



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

Leading in Times of Crisis

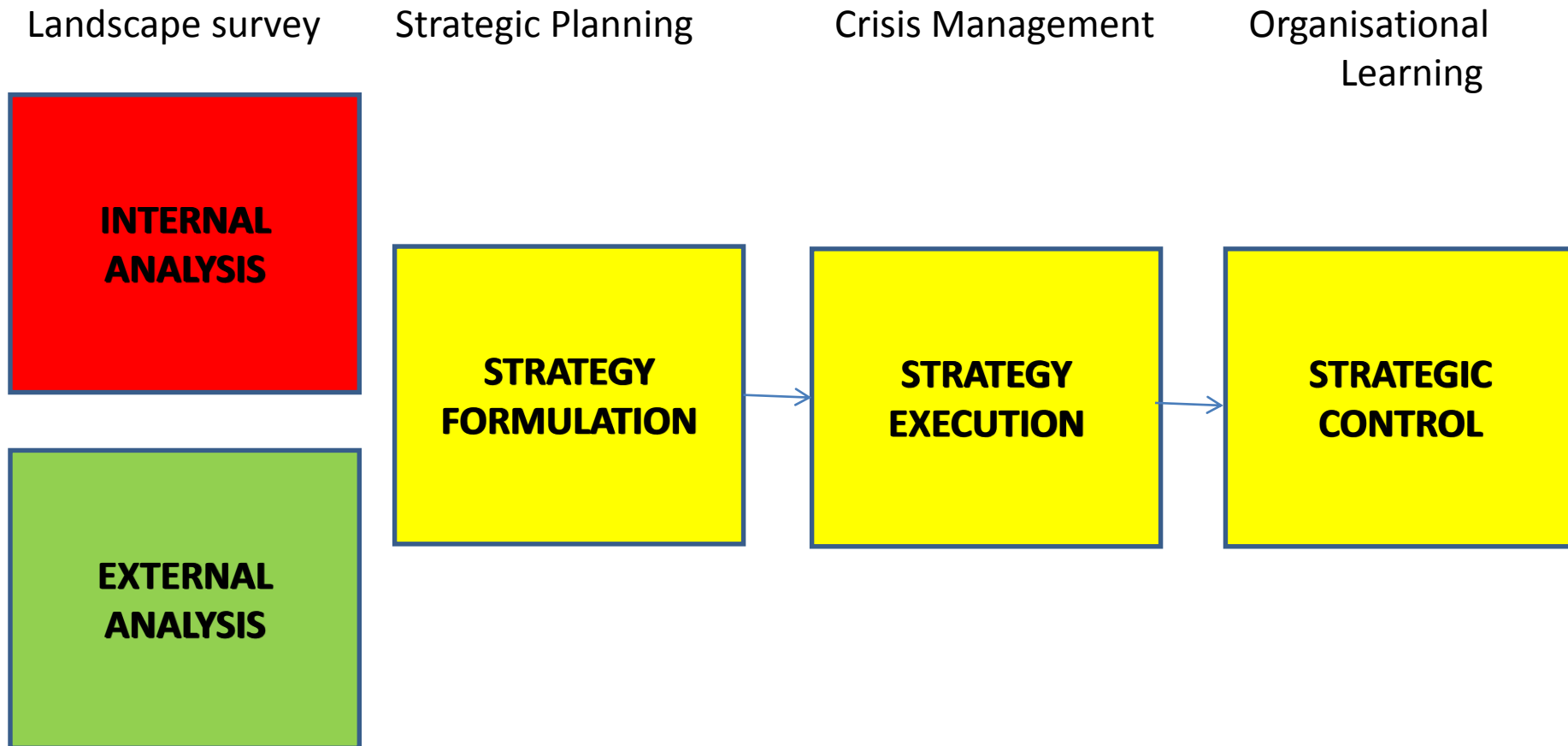
Trawsnewid Addysg; Trawsnewid Bywydau
Transforming Education; Transforming Lives



www.uwtsd.ac.uk



A Strategic Approach to CM



LAPD – A Search for Bedrock

- Reduce the complexity & focus on

Leadership

Accountability

Professionalism

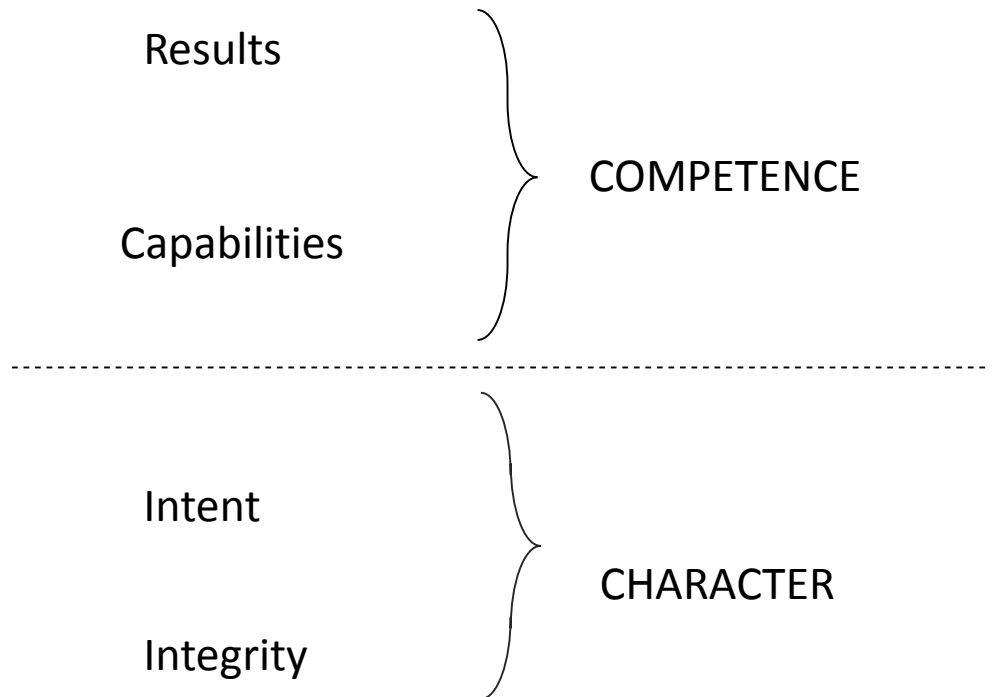
Delivery

Andrews – Trusted to Care

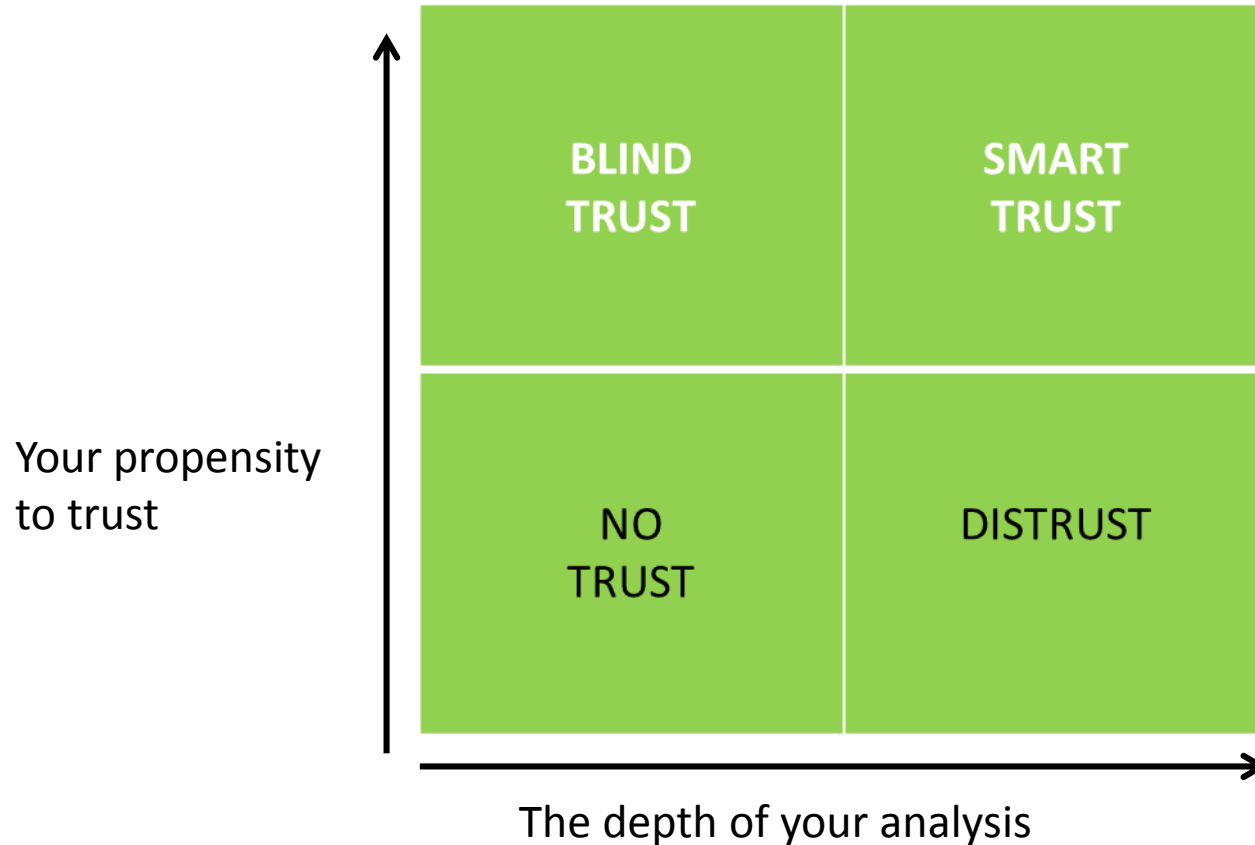
- “..some staff in certain wards felt ill equipped to meet the needs of patients. . this was not true of all wards or even shifts. There was a sense of hopelessness or ‘learned helplessness’ & the resulting variation in care seems to stem from the lack of immediate advice and support from .. leaders, the apparent failure to act or provide feedback on reports of problems & incidents .. and a fundamental lack of clarity from managers about what was expected of staff”

- *(pp2-3 Andrews & Butler 2014)*

Leadership Components - Covey



Covey on Trust



Common Causes of Broken Trust

- Disrespectful behaviours
- Communications problems
- Unmet expectations
- Ineffective leadership
- Incompetence
- Incongruence

Building Trust

- Talk straight
- Demonstrate respect
- Create transparency
- Right wrongs
- Show loyalty
- Deliver results
- Get better
- Confront reality
- Clarify expectations
- Practice accountability
- Listen first
- Keep commitments
- Extend trust

Stephen M.R.Covey's
13 Behaviours

LEVEL 5

**Builds enduring success through a
blend of personal humility &
professional will**

LEVEL 4

**Catalyses commitment to a clear &
compelling vision stimulating higher
performance**

LEVEL 3

**Organises people & resources toward effective
& efficient pursuit of predetermined objectives**

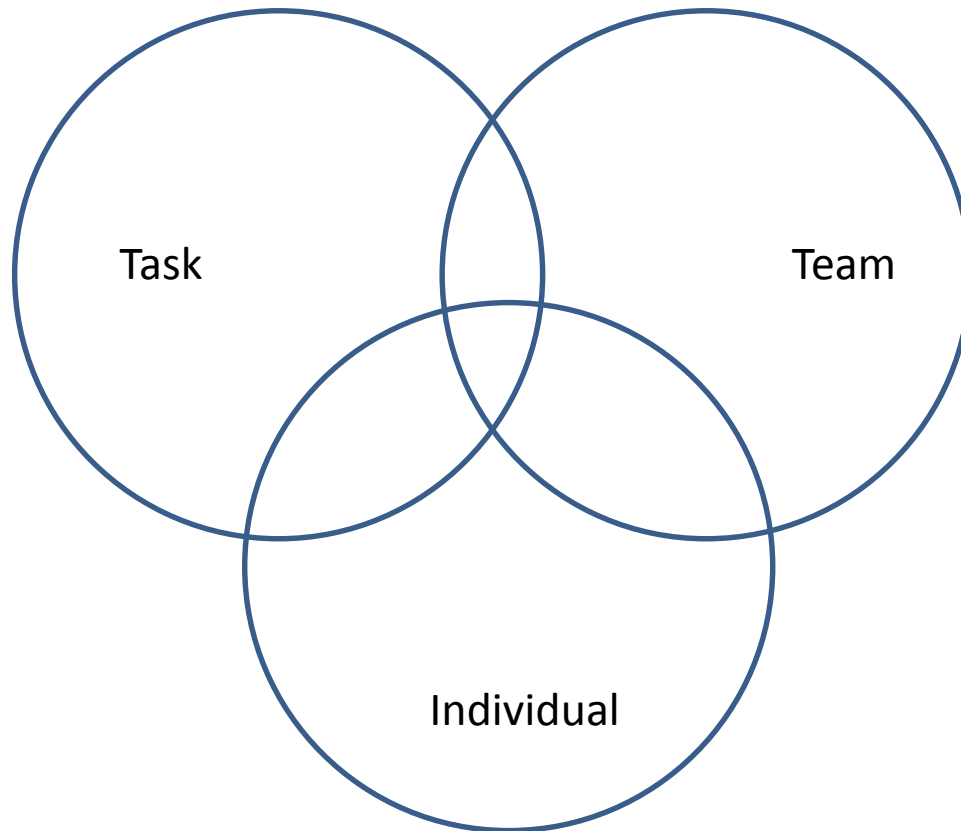
LEVEL 2

**Contributes individual capabilities to the
achievement of group objectives & works
effectively in a group setting**

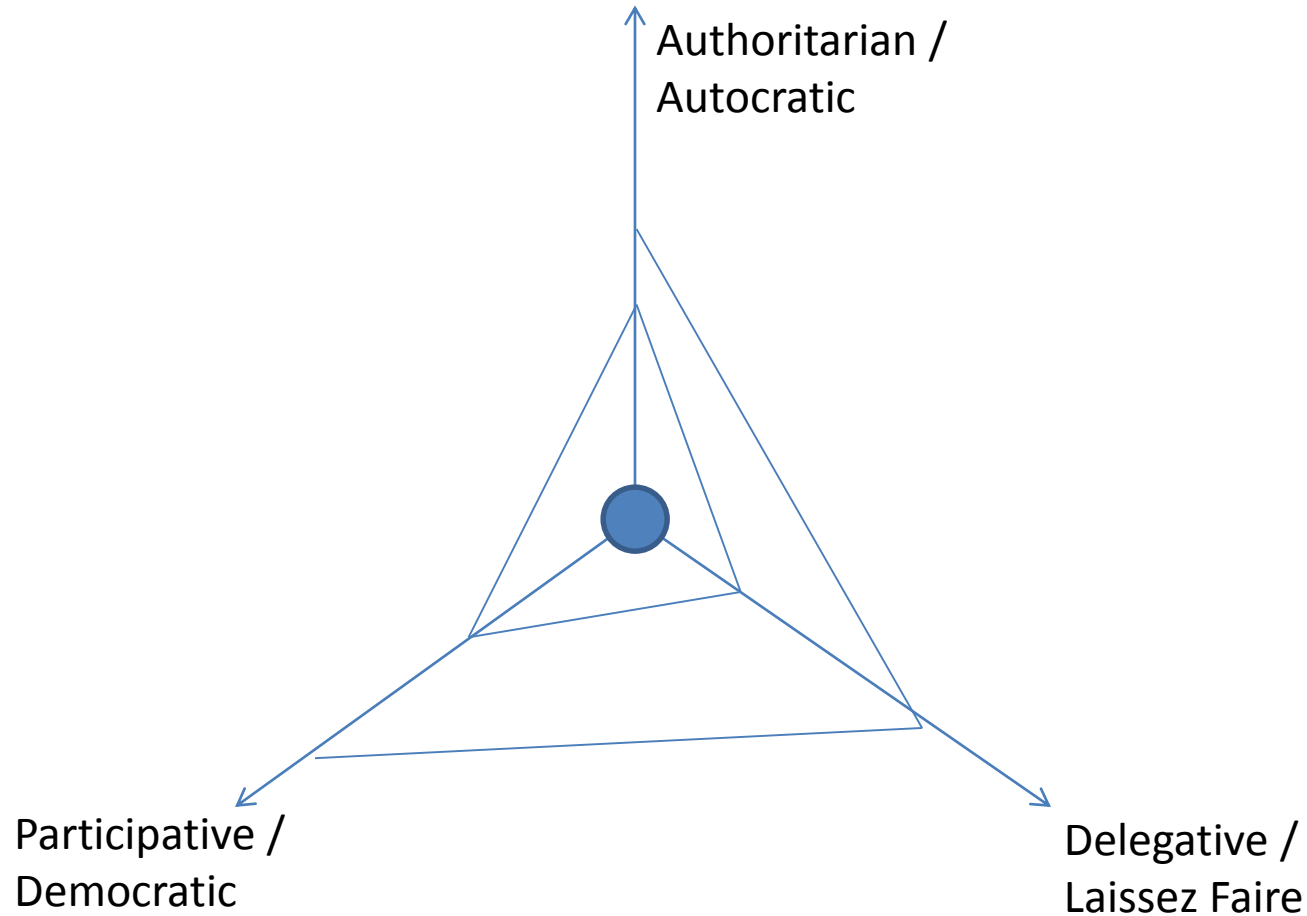
LEVEL 1

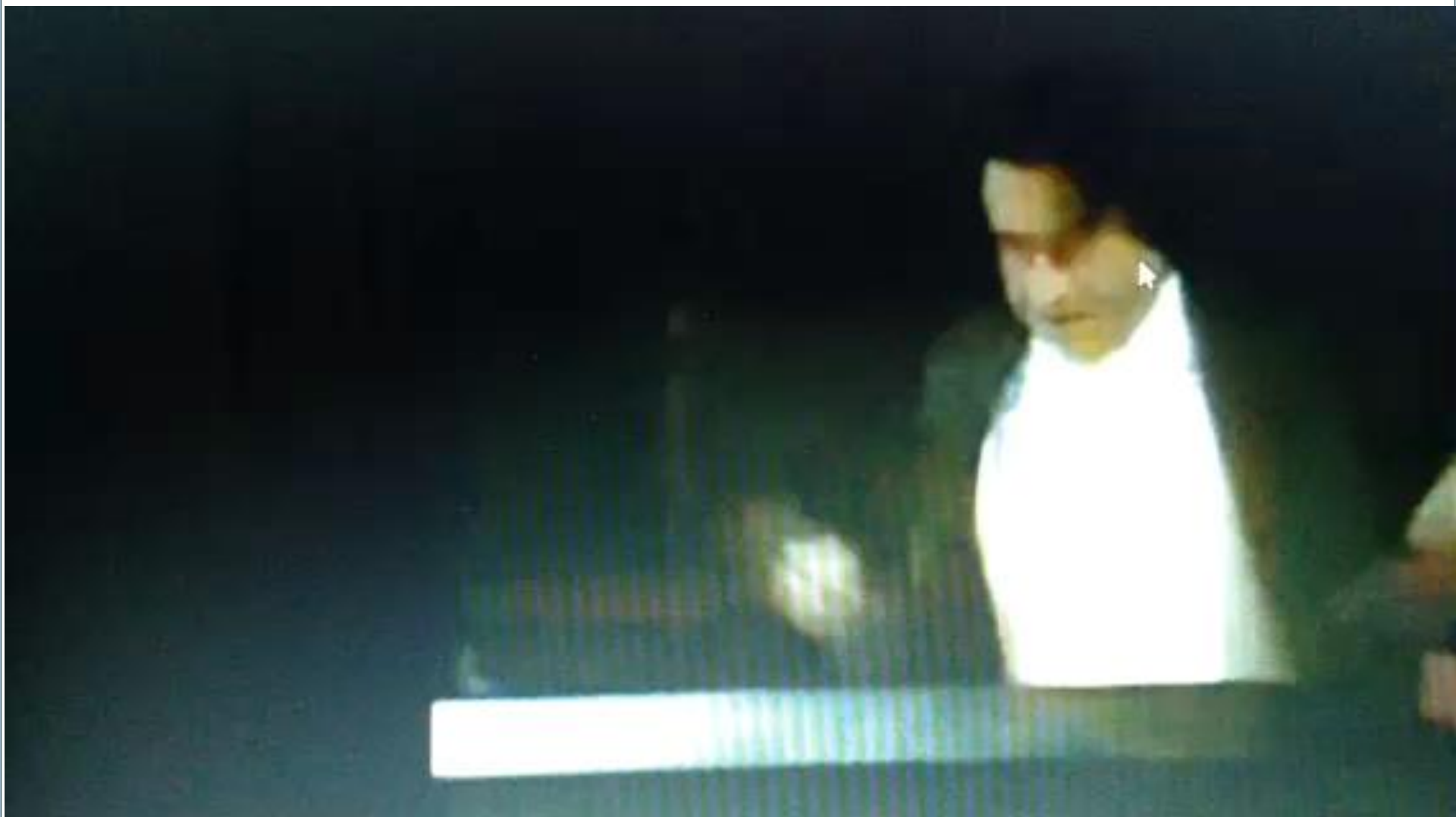
**Makes productive contributions through talent, knowledge, skills &
good working habits**

Leadership Models - Adair



The Leadership Spectrum







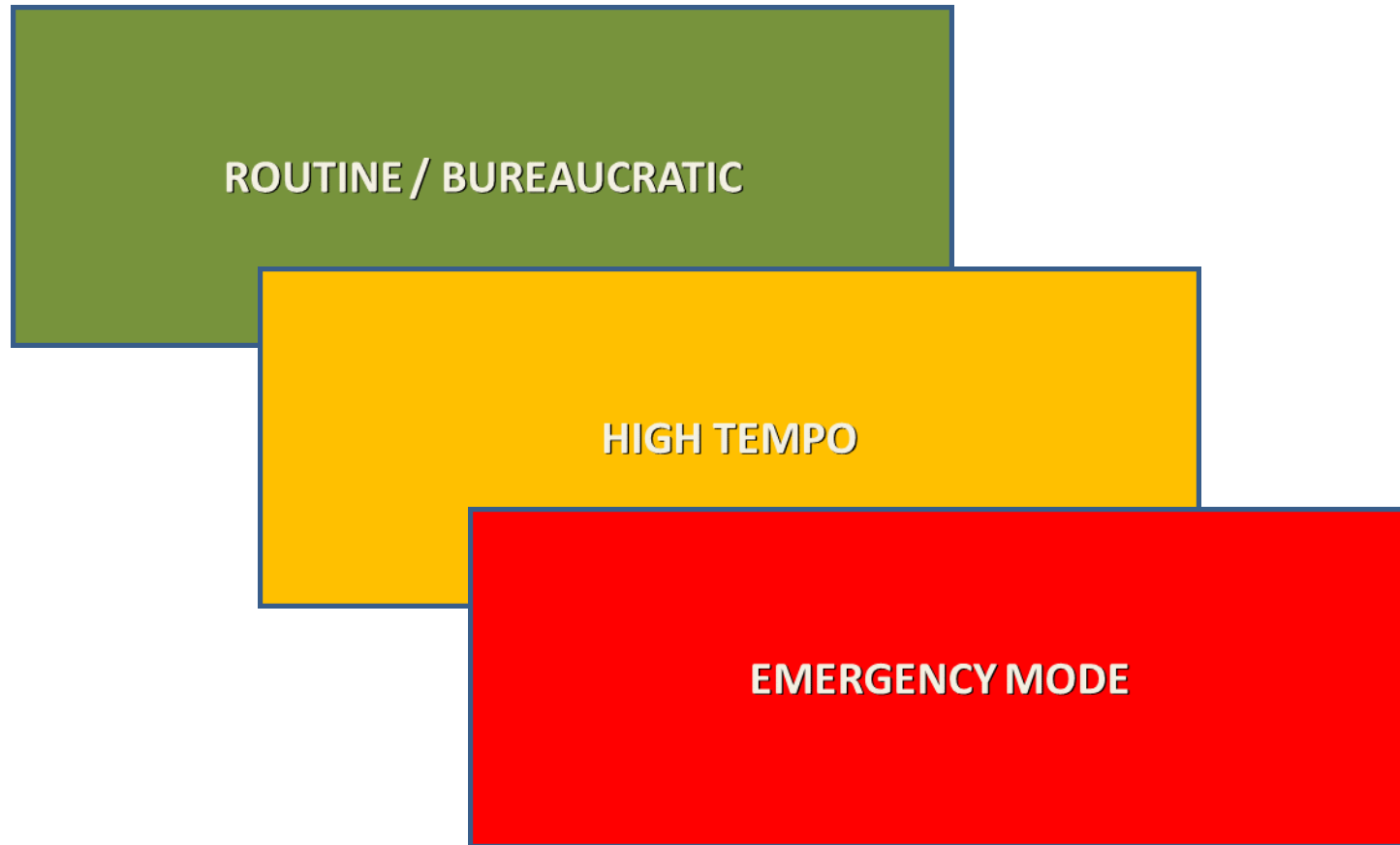
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From 'routine' to anything
but 'routine'



MULTI-LAYERED AUTHORITY SYSTEMS



Managing High Risk Organisations

To encourage:

- Reporting errors without encouraging a lax attitude towards the commission of errors
- Initiatives that identify flaws in SOPs & validate changes in those that are inadequate
- Error avoidance without stifling innovation
- Mutual monitoring without counterproductive loss of staff confidence, autonomy and trust

Questions

What do you think should be the key leadership characteristics for Fieldbay leaders to develop?

Would it be helpful if Fieldbay applied the principles of high risk organisations to its operations? If so, how best to do this?

Organisational Culture & Crisis Planning

‘Nobody gets credit for fixing problems that never happened’

Reppening & Serman 2001

‘An organisation’s crisis vulnerability is linked to its cultural norms and assumptions ‘

Smith & Elliot 2007

‘Some organisations, because of their cultures, seem to develop blind spots and completely miss the cues’

Smallman ~& Weir 1999

‘Crisis management must become the DNA of the organisation’

Coombs 2006

Crisis prepared cultures as opposed to crisis prone cultures

Pearson & Mitroff 1993

Contextual Factors

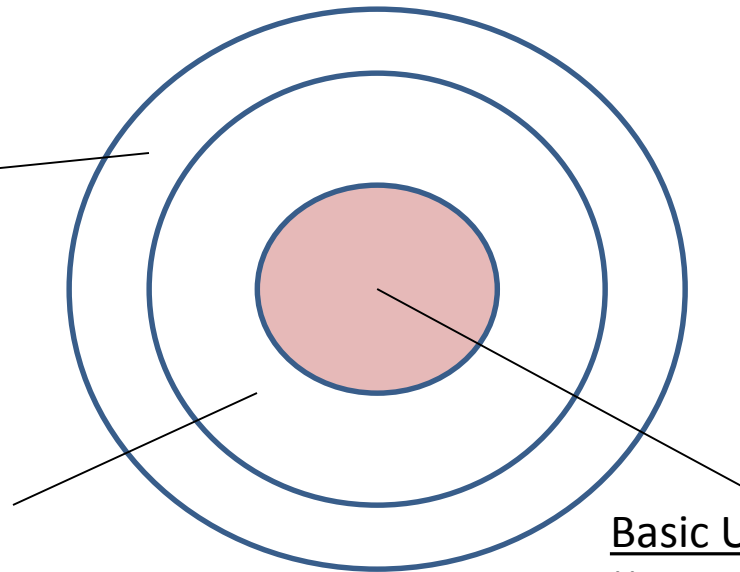
Organisational Cultures:

Artefacts:

- *Visible structures & processes*
- *Observed behaviours*

Espoused Beliefs & Values:

- *Ideals, goals, values, aspirations*
- *Ideologies*
- *Rationalisations*



Basic Underlying Assumptions:

*Unconscious, taken for granted beliefs & values
Determine perception, behaviour, thought & feeling*

Embedding Organisational Cultures

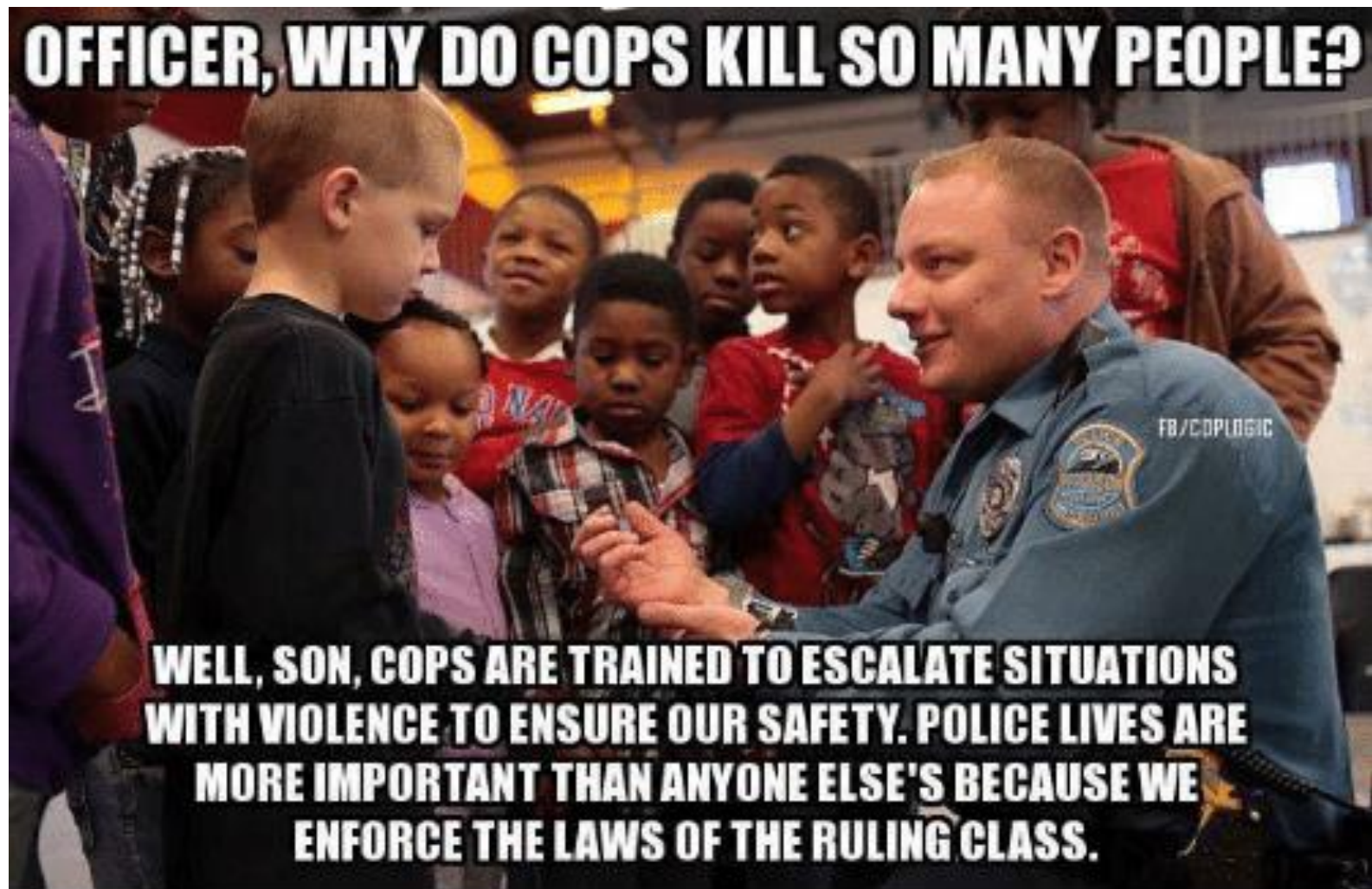
- Primary Embedding Mechanisms:
 - What leaders pay attention to, measure & control regularly
 - How leaders react to crises & critical incidents
 - How leaders allocate resources
 - Deliberate role modelling, teaching & coaching
 - How leaders reward & allocate status
 - How leaders recruit, select, promote & excommunicate

Embedding Organisational Cultures

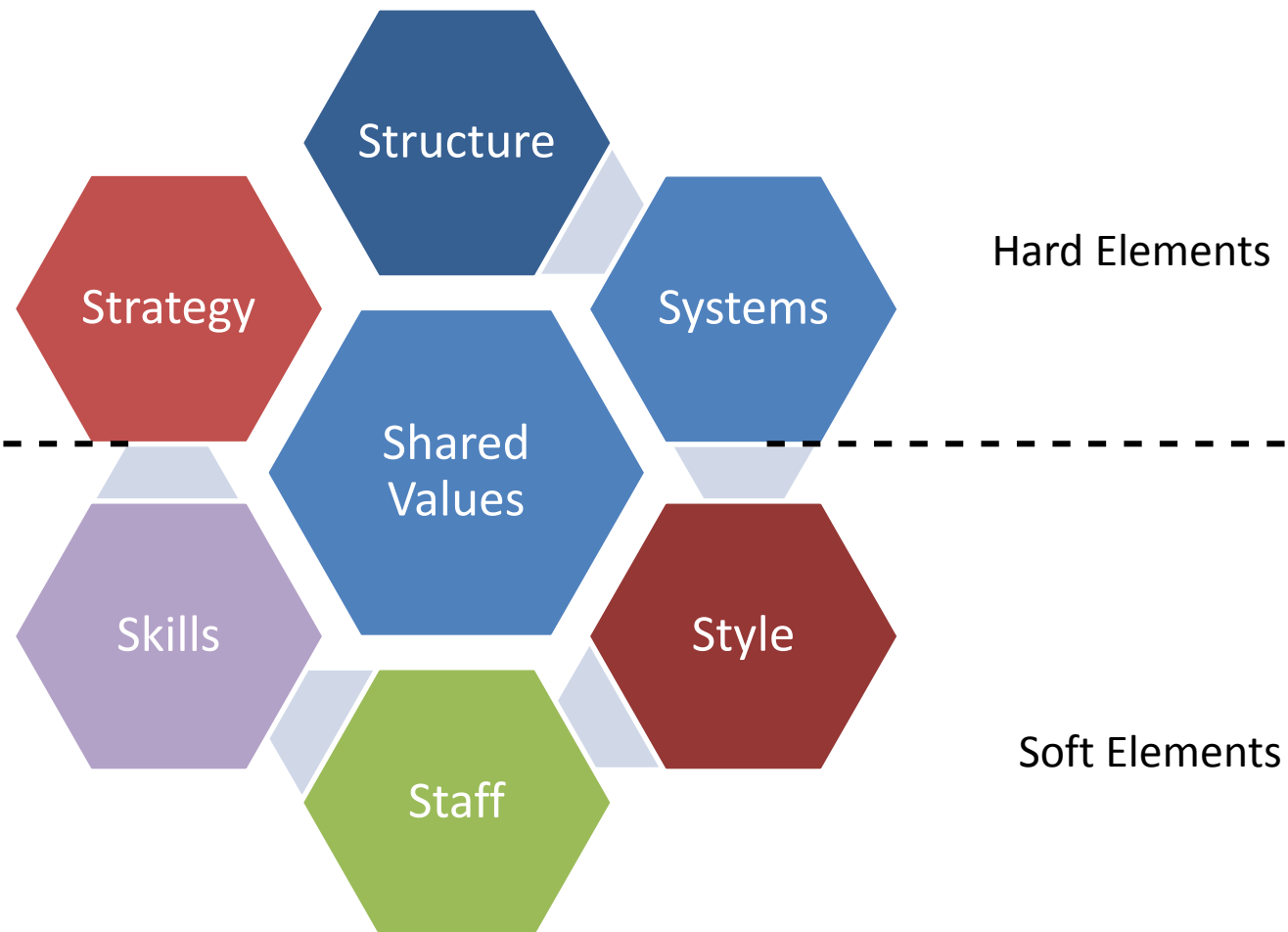
- Secondary Embedding Mechanisms:
 - Organisational design & structure
 - Organisational systems & procedures
 - Rites & rituals within the organisation
 - Design of physical space, facades & buildings
 - Stories about events & people
 - Formal statements of organisational philosophy, creeds & charters

Embedding Mechanisms

- On April 22nd 2015, at 7.30am outside a Wal-Mart store a white officer, Stephen Rankin, shot and killed an 18 years old black man. Four years earlier the same officer had shot and killed Kirill Denyakin, shooting him eleven times.



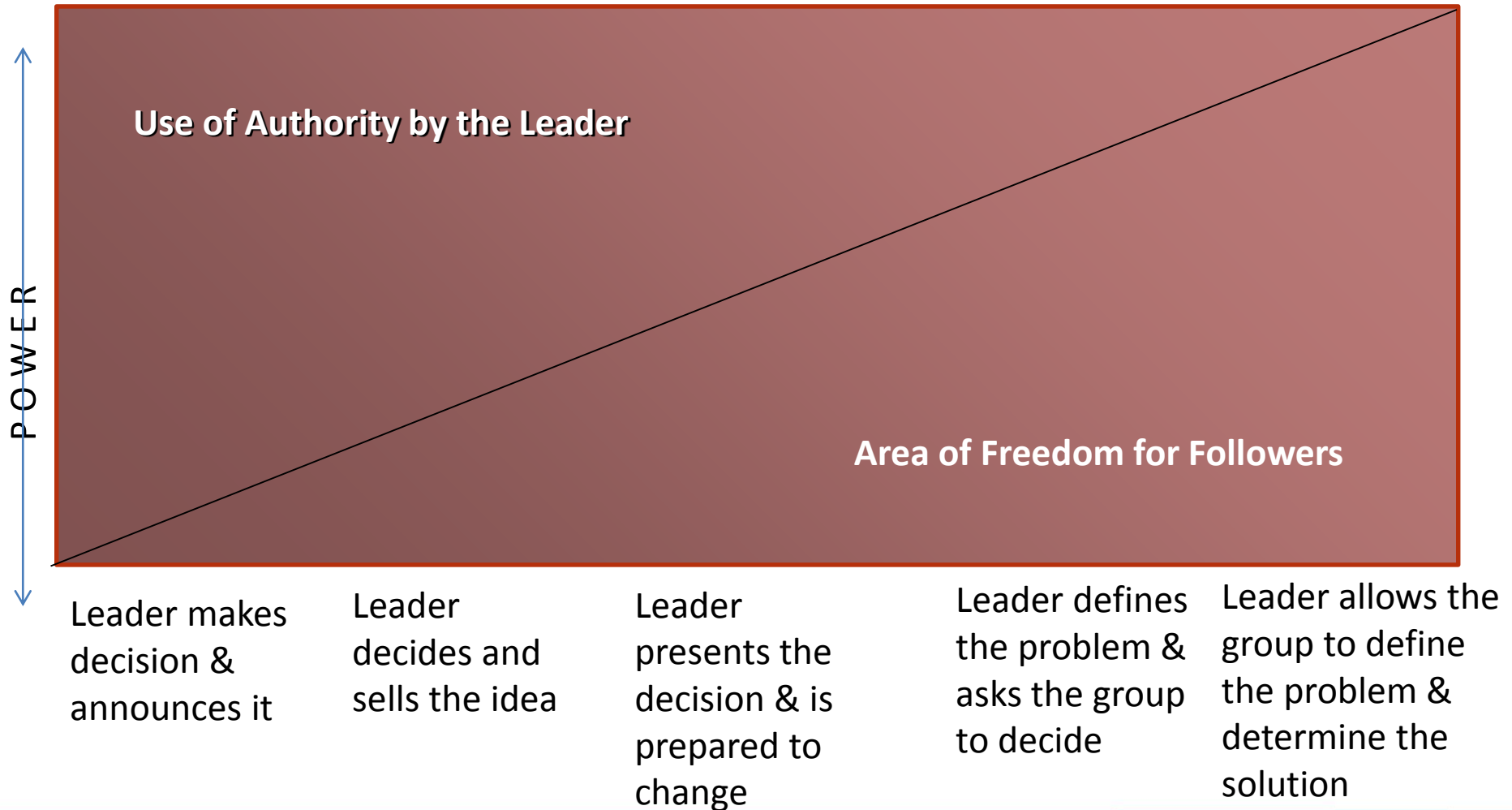
McKinsey 7s Framework



Shadow Factors *(Egan – Working the Dark Side)*

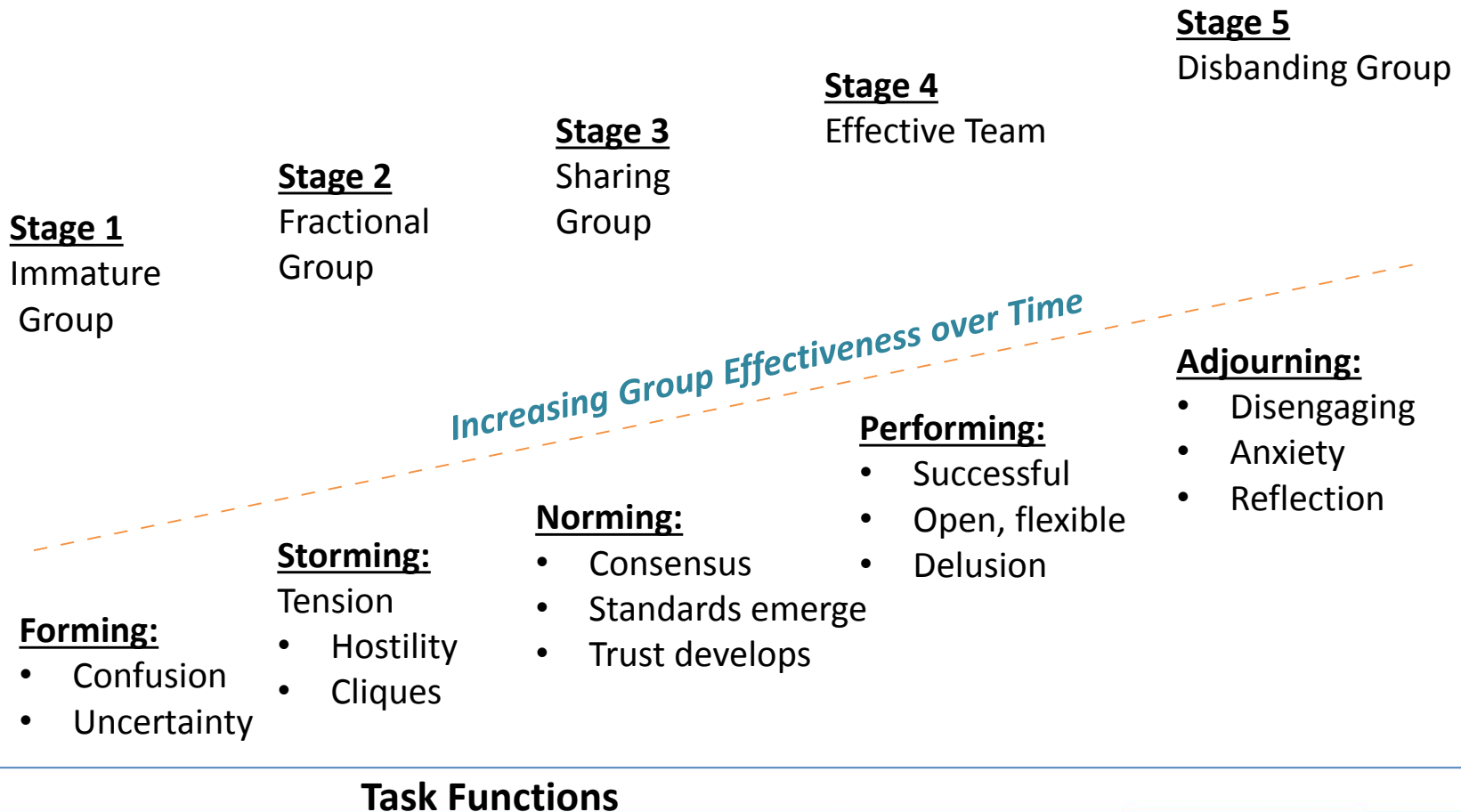
	Organisation	Individual
SURFACE FACTORS	Published reports Accounts Planned Strategy Mission Statement Espoused Values	Personal Goals Monthly reports Annual Appraisals Team Briefings
SHADOW FACTORS	Internal Politics Failed Projects Local custom & Practice Decision Making Informal Networks Untapped Resource Departmental Agendas	Personal Agendas Relationships Mistakes Recounted Desire to Change Stories

Team Dynamics



Stages of Group Development

Personal Relations between Group Members



Five Dysfunctions of a Team

- Absence of Trust
- Fear of Conflict
- Lack of commitment
- Avoidance of Accountability
- Inattention to Results

Patrick Lencioni (2002)

Groupthink

- I use the term groupthink as a quick and easy way to refer to the mode of thinking that persons engage in when *concurrency-seeking* becomes so dominant in a cohesive ingroup that it tends to override realistic appraisal of alternative courses of action

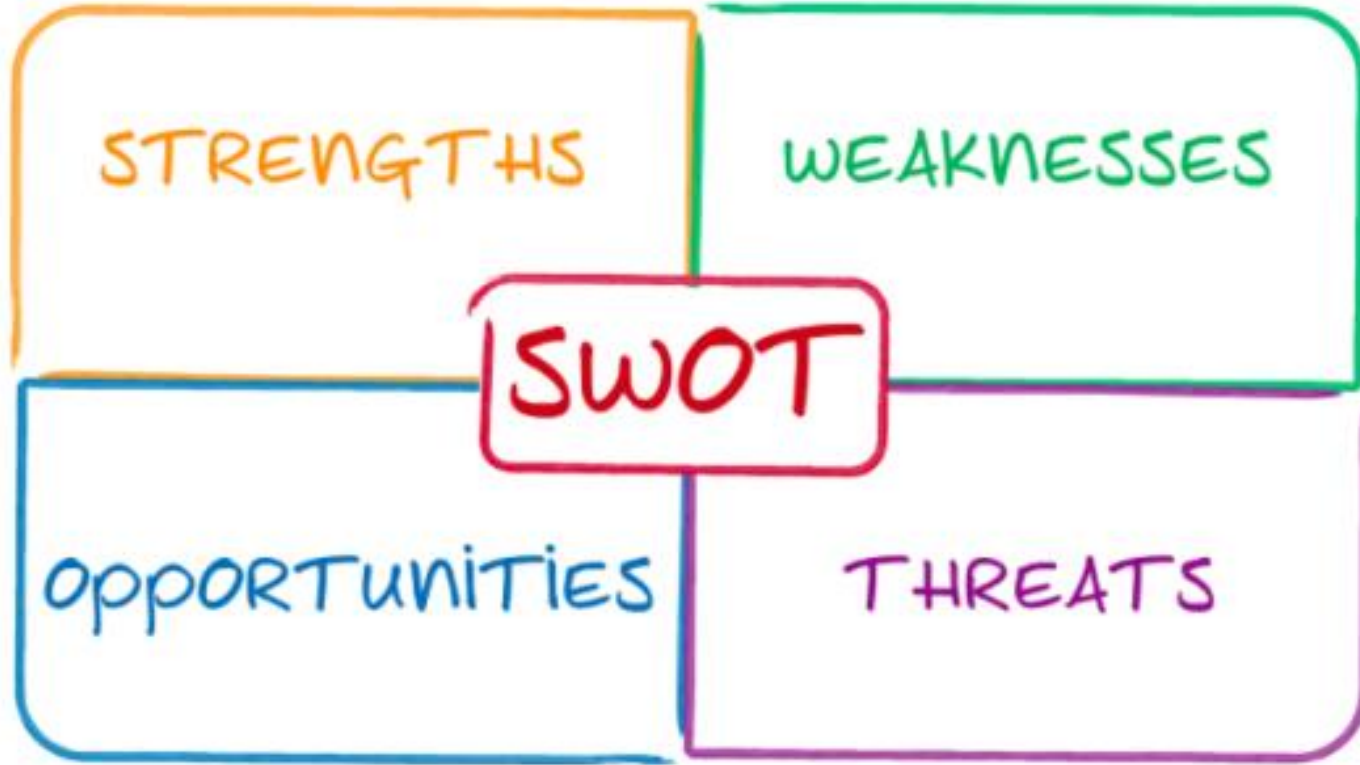
Wilfred Whyte

Symptoms and Preventative Steps

1. Illusion of invulnerability
2. Collective rationalisation
3. Illusion of morality
4. Shared stereotypes
5. Direct pressure
6. Self-censorship
7. Illusion of unanimity
8. Mindguards

1. Leader encourages expression of doubt
2. Leader accepts criticism
3. Higher status members offer opinions last
4. Obtain recommendations from outside the group
5. Periodically divide into sub-groups
6. Seek critical friends' views
7. Allow Devil's advocate
8. Develop alternate scenarios

SWOT of Fieldbay



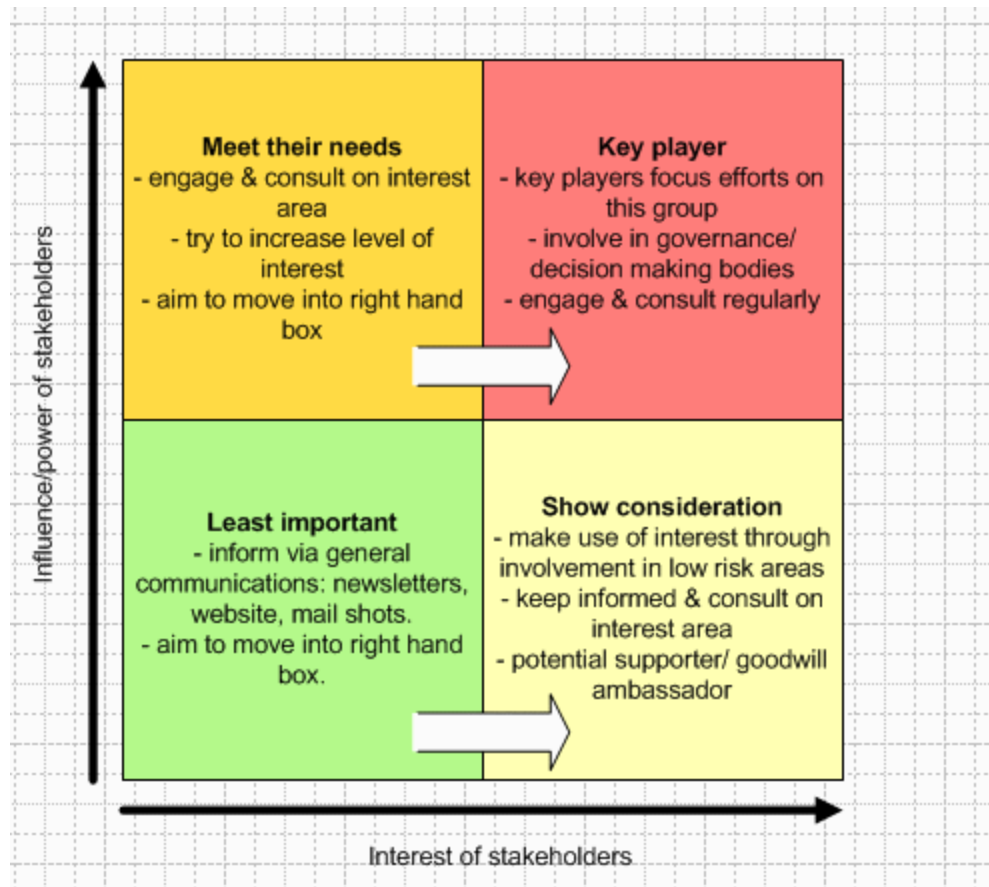
The 10 worst things that could happen here

Situation:

Mitigation:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

Stakeholder Analysis



Question

- How can Fieldbay develop its own organisational culture to deal more effectively with likely crises?
- What do you think are your major stakeholder groups and how would you engage with them in a time of crisis?

The three features of crises

- Severe threat
 - Time pressure
 - High uncertainty
-
- Calls into question the ability of 'normal' bureaucratic processes to manage the emerging crisis

What defines a Crisis?

“An organisational crisis is a low probability, high impact event that threatens the viability of the organisation and is characterised by ambiguity of cause, effect and means of resolution, as well as by a belief that decisions must be made swiftly”, *Pearson & Clair (1998:60)*

“A crisis is the perception of an unpredictable event that threatens important expectancies of stakeholders and can seriously impact an organisation’s performance and generate negative outcomes”, *Coombs 2007:2-3)*

What defines a Crisis? (2)

“A crisis is an event that has a low probability of occurring but should it occur, can have a negative impact on the organisation. The causes of the crisis, as well as the means to resolve it, may not be readily clear; nonetheless, its resolution should be approached as quickly as possible. Finally, the crisis impact may not be initially obvious to all of the relevant stakeholders of the organisation”(p5)

Crandall, Parnell and Spillan 2014



BREAKING NEWS

WFAA



**SHUTTLE FOLLOWED BY MULTIPLE
VAPOR TRAILS OVER TEXAS**

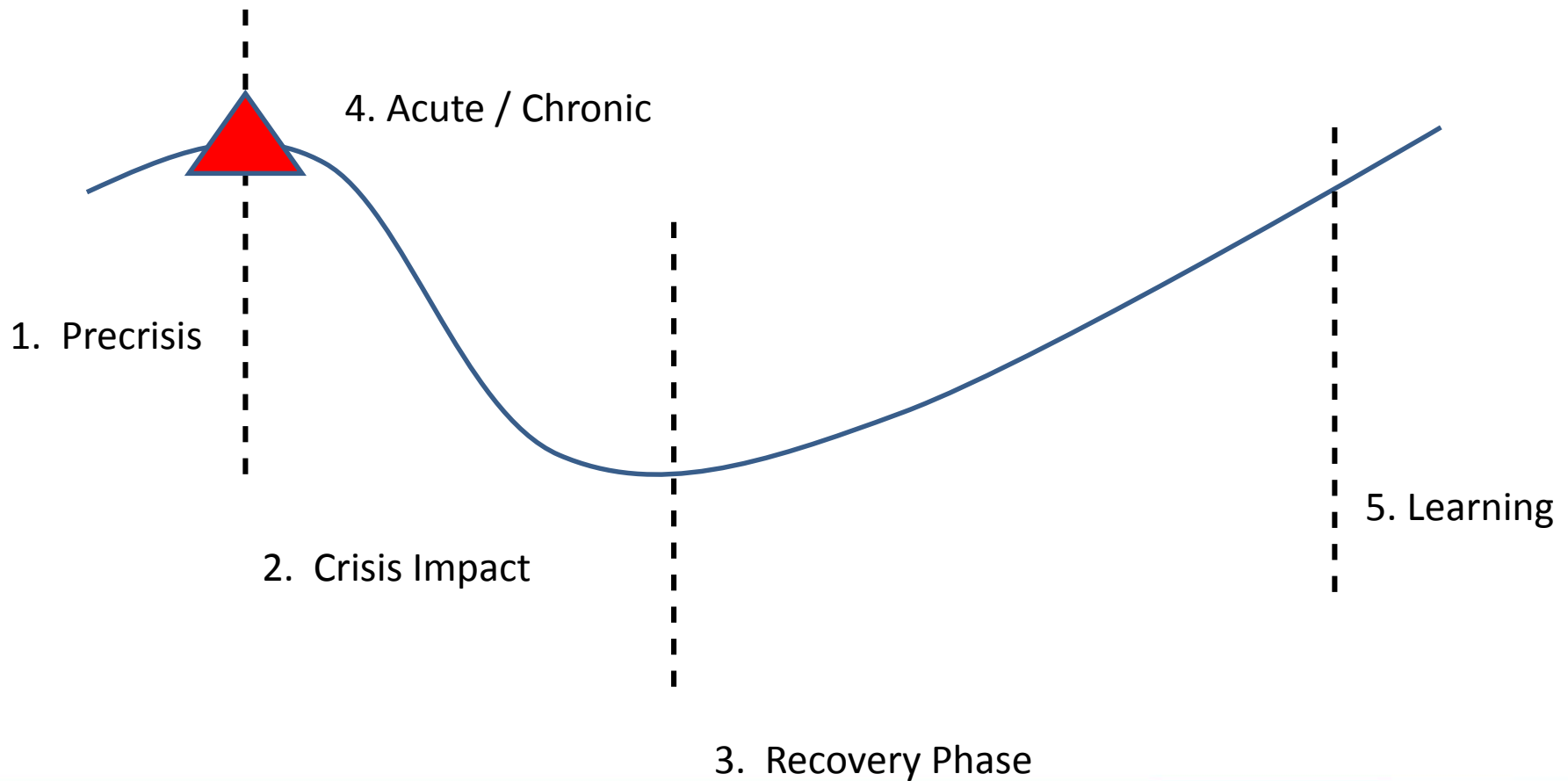
ORTH CENTRAL TEXAS AFTER CONTACT WITH SPACE SHUTTLE







The Lifecycle of a Crisis



Sources of a Crisis

External

- Political
- Economic
- Social
- Technological
- Environmental
- Legal

Internal

- Human error
- Mismanagement
- Workplace deviance
- Tight/Loose coupling
- Sloppy Management
- Epistemic blind spots
- Risk denial
- Structural impediments
- Hubris

Warnings of a Crisis

- Creeping / Slow Burn / Sudden Crises
- A technical discontinuity
- Industry watchdogs' reports
- Persistent rumours and speculation
- Client complaints
- Lax standards
- Poor accountability measures
- Pleas from staff going unheeded
- Failure to join the dots (think strategically)

Recognising Impending Crises

1. Pay attention to your instincts
2. Confront disturbing facts as they appear
3. Consider the consequences if they are found to be true
4. Ask (disconfirming) questions
5. Seek the counsel of others
6. Be guided by your values

RESPONDING TO THE CRISIS

- Think systematically – bring order to the chaos
- Have a plan ready
- Have a crisis team ready to respond
- Engage in defensible decision making
- Communicate

THINK SYSTEMATICALLY

GOLD (STRATEGY)

The overall intention is to combine available resources to manage and resolve an incident

SILVER (TACTICS)

The way that resources are used to achieve the strategic intentions within a range of approved tactical options

BRONZE (ACTION)

Organises the groups of resources to carry out the tactical plan

A command protocol will identify:

- a. The **desired outcome** of the operation
- b. **Who is responsible** for achieving each of the aims that will lead to the desired outcome.
- c. Who is responsible for minimising each risk identified.
- d. Who controls each of the resources.
- e. Who commands each separate geographic or functional area (if appropriate)
- f. How the individual aims are dependent on each other, for example a Firearms Silver Commander may not be able to operate until the Public Order Silver Commander has secured the scene.
- g. What instigates the transfer of Command from one Commander to another. This would include **how this is defined, communicated and recorded**

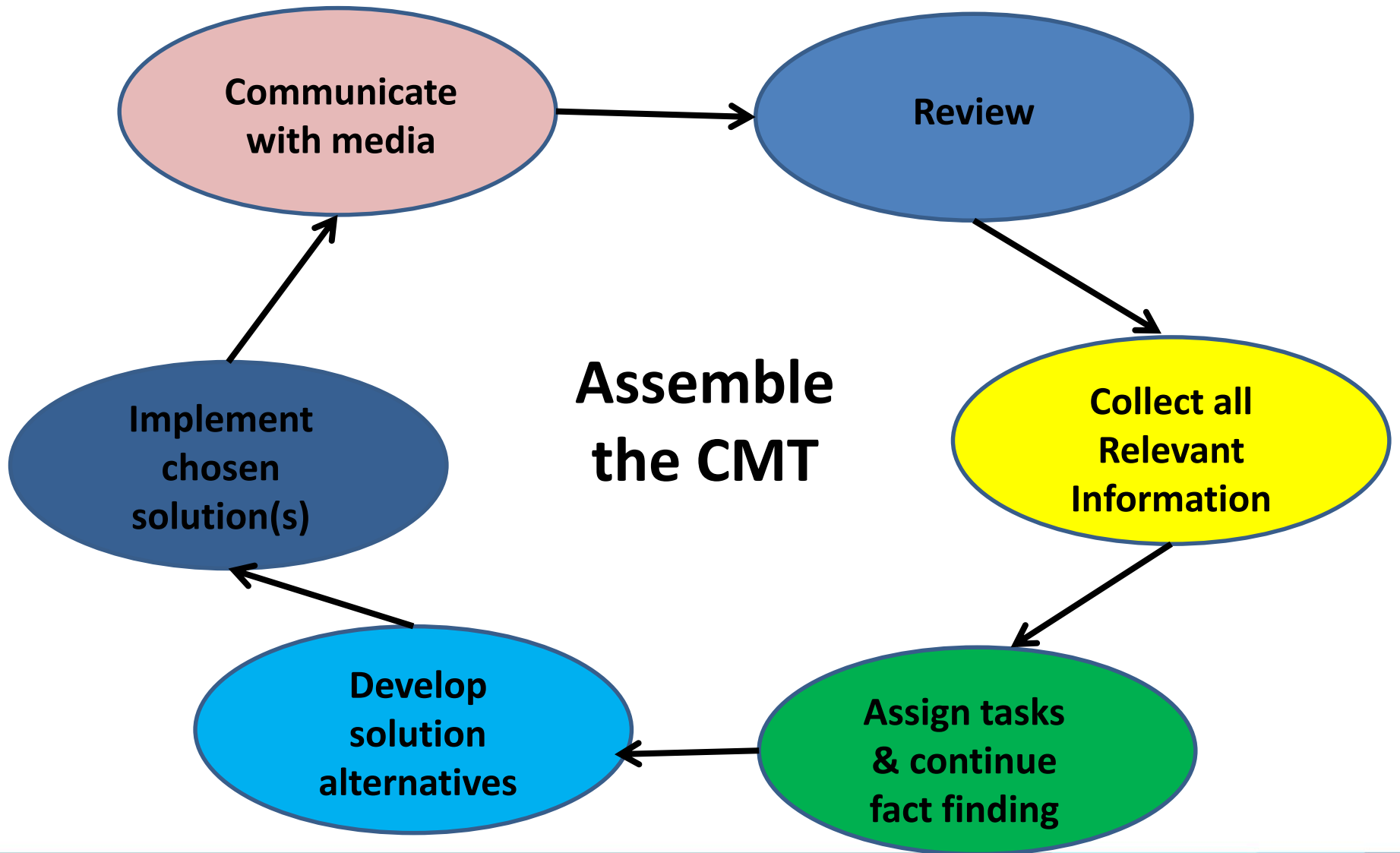
The Crisis Management Plan



C **RISIS**
M **ANAGEMENT**
P **LAN**

The Crisis Management Team





Strategies for dealing with a crisis

1. Situational Assessment
2. Decision Making
3. Team Coordination
4. Communicating
5. Monitoring
6. Delegating
7. Prioritising
8. Planning

Situational Assessment

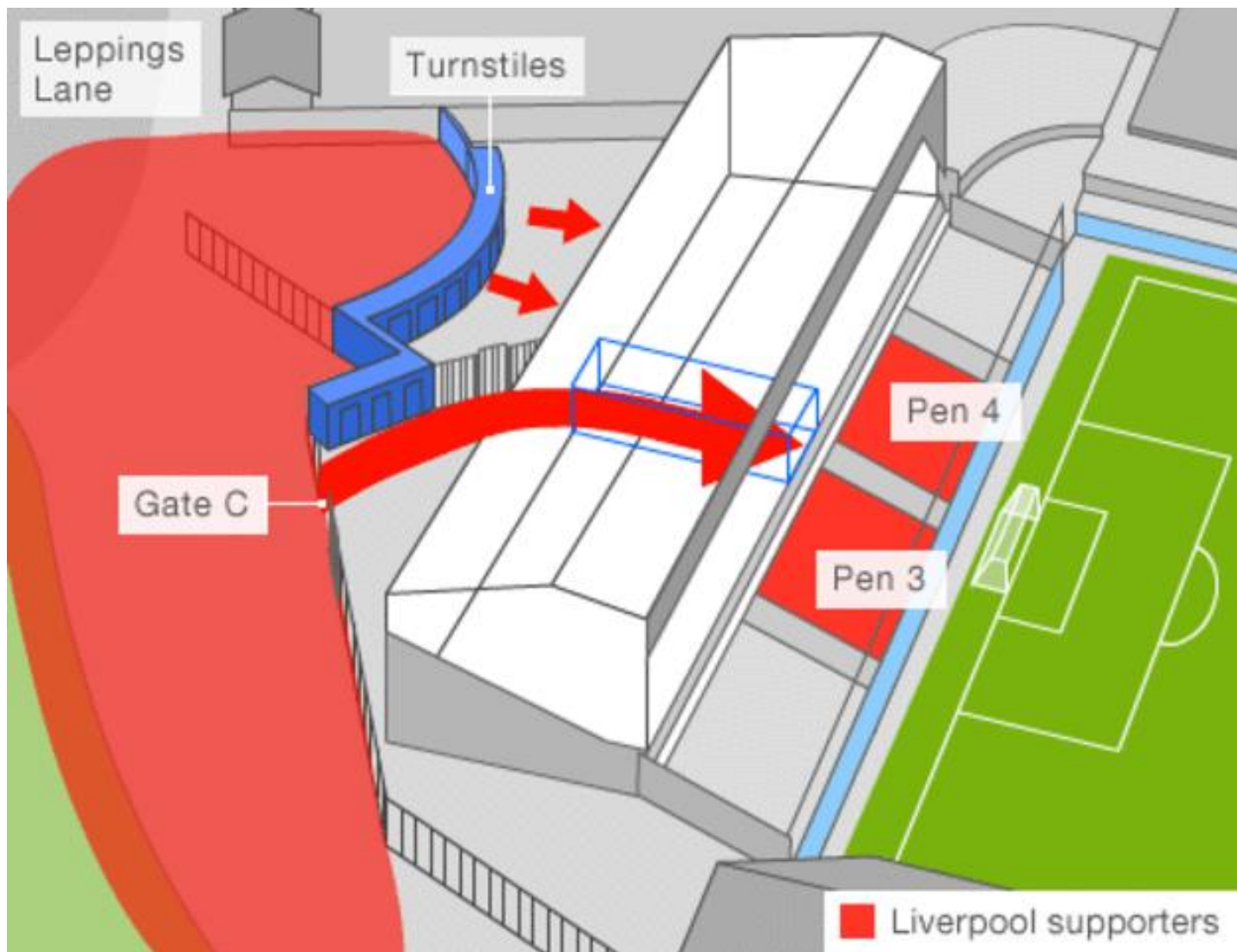
- Is the capacity to assess the situation so that decisions can be made to mitigate the crisis

(Wilson 2004)

- Refers to the information processing and knowledge creation aspects of crisis management

(Coombs 2007)





Decision Making

1. Act quickly and decisively – develop viable mitigation strategies
2. Put people first
3. Be visible
4. When in doubt, let your training, instinct and values guide you
5. Focus

Communicating

- Information should be timely
- Information must be accurate
- Procedures for gathering and monitoring information should be developed
- Spokespersons (*SPOCS*) should be appointed early
- Communications strategies will require flexibility as the crisis evolves
- Plan each contact and record

The Internet of Things

- 1983-93 cyberspace & 'meatspace'
- 1993 – 2003 convergence
- 2003 = 2016 a blended universe
- June 2015 – US Office of Personnel Management hacked
- October 2015 – Talk Talk hacked
- February 2016 – Biggest bank robbery in history
- March 2016 – Hospitals worldwide subject to 'ransomware' attacks
- October 2016 – Ddos attacks worldwide shut down major IT systems

Social Media

- How do we assess the threat posed by Social Media?
- Scan for negative comments
- Is this prominent on-line?
- Is there the potential for the message to spread?
- Does it fall under one of the three categories of on-line crisis?

Rumour – spreading false, incomplete information

Complaint – based on real or perceived issues

Challenge – the organisation's ethics or value base

A Classic Social Media Crisis

- Dominos Pizzas

- Group Task:

Using the eight strategies for crisis management, respond to what you have seen

Lerbinger's Eight Types of Crisis

- Natural Disaster
- Technological Crises
- Confrontation
- Malevolence
- Organisational Misdeeds

Skewed management values/deception/misconduct

- Workplace Violence
- Rumours
- Terrorism/Man Made Disasters

CASE STUDIES

EXXON VALDEZ	1989
BRAER	1993
SEA EMPRESS	1996
PAN AM 103	1985
JAL	1985
BRITISH MIDLAND	1985
HILLSBOROUGH	1989
THOMAS COOK COACH	1999
CHALLENGER	1986
COLUMBIA	2003
HERALD OF FREE ENTERPRISE	1987
GLEISION COLLIERY	2011

MEDIA - SUMMARY

- Never ignore the media
- Begin to communicate immediately
- Have a figurehead, ideally the CEO
- Focus on what the organisation feels & how it intends to address the problem
- Monitor all media constantly & respond to changed circumstances
- Channel your response & record engagement
- Let your people know your strategy

STRATEGY - SUMMARY

- Plan for the crisis
- Recognise one when it appears
- Be seen and heard to say the right things
- Remember its basically about trust
- People will (among other things) be angry
- Put people first, then the environment, then property & finally, money
- Prepare for media engagement
- Learn from the experience

**Questions?
Comments?
Observations?**

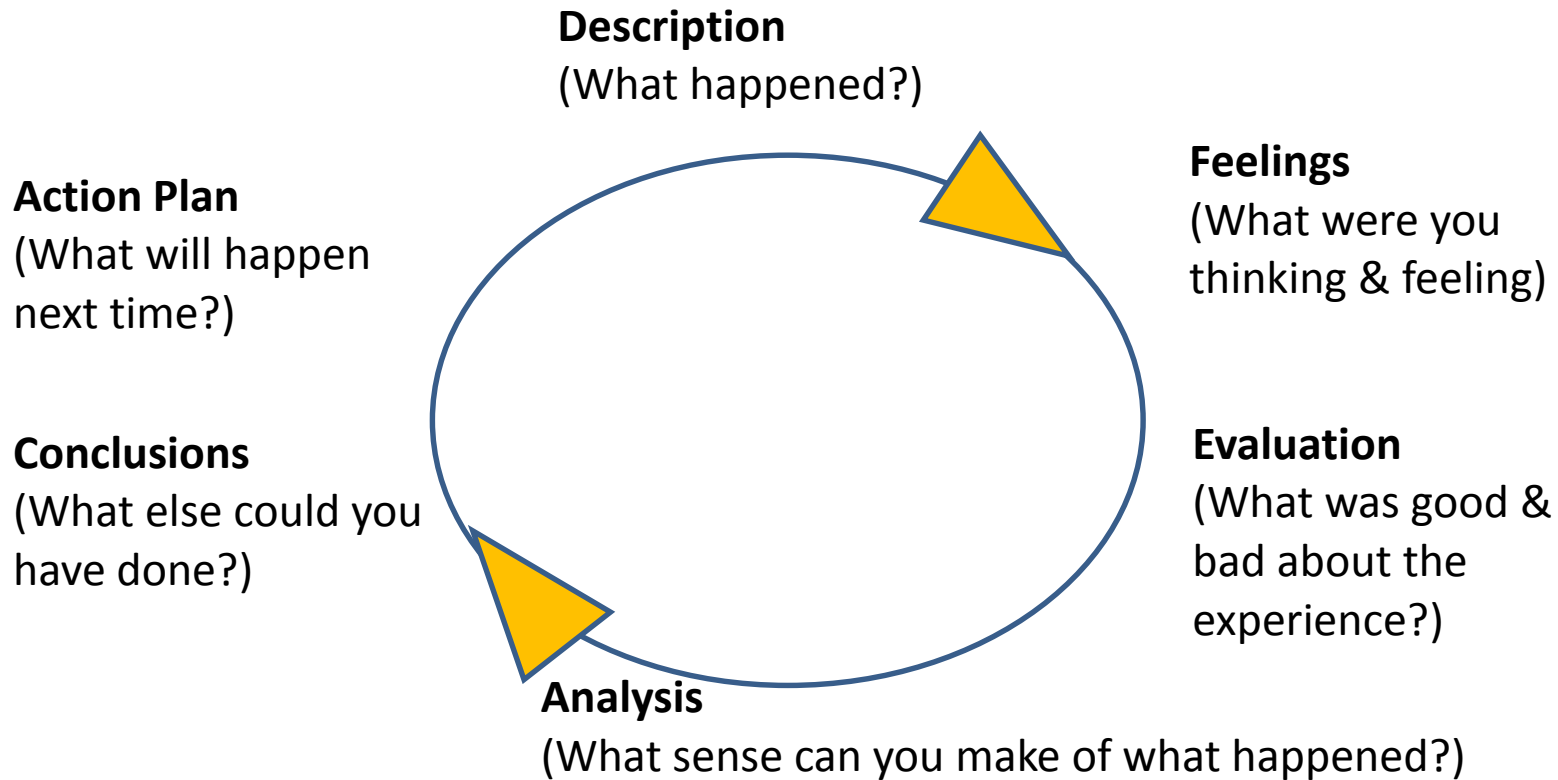


Team Coordination

- Informal Decentralisation
- Formal Decentralisation
- Non decision making
- Decisions not taken
- Decisions not to act on
- Paralysis
- Situational dominance
- Strategic evasion

End

Gibbs' Model of Reflection (1988)



REFLECT Model

R	Recall	The facts as you remember them
E	Examine	Your thoughts and actions at the time
F	Feelings	Highlight feelings
L	Learn	Highlight learning
E	Explore	Discuss options if a similar incident arose in the future
C	Create	A plan of action for future events
T	Timescale	For implementation

Single Loop & Double Loop Learning

