Wicked Problems & Clumsy Solutions: The Role of Leadership

Keith Grint & Clare Holt
1. Share an interesting fact about yourself with your colleagues.

2. What work problem is proving the most difficult to solve?
Change

1. Change, Blame & a typology of problems: Tame, Wicked & Critical

2. Elegant Solutions to Tame & Critical Problems

3. Why Elegant Solutions don’t resolve Wicked Problems but Clumsy Solutions might: but how do we start? Bricoleurs, New Beginnings & Dissent

4. What kinds of techniques might help in our Clumsy Solution Space?

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**Change as an annual event**

**The Problem of Change**

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The NHS: ¼ century of change (AKA Restructuring)

1982: Abolition of Area Health Authorities
1982-85: Introduction of general management
1985: Creation of NHS Board at the Dept of Health
1989-93: Establishment of NHS Trusts
1989-95: Creation of GP Fundholding & Commissioning
1989-95: Setting up NHS Management Executive (later NHS Executive)
1990: Replacement of FPCs (Family Practitioner Clinic) by FHSAs
1991-97: Reconfiguration of Health Authorities
1991: Restructuring of NHS Organisation Boards
1994: Reorganization of RHAs (Regional Health Authorities)
1994: Abolition of FHSAs & incorporation into Health Authorities
1995: Reconfiguration of Acute Services & Trusts
1996: Abolition of RHAs, incorporation into NHS Executive
1997: Abolition of GP fundholding, replacement with PCGs (Primary Care Group)
2000: Abolition of NHS Executive, incorporation into the Dept. of Health
2001: Abolition of NHS Executive Regional Offices, move to Regional DHSCs (Directorate of Health & Social Care) at Dept of Health
2001: Replacement of larger health authorities with SHAs (Strategic Health Authorities)
2001: Replacement of PCGs with PCTs (Primary Care Trusts)
2002: Creation of Foundation NHS Trusts
2002: Creation of Health and Social Care Trusts
2005: Merger of 300 PCTs into 100 larger PCTs
2005: Merger of 28 SHAs into 10 larger SHAs
2006: Reorganization of Dept. of Health to split NHS and DH responsibilities
2010 White Paper: abolition of PCT’s & SHAs; decentralization of budgets to GPs & Consortia

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On being Decisive or On Being made to React to another’s agenda: Reflection not Reaction

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<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1960</td>
<td>Establishment of the Royal Commission on the Police</td>
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<td>1964</td>
<td>Police Act – establishment of the Tri-Partite Structure for policing</td>
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<td>1967</td>
<td>Home Office circular encouraging unit beat Policing</td>
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<td>1968</td>
<td>Lord Denning ruling</td>
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<td>1976</td>
<td>Police Act</td>
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<td>1977</td>
<td>Fisher Report</td>
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<td>1980</td>
<td>Home Affairs Select Committee Report on Sus Laws</td>
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<td>1981</td>
<td>Royal Commission on Criminal Procedure, Byford Inquiry – The Yorkshire Ripper</td>
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<td>1983</td>
<td>Home Office circular 114/83 (Financial Management Initiative)</td>
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<td>1984</td>
<td>Police and Criminal Evidence Act</td>
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<td>1988</td>
<td>Home Office Circular 106/88 (new management strategies for Police)</td>
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<td>1989</td>
<td>Publication of the Operational Policing Review</td>
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<td>1989</td>
<td>Taylor Report on the Hillsborough Stadium Disaster</td>
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<td>1991</td>
<td>Royal Commission on Criminal Justice</td>
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<td>1993</td>
<td>Audit Commission publishes <em>Helping with Enquiries</em></td>
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<td>1993</td>
<td>White Paper on Police Reform</td>
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<td>1993</td>
<td>Publication of the Sheehy Inquiry report</td>
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<td>1994</td>
<td>Police and Magistrates Court Act</td>
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<td>1994</td>
<td>Audit Commission publishes <em>Cheques and Balances</em></td>
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<td>1995</td>
<td>Core and Ancillary Tasks Review – Final Report</td>
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<td>1997</td>
<td>Police Act – Creates PITO and NCIS</td>
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<td>1998</td>
<td>Crime and Disorder Act</td>
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<td>1999</td>
<td>Stephen Lawrence Inquiry report</td>
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<td>1999</td>
<td>Patten Report – future of Policing in Northern Ireland</td>
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<td>2000</td>
<td>Regulation of Investigatory Powers Act</td>
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<td>2001</td>
<td>Criminal Justice and Police Act, Cantle Report, Clarke Report,</td>
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<td>2002</td>
<td>Police Reform Act-National Policing Plan, PCSO’s introduced IPCC established</td>
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<td>2005</td>
<td>HMIC report on workplace modernization, <em>HO report – Neighbourhood Policing</em></td>
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<td>2005</td>
<td>Prevention of Terrorism Act, Serious and Organized Crime and Police Act</td>
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<tr>
<td>2006</td>
<td>Terrorism Act, Police and Justice Act (Establishes the NPIA)</td>
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<td>2008</td>
<td>Flanagan Report</td>
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<td>2008</td>
<td>Policing Green Paper</td>
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MOD changes to personnel 1964-2009

1964 MOD formed from Admiralty, War Office, Air Ministry, & Ministry of Defence itself.

Secretary of State for Defence: Nineteen since 1964

Chief of the Defence Staff: Twenty since 1964

Chief of the General Staff: Eighteen since 1964

Chief of the Naval Staff: Eighteen since 1964

Chief of the Air Staff: Fifteen since 1964

Ninety chiefs in 45 years (@ one every 6 months)

HMS QE decision via strategic defence review 1998
In service @ 2018

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Government's Whitehall Restructuring (National Audit Office, 2010)

1980 – 2009: 25 new government depts created (Cf. 2 in USA); 13 of these no longer exist
2005- 2009: 90 reorganizations of central gov & arms length’s bodies, cost: £780m - £1bn
Little attempt to assess VfM for any changes
Lord Palmerston, on assuming office, 5 February 1855 (aged 70)
‘There are too many laws already.’
Lord Salisbury, on assuming office, 25 June 1895 (aged 65)
My government ‘will drift slowly downstream, occasionally putting out a boat hook to avoid collision’.”
The Problem of Change

Drowning in the waves of change

BOHICA

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Top ten critical change issues

1. An accepted need to change
2. A viable vision/alternative state
3. Change agents in place
4. Sponsorship from above
5. Realistic scale & pace change
6. An integrated transition programme
7. A symbolic end to the status quo
8. A plan for likely resistance
9. Constant advocacy
10. A locally owned benefits plan

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The Problem with Change:

@ 75% of change programmes fail in their own terms
The Problem with Change

Do different kinds of problems require different kinds of change?

1. Critical Problems: Command

2. Tame Problems: Management

3. Wicked Problems: Leadership
Problems, Problems, Problems

Critical Problems: Commander

1. Portrayed as self-evident crisis; often at tactical level
2. General uncertainty – though not ostensibly by commander who provides ‘answer’
3. No time for discussion or dissent
4. Legitimizes coercion as necessary in the circumstances for public good
5. Associated with Command
6. Encouraged through reward

Commander’s Role is to take the required decisive action – that is to:
provide the *answer* to the problem

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Plato’s Philosopher-Kings: Omnipotent and Omniscient Commanders

White Elephants:

1. Albino Elephant: Deity - Omniscient & Omnipotent
2. Expensive & Unnecessary & Foolhardy Expense
Problems, Problems, Problems


Problems as PUZZLES – there is a solution
Can be complicated but there is a unilinear solution to them – these are problems that management can (& has previously) solved

The problem of heart surgery is a Tame problem
It’s complicated but there is a process for solving it & therefore it has a Managerial Solution/Answer

Launching a(nother) new product is a tame problem

Relocating is a tame problem

Heifetz: Technical leadership

Management’s role is to engage the appropriate process to solve the TAME problem

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Management as a Science
F W Taylor’s engineering:
the application of science to achieve the one best solution
Wicked Problems have no simple solution because:

Either novel or recalcitrant
Complex rather than complicated (cannot be solved in isolation)
Sit outside single hierarchy and across systems – ‘solution’ creates another problem
They often have no stopping rule – thus no definition of success
Sometimes the solution precedes the problem analysis
May be intransigent problems that we have to learn to live with
Symptoms of deep divisions – contradictory certitudes
Have no right or wrong solutions but better or worse developments
Uncertainty & Ambiguity inevitable – cannot be deleted through correct analysis – Keat’s “Negative Capability”

Heifetz: Adaptive Leadership

Problems for leadership not management; require political collaboration not scientific processes - role is to ask the appropriate question & to engage collaboration

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Wicked Problems tend to be beyond your experience

Hegel’s (1770-1831) Owl of Minerva – only spreads its wings at dusk

Soren Kierkegaard (1813-55)

‘Life can only be understood backwards, but it must be lived forwards.’

Walter Benjamin’s (1892-1940) Angel of History: Faces the past but is ‘blown backwards into the future’.

Samuel Taylor Coleridge (1772-1834)

‘If men could learn from history, what lessons it might teach us! But passion and party blind our eyes, and the light which experience gives us is a lantern on the stern which shines only on the waves behind us’

18/12/1831 Specimens of the Table Talk of by Coleridge

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By end 1948 NHS costs were £400 million - more than double predicted costs of £176 million,

2008: 811,000 people in UK hospitals through alcohol; cost - £2.7bn
2012: 1,000,000 people in UK hospitals through alcohol; cost - £3bn.
2014 cost £3.8bn. (£145 for each UK household)

33% admission to A&E are alcohol related (70% at weekends).
Includes 300 children under 11 & 6,500 <18s (majority females; worst Ayrshire/Arran)

Age range most likely to attend: 40-49 (20% admission)

Obesity costs £5bn – 25% adults; 14% children (33% obese or overweight)

Type 2 Diabetes cost NHS £9bn

Birmingham Total Place Final Report report (2010: 5)

96% of health spend on treating illness only 4% on keeping people well.

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The focus on the Tame Problem of efficiency of supply is not enough because medical demand constantly outpaces supply: We need to consider the Wicked Problem of reducing the demand.
2010-2014: English Social Care budgets cut by 12% while demand increased by 14%:
= Savings of 26%  (Association of Directors of Adult Social Services, 2/7/14).
NSW Experimental cost of overnight stay in police cell for drunk: $1,200

Results: typical # drunks on Friday: 15
         # drunks on first Friday: 12
         # drunks on second Friday: 3
Peter Connelly (also known as "Baby P")

But what happens when an issue like this occurs?
Peter Connelly (AKA "Baby P")

Extra Safeguarding Process

Jan 2012: 903 apps to take children into care
Jan 2011: 698 apps to take children into care

2011: 9,300 extra children now in need of fostering

+7.5% increase in referrals 2008/9 – 2009/10

Ed Balls
Children’s Secretary

Sharon Shoesmith
Head Haringey children’s service

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10/10/13
Sky TV, breaking news...Baby T

Clare Fallon (reporter) Haringey council - post baby p and Victoria Climbie...

'We were told by Haringey Council that things would change, that systems would be put in place to stop this kind of thing happening again and yet here we are this evening talking about another child who has been failed by the system'

'And anyone offering their resignation at all, Clare?' (Martin Stanford)
HUMAN ERROR

It cannot be eliminated – accidents happen!

Efforts can be made to minimise, catch and mitigate Human Error

How?

By ensuring people take responsibility, have the **appropriate skills** and the **right levels of discretion** to cope and manage the risks and demands of their work.

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Front line personnel are the last line of protection of any ‘system’
They regularly catch and correct their own and other’s errors
(sometimes without realizing – ‘Just doing my job!’)

Helmreich et al 2003

Aircraft flight decks

Airline pilots make an average of 2 errors per flight segment

BUT

most of these are caught and corrected by themselves
CLASSIFICATION OF ERRORS

UNSAFE ACT

UNINTENDED ACTION

INTENDED ACTION

BASIC ERROR TYPES

SLIP

LAPSE

MISTAKE

Attentional failures
Intrusion
Omission
Mistiming
Etc.

Memory failures
Forgetting
Omission
Place-losing

Rule-based
Misapplication of good rule
Application of bad rule

Knowledge-based
Many variables
Untested Process

Routine violations
Exceptional violations
Acts of sabotage

Taken from ‘Human Error’, James Reason (1990, 2009), p207 © copyright KCA Ltd 2015
You’ve made a mistake

Will it show? → YES → Can you hide it? → YES → Conceal it before somebody else finds out

NO → Bury it

NO → Can you blame someone else, special circumstances or a difficult client?

YES → Get in first with your version of events

NO → Sit tight and hope the problem goes away

Could an admission damage your career prospects?

NO

YES

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Integrity issues identified within BP practices in 1999 (Alaska Waste Dumping) and in 2005 (Texas City refinery blast). Despite this, nothing was done........ Employees felt pressured to put production ahead of safety and quality.

Any employees who did come forward with concerns over safety or other related problems that were happening or had the potential of causing an incident, were sanctioned and in a couple of cases, fired!

People become nervous, cover things up, don’t report

A shut down in the flow of safety related information

NO LEARNING!

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DISASTER!!!!!!

11 dead

Environmental damage

Corporate image damaged

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Rational Decision Making

Complex worlds therefore perfect rationality is impossible!

(Perfect Rationality - full knowledge of all relevant information, possible outcomes, relevant goals)

Human rationality is LOCAL – what’s going on immediately around you

Decision making in complex situations requires

- Judgment under uncertainty
- Ambiguity
- Time pressure

Governed by

- people’s local understanding
- Focus of attention, goals, knowledge

Dekker argues…….. “Complexities can lead to what might work locally, but not what is working globally [because of] limited access to information and possible solutions.”

No learning = Drift into Failure
‘First’ Story accounts

HARD SHELL
Externally very strong
Brittle
Designed to prevent HE via perfect processes
High risk of breaking!

• Human Error seen as the cause for failure (intended or unintended)
• Saying what people should have done, satisfies the way to describe the failure
• Telling people to be more careful will make the problem go away

‘Second’ Story accounts

SOFT SHELL
Externally weak
Flexible
Designed to be resilient
Capacity to learn and rectify errors

• Human Error is seen as the effect of systemic vulnerabilities deeper inside the organization
• Saying what people should have done does not explain why it made sense for them to do what they did
• Only by constantly seeking out vulnerabilities can organizations enhance safety

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SECOND STORY ACCOUNTS

BLUNT END
regulators, administrators & managers provide resources & constraints that practitioners have to integrate
e.g. regulators, CAA, Senior Management, Operators
Fail to appreciate information given to them about potential risks!

success & failure is a result of how sharp end practitioners cope with complexity & how their actions are shaped by resources & constraints of those at the blunt end

SHARP END
practitioners directly interact with a hazardous process, usually front line and the last line of protection of any ‘system’
e.g. ATCO, Nurse, Pilot, Police Officer
Inherit the accident rather than cause it!

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Mineshaft death: What delayed Alison's Hume's rescue?

For more than six hours, Alison Hume lay injured in the darkness about 40ft down a disused mineshaft.

Up above, firefighters argued about how to save her.

“But in a situation where there is human life involved I think some large injection of common sense is called for. I would employ the Latin expression, seize the moment and deal with the matter – and sort out the breaking of rules and regulations later.”

Alan Jeffreys, Team Leader of Scottish Cave & Rescue Organization (SCRO)
The other side of the Blame Culture Coin: Prozac Leadership
Prozac Leadership (Collinson, 2011)
Unremittingly positive approach:

1. Encourages leaders to believe their own propaganda
2. Discourages people for raising problems, admitting mistakes, focusing on failure
3. The only people that believe the corporate messages are the corporate leaders
4. Corporate leaders constantly surprised when things go wrong given how well everything seems to be going....
Prozac Military Leadership
Not just mind the internal gap but the external gap. They only live here: what would they know?

2004: International Security Assistance Force (ISAF) Commander, General Barno, ‘without question 2004 will be a decisive year’
2005: General Abuzaid, ‘2005 will be a decisive year’
2006: General Richards, ‘2006 will be the crunch year for the Taliban’
2008: General Champoux, ‘2008 will be a decisive year’
2009: General McChrystal ‘We are knee deep in the decisive year’
2010: David Miliband, ‘2010 will be a decisive year’
2011: Guido Westerwelle (GRM FM), ‘2011 would be a decisive year’
Hubris Rules OK!

The more powerful you are the more likely you are to make less accurate decisions.

Accountability? Responsibility?

ACCOUNTABLE
Answerable
Blunt End
Training
Selection
Appropriate equipment
Environment
Support
Management
Leadership

RESPONSIBLE
Duty, act on your own
Sharp End
Do the job, safely
Report observations &
Unusual situations
Practitioner

Openness
Relationships

“Unjust responses to failure are almost never the result of bad performance – they are the result of bad relationships.”

Dekker, 2008 p142

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No-BLAME CULTURE (2):

You’ve made another mistake

Will it show?  →  YES →  Don’t need to hide it
It wasn’t your fault
It was probably the fault of the system

No →  Ignore it

Personal Responsibility Avoided;
Organization Continues to Fail; no-one Seems to know why….
YOU’VE MADE A MISTAKE

YOU’VE MADE A MISTAKE

WILL IT SHOW?

YES

DON’T NEED TO HIDE IT

COULD BE PARTLY YOUR FAULT BUT IT’S LIKELY THAT OTHER FACTORS ARE ALSO INVOLVED

YOU HAVE A RESPONSIBILITY TO PREVENT IT HAPPENING AGAIN

NO

ADMIT IT

PERSONAL RESPONSIBILITY TAKEN.

ORGANIZATION CONTINUES TO IMPROVE – EVERYONE KNOWS WHY....

ORGANIZATIONAL LEARNING OCCURS

INFORMATION FED BACK TO INDIVIDUAL AS WELL AS THE ORGANIZATION

ADMIT IT

REPORT IT THROUGH THE APPROPRIATE CHANNELS

INVESTIGATED

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The highway from one merchant town to another shall be cleared so that no cover for malefactors should be allowed for a width of two hundred feet on either side; landlords who do not effect this clearance will be answerable for robberies committed in consequence of their default, and in case of murder they will be in the king’s mercy.

Given at Winchester, October 8, in the thirteenth year of the king's reign.

—Statute of Winchester of 1285, Chapter V, King Edward I
USS Benfold 1997-1999
Guided missile destroyer

The Problem: the worst performing ship in the US Pacific Fleet

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3C. BC Emperor Liu Bang held banquet on consolidation of China
Surrounded by nobles, military & political experts.
Guest asked Chen Cen (military expert) why Liu Bang was Emperor.
Chen Cen: ‘What determines the strength of a wheel?’
Guest: ‘The strength of the spokes’
Chen Cen: ‘2 sets of spokes of identical strength did not necessarily make wheels of identical strength. The strength was also affected by the spaces between the spokes, & determining the spaces was the true art of the wheelwright.’

Leaders as wheelwrights: Leadership as an art

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Differentiating ‘Authority’ (legitimate power)

- Command
- Management
- Leadership

- Space
- Tactical
- Operational
- Strategic

- Time
- Short Term
- Medium Term
- Long Term

- Problem
- Critical
- Tame
- Wicked

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Command: just do it (it doesn’t matter what you think)

Management: déjà vu (I’ve seen this problem before; I know what process will solve it)

Leadership: vu jàdé (I’ve never seen this problem before; I need to get a collective view on what to do about this)
Increasing uncertainty about solution to problem
WHAT KIND OF PROBLEM IS IT?

DO YOU KNOW HOW TO SOLVE THIS PROBLEM?

YES

IS IT A CRISIS?

YES

CRITICAL PROBLEM
ACT AS A COMMANDER
BE DECISIVE
PROVIDE ANSWERS

TAME PROBLEM
ACT AS A MANAGER
USE S.O.Ps.

WICKED PROBLEM
ACT AS A LEADER
ASK QUESTIONS & USE CLUMSY SOLUTIONS

NO

DOES ANYONE KNOW TO SOLVE THIS?

YES

NO

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Addressing Wicked Problems:

- Why Elegant Solutions don’t resolve Wicked Problems
Four primary ways of organizing - and understanding - social life (Weberian ideal types via Douglas)

GRID:
Rules & Roles

High

Low

GROUP ORIENTATION

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More freedom to pursue rational logic as the Individualists’ elegant solution to the Wicked Problem of making followers comply

Argument & the limits of elegant logic
More freedom to pursue rational logic as the Individualists’ elegant solution to the Wicked Problem of making followers comply

Festinger’s Cognitive Dissonance

‘Dissonance: discord

Aesop’s Fable: The Fox and Grapes

Pragmatics of Change

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Festinger’s Cognitive Dissonance

The power of faith: the god Sananda cult
Midnight 21 December 1954: global flood
Press release from Marion Keech
12.00 – no flood......
Festinger’s Cognitive Dissonance

The power of money: spools, pegs

$1 or $20
Two random groups: A & B  
Task: Estimate co. future sales & earnings 
Randomly Inform group A - very accurate; group B - very poor

Group A’s self assessment – success through:  
good cohesion, good communication, open to change, well motivated

Group B’s self assessment – failure through:  
low cohesion, poor communication, change resistant, low motivation

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"He that has once done you a Kindness will be more ready to do you another, than he whom you yourself have obliged."[1]

(Asked to borrow a book from a rival who subsequently became a great supporter)

Cf. “Benjamin Franklin Effect”

If you want someone to like you – ask them to do you a favour
We only do favours for people we like
If we’ve done them a favour they must be likeable

© copyright KCA Ltd 2015
But elegant solutions don’t solve Wicked problems

GRID:
Rules & Roles

High

Low

FATALISM
There’s nothing we can do

HIERARCHY
More power, rules & enforcing rules

INDIVIDUALISM
More freedom to use rational choice
Logic, Rationality

EGALITARIANISM
Greater solidarity

GROUP ORIENTATION
© copyright KCA Ltd 2015
Rule-following as the solution to the perennial problem of leaders: how to stop followers “using their initiative”
But elegant solutions don’t solve Wicked problems

GRID:
Rules & Roles

GROUP ORIENTATION

High
Low

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Greater solidarity

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The Asch Experiments 1951
Groups of 7-9 male students

Which line on (2) is the same length as on (1)?
First trial all agree; from then all except the ‘subject’ with occasional correct ‘lapse’ by one of group to allay suspicion:
THE LARGER THE GROUP THE MORE DOUBTFUL THE SUBJECT
ERROR of 123 subjects, each of whom compared lines in the presence of six to eight opponents, is plotted in the colored curve. The accuracy of judgments not under pressure is indicated in black.
Size of the Majority:

1: other is wrong
2: others are probably wrong
3: others are possibly right
4: others are probably right

SIZE OF MAJORITY which opposed them had an effect on the subjects. With a single opponent the subject erred only 3.6 per cent of the time; with two opponents he erred 13.6 per cent; three, 31.3 per cent; four, 35.1 per cent; six, 35.2 per cent; seven, 37.1 per cent; nine, 35.1 per cent; 15, 31.2 per cent.
Support by another

Red line = two ‘subjects’
Black line = one ‘subject’

TWO SUBJECTS supporting each other against a majority made fewer errors (*colored curve*) than one subject did against a majority (*black curve*).
Red line: partner ‘deserts’ to majority after 6 trials
Black line: partner leaves the room after six trials
Only 25% resisted totally

PARTNER LEFT SUBJECT after six trials in a single experiment. The colored curve shows the error of the subject when the partner “deserted” to the majority. Black curve shows error when partner merely left the room.
Why the elegance of egalitarians’ solidarity doesn’t solve Wicked Problems: Group think & Peer Pressure as regressive

Latane and Darley: The Bystander Problem (1968)

Room 1 has an individual staging an epileptic fit
Adjoining room has:
1 person = helps 85% of the time
5 people + = help only 31% of the time

Smoke emerging from room reported
75% of the time by lone passers by
38% of the time by groups passing by
Groups diffuse responsibility

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Latane and Darley: The Bystander Problem (1968)

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Groups diffuse responsibility
“If I look at the mass I will never act": Psychic numbing and genocide

Paul Slovic
Decision Research and University of Oregon

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Some problems appear so large people give up:
Go for small wins
Karl Weick: ‘Small Wins’
Small Talk & Big Ideas
Doron, N. & Wallis, E. (2014) *Pride of Place* (Fabian Society)

EXETER TAKES ACTION
Help create the first low carbon city

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Do we always need to discuss and agree everything?

Average manager spends about 17 hours a week in meetings & about 6 hours in planning

Over 1/3 of the average manager’s week is spent in meetings

Some 25 million meetings occur in corporate America daily. Roughly half that time is wasted

http://www.tsucceed.dircon.co.uk/timemanagementtips.htm
http://www.enewsbuilder.net/theayersgroup/e_article000450602.cfm?x=b11,0.w
Ignatius of Loyola  
1491-1556

General Congregation of 20,000 Jesuits meet to elect a new Superior General or agree a change of policy.

Formed 1534, how many meetings of the General Congregation since then?
But elegant solutions don’t solve Wicked problems

GRID:

GROUP ORIENTATION

High

FATALISM
There's nothing we can do

INDIVIDUALISM
More freedom to use rational choice
Logic, Rationality

HIERARCHY
More power, rules & enforcing rules

EGALITARIANISM
Greater solidarity

Low

GRID: Rules & Roles

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So how do you address wicked problems?

• First, recognize that Elegant Solutions probably won’t work
• Second, consider the pragmatic utility of Clumsy Solutions
Clumsy Solutions for Wicked Problems: Creating a Clumsy Solution Space

From elegant to clumsy; from straight line to crooked; from architect to bricoleur
‘You shall love your crooked neighbour with your crooked heart’
(W H Auden: As I walked out one morning)
‘Out of the crooked timber of humanity no straight thing was ever made’ (Kant)
Elegant (single mode) Solutions to Global Warming

GRID: Rules & Roles

FATALISTS
There’s nothing that can be done
People are selfish
AKA: we’re all doomed

HIERARCHISTS
The rules are inadequately enforced: get a disciplinarian in charge to sort it out
a Kyoto style agreement that works

INDIVIDUALISTS
Need to facilitate individualism & encourage creative competition
Technological innovation & market forces will resolve the problem

EGALITARIANS
Need to rethink our approach
To consumption and shift to decentralized & self-sustaining communities

GROUP ORIENTATION

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Clumsy Solution for Wicked Problem of global warming

Individualists
Technical innovations to address global warming at every level AND ...

Hierarchists
Stronger global regulation of carbon emissions AND ...

Egalitarians
Change in consumption patterns & more sustainability AND ...

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Innovation across sectors
(improvement suggestions per 100 employees)
2008 German Institute of Management
Elegant (single mode) approaches to Innovation

GRID: Rules & Roles

- **FATALISTS**: There’s nothing that can be done. AKA: we’re all doomed.
- **INDIVIDUALISTS**: Open market: let a hundred flowers bloom. Encourage mavericks. But no loyalty to help organization.
- **HIERARCHISTS**: Best Practice Rules OK. Centralized & Incentive-based. But inflexible, resistance likely, & lost in translation problems.

GROUP ORIENTATION

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Thai floods - 2011

- Around 800 killed
- Estimated cost to Thai economy - £28bn (World Bank)
- Up to 3 months for Thai people’s lives to return to any form of normality
- Up to 6 months for industry to start up (e.g. Honda)

Concerns for 2012 – how will it cope this year?

WICKED PROBLEM: How do we stop the flooding?

REALITY: Can’t stop it!
It’s getting worse – global warming, deforestation, etc.

© copyright KCA Ltd 2015
### Thai floods - 2011

#### ELEGANT SOLUTIONS?

<table>
<thead>
<tr>
<th>High</th>
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<tr>
<td>F:</td>
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<tr>
<td>Sit tight!</td>
<td></td>
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<tr>
<td>There is nothing that can be done.</td>
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<tr>
<td>H:</td>
<td></td>
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<td>Rules and regulations</td>
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<tr>
<td>1. new ‘Super Committee’</td>
<td></td>
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<tr>
<td>2. $11bn worth of contracts</td>
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<td>3. Flood retention zones</td>
<td></td>
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<tr>
<td>4. Build reservoirs/dams</td>
<td></td>
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<tr>
<td>5. River diversion</td>
<td></td>
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<tr>
<td>I:</td>
<td></td>
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<tr>
<td>Market/Choice</td>
<td></td>
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<tr>
<td>Market will solve it: e.g. Homeowners raise homes up to 1 metre higher (but not everyone can afford to do this!)</td>
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<td>E:</td>
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<td>Solidarity</td>
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<td>Honda, Canon, Nikon</td>
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<td>Built a 47 mile concrete wall around the Rojana Estate</td>
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<td>Communities following suit</td>
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**GRID:**

- **Rules & Roles**
- **GROUP ORIENTATION**

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Thai floods - 2011

Concerns from the experts about the Elegant approach:

**Engineering Institute of Thailand –**

“The Thai Government cannot just look at a map and designate an area to let the floodwater flow, saying it is urgent, with no time for preliminary assessments. It must study the environmental impact of these plans, talk to people affected, otherwise they won’t cooperate.”

**Climate Change and Disaster Centre –**

“Protect this year with walls, but what about next? If all communities build high walls, where will all the water go? It has to go somewhere making places downstream vulnerable.”

**Thai Squatter Community, canal resident of Bangkok for 32 years**

“If we don’t go they’re going to demolish our homes. The floods have nothing to do with us. We live above the water.”
Thai floods - 2011

WHY NOT ELEGANT FOR THIS WICKED PROBLEM?

Government and authorities rushing the ‘solutions’ – no element of negative capability

Deep divisions arising between government, residents, industry, experts, etc.

No right or wrong answer – suggested solutions could make situations for some even worse

Some solutions creating other problems (river diversions, flood barriers, flood retention-zones)

Uncertainty about future flooding – it’s a freak weather condition!

CLUMSY APPROACH

H: Investment, LT Strategies. regulations AND……

E: Organisational and Community support, investment, jobs, etc. AND……

I: Individuals innovation in how to protect property, etc. AND……
Thai floods - 2011

The future........

‘Nanotec’ (E and I) working with the Thai Red Cross (E), local people (I) and architects (I) to be innovative about ways to live with flooding:

1. SOS Mobile Water Filtration System – it floats!
   - Solar powered (no electricity required)
   - Can be used in isolated areas
   - Produces 200 litres of clean water an hour

2. ‘N’ sacks – a replacement for sandbags
   - When dry, 1/20th of the weight of a dry sandbag
   - Easier to store and transport around
   - Sand and gel mix which absorbs more water
   - 5 mins to swell and stop water
   - Reusable

3. The future!
   - Amphibious homes (already in the Netherlands)
   - Floating cities (Thai architects)
Wicked Problems require *Bricoleurs* not Rational Calculating Machines

Those who can prosper in a clumsy pragmatic way, not those restricted to elegant single logics:

Those who ‘do it themselves’, who experiment, & learn from mistakes – change comes from people doing real work, not telling others how to do it differently

Those who recognize that local engagement is critical *Bricoleurs* make progress by stitching together whatever is at hand, whatever needs stitching together to ensure practical success.

Not clean world of analytic models & rational plans for progress to perfection from the top down – it doesn’t matter where you start from, start from where the energy for change lies and follow the new connections
Bricoleurs & the possibility of rescue: First-Responders to the flooding in New Orleans

The CPR (Cardiopulmonary resuscitation) paradox:
5 trainee + 1 experienced paramedics filmed using CPR
Film shown to three groups: who is the experienced one?
1. Experienced paramedics get it right 90%
2. Students right 50%
3. Instructors right 30%

Why?
People sheltered on the bridge but the water rose rapidly. Police officer went to National Guard base near the bridge and asked a colonel for the buses to rescue the people. Colonel refused but said he would ask his general – but wasn’t sure where he was ... No buses left the depot.
One ambulance driver carried 42 people in one go.

Police officer commandeered (stole) a refrigerator truck siphoned (stole) diesel from abandoned vehicles to keep it running to feed 100 people for days.
But where do we start with a Wicked Problem? What if we don’t know what’s inside people’s heads? What’s the first move? Is gaining CONSENT the best start? Start with the beginning, start with relationships & focus on DISSENT

GRID:
Rules & Roles

High

Low

GROUP ORIENTATION

Cultural Cognition as a Conception of the Cultural Theory of Risk
‘Relationships are beginnings, not endings, they create opportunity for interests to grow, change and develop...... Participants may also discover common interests of which they were unaware.’ (Ganz, 2010: 514)
New Beginnings are the start of (re)building relationships

Creating an opportunity to exchange interests, ideas and experiences

Discovering what motivates an individual within the collective

Pooling ‘resources’ of what they know may be relevant

Helping to create a concentrated power

The concept of ‘New Beginnings’ is to organize people to come together and say whom they are, building trust, sharing common values and discovering common purpose, creating a foundation for allowing potentially powerful relationships.
New Beginnings allow individuals a voice at the start of a ‘wicked problem’, providing an opportunity for individuals to share ‘resources’ and understand the opportunities being faced, to better understand the relevance of their role, and share a collective purpose.

Professionals know what to do, but they do not always feel like they are able to do it - fear, blame and resignation, and an assumption “management knows best”.

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NEW BEGINNINGS – WHY?

Individuals have different experiences, they observe things differently and learn new ‘resources’ everyday.

They play many characters in their lives: parent, sibling, community leader, councillor, citizen, anarchist, and so on.

Each character they play provides individuals with experiences, knowledge, and skills, all of which have the potential of being transferrable into any given context.
RESOURCES

Not just the tangible e.g. budgets, equipment, etc.

What an individual can contribute

their skills (techne)

their knowledge - tacit and explicit (episteme)

their practical wisdom (phronesis)

New (and old) members to a collective can bring new perspectives to ‘wicked problems’, and encourage established members to change their habits and consider the different perspectives.

Explicit – transmittable knowledge
Tacit – embedded knowledge
(Nonaka, 1994; Polanyi, 1966)
By giving permission for an individual to tell a story of self

- engages individuals to have a voice,
- heard by everyone involved, and
- sharing resources to develop new ideas to make a difference.

A significant challenge for leaders is not always about discovering what to do, but how do you get people engaged to participate and share their ‘story’.
IT IS NOT....
An individual’s deepest darkest secrets!

An opportunity to bitch and gripe about a colleague or the organization!

What is a story of self in an organizational setting?

Organization/department/job description

Background (other organizations, roles, experience)

Why is the person in the room? How do they interpret their personal contribution?

How they understand and interpret the challenge/change or ‘wicked problem’?
WHO STARTS THE CONVERSATION?

It begins with the formal leader taking time to tell his/her story

- lowering the apprehension of the other individuals involved
- encouraging them to share their stories

This is a possible time for the leader in formal authority to admit they do not have all the answers, to admit they are also fallible, to interpret the problem how they see it, and to demonstrate openness and honesty.

NEW BEGINNINGS – HOW?

Temptation to start with data……..and it does have its place

**WARNING**: it can mean different things to different people. Too much focus can disengage some.

Personalize, dramatize and socialize

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As a leader, why is a ‘story of self’

Not just about permission giving…….if you don’t, others will!

Putting yourself at risk of…….

- others creating your story on your behalf
- telling your story out of context
- potentially in a way that you might not appreciate
- leading to gossip and rumour

A *story of self* is the first step to establishing your credibility, in the right context – especially important during times of change and challenge.
NEW BEGINNINGS - CONSIDERATIONS

- Some people have too much to say
- Some people don’t have much to say
- Some people are shy or embarrassed to speak
- Some are nervous in case they are wrong – blame
- Some don’t like exposing information about themselves

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NEW BEGINNINGS - CONSIDERATIONS

1. It takes **courage** and **creativity** for some, and is more natural for others,
   • but it can be a cathartic experience sharing thoughts, experiences and knowledge, knowing a contribution is being made.

2. **TIME** - it is precious in every individual’s life, especially within an organizational context
   • it is a common excuse why relationships are almost forgotten or left unattended in busy organizational settings.

3. Leadership is **not** just a formal position
   • It is a *process* of influence, facilitation and negotiation; going above and beyond an individual’s authority (Pascale, Sternin and Sternin, 2010:7).

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To summarize, New Beginnings is not about telling, it is about engaging the individuals to be their own pioneers to discover for themselves what ‘resources’ they have collectively to actually do something about a potential ‘wicked problem’.

That means accepting dissent is likely - & useful
Leaders often feel uncomfortable with dissent
Why?
Challenges poor or unfavourable decisions, and recognises impractical and ineffective policies and practices.

Typically regarded as negative
WHY IS DISSENT IMPORTANT?

- it encourages candor
- Consideration of conflict (saving time and money)
- allows debate

Avoiding silence
Encourages effective communication
Increases motivation
Engages and empowers
Critical to learning and improving
Origins of DISSENT

DISSENTRE

‘ dis’ – apart

‘sentire’ – feeling

Translation – ‘feeling apart’

Dictionary – disagree, dispute, conflict, non-concur

Therefore people ‘dissent’ because of feeling excluded, dissatisfied, disengaged

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Inappropriate – worst case ‘Anarchy’

Superficial – saying what you think the boss wants you to say (Prozac L’Ship)

Acceptance of status quo – no voice

Management knows best – Taylorist

Boat rockers (internal) and whistleblowers (external) – Redding, 1985

Antagonistic (Kassing, 1997) – irresponsible followers (Grint, 2005)

Displacement/Passive

Neglect, Resignation, Exit (Hirschman, 1970) – mentally as well as physically

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Gallup 2013 Poll on Employee Engagement *State of the Global Workplace*

Globally,
13% of employees are actively engaged
63% of employees not engaged
24% of employees actively disengaged.

‘Engagement’ defined as ‘emotionally invested in and focused on creating value for their organizations every day’
Work units in the top 25% of Gallup’s Q12 Client Database have significantly higher productivity, profitability, and customer ratings, less turnover and absenteeism, and fewer safety incidents than those in the bottom 25%.

U.S., active disengagement costs US$450 billion to $550 billion per year.
Germany: €112 billion to €138 billion per year
UK: £52 billion and £70 billion per year.

Worst place?
Best place?

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Useful – improvement and learning

Encouraged to disagree

Facts and solutions (Kassing, 2002, 2005)

Openness with honesty

Develop loyalty

Voice/Active

Personal responsibility

Engaged

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The Hill of Upward Dissent
So what kinds of ‘new’ techniques help address wicked problems?

Adopt the role of the *bricoleur*: stitch together a clumsy systems’ solution comprised of elements of all three ‘elegant’ modes to *reframe* the problem

**Clumsy Solution Space**

**Hierarchists**
- Relationships not Structures
- Constructive Dissent not Destructive Consent
- Extraordinarization of the Mundane

**Individualists**
- Questions not Answers
- Empathy not Egotism

**Egalitarians**
- Collective IQ not Individual Genius
- Positive Deviance not Negative Acquiescence
Individualists

Questions not Answers

Empathy not Egotism
Max Mayfield, National Hurricane Centre: “I don’t think anyone can tell you with any confidence right now whether the levees will be topped or not but it’s obviously a very very grave concern”

Michael Brown, Director FEMA, “My gut tells me this is going to be a bad and a big one … I don’t know whether the dome roof can withstand a cat 5 hurricane”

George Bush asks no questions

George Bush on national TV on the eve of the hurricane
George Bush: “I want to assure the folks at home that we are fully prepared”
Empathy not Egotism

How to acquire empathy: become an anthropologist


Walk a mile in my shoes:

Go back to the floor

Become a mystery customer

Not what people say in focus groups or in surveys – these are artificial environments –

but what they do under normal circumstances

Heifetz: The balcony & The dance-floor

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Egalitarians

Collective IQ not Individual Genius

Positive Deviance not Negative Acquiescence
Whole Systems or Hierarchies?

Wholes or Horizontal Slices or Vertical Slices?

IKEA & Ektorp sofa: 48 hours to change the system
2003, Future Search (Weisbord and Janoff)
52 stakeholders & 18 hours to redesign the product & system

Collective intelligence not individual genius –
**Problem** – MRSA is inevitable in a hospital environment. How do you reduce MRSA infections?

2004 19,000 die in the USA
100,000 exposed, extending hospital stays

Already implemented…..a ‘tame’, ‘top down’, ‘command and control’, ‘technical’ approach

1. Evidence-based protocol
2. Procedures about hand hygiene, gloves and gowning
3. Active surveillance
4. Training and certification
5. Signatures of compliance

**Assumption** – Health workers are told what to do and therefore know what to do

**Reality** – still too many deaths and too many patients contracting MRSA, therefore not everyone can be following the protocol!
If properly followed, it should work…. BUT:

1. Hospitals are complex social systems
2. Top-paid surgeons to low-paid cleaners
3. Many silos, departments and hierarchies
4. Complex and competing strategies

It required a ‘clumsy’ approach to influence behavioural change, which takes time……

Centers for Disease Control (CDC) asked a retired surgeon (Dr. Lloyd) to take up the mission of reducing MRSA in 42 US hospitals……

Dr. Lloyd realised the process driven approach relied on top-down intervention and NOT the hospital community – the staff and patients themselves – to focus on how to do it, not why they had to do it.
PD encourages a community to **own** the challenge and discover **how** to tackle it together

One hospital was chosen – a Veterans Hospital in Pittsburg, USA

1. Everyone invited to meet and learn a new approach to reach beyond the ‘usual suspects’ in the organization, involving the **whole system**
2. Personal stories were shared (nurse who lost her husband to MRSA) – putting a human face to the problem
3. Data was dramatized, personalized and socialized to encourage conversation (chocolate pudding and macaroni)
4. Questions were constantly asked:
   - What do you know about MRSA?
   - What do you do to prevent it spreading?
   - What are the barriers?
   - What are your thoughts and ideas?
5. A voluntary process – if interested opt in, if not opt out.
Ideas from the ‘bottom of this box’

1. Senior Dr. – completed her rounds with her students at the gel dispenser and ensured everyone used it.

2. Physical Therapist – infected and uninfected were not always known and using the same equipment, therefore ensured the use of patient lists.

3. Social Services Assistant – un-sanitized bingo cards used at weekly bingo, and snacks served. She ensured everyone ‘zapped before you snack!’

4. Hospital driver – regularly transporting patients between facilities, and requested gel dispensers in his van.

5. Hospital Chaplain – carrying his bible from patient to patient. Disposable bible covers and insisted all chaplains wore a gown and gloves.

6. Dementia Ward – not safe to have gel dispensers everywhere. Nurse carried a dispenser on her belt and washed the patients hands before and after eating.

7. Patients – dispensers were behind the bed. Now in front so patients can monitor all clinical staff and visitors use the gel.

8. Nurses – swabbing the nostrils of all patients at admission (early detection), at discharge or transfer (avoid further spreading), and death.
Summary

If the problem involves people, surely they are a vital part of any solution?

In this case, it affects every function and discipline of the hospital

Data has its place
• Who owns it and how is it used?
• Avoid it being too abstract and too sterile
• What is the meaning of the data?
• Make the data more human..... Abstract, real

Involving EVERYONE provides a catalyst for solutions – collective mindfulness, regardless of role

Emphasis shifted from teaching and telling people what to do, to engaging people as pioneers in discovering how to actually do it!
Hierarchists

Relationships not Structures

Permission Giving not Destructive Consent

Extraordinarization of the Mundane
The NHS: ¼ century of change (AKA Restructuring)

1982: Abolition of Area Health Authorities
1982-85: Introduction of general management
1985: Creation of NHS Board at the Dept of Health
1989-93: Establishment of NHS Trusts
1989-95: Creation of GP Fundholding & Commissioning
1989-95: Setting up NHS Management Executive (later NHS Executive)
1990: Replacement of FPCs (Family Practitioner Clinic) by FHSAs Family Health Service Authority
1991-97: Reconfiguration of Health Authorities
1991: Restructuring of NHS Organisation Boards
1994: Reorganization of RHAs (Regional Health Authorities)
1994: Abolition of FHSAs & incorporation into Health Authorities
1995: Reconfiguration of Acute Services & Trusts
1996: Abolition of RHAs, incorporation into NHS Executive
1997: Abolition of GP fundholding, replacement with PCGs (Primary Care Group)
2000: Abolition of NHS Executive, incorporation into the Dept. of Health
2001: Abolition of NHS Executive Regional Offices, move to Regional DHSCs
   (Directorate of Health & Social Care) at Dept of Health
2001: Replacement of larger health authorities with SHAs (Strategic Health Authorities)
2001: Replacement of PCGs with PCTs (Primary Care Trusts)
2002: Creation of Foundation NHS Trusts
2002: Creation of Health and Social Care Trusts
2005: Merger of 300 PCTs into 100 larger PCTs
2005: Merger of 28 SHAs into 10 larger SHAs
2006: Reorganization of Dept. of Health to split NHS and DH responsibilities

Structure

Process

Relationships & Identity:
Not - what do you do? (e.g., how many operations have you undertaken)
But – what are you? (e.g., what is your purpose?)

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Tackling violence
'I won't sit back again if I see trouble,' says Jeremy Vine

Leadership & Permission Giving
General Marshall, Chief of Staff US Army from 1/9/1939 – 1945
Increases army size from 200,000 to 8,500,000
Churchill called him, “the true organizer of victory”
1947 outlines what became The Marshall Plan for economic reconstruction Western Europe
1953 Awarded Nobel Peace Prize

Back to first week as Chief of Staff (5/9/1939) gathers his subordinates around him and expresses his disappointments in them:
2007, choirmaster Gareth Malone
Took a teaching position at Lancaster School, Leicestershire - largest all-boys comprehensives in the country noted for sports – not singing

1. Few boys interested
2. Response: “I tried about 25 different techniques to get them interested.”
Air Florida 90 (‘Palm 90’) (737), January 13 1982, due out 14.15 to Fort Lauderdale.
Captain Larry Wheaton; 1st Officer Roger Pettit
Take-off check list commences
   Pettit: Air conditioning & pressurization?
   Wheaton: Set
   Pettit: Engine anti-ice?
   Wheaton: Off
15.59: cleared for take off & throttles open
   Pettit: ‘It’s real cold, real cold’
   Wheaton: It’s spooled. Real cold, real cold.
   Pettit: God, look at that thing. That doesn’t seem right, does it?
       Uh, that’s not right.
16.00  Wheaton: Yes, there’s 80 (knots)
   Pettit: Naw, I don’t think that’s right. Ah, maybe it is.
   Wheaton: 120
   Pettit: I don’t know
   Wheaton: V1. (Lift off, but nose rises too quickly) Easy. V2
16.01 Crashes into bridge over Potomac: 6 survivors

Cf. RAF Crew Resource Management System
Army/Navy: ‘Stop Fire’
Navy: ‘Still’
Heifetz: Protect the voices from below
Tarnow ‘self-destructive obedience’ in Blass (ed.) *Obedience to Authority*
25% of all crashes caused by destructive consent (obedience)
Dr Mulhem – Specialist Registrar; Dr Morton – Senior House Officer
Dr Morton asked Dr Mulham whether the Vincristine should be given spinally
and said Dr Mulhem had told him yes.
Dr Morton said “He was surprised by this, but had not felt he could challenge a
superior. “
‘Gentlemen, I take it we are all in complete agreement on the decision here?’
Consensus of nodding heads.
‘Then I propose we postpone further discussion of this matter until our next meeting to give ourselves time to develop disagreement and perhaps gain some understanding of what the decision is all about.’
Sloan’s Dilemma & Constructive Dissent

What is to be done?
The Extraordinarization of the Mundane

Alvesson & Svenningson

‘little touch of Harry in the night’
Critical Learning Points:

1. What kind of problem are you facing?
   1. Tame – Manage the SOPs
   2. Critical – Command the answer
   3. Wicked – Lead the collaborative effort

2. Blame Culture
   1. Human Error happens! It cannot be eliminated
   2. Just Culture – accountability, responsibility, relationships, LEARNING!

3. Organizations generate default cultures:
   1. Hierarchists assume rules & power are critical
   2. Egalitarians assume greater solidarity is critical
   3. Individualists assume greater freedom is critical
   4. Fatalists have given up

4. Elegant (single mode) solutions are OK for Tame & Critical Problems but not Wicked Problems

5. Wicked Problems require New Beginnings and Constructive Dissent to initiate Clumsy Solutions that pragmatically use all 3 elegant modes – they require bricoleurs

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Some problems are so complex that you have to be highly intelligent and well informed just to be undecided about them.

Laurence J. Peter
Engaging with people

STORIES!
Domestic, Professional, Historical, organisational, media. etc.

1. **Inclusivity and involvement** – people like to feel a part of something
2. **Humour** – shared emotion, relaxes people
3. **Curiosity** – getting people’s attention
4. **Innovative** – a need to be innovative to be innovative
5. **Memorable** – exaggeration
6. **Learning** – sharing successes and failures
7. **Sense making** – breaking down problems
8. **Boundaries** – generational, cultural, departmental

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