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Risk, prevention and retribution: reflection on delivery failure in national tests and examinations

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6th Cambridge Assessment Conference

10 October 2012

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Outline

- Introduction – defining terms
- Delivery failures – the 2008 tests, what people had a right to expect
- From medicine:
  - Sir Kenneth Calman's test
  - Three kinds of prevention: primary, secondary and tertiary
- Lessons at each stage

Defining my terms

- “National tests and examinations
- “Delivery failure”

“Delivery failure”

- “A failure to deliver results of tests or national examinations on time and/or free from avoidable mistakes”
- Not “marking error” (=unreliability)
- Not controversies about marking or grading (although some of these have had delivery elements)
- See list in handout
- The tests in 2008

My own position

- I was there in 2008
- My bottom line for this presentation: the public good
- My question: How can we minimise the risk to the public good arising from delivery failures in tests and examinations?

What’s different about delivering tests and examinations?

- Some common elements with other delivery systems (eg “moving nine million test papers around the country in vans”); but also -
- Importance of outcomes for candidates’ life-chances
- Investment of effort and emotion by candidates, teachers and families
- Elements of judgement involved (lead to tensions and complications (particularly English))
- Context of edu-political controversy

What people reasonably expected in 2008

- Test results delivered on time, clearly identifiable, accurately recording the marks/grades given, in time to be issued to students before the end of term
- Concern for the secure delivery of tests shared by all, regardless of their educational or political view about them
- Tolerance of delivery failures in national exams and tests is low

Sir Kenneth Calman's standard for acceptable clinical care

Sir Kenneth Calman's standard for acceptable clinical care

Primary, secondary and tertiary prevention (in the words of the Dept of Health)

- "Primary prevention includes health promotion and requires action on the determinants of health to prevent disease occurring. It has been described as refocusing upstream to stop people falling in the waters of disease.
- Secondary prevention is essentially the early detection of disease, followed by appropriate intervention….
- Tertiary prevention aims to reduce the impact of the disease and promote quality of life through active rehabilitation."

Primary prevention

- Planning: try to win multi-partisan academic and political support
  - Computerisation of Australian NAPLAN tests
- Avoid layer upon layer of piecemeal change
- Special risks when regulating a monopoly
  - May be only one or two truly experienced providers
  - Stimulating the market can carry risks
  - Problems in controlling prices

The end-to-end process map

- “Ripple effects” and “multipliers”
- Finding gaps
- Risk of overcomplication and losing the will to live….

The end-to-end process map

Setting up risk registers

- Make it possible for the key strategic questions to be asked at the beginning and throughout
  - What are the risks of the contract not being delivered?
  - … if it not being delivered on time?
  - … of the quality being unacceptable?
- Synthesising upwards

Most risk registers end up looking like this

Secondary prevention

- Identifying real risk of failure in a world of near-misses and last-minute delivery
  - Set up regular review points to ask the summative question about delivery risk – don’t leave it till the end
  - Have a real “Plan B” and identify triggers for it (eg later delivery of results)

Beware of keeping your guns pointing in the wrong direction

Risk escalation – traffic lights

- Different cultures on use of “red”
- About relative priority or absolute risk?
- Sign of management weakness?
- Should be criterion-referenced, not norm-referenced
- Senior management/Board should be able to stand back from definitions and ask for a high-level view

Soft intelligence - “listening to gossip”?

- Reports of problems from disgruntled markers
- We must allow soft intelligence to prompt open-ended questions
- Paradox – “everyone knew” there were problems, but QCA/Government/Ofqual did not seem to know until the last minute
  - G4S

The Board and the wide-angled lens

- Board must be able to stand back and take a wide view of the organisation’s activities
  - Particularly if political/management attention is focused on something else
- If no Board, management must build in capability for challenge and taking the wider view

Tertiary prevention: when the worst has happened

- Any public statements must start with the “my mother” test
- Any revised/deadlines MUST be realistic and met
- Put a team of good people on to the recovery task and give them high status
- An independent inquiry?
  - Need for quick information on *what* happened and in *how many* cases?: inquiry by supervising authority
  - Longer-term need to determine *why* it happened and *who was to blame?*: public confidence may require an independent inquiry, beyond the highest- level organisation involved

Attribution of blame

- The Ombudsman’s “zone of reasonable behaviour”
- Watch language: excuses, explanations, blame, responsibility
- It may be necessary to state clearly that an outcome was unacceptable, even if no-one is to “blame”
- Expect, and anticipate, political blame-shifting behaviour
  - But the public are unlikely to be impressed – we are all “them”

Adam and Eve after the Fall

“And [God] said, .. Hast thou eaten of the tree, whereof I commanded thee that thou shouldest not eat?

And the man said, The woman whom thou gavest to be with me, she gave me of the tree, and I did eat.

And the LORD God said unto the woman, What is this that thou hast done? And the woman said, The serpent beguiled me and I did eat.”

Genesis 3, 11-13

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Compare the calmer political waters of Singapore

Compare the calmer political waters of Singapore

After inquiry into delays on two evenings by Singapore Mass Rapid Transit (SMRT) trains, the Minister said to Parliament:

“SMRT’s maintenance regime had shortcomings, but we too – both the [Ministry of Transport], as the supervising ministry, and the [Land Transport Authority], as the regulator, have to shoulder our share of the responsibility. We all could have done more and should have done better.”

The lessons: Primary prevention

- Multi-partisan long-term planning
- Avoid multiple layers of piecemeal change
- Identify special risks of monopolies
- End-to-end process mapping – not the Bayeux Tapestry
- Risk registers: the good, the bad and the telephone directory

The lessons: Secondary prevention

- Identifying real risk of delivery failure in a climate of near-misses – regular summative review-points; work up “Plan B”
- Guns pointing in the wrong direction
- Escalation and traffic-lights
- Soft intelligence [and common sense] should be able to prompt open questions
- The Board and the wide-angled lens

The lessons: Tertiary prevention

- Public statements must put people affected first
- Revised deadlines must be realistic and met
- Put good people on the recovery tasks
- An independent inquiry?
- Criteria, language and actions when attributing blame

And the last word on the 2008 tests – from Singapore

“We all could have done more and should have done better”

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