Reducing Post Project Blues

Course No: B02-010
Credit: 2 PDH

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Introduction

Research conducted in 1989[1] found that *prospective hindsight* – imagining that an event has already occurred – increases the ability to identify reasons for future outcomes by 30%

Using that as a foundation, this course will be a guide to leading your team's pending project in assuming it **has failed in a spectacular fashion** – not just asking *what could fail.* This assertion of what has happened instead of what could happen will help the team visualize the hypothetical disaster more clearly to avoid it in reality.

No, this is not another walk down the heavily-trafficked project preview road asking, *"What could go wrong with our project?"* It will be much more direct than that. Also, it's not an exercise in risk analysis that assumes we're going ahead 'as is' and asking "what is the risk if we do?"

This course wants the project's manager and key members to meet before the project planning stage (if possible) and assume the project **FAILED TOTALLY and COMPLETELY.** Then, if the findings from that 1989 research are correct, use the best brains on the team to identify what led to its hypothetical demise. Once you know what led to it, steps can be taken to prevent that from happening.

Albert Einstein is credited with saying (paraphrased), *"Insanity is doing things the way you always have and expecting different results!"* This course helps you go upstream to identify what (hypothetically) went wrong to kill the project and change those things so they do not lead to the same disastrous outcome.

There will be some discussion about organizational problems and traps that invariably arise and create havoc such as:

- The Abilene Paradox
- Group Think
- The dangers of True Believers (aka Project Champions)
- The lack of an Exit Champion
- The dangers of project Cheerleading Squads

We will talk about spotting potential problems in work process issues that can arise early in a project before people become too vested in it and start staking out their 'turf'.

Then we will show you how to structure a *controlled* (not chaotic) brainstorming session with key project team members before project kick-off and give you several specific questions to ask that will stimulate thought in this pre-project activity identifying what led to the death of the project.

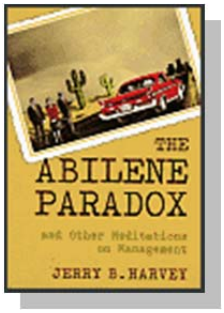
Once the team has identified the reasons for the project's hypothetical death, the PM can work to avoid the potential problems or develop contingency plans just in case the worst case becomes reality.

Typical Organizational Problems

Before we get into writing the project's obituary, it is important to have an understanding of situations that frequently arise in organizations where schedules, individual, departmental, and divisional goals usually conflict, and high expectations flourish: in other words, nearly everywhere!

Several of these situations are available as rentable instructional videos from CRM Learning (www.crmlearning.com). These can be used as part of the obit writing process with the key members of the project team or later when the full team, clients, and prime vendors are aboard. The course author has used them very effectively in team building programs to illustrate the issues we talk about in this course.

The Abilene Paradox



The Abilene Paradox is a situation in which a group of people collectively decide on a course of action that is counter to the preferences of any of the individuals in the group. It involves a common breakdown of group communication in which each member mistakenly believes that their own preferences are counter to the group's and do not raise objections. It stems from assumed agreement instead of a perceived conflict.

It was observed by management expert Jerry B. Harvey in his book, *The Abilene Paradox and other Meditations on Management.*[2] The name of the phenomenon comes from an anecdote in the book which Harvey uses to describe the paradox:

> *On a hot afternoon visiting in Coleman, Texas, the family is comfortably playing dominoes on a porch, until the father-in-law suggests that they take a trip to Abilene [53 miles north] for dinner. The wife says, "Sounds like a great idea." The husband, despite having reservations because the drive is long and hot, thinks that his preferences must be out-of-step with the group and says, "Sounds good to me. I just hope your mother wants to go." The mother-in-law then says, "Of course I want to go. I haven't been to Abilene in a long time."*
>
> *The drive is hot, dusty, and long. When they arrive at the cafeteria, the food is as bad. They arrive back home four hours later, exhausted.*
>
> *One of them dishonestly says, "It was a great trip, wasn't it." The mother-in-law says that, actually, she would rather have stayed home, but went along since the other three were so enthusiastic. The husband says, "I wasn't delighted to be doing what we were doing. I only went to satisfy the rest of you." The wife says, "I just went along to keep you happy. I would have had to be crazy to want to go out in the heat like that." The father-in-law then says that he only suggested it because he thought the others might be bored.*
>
> *The group sits back, perplexed that they together decided to take a trip which none of them wanted. They each would have preferred to sit comfortably, but did not admit to it when they still had time to enjoy the afternoon.*

That situation – that some communication problems do not flow from conflict but *agreement* - is common in everyday life and so potent if allowed to flourish that a team must make special efforts to:

1. Make sure each team member at every level is aware of its existence. This can easily be done by renting the video and investing 26 minutes in showing it to your project team before the project begins.

2. Lead a discussion by soliciting examples from the team about past experiences when this – an unspoken assumption of mutual agreement that leads to undesirable outcomes - happened to them. A typical clue indicating this has happened is when someone starts their comments with, "Well, I could have told you…." (It makes you want to shake them while screaming, "Why didn't you say something??!!")

3. Adopt a code phrase that signals a warning that the team may be making this mistake of assumed agreement. We suggest just saying, "Let's not take a trip to Abilene – please speak up if there isn't agreement on this." But before that phrase has meaning for the team, they will have to see the video.

A word of caution here is to create an environment where team members feel it is safe to speak up. There must be a sense of security in knowing no one will discount their comments or laugh at them because it may be the team's meekest member who spots a potential landmine that could kill the project.

If they don't feel comfortable speaking up in front of the group, then invite them to come to your office and talk, send an anonymous note via interoffice mail, slip a note under the door, or anything that encourages them to share their concerns!

The Abilene Paradox is related to the concept of groupthink (next) in that both theories appear to explain the observed behavior of groups in social contexts. The crux of the theory is that groups have just as many problems managing their agreements as they do their disagreements.

Groupthink

Groupthink is a type of thought exhibited by group members who try to minimize conflict and reach consensus without critically testing, analyzing, and evaluating ideas. During Groupthink, members of the group avoid promoting viewpoints outside the comfort zone of consensus thinking. A "steamroller effect" may be created, especially by the more powerful members of the group, as the less powerful want to avoid being seen as foolish, not "team players", or a desire to avoid embarrassing or angering other members of the group.

The course author was once a part of a project team meeting when the project manager, a textbook Type A controlling personality, said, *"Anyone with any sense can see this is a good idea! Are there any objections?"*

Naturally, there were no objections at the time. Later on, the project did run into problems from issues that were discussed at this meeting. His response then was to ask the team in a very demanding manner, "*Why didn't someone speak up? Couldn't you see this would be a problem?"*

While I am certain at least one person was aware of the potential problem, the PM's steamroller approach made it nearly impossible for anyone to speak up. Groupthink may cause groups to make hasty, irrational decisions, where individual doubts are set aside, for fear of upsetting the group's balance or authorities.[3]

According to Irving Janis[4], decision making groups are not necessarily doomed to groupthink and identified several ways to prevent it:

- Leaders should assign each member the role of "critical evaluator". This allows each member to freely air objections and doubts.

- Higher-ups should not express an opinion when assigning a task to a group. (The course author adds this: call on team members in reverse order of team seniority to speak up. This prevents the most powerful from influencing their comments. Naturally, this also assumes the project environment is one where members can feel free to speak up. If there is a sense of intimidation, no one will speak up and the project is doomed from the start.)

- The organization can set up several independent groups, working on the same problem.

- All effective alternatives should be examined without initial judgment being made

- Each member should discuss the group's ideas with trusted people outside of the group.

- The group should invite outside experts into meetings. Group members should be allowed to discuss with and question the outside experts.

- At least one group member should be assigned the role of **Devil's Advocate**. This should be a different person for each meeting.

This example is available as a video learning tool from CRM Learning, also. The Groupthink example is the *Space Shuttle Challenger disaster* (1986)

The Danger of True Believers

The typical project true believer usually begins as a project champion whose drive serves as the motive power behind the project. But, if that drive becomes all-*consuming to the point where they put on rose-colored glasses and start saying (figuratively), "Damn the torpedoes, full speed ahead"*, there can be great danger for the project as well.

They become crusaders and develop an unyielding conviction—based, often as not, on a hunch or personal biases rather than on strong evidence—that a project will absolutely succeed and that potential threats are not really as large as everyone thinks

This blind belief in the value of the project then spreads to others. This 'blind faith virus' may stem from his or her personal credibility and charisma within the company. If the champion's reputation is strong enough, the belief of a guaranteed success for the project can pass from person to person until it is shared by individuals who don't even know the champion and know little of the project. This is especially true if the champion is a corporate "golden child." If they are, an aura of invincibility tends to grow around the project and its leaders. The dangers of this are obvious.

There is certainly a need for the role of a champion, for someone to be the spirit behind the project that keeps it going through rain, snow, sleet, adversity, and anything else that may threaten the goal. However, while the role of a champion is absolutely critical to a successful project of any size, there is more to it than just being a true believer with blinders to the realities around them.

A search through business-related literature finds that most large capital investment projects come in late and over budget, never living up to expectations. More than 70% of new manufacturing plants in North America, for example, close within their first decade of operation. Approximately three-quarters of mergers and acquisitions never pay off—the acquiring firm's shareholders lose more than the acquired firm's shareholders gain. And efforts to enter new markets fare no better; the vast majority end up being abandoned within a few years.

According to standard economic theory, the high failure rates are simple to explain: The frequency of poor outcomes is an unavoidable result of companies taking rational risks in uncertain situations. But what if the reason for failures is more than just bad luck tied to "uncertain situations?" How about mistakes in the way they make decisions? When forecasting the outcomes of risky projects, true believers easily fall victim to a common problem in planning: **delusional optimism.**

Any complex project is subject to myriad problems—from technology failures to delivery problems to bad weather—and it is beyond the reach of the human imagination to foresee all of them at the outset. As a result, scenario planning can seriously understate the probability of things going awry.

For instance, true believers will establish a "most likely" scenario and then assume that its outcome is in fact the most likely outcome. But that assumption can be wrong. Because they have not fully considered all the possible sequences of events that might delay or otherwise disrupt the project, they are likely to understate the overall probability of unfavorable outcomes. Even though any one of those outcomes may have only a small chance of occurring, in combination they may actually be far more likely to happen than the so-called most likely scenario.

The greatest danger posed by an organization's collective belief in a project is that problems, even if acknowledged, won't be seen as signs of failure—or at least as issues that should be resolved before moving on to the next stage of development.

This blindness persists in part because collective belief undermines normal organizational procedures and safeguards. For one thing, the enthusiasm generated by faith in a project can lead to an unrealistically tight development timetable. Or, it can result in lenient procedures for reviewing the viability of a product throughout its development.

The Cheerleaders

All too often, project teams are self-selected. They include people who have volunteered because they share an initial enthusiasm for the project. They may even have worked together on successful projects in the past. They know the drill and can anticipate one another's moves. In fact, they know them too well.

This familiarity may lead to a communication breakdown where members assume they know the others' thoughts and intentions because "that's what we did on the previous project."

As they interact with each other, there are none of the awkward missteps or misunderstandings that can produce unexpected insights—or signs of trouble. Warning flags that do appear when former strangers work on a project may be ignored. After all, they know each other and everyone is rooting for something they believe in.

Another dual-edged danger here is that team members begin to refer to it as "my project." While it is important to develop a sense of ownership in a project, there is a danger in identifying too closely with it.

For example, if it is "your" project, how willing are you to listen to someone point out problems with it? Is there a chance that problems with 'your' project may also suggest there is something wrong with your role in it, too? Naturally, everyone wants to be associated with a winner because, by inference, that makes them winners.

Unfortunately, the opposite is also true – that no one wants to be associated with a losing proposition because that may taint them indirectly. This avoidance of that negative association may create blinders on otherwise objective team members.

Executives launching a project would do well, then, to include skeptics along with believers in the project teams from the outset, paying particular attention to those who will be directly involved in making decisions. Then, over the course of the initiative, some decision makers should be replaced with others, who will look at the project with fresh eyes.[5]

Lack of an Exit Champion

As much value as a champion can bring to a project, there is also a danger they will evolve into a true believer that will disregard or diminish genuine warning signs indicating the project has problems. One way to build in a safety value is the identification of an Exit Champion whose job it will be to stay grounded and avoid getting caught up in the excitement and hype while looking for objective reasons things are not going well or should be stopped altogether.

They must gather hard data that will be convincing enough to overcome the emotions of the true believers because the excitement surrounding a true believer may not contain a lot of facts. Frequently, followers get more caught up in the emotion of the charismatic leader than they do with the facts (if any) leading to their excitement.

The Exit Champion will need clear criteria for deciding whether to kill the project. This "when-to-kill-the-project" issue can be an excellent topic to introduce during the project 'premortem' when the team is hypothetically looking at what killed the project.

Suppose that a team member speculated that the project failed because *"we didn't acknowledge the warning signs and kill it when we had the chance."* If you like the idea of having an Exit Champion, then also give them some help by identifying key issues, milestones, or measurables that can lead to project termination. We will talk more about these project killers on page 14.

When existing procedures don't include such "when-to-kill-it" criteria, they need to reach an agreement with believers on the criteria for assessing the new data; otherwise, reaching an agreement on the decision will be impossible. Thus, while project champions often violate procedures, exit champions typically have to introduce or restore them.

These people are more than devil's advocates. Instead of simply raising questions about a project, they seek objective evidence showing that problems in fact exist. This allows them to challenge—or, given the ambiguity of existing data, conceivably even to confirm—the viability of a project. They then take action based on the data.[6]

To be effective, an Exit Champion needs to be directly involved in the project; a negative assessment from someone based elsewhere in the company is too easy to dismiss as ill-informed or motivated by organizational rivalry. The Exit Champion also needs a high degree of personal credibility. They can expect to face inevitable hostility from project supporters, so they need to be fearless, willing to put their reputations on the line and face the likelihood of exclusion from the camaraderie of the project team.

They should also be very determined because it may take a sustained effort to stop a project if warranted. Perhaps most important, exit champions need to have some incentive for putting themselves out to halt a bad project. For many, this will simply be an acute distaste for wasted effort.

Project Killers

What are the job functions or work processes within the various project *components* that could tell us this portion of the project may not be running as smoothly as we think it is?

> Project components are work groups like accounting, document control, safety, drug testing, filing documents, human resources, engineering, drafting, surveying, vendor relations, permitting, etc. (A job function within the component called Project Accounting may be "Accounts Payable.") We recommend you consider all functions in the project, not just the ones *your experience* tells you are the most important.

If any part of the project's expected output was not going to meet project quality, quantity, or schedule expectations, when and how would we know?

> Suppose your department produces a daily report for the project that must be sent out by 9:00 AM but for some reason it does not meet expected standards or does not go out at all. How would you know? Or, if it were an automated report that sends data without need for human oversight, how would you know if it did not go out or if it sent the correct data?

Your possible answers may be something like these:

1. *<u>We would know immediately</u> because we create it. If we cannot deliver the output by a specific time, we will know it first because (why?)*
   Other questions flowing from this could be:
   a. If we do our part wrong and <u>we catch it</u>, how long would it take to fix it?
      i. What would we do to fix it?
      ii. Is anyone else involved? If so, who and how do we contact them?
   b. If we do our part wrong and <u>we do not catch it</u>, how long would it take for them to discover it, tell us, and we fix it?
   c. What parts of our product can go wrong?
      i. Data – how?
         1. What can we do to reduce the chance of that happening?
      ii. Supporting information – how?

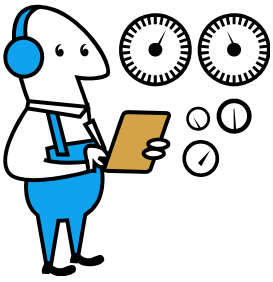
1. What can we do to reduce the chance of that happening?

d. What or who are the sources upon which we rely to produce our output?
   i. Who by name (and contact information) are they?
   ii. How can we tell if we are receiving accurate information or products from our sources? (Describe this)
   iii. What do we do if they are not available to provide what we need? (Describe this)

2. *<u>We would not know immediately</u> because our product is a secondary (supplemental) product for someone else. Products from us (such as reports) would stop showing up somewhere.*
   a. How long would it take before anyone noticed?
   b. Once noticed, how long would it take us to fix it?
3. *What indicators in our workflows could we use to monitor how well our processes are working*? (Using the 9:00 AM report example above, you rely on data coming in from various sources to be in your office by 8:30 so you will have time to produce the report. If all of your source data is not on your desk by 8:30, that is an indicator that this piece of your workflow is at risk. If you didn't realize it was missing until 8:45 when you compiled all the data, it may delay your 9:00 deadline.)

List the indicators from #3 above and make the list available to all key team members within your section. Encourage them to add other indicators, if any.

What are the reliable indicators within those job functions or work processes that could tell us this isn't a temporary aberration in performance and we need to pay attention?



Pressure gauges within a power generating plant provide reliable indicators of steam line pressures. Technicians use those gauges to determine if things are running as expected or they need to start paying closer attention.

Work processes are very much like the steam lines in a power plant. Work flows from one station to another until it ultimately emerges as a tangible product or the data

necessary for a decision. If team members are waiting downstream for a product or data, it is prudent for the functional work group to have ways of monitoring the flow of work on the project just like the flow of steam through the power plant.

We will continue using the 9:00 AM report example from above. Suppose the data is supposed to be on your desk at 8:30 but today it arrives at 8:40. Although you still have time to use it in your report, it is still 10 minutes late.

We suggest you document the time of its arrival and then put the data into the 9:00 AM report as you normally would. A late report one time is an *event* but a report that arrives a little later every day or is late three days out of five becomes a *trend.*

We cannot tell you how many times it arrives late should be a cause for worry because we are not present on your project. The point we are making is that simply recording the arrival time of critical data every day is an excellent way to create a reliable process indicator that will give you a little warning before things get beyond control. We call an indicator like that a “trip wire.”

What are the trip wires within those indicators that will tell us to ACT NOW!

Now that you are documenting when the data arrives that you need for your 9:00 AM report, you should set some “trip wires” that signal a need for action on your part.

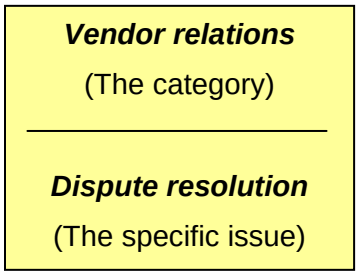
For example, a trip wire may be <u>anytime</u> it is more than 15 minutes late (not there by 8:45 AM), you will call someone and start tracking it down. Or, if it arrives after 8:30 but before 8:45 any <u>two days in a row or any three days out of five,</u> you will call someone and ask if the delay is temporary or should you begin adapting your schedule or contacting those relying on your report to accommodate its late arrivals. The idea is to stay ahead of the action and not get caught by unexpected events or trapped into a situation that will cause a ripple effect of problems downstream from you.

Brainstorming Reasons the Project Died

We suggest a brainstorming session to collect from the project's key members reasons for the project's (hypothetical) failure. Although there are many ways to do this, we have found three methods useful which we will describe here.

- "Around the Table"
  - Everyone adds an idea while someone records them. If they do not have an idea, they just say "Pass." No evaluations or opinions on ideas presented are allowed from members - just solicit their ideas. Keep going around the table until everyone has exhausted their ideas and says "Pass."

- "Chaining Ideas" Once again, there should be no discussion among team members after initial instructions are given.
  - Each member gets a small packet of Post-It notes
  - The member writes only two things on each note: one is the category of the topic (write it at the top half) and the second is the specific issue of concern within that topic (written at the bottom like the sample to the right.)



  - Then, without comment being made, they silently take their post-it notes to the wall or white board, and stick their note on it. If they are not the first, they look for any other category that matches theirs or is close to theirs. Then they stick their note to the bottom of the previous one posted. This creates a chain of ideas under different categories without argument and potential intimidation between team members.
  - The facilitator reviews all the categories and combines them when they are similar.
  - The length of the chains or the number of different ones will give a visual idea of the range of potential problems (categories) and specific issues within those topics.
  - Another value of Post-It notes is that chains can be moved or rearranged in any manner. It makes it very easy to manipulate the data for ease of discussion and analysis.

- "Rapid List Generation and Prioritization" This is an easy way to collect ideas and put them into a priority rank order with minimal discussion and argument.

  We will demonstrate how it works with an example of trying to get the team to agree on what they want for lunch.

  - **Step 1** - Make a vertical list of about five or six ideas for lunch: pizza, bar-b-q, Chinese, Italian, salad bar, sub sandwiches

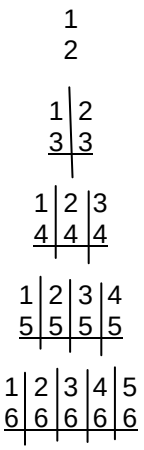
Step 1 –
Solicit a random-response list
Pizza
Bar-b-q
Chinese
Italian
Salad bar
Sub sandwiches

  - **Step 2** – Number the responses in the vertical list

Step 2 –
Number the responses
1. Pizza
2. Bar-b-q
3. Chinese
4. Italian
5. Salad bar
6. Sub sandwiches

  - **Step 3** – Pair the numbered responses like the sample shown in vertical arrangements.

Step 3 - Set up the scoring by vertically pairing the response numbers

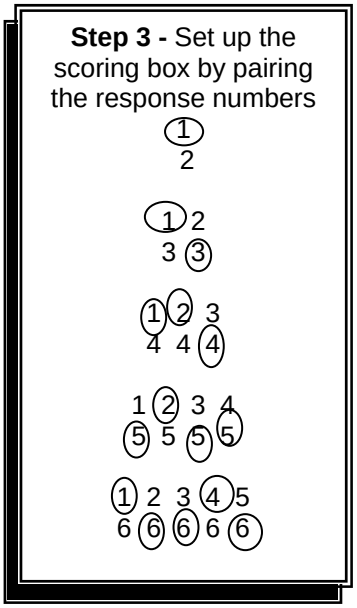


After the responses are numbered and vertically paired, ask the team members for their preferences between each pair at a time, NOT THE ENTIRE LIST AT ONCE. They vote with a simple show of hands, not a discussion.

The facilitator would say, *"We are looking only at numbers 1 and 2; pizza and bar-b-q, NOTHING ELSE at this time. All of those who would prefer pizza please raise your hand without comment."*. The facilitator counts the hands (without group discussion) and circles the number that represents the largest choice – either pizza or bar-b-q. (If there is a tie, the facilitator breaks it.)

Then the facilitator continues to compare them in vertical pairs and says, “Now your choice between #1 pizza and #3, Chinese.” Once again, count the hands and circle the number with the largest number. This goes on until the team has voted for their preference of each pair.

The end result could look like this sample.



Then, just count the number of circled choices to determine the priority is **PIZZA!**

1. Pizza (4 wins)
2. Bar-b-q (2 wins)
3. Chinese (1 win)
4. Italian (2 wins)
5. Salad bar (3 wins)
6. Sub sandwiches (3 wins)

If there had been a tie between categories, then match the categories and vote again with the facilitator being the tiebreaker. The beauty of this process is that there are no comments during the voting, it happens right in front of the audience so no one can claim the outcome was somehow biased, and you may get an unexpected outcome.

Additional Critical Questions

After you have collected your team's speculations on the project's "death", ask these additional questions as a way to make sure you have considered as many contingencies as possible.

1. What are our intended results and measures for this project overall?
    a. Do they include specific measurements of quality, quantity, and time or are they 'soft" and focused more on intangibles such as a "satisfied client?" Using measurables, at what point is the client satisfied? Is it an either-or event ("satisfied -Y or N?") or can there be degrees of satisfaction?
    b. Do we have progress measurements for each functional group within the project so we can monitor their progress, too? Think back to the 'Project Killers' topic starting on page 14. Since the overall project outcome is the sum of the success of the functional parts, how will we know if things within the lower portions of the project are going well?
2. What challenges can we anticipate that may have not been identified earlier?
    a. How well do we communicate with each other in the project?
    b. Are there clear channels of responsibility or is there a danger of 'turf wars?'
3. What have we learned from previous projects like this?
    a. Have any of our project members been on projects like this that can help us get an idea of what may happen?
    b. Can we create lists of activities we should start, stop, or continue doing on this project that can act as a lesson learned from other projects?
    c. How can we share the learning throughout our team?
4. What will make us successful this time based on what we have learned from the previous attempts? (The Albert Einstein 'insanity' definition again.)
5. Can we break the large project down into smaller chunks for easier analysis, measurement, and monitoring progress?

Writing the Project's Obituary

Once the PM and any assisting key project members have a list of issues that theoretically killed the project, he or she can begin taking steps to remove the potential problem or develop a work-around that will diminish its impact.

For example, some potential issues could be:

1. "The project champion left and momentum just died" – What would you do as a precaution against that?
2. "The turf wars between design and construction were more important than successful project execution."
3. "Our source for the critical component went bankrupt and delivery stopped."
4. "We never heeded the warning signs that the project was slipping beyond recovery."

Some of the topics you receive may seem to be so far fetched that they defy reality while others may seem so obvious you wonder why someone took the time to write them down. This process of collecting reasons the project died is about getting as many ideas as possible as early as possible. Save the judgment until later because you do not want to inadvertently discourage anyone from speaking up.

Please remember this; the most critical idea may come from your least expected source.

Endnotes

[1] Deborah J. Mitchell, Wharton School; Jay Russo, Cornell, and Nancy Pennington, University of Colorado

2 Harvey, Jerry B. (1988). *The Abilene Paradox and Other Meditations on Management,* Lexington, Mass: Lexington Books.

3 Safire, W. (2004, August 8). On language: Groupthink. New York Times

4 Janis, Irving L. Victims of Groupthink. Boston. Houghton Mifflin Company, 1972 page 9.

5 Harvard Business Review, Why Bad Projects Are So Hard to Kill, February 2003, Isabelle Royer

6 ibid