INTRODUCTION TO
Failing Forward Activities

Failure.

The word can bring up a number of emotions: while failure often leads to some negative emotions, harnessing its power can also be a catalyst for positive change, such as learning and adaptation, as well as creativity and innovation.

This set of activities accompanies a webinar featuring Ashley Good and Dr. Natasha Blanchet-Cohen, entitled "Building on Failure: Learning When Things Go Wrong". If you have not already watched it, please do so in preparation for engaging with these activities. During this webinar, Ashley provides an overview of how to "fail forward", an approach that is grounded in years of generating failure reports with Engineers Without Borders Canada. Natasha highlights some failures (and lessons learned) related to a pan-Canadian long-term youth engagement initiative that took place from 2005-2010, called YouthScape. Her examples illustrate the powerful learning that comes from failing forward.

You can imagine that sharing thoughts on failure can be difficult (and it usually is). In order to facilitate open exchanges, four activities have been developed to help focus on staying positive and being constructive through providing different ways to talk about failure.

These activities target knowledge, skills and attitudes that form the basis of a fail forward environment (Figure 1). The knowledge component highlights how to understand failure from a positive perspective. The skills component focuses on creating ways within an organization to share information and adapt based on what is learned. The attitudinal component aims at developing an organizational culture that is conducive to innovation and learning.

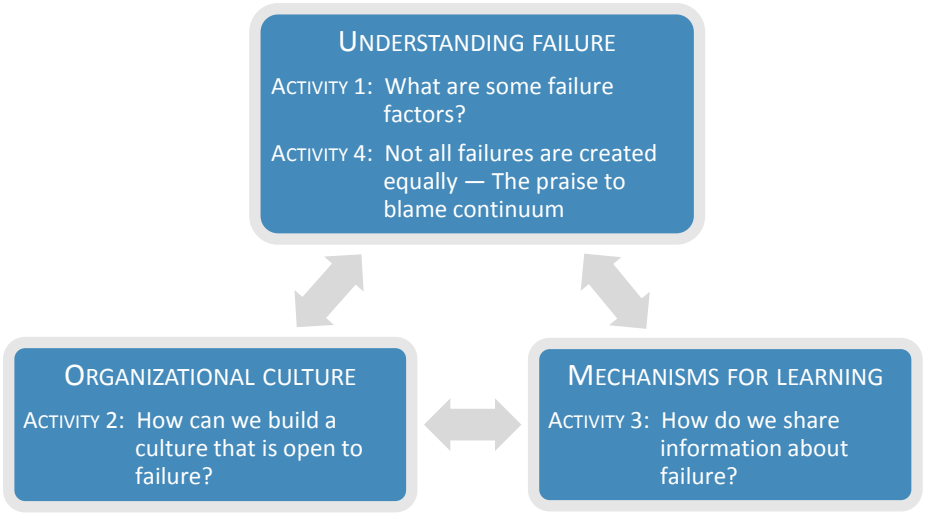

Figure 1. Knowledge, skills and attitudes for a failure framework.

Approaching Failure with a Positive Attitude

The following mindsets are helpful to ensure you get the most from this material:

- Stay willing and oriented to learning
  - Be open to new ideas and continuously think of opportunities in your day to day life where they can be applied
  - Draw from your own experiences to enrich your depth of understanding
- Internalize the locus of responsibility for creating change
  - Avoid placing blame externally
  - You can always do something: even if you may only impact 1% of a solution, focus on that as your responsibility
  - People learn in practices so seek out others who are willing to join you as you apply and push these ideas further within your own organization or context
- Keep in mind that engaging with failure in new ways is inherently challenging
  - It is therefore important to celebrate all the steps forward – big and small
- Don't worry and enjoy the learning!
  - It may be challenging and new, but if you stick to your ground rules (see below) you're guaranteed to learn from the experience

Ground Rules

Discussing failure can be a sensitive process, so it's important to set some ground rules for everyone to follow as you explore new ideas (especially when sharing your failure stories). Some suggestions for your group work include acknowledging that:

- People share what they believe to be true
- Opinions need to be respected
- Different perspectives are relevant, useful and valid
- You respect your fellow participants and hold each other in high esteem as hardworking, worthy individuals
- Being respectful to each other is critical
- Everyone in your organization is doing their best and making decisions based on their experience and the information available to them
- Everyone comes with their own sets of assumptions that can be articulated and tested for validity
- It's easy to criticize because nothing is perfect; better than criticizing is working with others to improve their good ideas
- Stories should be genuinely self-reflective (blaming others is damaging to the group and inhibits learning)
- Just because someone fails, does not mean they are a failure; decoupling ego from activity is a part of the learning from failure experience

Feel free to adapt this list to meet the needs of your particular group.

The activities that we have provided are suggestions on how to lead discussions on failure in a constructive manner. As they are not perfect, these activities can benefit from your suggestions around how to make them more effective in facilitating open exchanges around failure. Once you have tried

them out, feel free to contact Ashley Good (ashleygood@admittingfailure.com) with your comments, questions, or to discuss how your organization may take these ideas further.

Best wishes on failing forward!

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AdmittingFailure.com

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Activity 1: What are some failure factors?

Description

Failures can be overwhelming to think about because of their perceived complexity. In order to help deepen understanding of situations where things have not gone well, you can use this activity to deconstruct failure into manageable parts.

Objectives

At the conclusion of this activity, participants will be able to:

- Describe experiences of failure from individual, interpersonal, and institutional levels
- Analyze examples of failure using this framework
- Explain how this framework might be used to diagnose an organization

Materials

- Flip-chart paper
- Post-it notes

Time

30-45 minutes

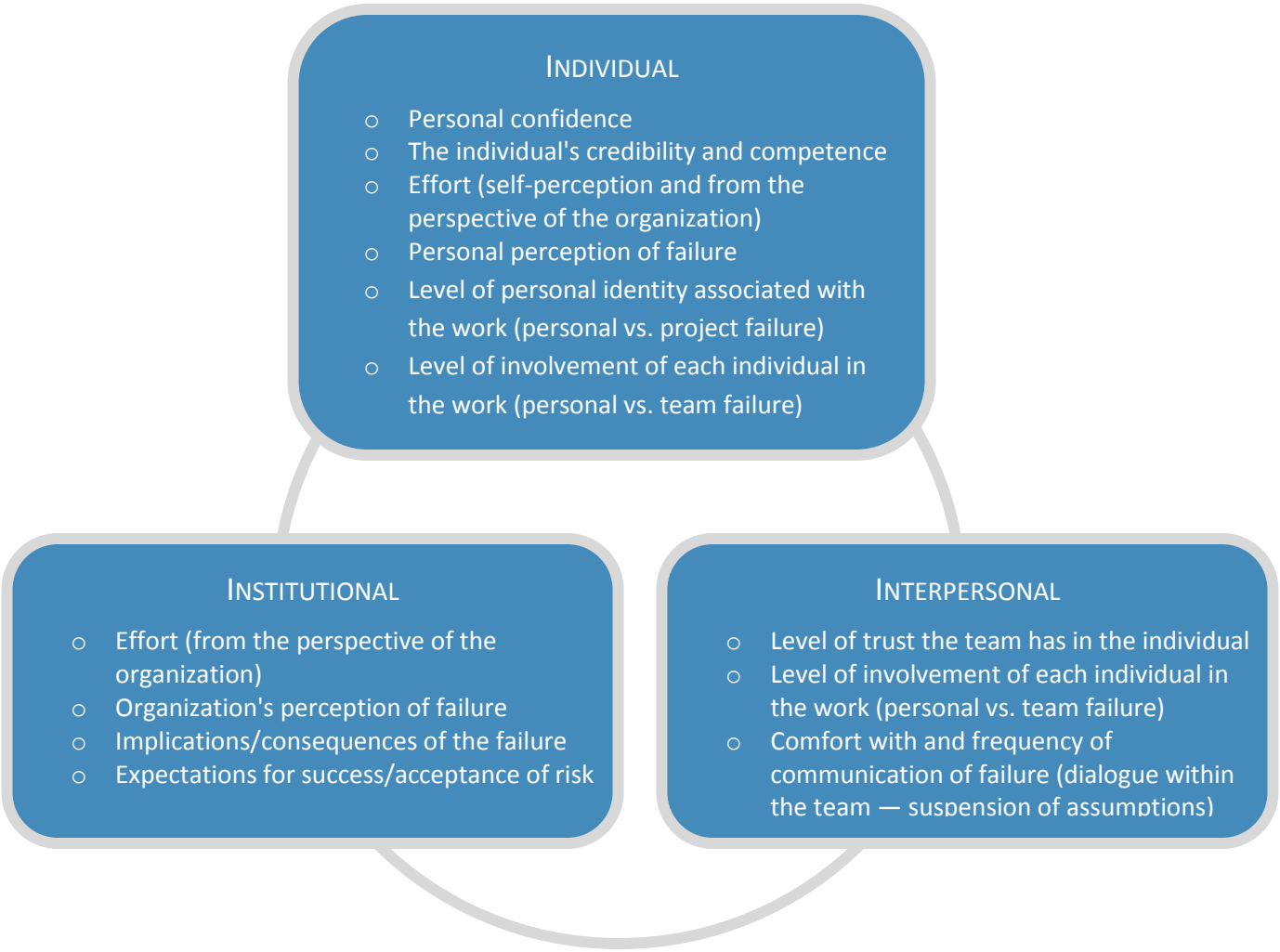
Instructions

Step 1: Deconstructing failure

1. Explain to the group that there are many ways to understand failure. One way is to deconstruct it into three different, but related, levels:

    - Individual: Personal factors that influence engagement with failure
    - Interpersonal: Group dynamics that influence engagement with failure
    - Institutional: Organizational culture that influences engagement with failure

2. Present the following image to the group:



3. Ask participants to think about additional factors that could be added to each box.
4. Add these to the image in the appropriate box.
5. Ask participants if any ideas are brought to mind when looking at this list of factors that help deconstruct failures.

Step 2: Deconstructing a story of failure

1. Play the TED talk video featuring David Damberger (http://www.ted.com/talks/david_damberger_what_happens_when_an_ngo_admits_failure.html).
2. At the conclusion of the video, ask participants to work in pairs and identify which factors from each level may have played a role in David's experience.
3. Have pairs write each of their responses on a post-it.
4. Ask one person from each pair to share their responses and stick them in the appropriate row on a flip-chart sheet with this table:

LEVEL	FACTORS
Individual	
Interpersonal	
Institutional	

5. Ask participants the following questions:

   - Did anything interesting emerge from generating this list? If so, what?
   - Do any of these factors apply to your organization? If so, which?
   - How might these factors be improved within your organization? How would this take place?

Activity 2: How can we build a culture that is open to failure?

Description

Drawing inspiration from failure is greatly supported by having an organization that promotes the development and maintenance of a learning culture. This activity leads participants through a process of building on existing strengths by discussing and identifying key elements that contribute to this type of learning environment.

Objectives

At the conclusion of this activity, participants will be able to:

- Describe how control plays a part in engaging with failure
- State the level of risk-taking that the organization encourages
- Explain the types of processes that can help surface learning around failure

Materials

- Flip-chart paper
- Post-it notes

Time

30-45 minutes

Instructions

Step 1: Framing how themes are relevant

1. Present participants with a structure for framing an open culture for failure (Appendix 2.1).
2. Distribute post-its and ask participants to write down examples that describe how each theme influences how their organization engages with failure. Remember to be respectful when sharing comments!
3. After 5 minutes, ask participants in turn to read out their examples, and attach post-its to the appropriate area of the figure.
4. Ask participants to identify any patterns they might see in their responses.
5. Facilitate one consensus statement for each theme that summarizes group sentiment. For example, “We feel that our organization provides a sufficient amount of space to experiment”, or “Staff would like to have more support in sharing failures with one another as a learning process.”

Step 2: In-depth discussion of themes

1. Select one or two questions from each column to help discuss how your organization is influenced by each theme (Appendix 2.2).
2. Facilitate a discussion with participants for each question selected.
3. Summarize some of the key points that have emerged from this discussion.
4. Ask participants to share how these three themes (control, risk-taking, and recognizing the value of failure) may be inter-related.

Appendix 2.1: Structure for Framing an Open Culture for Failure

Appendix 2.2: Themes for Working with Failure

(Adapted from: http://www.briljantemislukkingen.nl/awardOS/mediamanagement/user/71.pdf)

CONTROL	RISK-TAKING	RECOGNIZING THE VALUE OF FAILURE
Control tends to suppress evolutionary, spontaneous processes. The windows of opportunity that arise are left unexplored with no option to capitalize on their potential. To counter this, organizations need to examine where they could control less and navigate more.	Many organizations and employees tend to play safe, to stay in their comfort zones. As a result they implicitly or explicitly take the low end of the risk-return trade off. To counter this, organizations need to examine where, and what type of risk taking, they want to encourage.	Many organizations tend to either brush failure under the carpet or punish those responsible. In this respect the brilliant failure attitude is: "there is no such thing as failure only feedback". Organizations need to put processes in place to recognize the value of "failure" and maximize the learning from this.
➢ How do you mobilize the creativity of all your stakeholders, and of your employees in particular, in order to define the best way to reach your project and organizational goals? ➢ How does your organization check existing conditions and create space to navigate through this? ➢ How does your organization react if the initial project assumptions and/or goals turnout to be invalid/unachievable? What degrees of freedom and ability do you take to readjust to the new reality?	➢ What are the top three risks to which your organization and project is exposed? ➢ What is the understanding in your organization of what risks you would like to encourage and which you want to avoid? ➢ What percentage of your budget is reserved or allocated to experimental or innovative projects? ➢ On average, what percentage of your projects do you consider as partial or total failures? ➢ What mechanisms do you have in place to encourage proactive behaviour, e.g., experimentation combined with ownership and accountability?	➢ What mechanisms are in place to learn from failure, both at the individual project level and throughout the organization, e.g., actively rewarding employees who went the extra mile in addressing failure? ➢ How are these learnings shared with others both inside and outside your organization? ➢ To what extent does your organization really act on these learnings and implement the necessary changes in strategy and operations?

Activity 3: How do we share information about failure?

Description

Once an organization has committed to developing a learning culture that includes discussions of failure, there needs to be various mechanisms and/or approaches for promoting and sharing learning. As many organizations have departmental or group silos, there is always a risk of not sharing useful information that could help spur new ideas. In order to build on existing best practices — and create new ones — this activity outlines how different channels of information-sharing can be identified to promote the sharing of ideas.

Objectives

At the conclusion of this activity, participants will be able to:

- Explain whether their organization has been able to learn from its past experiences
- Describe strengths and challenges for initiating knowledge exchange processes
- Identify possible ways to exchange knowledge within the workplace
- Develop an initial plan to start knowledge exchange

Materials

- Flip-chart paper

Time

30-45 minutes

Instructions

Step 1: Looking at an example of failing

1. Invite participants to read the text written by Marilyn McHarg, Executive Director, Médecins Sans Frontières (MSF).
2. Ask participants the following questions:

    - Based on what you have read, what would you describe as key reasons for failing in this situation?
    - Are there any similarities in Marilyn's situation and your organization, i.e., not being able to learn from past experiences? What was the context? What happened?

Step 2: Brainstorming ways to share information

1. Ask participants to take stock of their current formal and informal ways of sharing information with one another, e.g., through specific meetings, conversations in the kitchenette, e-mail exchanges.
2. Write down participants' responses in the following chart:

TYPE	EXAMPLES
Formal (Structured, planned)	
Informal (unstructured, unplanned)	

3. Ask participants the following questions:

   - Which of these examples has led to any learning about failure and how to build on them?
   - Are there any existing or new organizational processes that might be useful for integrating into a discussion around failure?
   - How can you go about integrating discussions around failure into existing or new organizational processes?

4. Present the concept that people learn and change their behaviour in practices with others, not individually. Ask participants the following questions:

   - How does this idea affect how you might learn from failures and adapt to them?
   - How will you connect with other people in their team/office/community to build reinforcing support for continuing this group behaviour?

Appendix 3.1: Case study on making use of failure

(Taken from http://www.admittingfailure.com/failure/marilyn-mcharg/)

FAILURE

by Marilyn McHarg, Executive Director, Médecins Sans Frontières (MSF)

Médecins Sans Frontières (MSF) is an organization that thrives on critical debate. Across the five MSF operational centres, we readily point out each others' errors and shortcomings. When this dynamic is kept within the range of "healthy tension," it serves the operational teams and the patients we treat. Everyone has to defend or adjust their actions in response to the criticism of colleagues. This pushes program quality to the forefront and reinforces accountability.

Added to this, MSF headquarters staff regularly visit field teams to ensure that our medical action adheres to the standards and goals of the organization. We also do formal evaluations, particularly after major emergencies. Some within MSF will say we don't do enough evaluations. Having been with the organization for almost 20 years, I believe that we tend toward the opposite.

We do so many evaluations, alongside the regular supervisory visits, that our teams tend to be swamped with recommendations that risk being lost over time. Trying to prioritize and follow through on the multitude of well-intentioned insights can be overwhelming.

Learning lessons in MSF is not a problem. We learn lessons easily. Unfortunately, the same lessons are sometimes learned by different teams at different times. Our challenge is to swiftly integrate what we have learned across the vast MSF movement – more than 27,000 MSF aid workers served patients in over 60 countries in 2010.

As an organization that works largely in sub-Saharan Africa, historically we have focused on treating people with infectious diseases found in low-resource settings. This was reflected both in our clinical guidelines, and in our emergency medical supply kits containing standard drugs and medical supplies for the most common diseases.
In 2003, I was supervising MSF operations in Iraq. There, many of the illnesses people suffered were non-communicable, like heart disease and diabetes. In the aftermath of the U.S. invasion, our teams quickly positioned themselves with the usual emergency medical supply kits. Armed with malaria drugs and antibiotics, teams were not well prepared to encounter the kinds of health needs associated with middle-income countries, namely non-communicable diseases.
It was a frustrating situation. Not only were we unprepared, but our teams struggled with the change in focus. We needed substantial additional supplies to make our medical action fit the main needs. Even more frustrating was when we realized that an evaluation of our previous work in Kosovo had already highlighted the importance of being ready to treat chronic, non-communicable diseases in middle-income settings.

But still we failed to learn our lesson, and repeated the same mistakes after the 2010 earthquake in Haiti. From "Haiti One Year After" (2011), the report on our response:
"*Furthermore MSF did not have the appropriate medicines on hand in the emergency phase to care*

for patients suffering from non-communicable conditions such as hypertension, diabetes, and epilepsy. Of 850 patients treated in one location between March and September, there were 72 cases of hypertension. Recognizing this shortfall in the package of available care in some MSF medical structures, the organization is already evaluating the feasibility of including chronic disease kits in the emergency preparedness stocks it maintains in different countries."

Learning

With all the competing pressures and impossible choices, we had failed to prioritize patients with non-communicable diseases caught up in emergency situations. Our planning was still determined by conditions in the places where MSF had worked for most of its history, and by the epidemiologic patterns encountered there.

The balance is shifting, however. As we encounter more and more patients with non-communicable diseases, and as we strive to better meet our patients' medical needs, MSF is moving toward more holistic approaches and integrated medical action, rather than vertical, infectious disease-focused strategies. Consequently we are shifting from providing basic care for many, to treating fewer people more comprehensively.

This shift has helped the organization to take on the challenge of treating patients with non-communicable diseases. After the earthquake and tsunami in Japan in April 2011, MSF assisted patients suffering from these diseases from the start, demonstrating that we are becoming better prepared to meet longer-term patient needs under the temporary circumstances of an emergency.

However, this still leaves the question of how to rapidly integrate lessons learned on a more systemic level, right across the MSF movement. As the field evaluations and debates around quality continue, the organization has started to place more emphasis on centralized mechanisms. Step by step, evaluations are becoming more centrally driven, and operational progress is being monitored and documented for future reference.

This increasing centralization is exemplified by a new, annual mutual accountability exercise between the directors of MSF's operational centres. By placing accountability at a more central level – with the participation of board presidents, general directors, operational directors and medical directors – we think that valuable lessons requiring concerted action will be better integrated across the movement.

The trick will be to ensure that, even as these new mechanisms help us act on the lessons we've learned, we still maintain a healthy tension and the room to challenge one another through our traditional monitoring processes. Keeping this balance will allow MSF teams around the world to assist people in need with the most medically relevant quality care possible.

Activity 4: Not all failures are created equally — The praise to blame continuum

Description

There is a continuum of failure, ranging from: (a) preventable, (b) complexity-related, and (c) warranted. In other words, failure can range from blameworthy to praiseworthy. This activity allows participants to explore these different types of failure, in order to provide an increased appreciation for warranted failures, while acknowledging the fact that some failures are still bad!

Objectives

At the conclusion of this activity, participants will be able to:

- Assess failures as either blameworthy or praiseworthy
- Categorize examples using a spectrum of reasons for failure

Materials:

- Flip-chart paper
- Post-it notes
- Colored dots

Time

90 minutes

Instructions

1. Form groups of 4-5 people. If there are insufficient people, you can do this activity as one large group.
2. Distribute one type of failure on a sheet of paper to each group (see Appendix 4.1).
3. Ask group members to think of a brief example where s/he (must be personal example) has acted in that way that led to this type of failure.
4. Ask one volunteer to share her/his example within her/his group.
5. Group members then decide if this failure type is blameworthy or praiseworthy using the "Dot-mocracy" method: Each group member indicates their response by affixing either a blue dot (praiseworthy) or a red dot (blameworthy) to the sheet.
6. Convene the groups, and ask if anybody feels comfortable sharing their example.
7. On a prepared flip chart, present the following continuum to the group:

8. Ask each group to decide where their type of failure belongs on the spectrum and tape it to the flip chart under the appropriate heading. The group that has the description "An individual chooses to violate a prescribed process or practice" will hopefully see that that type of failure is blameworthy and place it under “Deviance” or at least fairly far along the blameworthy end of the spectrum.
9. Comment on whether the coloured dots correspond well with the blameworthy and praiseworthy continuum.
10. Ask participants the following questions:

    - Under what conditions are people comfortable admitting failure?
    - How can you ensure that people are feeling praised when appropriate, and also take responsibility when more blameworthy failures happen?

11. Conclude with the following two points:

    - Not all failures are created equally
    - Failure can be a source of learning and innovation but it requires an environment that supports the praiseworthy failures while also encouraging open dialogue around all types of failure in order to learn and adapt.

Appendix 4.1: Examples of Failure

- An individual inadvertently deviates from specifications.
- An individual doesn't have the skills, conditions, or training to execute a job.
- A competent individual adheres to a prescribed but faulty or incomplete process.
- An individual faces a task too difficult to be executed reliably every time.
- A process composed of many elements breaks down when it encounters novel interactions.
- A lack of clarity about future events causes people to take seemingly reasonable actions that produce undesired results.
- An experiment conducted to prove that an idea or a design will succeed fails.
- An experiment conducted to expand knowledge and investigate a possibility leads to an undesired result.
- An individual chooses to violate a prescribed process or practice.