were encountered, each with their own benefits and drawbacks.

In some cases, interventions are triggered by inadequate service provision and are withdrawn once adequate provision, typically determined by a regulator, is restored. This is typical of approaches for managing failure in schools and hospitals where there is the presence of a strong regulator.

In other cases, interventions are triggered when two criteria are met:

- a. standards are inadequate
- b. the governance of the organisation is incapable of returning those standards to adequacy.

In this approach, the intervention can be withdrawn once condition (b) no longer applies, even if condition (a) still holds. Standards might still be unacceptable, but an external influence is no longer required to address this failure. In Doncaster, the research found that the commissioners exited because they "were confident enough in the governance to think they could do the rest of the journey".

The first approach, which is based on outcomes, affords more control to the agent in the system responsible for the intervention and may be appealing for the most politically sensitive issues (such as where lives are at stake). But there is also a risk that, in waiting for standards to return to normal, an outcomes-based approach may inhibit the development of sustainable governance arrangements within the failed organisation, creating a culture of incapacity or dependency. The decision regarding when to exit has a clear impact on the type of organisation that an intervention leaves behind.

### Recent updates to managing failure in local government

The intervention in Doncaster was triggered by the corporate governance inspection conducted by the Audit Commission in 2010. The Audit Commission was abolished in 2015 (as covered in the Institute for Government's publication 'Dying to Improve').<sup>40</sup> Rather than engaging with a single, national body, local authorities now make use of a network of local auditors. This is supplemented by additional auditing contracted from the private sector. For instance, in November 2014, the then Secretary of State announced a commissioner-led intervention into Tower Hamlets in the wake of a governance inspection by PwC.<sup>41</sup> Some interviewees viewed these developments as a positive part of a broader trend of decentralisation. Others were concerned that this decentralised approach foregoes the opportunity to pool insights and creates a risk that local authorities will develop their own expectations of acceptable performance.

## Eltham Foundation School (now the Harris Academy Greenwich)

In 2010, Eltham Foundation School was a co-educational secondary school controlled by Greenwich Borough Council. The school leadership had changed often. In October 2010, the head teacher quit days before the Ofsted inspection that would send the school into special measures. Standards of behaviour among students were challenging. At its worst, staff recalled furniture being thrown from windows and run-ins between students and the police. More routinely, students were late or absent from lessons, smoked outside the school building and were rude to teachers. But, by 2012, Eltham was a Harris Academy school, out of special measures and narrowly missed being designated 'good' by Ofsted. In July 2014, it was awarded 'outstanding' status in every area.

### Coming to terms with failure

*"It was absolutely crystal clear the second I walked in that building that the school was failing. What was terrifying was that it wasn't clear to the people inside it."* (Interviewee)

Eltham Foundation School had been in trouble for some time. Persistent staff turnover had a negative impact on the school's effectiveness, achievement was well below the national average and, as outlined above, student behaviour could be poor.<sup>42</sup>

These evident failings had not led to a concerted effort to restore performance at the school. Interviewees who joined as – or just before – the turnaround process began attributed this to an atmosphere of insularity, in which many school staff had lost sight of what 'good' looked like. Failings that were too bold to ignore were explained as an unavoidable consequence of working with 'Eltham kids'. This quality of insularity was also observed in the Doncaster case study.

### INSIGHT 3: INSULARITY IS OFTEN A CHARACTERISTIC OF FAILING ORGANISATIONS

One interviewee said that the staff at Eltham Foundation School had "lost sight of what standards looked like in other schools". This meant that the outcome of Ofsted's November 2010 visit – which put the school into special measures – was, if not out of the blue, difficult to accept:

*"[The staff] were genuinely very, very upset by it but I think [the school] had become such an insular institution that actually they weren't even able to say what 'good' looked like anymore. So a teacher that was capable of controlling a class was automatically good. It didn't matter what the quality of the learning was that went on in that lesson."* (Interviewee)

Throughout our research, interviewees said that failing organisations were typified by their insularity, which had allowed warped perceptions of acceptable service quality to develop. The insularity of Eltham Foundation School was manifest in:

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- a lack of contact with other schools
- continued poor standards of provision
- failure to respond to clear warning signals that things were not working.

In the case studies that were examined for this report, insularity was challenged either by emphatic designations of failure by an external body (usually a regulator) or through introducing the perspective of peers. Eltham Foundation School's insularity was dispelled by the definitive diagnosis of the Ofsted report. It provided clear evidence that the school was failing, which was used to bring the staff on board with an improvement programme. One interviewee remarked that the Ofsted report was a "vehicle for change ... we would say, you're not going to lose your jobs. But the school is going to get closed down unless we sort this out, so either get on or get off". Ofsted reports do not always have this impact – the regulator was heavily criticised by the House of Commons Communities and Local Government Committee for failing to 'get under the skin' of Rotherham Council.<sup>43</sup>

Similarly, the Audit Commission's report on its corporate governance inspection at Doncaster Metropolitan Borough Council served a comparable role, providing clear evidence of failure. While it was nevertheless vocally rejected by some councillors – perhaps the strongest testament to the council's insularity – the document provided the foundation for the local authority's improvement plan. The local authority's inward-looking culture was also tackled in part through the use of peer challenge. The leader of Barnsley Metropolitan Borough Council was brought in as a member of the Recovery Board to provide "an independent outside view, which would be likely to be accepted and seen as relevant".

### **New structures: executive heads and academisation**

The successful turnaround at Eltham Foundation School owed much to the adoption of a new 'executive head' model of governance, whereby two head teachers take joint responsibility for a school. In the January following the Ofsted report, Chris Tomlinson was appointed as executive principal and George McMillan joined as the new principal. Under the new system, Tomlinson (appointed on the basis of his extensive experience in sector leadership) held responsibilities across a number of schools, while McMillan worked solely with Eltham. Tomlinson acted as a mentor to McMillan, who stressed that their partnership involved intensive work in the classrooms and corridors of the school, rather than lofty oversight: "I think the executive headship model ... works brilliantly. It is having two people driving change. And I'm not talking about an executive who has got oversight; I'm talking about having them on the ground."

If the school had been inward-looking during its slide into failure, it began to be outward-looking as things improved. The presence of Chris Tomlinson was the first opportunity to re-engage with what other schools were doing as a means of improving the standards of Eltham. One senior leader recalled bringing in the head of art from Tomlinson's other school, Harris Academy Chafford Hundred in Thurrock, to train and support teachers and students.

The second structural change at the school was its academisation. The school joined the Harris Federation in September 2012, shortly after leaving special measures. Interviewees acknowledged that the additional financial support provided by the conversion to an academy had been very important to the school's continued improvement. They also singled out the impact of the peer

support available within a federation of schools, particularly in providing aid on specific subjects – the Harris Federation has consultants on a range of subjects, including history, geography and mathematics. But staff members were more sceptical about the extent to which academy status alone supported improvement: “I think that was back still in the days of pots of money being available if you converted, so I think that helped. So yeah, from that perspective academisation was a helpful strategy but I think it was the leadership that turned the school around. I don’t think it was our particular status.”

#### **INSIGHT 4: RESPONSES TO FAILURE CAN BE OVER-RELIANT ON STRUCTURAL REFORMS**

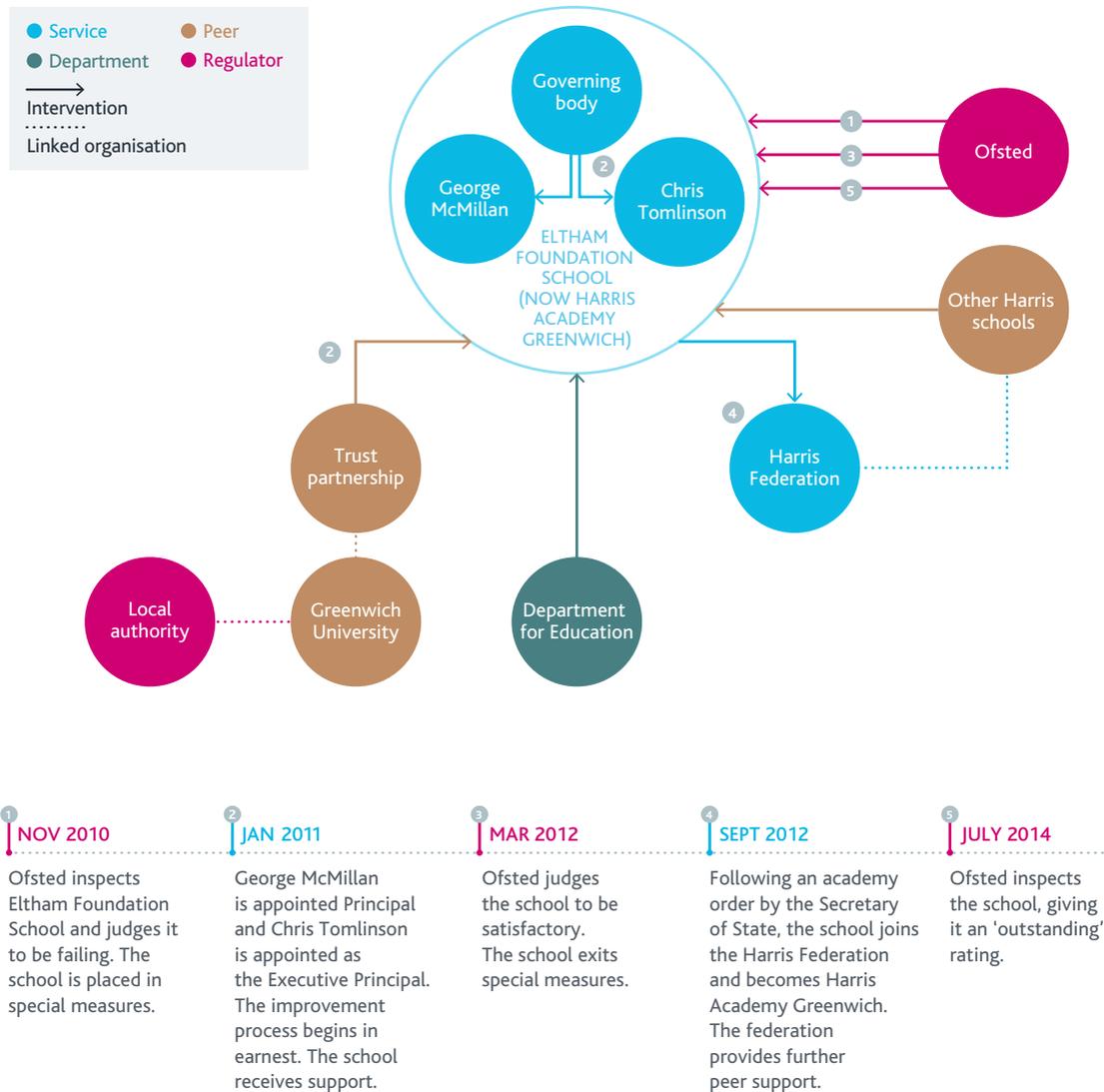
Structural change is one of the most common responses to failure; high-profile scandals are often followed by conspicuous changes to corporate governance or mechanisms for oversight and accountability. There is a risk that those with responsibility for formulating the response to failure place too much faith in these structural changes. While not a case study in this research, this was recognised in the inquiry into the failings at Mid Staffordshire NHS Foundation Trust:

*“Where there are perceived deficiencies, it is tempting to change the system rather than to analyse what needs to change, whether it be leadership, personnel, a definition of standards or, most importantly, culture. System or structural change is not only destabilising but it can be counterproductive in giving the appearance of addressing concerns rapidly while in fact doing nothing about the really difficult issues which will require long-term, consistent management.”<sup>44</sup>*

While discriminating between the impact of the change in leadership structure and the impact of the change in leadership personnel is not straightforward, it was clear at Eltham that the ‘executive head’ model had facilitated significant cultural change – bringing in a different type of leader – which was critical to the turnaround. Similarly, it was not academy status alone that led to dramatic improvements at the school – it was also access to the resources and connections of the Harris network as well as the financial benefits that were, at the time, on offer to schools that converted to the academy system.

In Doncaster, failures identified in the ‘Donnygate’ corruption scandal in 2001 prompted the Government to introduce a directly elected mayor with executive control of many of the local authority functions. As the arrival of commissioners nine years later demonstrates, structural reform may have given the appearance of addressing problems at Doncaster, but arguably these changes alone did not drive the behaviour change required for sustained improvement.

**Figure 2 Timeline of the turnaround at Eltham Foundation School/Harris Academy Greenwich**  
 Failure in schools is managed by a combination of Ofsted’s monitoring role and the Department for Education’s intervention. The infographic below shows the main stages and actors involved in Eltham Foundation School’s turnaround and conversion into an academy



Sources: Academy Funding Agreement, [www.gov.uk/government/publications/academy-and-free-school-funding-agreements-single-academy-trust](http://www.gov.uk/government/publications/academy-and-free-school-funding-agreements-single-academy-trust); Ofsted, *Inspection Report: Harris Academy Greenwich*, 3–4 July 2014, Ofsted, London, 2014; Ofsted, *Inspection Report: The Eltham Foundation School*, 29 February–1 March 2012, Ofsted, London, 2012; Ofsted, *Inspection Report: The Eltham Foundation School*, 17–18 November 2010, Ofsted, London, 2011.

### Ofsted: beyond inspections

The role of Ofsted was also singled out by staff at Eltham as an important factor in the turnaround process at the school. In addition to conducting the inspection that created the impetus for change, Ofsted monitored improvement in a manner that was seen to be constructive. One interviewee felt that the lead inspector set the tone on day one, introducing herself to the staff and clarifying her role:

*"I remember before the first monitoring visit she actually spoke to all of the staff and she explained how her role as the inspector who was leading the monitoring visits was different from an inspector who comes in and puts the school into special measures. I think that was helpful in the sense that I think she was in some ways ... perceived differently, or I felt differently about her anyway."*

There followed honest and open conversations with Ofsted, exemplified by the frank admission to monitoring inspectors that the school's "exclusions rate was about to go through the roof" soon after it went into special measures, as staff worked to get student behaviour under control. The school also had a regular line of communication outside of official monitoring inspections, which allowed the lead inspector to play a more recurrent and engaged role in the improvement process than might ordinarily be expected.

### The nerves and the brain: detecting failure in the future

Participants felt that a return to failure in the future was unlikely, in large part because of the role played by the Harris Federation. The federation was felt to have nerve-endings for detecting failure in the school and would, as one interviewee put it, "effectively act as a local authority should". However, not all academies operate within a chain or federation, and the quality of such groups varies,<sup>45</sup> with Ofsted recently issuing a public criticism of England's largest chain.<sup>46</sup> Interviewees were also sceptical about the level of oversight at non-chain academies: "If you're an independent academy then I think things can go badly wrong very quickly and you can end up in all sorts of problems without any sort of oversight at all."

In 2014, regional school commissioners were introduced, in part, to provide oversight to all academies and free schools. Participants were unclear about their role and sceptical about whether they were sufficiently resourced to oversee the rapidly expanding number of academies and free schools. Subsequent to the turnaround at Eltham, a government white paper tabled proposals to dramatically increase the responsibility of regional school commissioners by setting out plans for the conversion of all schools to academies or free schools.<sup>47</sup>

### Learning from failure

In March 2012, Eltham Foundation School came out of special measures. The accompanying Ofsted report found that 'a relentless and uncompromising drive for improvement, led by the executive head teacher, head of school and senior management team, has transformed attitudes and expectations, which are now characterised by pride and ambition'.<sup>48</sup> In 2014, the school was rated 'outstanding' in every area.<sup>49</sup> The turnaround was a success. But the leadership of the school noted that there has been limited formalised learning from their case. The interviewees said they are keen that learning about what works is made more routine across the sector:

*“So you’re saying you’ve got a problem with, let’s say for example, support staff and teaching assistants. Well here’s a case study of 10 schools and here’s how they use their teaching assistants, [in] which they have been quite successful. And here are the phone numbers of those schools and contacts that they’ve said quite openly that they would be happy to help schools to come and learn.”*

While they were sceptical about the extent to which their experience could or should be standardised, capturing a range of different approaches to managing failure and making them available to schools that need support would help them to learn from Eltham’s – and others’ – experiences.

### Recent updates to managing failure in schools

In March 2016, the Government launched the Educational Excellence Everywhere white paper, which sets out plans for the conversion of all schools in England to academies or free schools.<sup>50, 51</sup>

Regional school commissioners will play a key role in mitigating failure at these schools, and will be ‘responsible for commissioning interventions when academies and free schools in their area are underperforming’.<sup>52</sup> The white paper stresses that regional school commissioners will not provide improvement support to schools and will have ‘no responsibility for the performance of, or powers over, academies that are not coasting or failing’.<sup>53</sup> The white paper, in part, serves as a response to the call from the House of Commons Education Committee, issued in January 2016, urging the Government to:

- clarify the role of regional school commissioners
- review and increase the number of school commissioners
- ‘as a matter of urgency’, clarify the respective roles of local authorities and regional school commissioners in relation to academies.<sup>54</sup>

It remains to be seen whether the Government will more clearly define the role of regional school commissioners in dealing with failure in schools.

## Basildon and Thurrock University Hospitals NHS Foundation Trust

Basildon and Thurrock University Hospitals NHS Foundation Trust was part of the first wave of NHS foundation trusts to be established in England in 2004. Foundation trust status was awarded to those hospitals that were considered to be the elite performers of the NHS.<sup>55</sup> For their excellence they were granted greater managerial and financial freedom. But by 2013, the regulator set up to oversee these new trusts – Monitor – had placed Basildon into special measures. A series of visits from the Care Quality Commission (CQC) exposed declining standards of care and safety, while data indicated that mortality rates at the hospital were significantly higher than the national average.<sup>56</sup>

Yet less than a year later, Basildon and Thurrock came out of special measures in what the Health Secretary described as a 'remarkable turnaround'.<sup>57</sup>

### The failure trajectory

Problems were beginning to show at Basildon and Thurrock long before the trust was placed into special measures. In 2009, the CQC issued the hospital with a 'warning notice' after it found some sections of the hospital to have stained floors and privacy curtains, blood-splattered trays and equipment, badly soiled mattresses and some equipment still being used after the use-by date.<sup>58</sup> A CQC taskforce was appointed to drive improvement at the hospital.<sup>59</sup> In September 2012, a new chief executive, Clare Panniker, was appointed to the trust. Two months later, in November 2012, the CQC issued Basildon and Thurrock with a further series of enforcement actions and warning notices following a poor inspection, but did not push the trust into special measures. The trust was required to report by January 2013 on its plan to rectify three breaches of its regulatory requirements. This would include the introduction of 'an effective system ... to identify, assess and manage risks to the health, safety and welfare of children who use the service'.<sup>60</sup> With the new chief executive at the helm, improvement and turnaround began immediately.

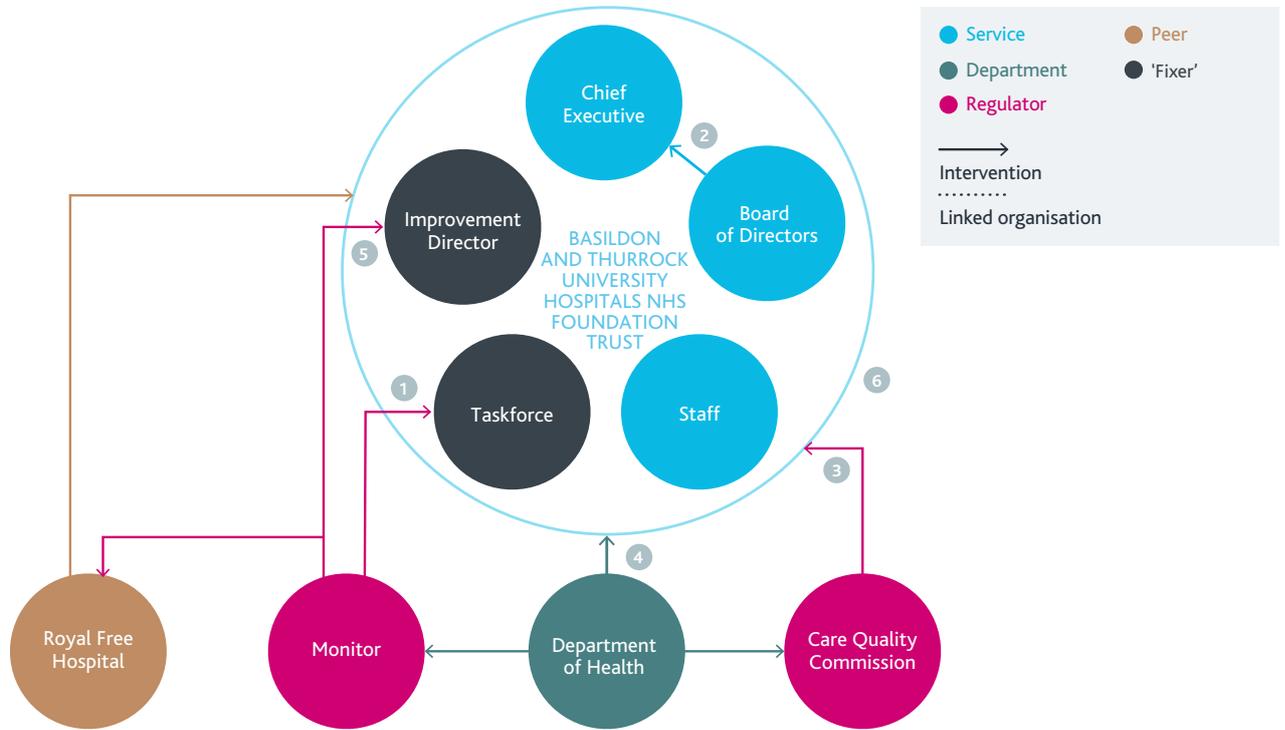
Then, in July 2013, the trust was one of 11 trusts placed into special measures by the Health Secretary, Jeremy Hunt, in the wake of the Mid Staffordshire crisis and the Keogh mortality review.<sup>61,62</sup> While acknowledging that the trust was already improving in response to the CQC action the previous November, the Keogh review found that the trust still had a high mortality rate.<sup>63,64</sup>

This designation dealt a massive blow to Basildon as many, including the chief executive, believed that it was already on an improvement trajectory. As she has written elsewhere: "[I]t was disappointing, as our turnaround was under way. Morale was improving, staff were raising concerns and we were listening and changing."<sup>65</sup>

Despite the momentary shock, the hospital board drew up a new improvement plan to take Basildon out of special measures. The response also included the appointment of an improvement director and the recruitment of around 240 new clinical staff. A partnership with the Royal Free London NHS Foundation Trust was also put in place to support the trust's leadership in its turnaround journey.

**Figure 3 Timeline of the turnaround at Basildon and Thurrock University Hospitals NHS Foundation Trust**

Failure in hospitals is largely managed by national regulators such as Monitor and the CQC. The infographic below shows Basildon’s journey from a failing trust, to special measures, to continued improvement



- 1 NOV 2009**

Following a CQC inspection and negative report, Monitor sends in a taskforce to secure improvements at Basildon and Thurrock. The trust is required to take immediate action.
- 2 SEPT 2012**

Clare Panniker is appointed the trust's new chief executive.
- 3 NOV 2012**

Following a poor CQC inspection result, the trust receives a series of warning notices.
- 4 JULY 2013**

In the wake of the Francis Inquiry, Health Secretary Jeremy Hunt announces Basildon and Thurrock will be one of 11 trusts placed in special measures.
- 5 OCT 2013**

Monitor appoints an improvement director, Adam Cayley, and arranges a partnership with the Royal Free Hospital. An improvement plan is created.
- 6 JUNE 2014**

Following a recommendation by the Chief Inspector of Hospitals, Basildon and Thurrock exits special measures.

Source: Monitor, Care Quality Commission and the NHS Trust Development Authority, *A Guide to Special Measures*, Monitor, London, 2015, [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/403083/Special\\_measures\\_update\\_feb\\_2015\\_final\\_for\\_publication.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403083/Special_measures_update_feb_2015_final_for_publication.pdf)

### A new approach to clinical governance

The primary focus of the improvement plan was on improving the standards of patient safety and quality of care. One interviewee noted: “[T]he chief executive was very clear that patient safety and quality came first and foremost and that was what had to be the priority for the organisation.”

To achieve this, a radical transformation of the trust’s clinical governance systems was undertaken. The research found that the current systems were not very good at “evidencing what was going on” and were in need of streamlining. It also revealed that some of the quality assurance systems, including the risk management policy and structure, were “outdated”.

As a result, the hospital’s quality assurance frameworks, incident reporting systems and risk registers were reviewed and improved. This included the introduction of an in-house calculator for the ‘Summary Hospital-level Mortality Indicator’ – one of the metrics on which the hospital had been placed into special measures – as well as ‘clinical dashboards’ to monitor any ‘performance slip’ across the hospital.<sup>66</sup> A streamlined approach to governance was also launched, with all divisions of the hospital presenting data at three key meetings – on patient safety, patient experience, and risk and compliance.<sup>67</sup>

Interviewees described these changes as integral for turnaround as they provided both front-line staff and management with the necessary information, forums and feedback loops to identify and act on emerging trends and risks to patient safety and care.

Critical to this was making sure that the new governance systems were made meaningful for front-line staff. Bespoke training sessions were provided for different staff groups and it was made clear how staff would be supported to drive improvement in their area of work. One interviewee remarked: “I think the key aspect, for me, was making it meaningful for front-line staff ... if you are a nurse or a doctor working on the front line, looking after patients on a day-to-day basis, or you are an operational manager that is focusing on referral-to-treatment times, how do you instil governance as part of business as usual?”

While the strategy was set from the top, it was clear that Basildon was able to achieve the pace of turnaround it did because the whole organisation had a role in raising standards of care. Staff were able to integrate risk, quality assurance and patient safety as part of their day-to-day jobs rather than them being seen as additional tasks.

### A new culture of openness and transparency

Crucially, the leadership recognised that in order for the new assurance systems to be embraced, significant culture change was required: “You can put all the policies and procedures you like in place, but actually if you don’t have the people believing and wanting to make a change, then it is never going to happen.”

An open, no-blame approach to incident reporting was promoted throughout the organisation. Care had to become everyone’s concern. Staff at all levels, including non-clinical roles such as porters and cleaners, were proactively encouraged to speak up. The leadership assured staff that raising an incident or reporting a near miss would not result in negative repercussions: “If they [staff] were going to raise an incident report, nobody was going to get blamed, nobody was going to come back to them from middle management to say why have you raised that incident report” (interviewee).

The changes to clinical governance and culture meant that incident reporting increased substantially – meaning that the trust, which had previously had one of the lowest reporting rates in England, now had one of the highest.<sup>68</sup> But the increase was indicative of the cultural transformation at Basildon and Thurrock. Patient safety and patient quality had gone to the front of everyone's mind and it allowed the trust's leadership to have a richer understanding of what was going on inside the hospital.

### **INSIGHT 5: CREATING AN OPEN, NO-BLAME CULTURE HELPS TO PROTECT AGAINST FUTURE RISK OF FAILURE**

The turnaround at Basildon meant an unrelenting focus on improving quality of care and patient safety. This was not brought about by a top-down restructuring, but by fostering a culture of openness and transparency where all staff felt able to contribute to a safer, higher-quality health service. At least in the short term, greater transparency meant increased incident reporting. Similarly, the turnaround at Eltham Foundation School began with an honest statement to the local authority about the anticipated increase in exclusions data. This culture, now firmly embedded at Basildon, serves not only as a platform for continuous improvement, but also as the trust's first line of defence against any future risk of failure.

The inquiry into the well-known failings at Mid Staffordshire revealed that the early warning signs from front-line staff were not recognised because the culture was one of fear and secrecy.<sup>69</sup> Staff were actively discouraged from speaking up and the Board had disassociated itself from what was happening on the front line. Such an environment provided the conditions for failure to 'incubate'<sup>70</sup> and poor care to be 'normalised' as declining standards of care became accepted over time.<sup>71</sup> This concept of normalisation may also partly explain why teachers at Eltham Foundation School had such difficulty in accepting that the school was failing.

This was the type of scenario that Basildon worked hard to avoid. The culture of openness and transparency at the trust now provides staff with a clear indication of what 'good' looks like and allows early warning signals to be recognised and flagged without fear of blame.

#### **The journey is not over**

In June 2014, Basildon was removed from special measures after receiving a 'good' rating from the CQC – just under a year after it had been given notice in July 2013. The dedicated improvement director stood down, and the foundation trust was no longer required to publish progress on its recovery plan. For the first time since 2009, the trust was functioning without any regulatory intervention.<sup>72</sup> But the journey is not over. The goal for Basildon now is not only to sustain the improvements it has achieved, but also to continue making improvements. Its ambition is to get an 'outstanding' rating from the CQC: "[J]ourney' is the word that has been used at Basildon for two and a half years now ... but actually, the journey will continue and even when they get to outstanding, they will be looking at what else they need to do" (interviewee).

Organisational learning throughout the turnaround process has been and will continue to be crucial to this journey. One senior leader described the hospital's management team regularly taking time to reflect on how the improvement process was functioning:

*"[O]rganisationally, I think there is a lot of learning that goes on and I think the culture is very much around learning. I think certainly at Basildon the executive directors and the senior management team often reflected on how the organisation had got to where it got to and knew what needed to take place and be sustained to prevent that from happening again."*

Basildon has also been sharing its experience of failure management through external engagement – talking about its journey and helping other hospitals to ensure that the right leadership, culture and assurance systems are in place in order to avoid failure.

## **INSIGHT 6: THERE IS SCOPE FOR MORE SECTOR-WIDE LEARNING FROM FAILURE**

Basildon's experience aside, learning from failure – and learning how to avoid further failure – is not necessarily commonplace across all hospitals. Our research found this in other sectors too. For instance, an interviewee from the children's services sector suggested that while "we're good at responding to failure ... I'm not so sure that we are good at learning from it".

Where learning, sharing and dissemination do occur, it tends to be localised and led by proactive organisations and groups of organisations that "want to be open and transparent", rather than opting to "stay behind closed doors and get out of special measures". While Basildon was eager to share its experience, this was symptomatic of its culture rather than something that is routine.

This feedback suggests that there is an opportunity to capture and more widely disseminate lessons on turnaround, as well as guidance on how organisations can mitigate the risk of future failure. While there was evidence of semi-organised learning in the sectors that were looked at for this research – for example the LGA's peer review process or organised support brokered through central resources offered by the Harris Federation – the over-riding conclusion of the interviewees was that sector-wide opportunities to capture learning are currently quite limited.

Arguably, there is a case to bolster those institutions that broker support within the sectors, to allow them to convene more routine opportunities for learning and sharing. Interviewees were sceptical about whether existing organisations – including professional colleges – currently fulfilled this role.

### **Recent updates to managing failure in hospitals**

In June 2015, NHS England published its new 'Success Regime' for failing services.<sup>73</sup> This introduced techniques and processes for dealing with failure on a systemic level, focusing on the wider health and social care economy rather than solely on the performance of individual services. This broader scope distinguishes the new approach from existing special measures or 'trust special administrator' methods of intervention. Under the Success Regime, failing health economies are subject to an intervention under the collective governance of regional directors from NHS England, Monitor and the NHS Trust Development Authority.<sup>74</sup> To date, Essex (of which Basildon and Thurrock University Hospitals NHS Foundation Trust is a part), Cumbria and Devon have been subject to the new Success Regime. It is too early to comment on the effectiveness of this approach.

## West Sussex children's services

In 2009, West Sussex children's services were issued an improvement notice by the Department for Education. Despite a restructuring, a subsequent joint Ofsted and CQC inspection of safeguarding and looked-after children's services in April 2010 rated parts of the service 'inadequate'. Their report raised numerous concerns, including:

- weaknesses in the protection of children
- inadequate performance monitoring
- poor capacity for improvement.<sup>75</sup>

While West Sussex County Council's systems for safeguarding children had not collapsed, they were an area of sustained underperformance. Further remedial action was taken in March 2011, when the Minister of State for Children and Families issued the council with an improvement notice. This required it to work harder to resolve the areas of weakness identified in the 2010 Ofsted/CQC inspection.<sup>76</sup>

After a period of intervention, West Sussex received an 'adequate' Ofsted rating in 2011 and a 'requires improvement'<sup>77</sup> rating in 2015. West Sussex children's services' journey from failure, to turnaround, to improvement has been drawn out, but it is one with many lessons.

### A shock to the system

When Ofsted and the CQC rated the service as 'inadequate' in 2010, it had an immediate impact on morale and financial resources:

*"You can't recruit staff, they don't want to work in a failing system ... You also I think end up spending an awful lot of money ... you're then having to have very difficult conversations with your politicians around, you know, this is going to cost us £7 million to £10 million and the state of local authority budgets at the moment, that's difficult."* (Interviewee)

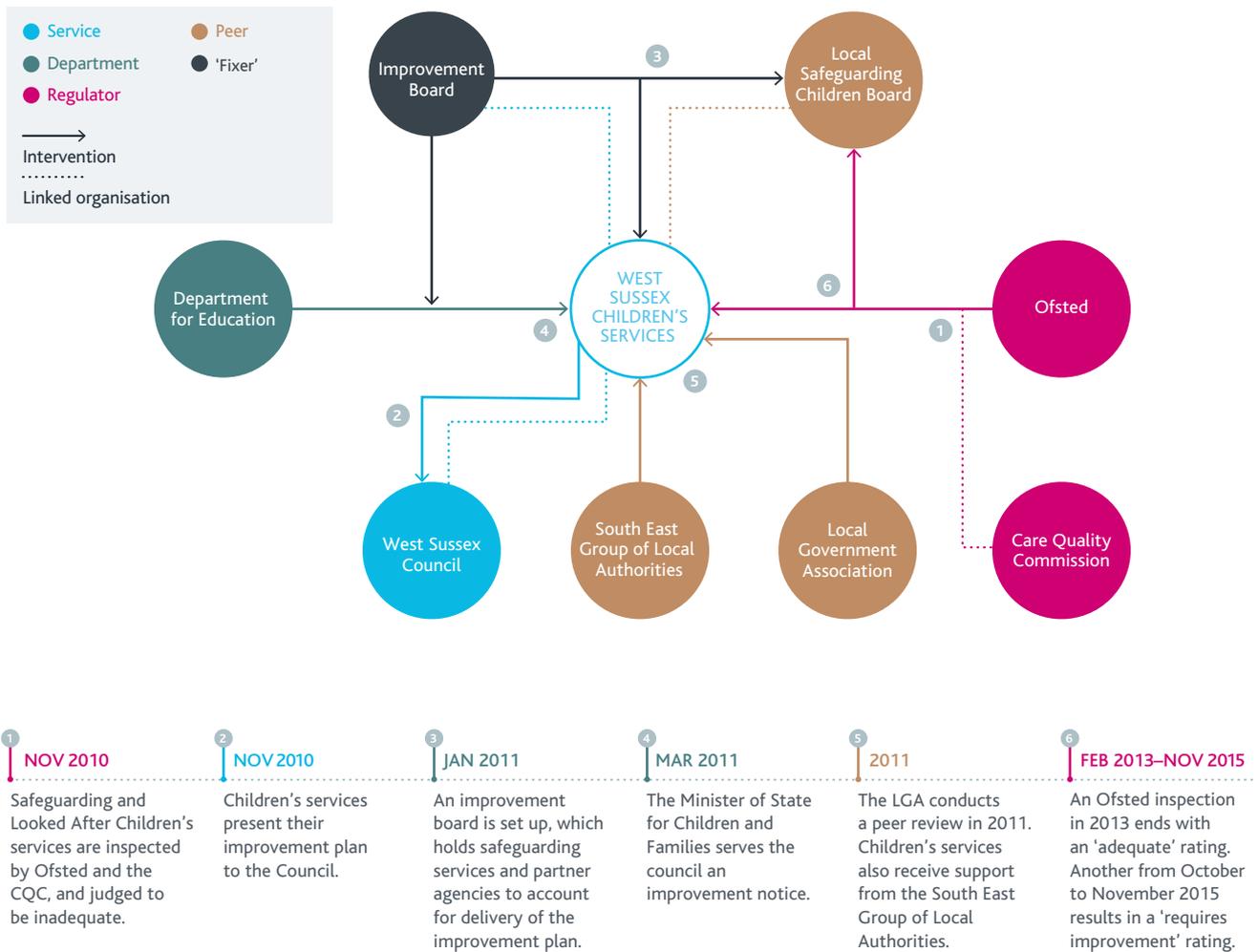
Designating the organisation as 'inadequate' may have initially impeded the turnaround process, complicating the recruiting of new staff and diminishing already tight budgets, but the inspection report also prompted action. Children's services presented an improvement plan to the council's select committee. The plan focused on:

- child protection processes
- improving management and leadership
- social work practice
- improving educational attainment
- performance management arrangements
- partnership and governance arrangements
- corporate parenting.<sup>78</sup>

Progress against this plan was measured by an Improvement Board chaired by experienced children's services director, Nick Jarman. A new head of improvement, Kevin Peers, was also appointed.<sup>79</sup>

**Figure 4 Timeline of the turnaround at West Sussex children’s services**

Performance in children’s services is assessed and monitored by Ofsted, while the Department for Education issues improvement notices. Councils and children’s services are responsible for their own improvement, drawing on the support of peers and external experts. The infographic below shows the experience of West Sussex, and the main actors involved



Sources: Ofsted, *Inspection of local authority arrangements for the protection of children: West Sussex County Council*, 11–20 February 2013, Ofsted, 2013; Ofsted, *Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board*, 26 October–19 November 2015, Ofsted, 2016 [n.b. published following year].

## **INSIGHT 7: FAILURE CAN (APPEAR TO) GET WORSE BEFORE IT GETS BETTER**

The attribution of 'failure' is a performative act – simply by applying this label, a regulator or inspector will change the organisation's relationship with its staff, users and peers. In some instances, the initial designation of failure can push an organisation further away from turnaround.

At West Sussex it was found that being labelled as 'inadequate' had an immediate, partly detrimental effect that "almost conversely tips you into being more inadequate for a period of time" (interviewee). These impacts included:

- immediate financial costs to recruit turnaround assistance
- deteriorating staff morale
- challenges in retaining staff.

One interviewee said that it can take "a good three to six months to just get back to the point where Ofsted left you", let alone a complete turnaround.

However, our research also revealed that in some cases what appears to be worsened performance is in fact the beginning of honest reporting; the ascription of failure often reveals the true extent of the problems being experienced. At Eltham Foundation School, for example, exclusion rates went "through the roof", as one interviewee put it, soon after it went into special measures as the school leadership started to manage behaviour standards among students more proactively. Similarly, at Basildon, incident reporting increased dramatically as a result of the changes to reporting systems as well as broader cultural change promulgated as part of the turnaround.

In West Sussex, the designation of failure had a genuinely negative effect in the first instance and more needs to be done to mitigate the traumatic impact that the designation of failure can have on recruitment and retention in particular. However, the labelling of failure can also be a pivotal moment in breaking an organisation's insularity, bringing problems into the open and galvanising it into action. While this was perhaps best illustrated in the account of the turnaround at Eltham, Basildon and eventually Doncaster displayed similar properties, where the designation of failure prompted the appearance of a momentary slide backwards that was in fact indicative of a move towards more effective reporting procedures and failure management.

### Difficulty in designation

One difficulty that was raised by interviewees was the changing context in which they were operating – what felt to them like “shifting priorities”. The sector was already undergoing major changes – the failure at Rotherham had meant that the boundaries of what front-line staff were required to address changed on a “fairly regular basis”. Child sexual exploitation, extremism and female genital mutilation were all rising up the political agenda and being added to an already significant list of priorities for children’s services.

This mix of issues and actors meant that it was difficult for local services to know what to prioritise or to know who in the system was ultimately responsible for defining what constituted failure. This was compounded by the fact that the organisation was also struggling to understand what good performance looked like in each of the areas flagged for improvement: “At the point we went into intervention, everyone thought they knew what ‘good’ looked like. The only problem was we had four or five different definitions of good amongst the management team” (interviewee).

### The importance of assurance

The turnaround process at West Sussex was supported by strong mechanisms for monitoring and assuring progress. Peers provided one source of critical assurance: a 2011 review by the LGA analysed the strengths and weaknesses of the local authority’s children’s services, while suggesting areas for improvement.<sup>80</sup> The local authority also benefited from data benchmarking among local authorities in the South East of England.

The improvement board also made a significant contribution to assurance. Its role was to hold safeguarding services (the focus of the intervention) and partner agencies to account for the delivery of the improvement plan. It was made up of councillors, council leadership, children’s services’ professionals and representatives of partner agencies. Two officials from the Department for Education sat as observers and provided challenge.<sup>81</sup> The LGA review noted that the board was undertaking a ‘good range of work and helping to drive improvement’.<sup>82</sup>

Some interviewees raised questions over the relative balance of assurance processes, noting the importance of ensuring that assurance processes are not pursued at the expense of improvement: “You have got to do a huge amount in terms of public reassurance. You end up feeding a beast which is an improvement board, and it is a beast, rather than actually being able to clear the decks and say right, we need to roll our sleeves up and turn this round.”

However, as later noted by Ofsted, clear scrutiny of progress was an important factor in driving the turnaround at West Sussex.<sup>83</sup>

### Sustaining improvement

In line with the requirements of the improvement plan, children’s services adopted new assessment processes informed by the 2011 Munro Review of Child Protection.<sup>84</sup> Recognising the challenges associated with recruitment, the council also increased support for social workers and set out plans to develop a local ‘social care academy’ to support newly qualified social workers through their first year of practice and to retain them.<sup>85</sup>

An unannounced Ofsted inspection in 2013 of the arrangements at West Sussex for the protection of children rated them ‘adequate’, with no systemic failings. The inspection report

credited the council and the local safeguarding children board for their clear improvement plan, commitment to implementing it and the scrutiny of its progress.<sup>86</sup> Inspectors also credited senior leaders for having 'created an open learning culture in which staff at all levels are fully engaged'.<sup>87</sup>

Another Ofsted inspection in late 2015 rated West Sussex children's services as 'requires improvement'. The inspection report acknowledged the service's recent improvement, but noted that too many children experienced changes in their social worker and a small number of care leavers were living in bed and breakfast accommodation.<sup>88</sup>

The trajectory of failure and turnaround is not always linear. Rather, it is often messy and fitful, where the designation of failure does not always match the last or lowest point of poor performance, as shown in both West Sussex and Basildon, where the turnaround was already underway when the hospital was tipped into special measures. What both these case studies illustrate, however, is the importance of building an open learning culture that allows for continuous, self-sustaining improvement that is able to withstand short-term setbacks.

### **INSIGHT 8: TURNAROUNDS SHOULD SET THE FOUNDATION FOR LONG-TERM IMPROVEMENT, AS WELL AS DEALING WITH IMMEDIATE PROBLEMS**

Recovery from failure is only half of the journey; all of the interviewees aspired to convert their turnarounds into lasting and sustainable improvement. But the method of intervention – its demands for resources, its potential propensity to inculcate short-term thinking and the nature of its cessation – had an impact on the organisations' ability to transition out of recovery and into enduring improvement.

Our research found that some organisations can be too focused on achieving an 'adequate' rating without addressing the underlying causes of poor performance. One interviewee from West Sussex noted how some children's services simply hire new staff until their ratings are dragged up to an acceptable level, only to see them fall once they leave. Others said that the barrier to ongoing improvement can simply be exhaustion from tackling immediate problems, or from the turnaround process itself.

But throughout the case studies, multiple strategies were used to move beyond tackling immediate problems and help sustain turnaround and improvement:

- In Doncaster, interviewees talked about the importance of ensuring that interventions are designed in a way that allows organisations to build their internal capacity during the turnaround process. This included thoughtful specification of the commissioners' powers and the option for a tapered exit.
- In Basildon, they emphasised the importance of leadership in driving cultural change and clearly articulating the vision for improvement from the outset. The goal at Basildon was always to not only come out of special measures, but to go one step beyond that and take the organisation to outstanding.

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- In West Sussex and Eltham, interviewees noted the importance of drawing on peers for ongoing support and challenge between periods of formal inspection.

Interventions clearly place extraordinary demands on services to transform. But, as one interviewee put it, organisations that can focus on continuous improvement beyond formal inspections “is the difference between those services that ‘yo-yo’ in and out of intervention and those that end up on a constant improvement track”.

### Recent updates to managing failure in children’s services

In December 2015, the then Prime Minister David Cameron announced that, under new reforms, failing children’s services will be transferred out of the control of local authorities. If the service does not show improvement within six months of their Ofsted inspection, ‘a new service leader (Commissioner) will be put in place and high-performing local authorities, experts in child protection and charities will be brought in’.<sup>89</sup> The announcement coincided with news that children’s services in Sunderland, which received an ‘inadequate’ judgement from Ofsted in July 2015, would become a voluntary trust. However, it is not clear where responsibility will lie for monitoring these new independent trusts and whether a new layer of oversight might be introduced. There is also ambiguity about whether such arrangements will become a ‘new normal’, or whether they represent a time-limited intervention before the services are returned to local authority control. If it is to be the latter, greater clarity will be required about the criteria for exiting the intervention.<sup>90</sup> The Government has also announced a review of local safeguarding children boards and the centralisation of serious case reviews to create a single hub for learning from serious incidents.<sup>91</sup>

# Chapter 4

## Conclusions

This research has looked at examples of failure management across a range of sectors – local government, schools, hospitals and children’s services. The passages through turnaround that have been described have involved different types of intervention – from the use of centrally appointed commissioners to softer forms of partnership working and support. From these individual case studies, eight insights about managing and responding to failure have been identified:

- Peer-to-peer support provides opportunities for earlier intervention – but it needs a trigger.
- Interventions may not need to remain in place until the turnaround is complete.
- Insularity is often a characteristic of failing organisations.
- Responses to failure can be over-reliant on structural reforms.
- Creating an open, no-blame culture helps to protect against future risk of failure.
- There is scope for more sector-wide learning from failure.
- Failure can (appear to) get worse before it gets better.
- Turnarounds should set the foundation for long-term improvement, as well as dealing with immediate problems.

While the focus of the case studies was on events several years past, all of the interviewees were acutely aware of the changing nature of the response to failure in their sector. The abolition of the Audit Commission,<sup>92</sup> the introduction of regional school commissioners,<sup>93</sup> the transfer of failing children’s services to independent trusts<sup>94</sup> and the new NHS Success Regime<sup>95</sup> all represent major changes and remain in the early stages of their implementation. So, in addition to the eight insights, three broader conclusions emerged from the research that helped in understanding the nature of failure in the first place and should be borne in mind as further reforms are implemented.

### The ownership of failure is shared

It is rare that one single thing goes wrong when failure occurs or that a single person is to blame. Instead, the ownership of failure is shared. This idea can be counter-intuitive: in public services, as in many organisations, the identification of failure is frequently followed by the attribution of blame.<sup>96</sup> Indeed, research is consistent in showing that 70 to 80% of inquiries across a range of industries and professions attribute tragedies to the error of particular individuals.<sup>97</sup> However, the case studies suggest that an over-reliance on the blame of an individual could forestall a more rigorous attempt to understand why failure arose, how it could be resolved and what might be done to prevent its re-occurrence.

In the case studies, collective responsibility frequently extended beyond the individual public service organisation in which failure was most acutely observed and incorporated a wider system, including the central government department, local government structures, the regulator and neighbouring services. For example, the House of Commons Communities and Local Government Committee found that the failure of Rotherham’s children’s services resulted from complementary underperformance in the police service, the Home Office and the local authority.<sup>98</sup> When failure is not owned and approached at a system level, the result can be unco-ordinated interventions at notionally separate organisations whose failure is nonetheless inherently linked, such as the parallel interventions at Doncaster Council and its children’s

services.<sup>99</sup> The new NHS Success Regime, with its focus on wider healthcare economies rather than individual organisations,<sup>100</sup> appears to be an attempt to respond in a way that acknowledges the shared nature of failure.

### Failure has fluid boundaries

Throughout the research, it was difficult to cordon off a discrete 'period of failure' in the timeline of an organisation. Instead, phases of failure and of improvement appeared to overlap or to be intermingled. For instance, in Doncaster, the governance of the council was judged effective enough for the commissioner-led intervention to end before the organisation had raised service standards to an acceptable level. Organisations were sometimes likely to get worse – or appear to get worse – before they got better. In Eltham, one of the first signs of improvement was tackling behaviour problems, which led to a spike in exclusions data.

As well as having fluid chronological boundaries, failure also appeared to have fluid definitional boundaries. For instance, the definition of failure was frequently observed to be responsive to unforeseen events and therefore liable to unpredictable change. The CQC investigated Basildon and Thurrock University Hospitals NHS Foundation Trust in November 2012 and did not judge it to be failing.<sup>101</sup> In 2013, a clearer description of what had happened at Mid Staffordshire was produced that changed the understanding across the sector of what failure looked like, and Basildon was placed in special measures.<sup>102</sup> In West Sussex children's services, there were new emphases on radicalisation, female genital mutilation and other issues after high-profile scandals. In sum, the definition of failure is subject to change, which means that responses to failure will need to be continuously updated in light of the ever-evolving understanding of what constitutes failure. This places an emphasis on the capacity of the system to learn from experiences of failure, both through the centralised pooling of insights and through normalising routines of learning and diffusion closer to the front line.

### Cultural reform is key to responding to failure

In all of the case studies, turnarounds were to some extent predicated on the adoption of new cultures and ways of working. This was seen most starkly at Eltham and at Basildon, where new patterns of behaviour were seen as means of both overcoming extant failure and preventing its re-occurrence. Open, blame-free cultures, where staff are actively encouraged to flag risks or concerns about standards of provision, allow organisations to prevent further failure and encourage reflection when failure does occur.

In contrast, a cultural environment like that of Mid Staffordshire NHS Foundation Trust – where staff were actively suppressed from speaking up – allows insularity to set in and failure to incubate. This insularity creates the conditions in which organisations lose the ability to diagnose their own problems, as observed at Doncaster. Peer interventions were felt to be a particularly powerful tool in overcoming this insularity and driving cultural reform. Many of the interviewees felt that an over-reliance on purely structural reforms might overlook the necessity of this type of cultural change. While structural reforms can be an important part of managing failure, unless these are grounded in a forensic understanding of the causes of failure, they are unlikely to succeed alone and in some instances could create further disruption.

## Next steps

This report represents the Institute for Government's initial research into the subject of failure in public services. It is hoped that the report has enhanced understanding of how services – and the systems that support them – can respond to the increased risk of failure in the context of continued pressure on public spending, public service reforms and evolving regimes of oversight and accountability. The Institute will look to publish further work on this subject in the future.

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#### Chapter 4: Conclusions

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