Audit & Governance Committee

Dorset County Council

Date of Meeting	20 September 2016
Officer	Head of Corporate Development
Subject of Report	**Learning from Service Failures in other Authorities and Implication for Governance**
Executive Summary	This paper highlights the impact and causes of service and governance failures across the organisation. Drawing on a range of publications the paper consolidates the learning that has taken place as organisations turn themselves around and change. The paper also categorises failure and uses four examples to illustrate the point.
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: N/A
	Use of Evidence:
	Budget: N/A
	Risk Assessment: The paper highlights potential risk but the paper provides information only.

	Other Implications: The learning from others experience of failure is such that it provides some useful information that support the role oversight and scrutiny is protection from failure and ensures correction where needed.
Recommendation	The committee is asked to note the contents of the report and comment on any future actions that may be required as a result.
Reason for Recommendation	The committee will need to reflect on any actions required across the authority that result from the points raised in the report.
Appendices	None
Background Papers	None
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1. Background

1.1 Over the recent past there have been reports that have detailed the service failures across a range of public sector organisations. A variety of publications have highlighted the failures and a very useful synthesis has been undertaken by the Institute of Government[1] that provides some insight into the factors that came into play to create such failures in public services.

1.2 This paper seeks to summarise the adverse impacts that failure can have on organisations and the public. These impacts may include:

- Unacceptable standards of service
- Harm to service users
- Disruption of service provision
- Discontinuation of service entirely

For the organisation in question these impacts may lead to reputational damage, additional costs or direct intervention by others.

1.3 This paper will use the analyses by others to assess the implication for Dorset County Council with a particular emphasis on learning from governance and oversight failings of a variety of public sector organisations.

2. Categorisation of failures

[1] Failing Well. Institute for Government 2016

2.1 It is suggested in much of the current literature that failure is a contested term. However there have been attempts to categorise types of failure and these are listed below.

Type	Description
Financial	Organisations are unable to continue 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 user's needs are successful but they fail to coordinate and so lead to unacceptable outcomes

2.2 The categories are not discrete and they do overlap and it is worthwhile to examine the issues from a range of organisational and sectorial perspectives.

3. Summary of Failures and Consequences.

3.1 For the purposes of this paper the primary category reported will be that of governance failure and they will be examined from the learning derived from the following organisations:

- Tower Hamlets
- Doncaster Metropolitan Borough Council
- Rotherham Metropolitan Borough Council
- Basildon and Thurrock University NHS Trust

The following table highlights the failures and the consequences that resulted from such failures and section four will reflect on what the authority might learn

Learning from Service Failures in other Authorities and Implication for Governance

Organisation	Summary	Consequences
Tower Hamlets LBC	Best Value review undertaken by PWC revealed: 1. Grant awarding process lacked transparency and rigour with very poor monitoring which compromised best value principles. 2. Transfer of property to third parties was subject to certain irregularities. 3. Spending on media and publicity were subject to questions about appropriateness and value for money. The inspection identified failures to comply with the best value duty, these failures have occurred under the Authority's governance arrangements as they have existed throughout the period and continue to exist at the present time	Secretary of State imposed three commissioners on Tower Hamlets LBC. They are set to remain in place until 31 March 2017. Appointment of new Chief Executive. Many day to day functions returned to members but commissioners still oversee grant making by the authority.
Doncaster Metropolitan Borough Council	Long history of governance issues with relationship breakdown between the mayor, chief executive and councillors. Audit Commission report 2010 found a failure of governance led to a situation where the authority was failing in its legal duty. Other factors included Serious Case Reviews and a disagreement about budget setting between the mayor and councillors	Secretary of State appointed new chief executive and a team of commissioners to oversee the turnaround of the council. This included the ability to intervene and direct activity of the local authority

Rotherham Metropolitan Borough Council	It is estimated that at least 1400 children were sexually exploited in Rotherham between the years 1997-2013. In just over a third of cases, children affected by sexual exploitation were previously known to services because of child protection and neglect. There was a collective failure by both the Council and the police to stop the abuse. There were serious failings in the council over a number of years with regard to the safeguarding of children, and also serious failings of corporate governance, leadership, culture, and the operation of the overview and scrutiny function. Inspection reports found the Council was in denial both of the issues around safeguarding, and its inability to address them. In its actions, Rotherham has at times taken more care of its reputation than it has of its most needy The council was repeatedly told by its own youth service what was happening and it chose, not only to not act, but to close that service down Rotherham Council was failing in its duties to protect vulnerable children and young people from harm. The inspection revealed past and present failures to accept, understand and combat the issue of child sexual exploitation, resulting in a lack of support for	Rotherham Metropolitan Borough Council is managed by four commissioners appointed by the government in February 2015 after a number of reports highlighted serious failings across the authority. On 11 February 2016 a recommendation by the commissioner, the secretary of state for CLG confirmed new directions that handed back powers of functions to council members. These included: • Education and schools • Public Health • Leisure services • Customer and Cultural Services • Housing and Planning

	victims and insufficient action against known perpetrators Reports highlighted serious failings in the council over a number of years with regard to the safeguarding of children, and also serious failings of corporate governance, leadership, culture, and the operation of the overview and scrutiny function	
Basildon and Thurrock University NHS Trust	Monitor and CQC inspections placed the trust into special measures. This was the result of declining standards of care and safety while data indicated that morality rates were significantly higher than the national average.	CQC task force appointed to drive improvement at the hospital and included the introduction of an effective system to identify and assess risks to the health, safety and welfare of children. The trust quickly come out of special measures. New Governance arrangements had to be made more relevant to front line staff.

4. Lessons Learnt

4.1 Early intervention is required at the first signs of potential failure. All the information above indicates that government only intervenes when failure is apparent rather than when it might begin to emerge. Governance structures must be in place and able to effectively investigate those areas which are most susceptible to failures. This can be achieved by the use of peer-peer support, offering governance and oversight structures with assurance and early warnings.

4.2 Insular organisations are more prone to failure. Those organisations tend to lack the objectivity to use comparisons to judge where standards are not as good as they could be. The importance of networks and national organisations cannot be underestimated and connections should be actively encouraged.

4.3 Structural reforms will not by themselves change failing organisations. It has to be accompanied by other efforts.

4.4 There is a natural disposition to blame when failure occurs. The inquiry into Mid-Staffordshire NHS Trust concluded that early warning signs from front line staff

were not recognised because of the prevailing culture. A culture of transparency is vital for the early signs of failure to be identified.

4.5 We need to be able to learn from other experiences of failure. We also need to learn from organisations who have successfully been able to turn themselves around after significant failures.

4.6 There is a need to make sure the ownership of failure is shared and responses to failure should be as much about the whole system as it is about organisation and individuals.

4.7 We need to be vigilant and aware that failure is always possible and maintain the appropriate level of scrutiny to avoid such major failures.

4.8 There is a significant role for governance structures to prevent failure from occurring and where it becomes evident that early action is undertaken and where significant failures do occur then we are able to understand the cause, impact and turnaround.

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