presents:

'Organising for Resilience' by Paul Barratt AO

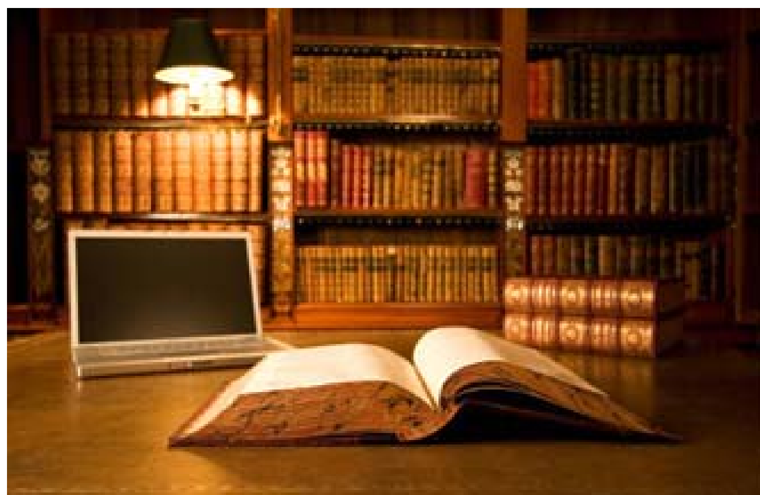
We are pleased to make this document available to you and hope that it provides you with some new ideas and insights into organising and managing in your world of work.

Documents available for download are selected discussion papers written by PeopleFit advisors, colleagues, and client practising managers on the meaning and application of Requisite Organization and related topics.

If you make further use of these documents or the ideas contained in them, or you pass the papers or ideas onto other parties, we ask simply that you provide proper attribution and that you acknowledge the author.

A Quiet Place

You can read more about the use of *Requisite Organization* in the workplace by visiting our website. Just click the link above.



Organising for Resilience

Paper first published in the Australia 21 report *Brighter prospects: enhancing the resilience of Australia*, Steve Cork (editor) 2009.

Paul Barratt AO, Director, Australia 21
Former Secretary, Departments of Primary Industries and Energy, and Defence.

> *Over the years, if imperfectly, socialists have had to learn that faith is not enough. Things have to work. Frequently the best course is to rely pragmatically on the market. Now ... the lesson for conservatives is equally clear. Faith in the universal efficiency and beneficence of the market, however devout, is also not enough. Here, too, ideology is not a substitute for thought.*
>
> ***John Kenneth Galbraith***[1]

This Australia 21 publication outlines the considerations that will determine the extent to which Australia is resilient in areas that are important to the nation's future. If we wish to ensure our resilience, we will no doubt make various arrangements designed to contribute to that result. This will typically consist of some mix of regulation, agencies to oversight compliance with the regulations, and agencies to deliver services consistent with both the policy goals of the Government and the regulations designed to align action with those goals.

Of fundamental importance to the achievement of resilience is ensuring that all organisations with a contribution to make are fit for purpose – they have a clear mission, they are adequately resourced and adequately governed, they have high quality leadership, their staff is adequately trained and has appropriate authorities and resources, and their relationships with other relevant organisations are clear.

Consider the following examples:

- The United States Government has a Federal Emergency Management Agency, but as the case of Hurricane Katrina showed, if the Agency is not capable of performing its functions, then the supposed capacity of the society to absorb a shock and continue to function turns out to be illusory.
- Australia was an enthusiastic supporter of sanctions against Saddam Hussein's Iraq, and put Customs Regulations in place to implement them in accordance with UN Resolutions, but the sanctions were totally ineffective and Australia distinguished itself by the volume of cash that was paid by way of kickbacks to the Saddam Hussein regime.
- The world's major ratings agencies gave AAA ratings to Collateralised Debt Obligations and other paper that turned out to be worthless, thereby making a significant contribution to the global financial crisis.
- Investors in funds controlled by Bernard Madoff were entitled to expect that they would be protected by the regulatory activities of the Securities and Exchange Commission and by the annual audits of the funds, but in both cases these

[1] John Kenneth Galbraith, *Oil: A Solution,* New York Review of Books, 27 September 1979.

protections turned out to be illusory. Those who invested indirectly through the wealth management activities of banks or other funds were entitled to rely also on both the due diligence of the fund managers and their professional prudence in spreading risk, but again they were not protected.

Failures of this kind are not new. Consider the following example:

- Norway sold 20 tons of heavy water to Israel in 1959 for use in an experimental power reactor. It was to be used for peaceful purposes only. Norway insisted on the right to inspect the heavy water for 32 years, but did so only once, in April 1961, while it was still in storage barrels at Dimona, the reactor site. Israel simply promised that the heavy water would be used for peaceful purposes, and Norway relied on that promise[2]. In 1967 Israel assembled its first two nuclear devices, using plutonium derived from the Dimona reactor; ten days later it went to war[3].

A more positive example is the emergency response to the bombings in the London Underground, where the close proximity of working hospitals and the effectiveness of the medical and para-medical response undoubtedly saved many lives.

Fitness for purpose is to a very important degree ensured by the quality of the organisation's corporate governance. Corporate governance is, or ought to be, directed to ensuring that all aspects of the business of the organisation, be it a regulatory authority, a service delivery agency or a private business enterprise, are under control while the organisation goes about meeting the expectations of its legislation, clients or customers. As high-performing business leaders understand implicitly, controlling the business and maintaining the connection with customers are the *sine qua non* of staying in business, the ultimate test of resilience.

Having the organisation's business under control refers not only to being in control of the entity's functions and delivering the desired outcomes. It refers also to the systems in place to enable the governing body ("Board") and senior management to ensure that:

- The organisation is meeting all of its responsibilities and acting within the boundaries of all applicable laws and regulations including those relating to public safety, occupational health and safety, environmental impacts, employment law etc.
- All risks to the achievement by the entity of its corporate objectives (regulatory, service delivery, commercial or compliance) are, as far as possible, identified, assessed and controlled.
- There are systems in place to ensure the sustainability and continuity of the organisation's capabilities.
- There is in place an appropriate framework to ensure that the organisation's personnel at all levels are held accountable for delivering what is required of them, and that they are suitably recognised when they do so.

---

[2] Warner D. Farr, LTC, US Army, *The Third Temple's Holy of Holies: Israel's Nuclear Weapons,* The Counterproliferation Papers, Future War Series No. 2, USAF Counterproliferation Centre, Air War College, Air University, Maxwell Air Force Base, Alabama, 1999.

[3] War D. Farr, *op.cit.*, citing Burrows, William E. and Windrem, Robert, *Critical Mass. The Dangerous Race for Superweapons in a Fragmenting World* (New York, New York: Simon and Schuster, 1994), 282-283; Avner Cohen, *Israel and the Bomb,* Columbia University Press, 1988, p. 274.

- Not only must staff know what they should do: they must also know what they should NEVER do, and understand the sanctions that will be applied for crimes and misdemeanours.
- The Board and senior management have timely notice of any shortfalls in performance in relation to any of the required parameters.
- The Board and senior management as appropriate can take timely and effective action to rectify such shortfalls and prevent their recurrence.

Achieving this state of affairs requires leadership of the highest order, and sound management practice. The people appointed to lead the organisation must have the moral and intellectual authority to command respect throughout the organisation, and credibly demand ethical behaviour from all staff. They must have the skills to select, motivate and reward executives who have appropriate skills and potential not only to carry out their assigned tasks, but to align, motivate and mentor their subordinates in accordance with the organisation's purpose. They must have the capacity and will to recognise quickly and deal decisively with underperformance, malpractice and inappropriate behaviour. The leadership must also have the management skills to design, roll out and operate the required systems, and the domain knowledge for effective decision-making regarding organisational risks.

The role of the Chief Executive Officer (CEO) within this framework requires the CEO, under the policy direction of the governing body, to establish five managerial frameworks:

- A **client/customer framework** which requires the organisation to deliver the required portfolio of goods and/or services to its clients or customers, in a manner that meets their expectations in respect of all the attributes they would value: price, quality, performance, reliability, safety, security etc.
- A **resource acquisition framework** that establishes the protocols by which the organisation obtains necessary funds, acquires physical inputs such as plant, equipment and infrastructure, and acquires human resources and specialist skills such as IT skills, training and various forms of specialist advice.
- A **resource allocation framework** defining how financial resources, human resources, technical resources and physical assets are to be allocated having regard to competing claims and priorities.
- An **accountability framework** which establishes who is accountable to whom, for what, by when, with what resources, and to what standards. This framework must do more than define accountability within the chain of command: it must also define role relationships outside the chain of command, ie, what duties individual managers and front-line staff owe to people who are not in direct supervisory positions over them, and who has authority to decide upon matters upon which they cannot agree.
- A **control framework**, ie, all the systems that enable the Board and higher management to monitor what is going on within the organisation and take timely steps to intervene when corrective action is necessary.

Clearly achieving an appropriate degree of control over the business of the organisation requires a level of assurance about the behaviour of each and every person within the organisation, and their alignment both with the purpose of the organisation and with its compliance obligations.

No organisation can hope to achieve the required level of assurance through attempts to micromanage the behaviour of individuals through ever more elaborate rules, regulations, codes of practice etc. The assurance must be systemic, part of the organisation's DNA. It can only be achieved by leadership which communicates clearly what is required of staff, which motivates and resources them to deliver it, and which recognises them when they do.

There are several modern trends that are inimical to the standards of competence and governance that are required in order to provide the necessary assurance and deliver resilience. These include:

- "Mate-based" appointments – the practice of appointing Board members, CEOs and other senior officers on the basis of their known political allegiance, membership of some kind of "inner circle", or being someone that the person to whom they will be reporting is "comfortable with", rather than on the basis of a rigorous assessment of their knowledge, skills, experience and relevant personal attributes.
  - The tendency of a number of Australia's top 100 companies to recycle the members of a small and remarkably narrow though well remunerated elite – one that is not particularly distinguished by either competence or expertise – through their governing Boards may have been a significant contributor to the decline in shareholder value during 2008.
  - The practice of populating government agencies with the politically aligned can hardly be said to have enhanced the quality of government policy making or service delivery in recent years. Australia has experienced more than a decade of economic boom conditions, but there is widespread dissatisfaction with the state of the nation's infrastructure, education and medical services, to name just a few.
- The cult of the generalist, the notion that a person who is smart enough can do anything he/she turns his/her mind to, thereby discounting domain knowledge to zero. There have been countless disasters in the corporate, public sector and military realm perpetrated by people who were perhaps intelligent but lacked the requisite domain knowledge and experience. Wisdom is always a product of experience and knowledge, not intelligence.
- The illusion that all risks can be quantified and therefore can be regulated. This is often associated with the illusion that the past is a guide to the future. These two illusions have come together disastrously in the "Value at Risk" approach to the management of financial market risk[4].
- Confused thinking about who owns various risks. State Governments have assumed that when they privatise the electricity system or the public transport system they are passing all the risks to the private operator, but the public still holds the government accountable for the safe and reliable operation of the system. If the lights go out, or the trains are crowded or do not run on time, or privately-owned and operated infrastructure costs much more than a traditional publicly-owned infrastructure investment, governments soon find out that they are still carrying the political risk, even though they are not the ones managing the risk.

---

[4] See for example *Professionally Gloomy: risk managers take a hard look at themselves,* The Economist, 15 May 2008.

- A touching faith that outsourcing is synonymous with efficiency.
- An obsession with efficiency at the expense of effectiveness and resilience. There are two aspects of this:
  - Especially in the military domain, laudable as efficiency is, effectiveness is usually the most important objective. When people are being put in harm's way, utilising equipment that is difficult or impossible to replace, the important thing is to maximise the prospects of victory, not to achieve some sort of trade-off which is a "reasonable balance" between cost and prospects of success.
  - If the desired state of critically important organisations is that everyone works very hard all the time, where is the capacity to deal with peaks of activity? Why should we expect in those circumstances that hard-pressed regulators would spot unusual patterns of activity and have the time to reflect that there is something not quite right, something that should be investigated more closely? And if everyone is hard pressed, just who would undertake that closer investigation? Should we be aggrieved if regulators, emergency responders and military personnel are not flat out all the time?

Case Study: The Waterfall Rail Accident

The findings of the Special Commission of Inquiry into the Waterfall Rail Accident present a striking case study of how corporate governance is not a dry as dust matter of who attends how many meetings and whether or not there is a nominations committee or a remuneration committee. It is a real world matter of how those who are charged with the governance of an organisation make sure that their writ runs, and how ensuring that the organisation is effectively governed and led can literally be a matter of life and death.

Poor governance at the State Rail Authority of NSW (SRA) led directly to poor managerial leadership, a confused, ramshackle organisation, confused lines of authority, no effective accountability, bizarre approaches to human resource management, decisions made with no regard for attendance to safety, and a reactive rather than a systemic approach to risk.

The accident which was the subject of the inquiry occurred at approximately 7:14 am on 31 January 2003, when a four car Outer Suburban Tangara passenger train, designated G7 and travelling from Sydney Central railway station to Port Kembla, left the track at high speed and overturned approximately 1.9 kilometres south of Waterfall railway station. The train driver and six passengers were killed. The train guard and the remaining 41 passengers suffered injuries ranging from minor to severe[5].

In the Executive Summary of the Final Report of the Inquiry, the findings of the interim report on the proximate causes of the accident were summarised as follows[6]:

> *Investigation of the causes of the accident at Waterfall proved to be an extraordinarily difficult task. The cause of the accident was not apparent. The train driver was deceased and the guard claimed to have no recollection of events prior to*

---

[5] Special Commission of Inquiry into the Waterfall Rail Accident, *Final Report, Volume 1,* January 2005, Executive Summary, page i.
[6] *Ibid.*, pp.iii-iv.

the derailment. While G7 had been fitted with a data logger, it was not operating at the time. Consequently, there was no record of the actions of the deceased driver in the period immediately before the derailment.

In the interim report of the Inquiry, the Commissioner concluded that the mechanism of the accident was a high speed rollover. G7 was travelling at approximately 117 km/h as it entered the curve on which it derailed. The speed limit at that point was 60 km/h.

Extensive investigation and testing led to the conclusion that both the condition of the track and associated infrastructure, and mechanical malfunction of G7 could be excluded as possible causes of the accident. Deliberate or reckless behaviour on the part of the driver could also be excluded.

The train driver, Mr Zeides, had a number of risk factors for coronary heart disease. *Post-mortem examination revealed that he had a 90 per cent blockage of the left anterior descending coronary artery. While this did not establish conclusively that he had a heart attack, the preponderance of evidence was that he was at considerable risk of an incapacitating cardiac event.*

Being able to exclude the possible causes mentioned above, the inference from the known state of Mr Zeides' health led the Commissioner to find that he suffered a sudden incapacitating heart attack at the controls of G7.

That conclusion led the Commissioner to examine why, in those circumstances, there was a failure of the deadman system, which is supposed to prevent an accident of this kind if the driver has a sudden heart attack. The deadman system was designed to stop the train unless the train driver maintained continuous pressure either on a spring-loaded hand control or a foot pedal. The foot pedal was designed so that if too much or too little pressure was applied, the emergency brakes would be applied.

Expert evidence before the Special Commission indicated that an incapacitated driver weighing more than 110 kilograms could, by the static weight of his legs, hold the foot pedal in the set position whilst G7 was in motion, preventing an emergency brake application. Mr Zeides weighed 118 kilograms at autopsy.

The Commissioner was satisfied that Mr Zeides was using the foot pedal when he had a heart attack and that the foot pedal failed to operate as intended.

It became apparent that the SRA had information for approximately 15 years that the deadman foot pedal in Tangara trains had the inherent deficiency that train drivers over a certain weight could set the pedal inadvertently if they became incapacitated. In attempting to determine why such a dangerous state of affairs had been allowed to exist for such a long period, the Commissioner concluded that there were serious deficiencies in the way in which safety was managed by the SRA over that period of time.

Apart from the unsafe rolling stock, it was also necessary to understand why the train guard failed to take any action when it became apparent G7 was travelling at excessive speed sufficient to alarm the passengers, and how the train driver, a person at considerable risk of a heart attack, could have passed the periodical medical assessments.

As well as these deficiencies, there were deficiencies in the way in which the safety regulatory system operated. The safety regulatory regime in place, which had as its purpose the prevention of incidents of this kind, failed to operate on this occasion. This must be regarded as one of the latent or indirect causes of the accident.

The Commissioner's findings on the emergency response when the accident occurred are disturbing and give an idea of just how pervasive the safety problems of SRA were[7]:

- The Rail Management Centre (RMC) did not trigger a major incident management response until 7:32 am, although information sufficient to do so was known 14 minutes earlier.
- Power to the area was not isolated until 8:06 am; during the intervening period several attempts were made to reset the circuit breakers that had been tripped by the derailed carriages – fortunately these were not successful.
- Valuable time was lost by police, fire brigade and ambulance officers as a result of inaccurate information as to the location of the accident, and lack of knowledge about access gates and tracks.
- Emergency response personnel were not aware of the external door release on Tangara carriages, which would have enabled passengers to be promptly evacuated.
- The train guard was not permitted to use the most efficient means of communicating critical information to the RMC, namely the Metronet radio in his cabin.
- There were other communications equipment deficiencies, including the lack of awareness of signal telephones by emergency response personnel, and the fact that satellite telephones were not immediately available.
- There were deficiencies in communications procedures, including the fact that there was no single nominated person at the RMC and no compliance with any language protocol.
- The procedure for identifying a site controller in charge of the accident site was not followed.
- The emergency services were not operating under a co-ordinated response plan.
- There was no proper site control; there were unauthorised persons on the site and congestion on the access track caused by vehicles with the keys removed.
- The rail commander on site failed to perform the emergency response function intended for that role.

[7] *Ibid., p. xiii*

At a corporate governance level the Commissioner made the following findings with respect to successive Boards and Chief Executives of the State Rail Authority and its successor RailCorp[8]:

- They failed to implement a system by which each could quickly and readily obtain information as to the overall safety of the organisation.
- They failed to have clearly identified measures for determining the level of safety of each organisation and the safety performance of managerial staff.
- They failed to have clearly defined and appropriate safety responsibilities and accountabilities included in managerial position statements.
- They failed to have measurable criteria for assessing the safety performance of individuals in managerial positions.
- They failed to have adequate internal audit systems in place to test the adequacy of the safety management systems in place.
- They failed to use external auditors to test the adequacy of the safety management systems.

There were many more findings on the adequacy of the safety management systems applicable to the circumstances of the accident, 139 in all, covering emergency response, design and procurement of rolling stock, driver safety systems, risk management, data loggers, communications, train maintenance, medical examinations, safety document control, training, rail accident investigation, safety culture, occupational health and safety, passenger safety, corporate safety governance, RailCorp Safety Reform Agenda, safety regulation, integrated safety management and the independence of the regulators and the Rail Accident Investigation Board[9].

The Special Commission's Report serves to illustrate just how thorough and comprehensive are the measures required to ensure that a large and complex organisation is in control of its affairs and delivers what is required of it, including when it is under stress.

Such organisations require a robust system of managerial accountability, something that was conspicuously lacking in the case of the State Rail Authority of NSW, and would no doubt also be found to be lacking in the organisations that contributed to the failures mentioned at the beginning of this paper.

Robust systems of managerial accountability do not occur by accident; they require thorough and interlocking systems of authority, training, staff selection, mentoring and resource allocation, to name some of the more important.

There is no one system which alone can deliver the required managerial accountability, but the brief summary below is offered to illustrate what is involved.

[8] *Ibid. pp. liii-liv*
[9] *Ibid.,* Full Report, pp. 318-332.

The Management Accountability Hierarchy

A well-known framework for effective leadership of a so-called Management Accountability Hierarchy is that developed by Elliott Jaques over a long period of time from the 1970s and implemented in, amongst other organisations, CRA during the 1980s and 1990s[10]. The following draws on his work. It gives an indication of the personnel accountability and performance management practices that would need to be set up in order to ensure that a large organisation's governing authority and leadership could have confidence that the business is under control in every relevant sense and can not only deliver its core business purpose but can comply, and know that it complies, with all of its statutory and regulatory obligations.

The framework for establishing the "Requisite Organization" has five key themes:

- **Placing the right people in the right jobs**
  Ensuring that the job descriptions throughout the organisation are properly constructed, and that all of the people appointed to them are equipped, by way of personal qualities, qualifications and experience, to perform their duties to the requisite level of effectiveness.
- **Doing the right work at the right level**
  Ensuring that all of the work that is done needs to be done (people not just doing things right, but doing the right things) and that it is done at the lowest level at which the individual to whom the work is assigned can reasonably be expected to perform it to the requisite standard.
- **Adding value at every level**
  No work should pass through a pair of hands that has no contribution to make. This only imposes delay, and prevents the real players from dealing with each other directly.
- **Holding authorised managers accountable for their performance**
  Ensuring that all managers have the authority (standing, skills, resources and authorisations) to undertake their assigned duties, and that they are held to account not only for their own personal effectiveness but for the personal effectiveness of those whom they manage.
- **Establishing a culture of continuous improvement.**
  Holding all managers accountable for establishing continuous improvement arrangements for all programs and processes that they control.

Many organisations are reluctant to invest in their own capacity to improve, to change and to adapt. In order to realise these five themes, re-skilling of the workforce, encouraging new ideas, rewarding initiative, training managers, developing leadership skills, investing in new technologies – all these forms of investment are critical to building resilience within organisations, and to building organisations that are resilient. World's best practice is a laudable aim. But it cannot be achieved by complacently protecting mediocrity, or failing to

[10] Elliott Jaques, *Requisite Organization: A Total System for Effective Managerial Leadership for the 20th Century,* Cason Hall & Co., Arlington VA, Revised Second Edition, 1996.

find out what world's best practice is, and where it is practised. Singapore gets it right. In 1999, Singapore had six of its up and coming Government officials at the Kennedy School of Government at Harvard University. Australia had none from any level of Government.

These objectives of the five key themes are realised by setting down a clear set of expectations for managers at every level, plus rules for induction and coaching, performance appraisal, establishing continuous improvement processes, responsibilities of supervisors of managers, and protocols for staff selection and deselection.

In any organisation a manager is by definition a person in a role in which he or she:

- Has legitimated power to expend material, technical and human resources.
- Is held accountable not only for his/her personal effectiveness but also for the output of others.
- Is also accountable for building and sustaining an effective team of subordinates capable of producing the required outputs, and for exercising effective leadership.

In performing their management role, managers are expected to add value by:

- Setting context, including imparting a clear sense of corporate direction in accordance with the corporate plan.
- Disaggregating the more complex tasks into a multiplicity of simpler tasks and assigning the component tasks to officers who at their level could reasonably be expected to complete the task effectively with a minimum of guidance and supervision.
- Reintegrating the completed components into a finished product of appropriate quality.
- Ensuring that subordinates are allocated the resources to enable them to complete the task in a timely manner to the required standards.
- Reviewing outputs retrospectively in order to sustain standards and judge the effectiveness of their subordinates.

In assigning tasks to subordinates all managers should specify what is required, to what standard, by when, and what resources are allocated to apply to the task. Managers are held accountable for instituting effectively a range of processes and procedures that will lead to maximum work unit effectiveness through maximising the personal effectiveness of staff:

- They are required to take a systematic approach to the induction of new staff, and give to them personally a wider picture of the work to be done, current problems and priorities, how the work fits into the wider business unit and organisation-wide context, and any other information relevant to the subordinate's rapidly gaining a rounded picture of the situation.
- They are also expected to coach their subordinates day by day for their work in their current role both in the interests of the organisation and in the interests of the growth and advancement of the subordinate. Training should be arranged to extend the subordinate's knowledge and skills for the work in the role.
- Managers must conduct performance appraisals which measure the personal effectiveness of staff in producing the required outputs under the prevailing circumstances.

- All managers are accountable for establishing and maintaining continuous improvement arrangements for all programs and processes that they control.

Ensuring that managerial subordinates are effectively discharging their managerial leadership accountabilities is itself a key accountability. All managers must ensure that each and every one of their subordinate managers is doing the following both consistently and effectively:

- Regularly meeting with immediate subordinates in managerial team working sessions.
- Setting context, and regularly updating it.
- Conducting manager-led two-way planning discussions.
- Engaging in just-in-time task assignment that specifies what is to be produced, to what standard, by when, and what resources are assigned for the task.
- Engaging in personal effectiveness discussions and coaching.
- Ascertaining whether the subordinate manager's evaluations of the applied capability of subordinates equilibrate with the judgements of their own subordinates by the manager's colleagues.
- Showing evidence of good selection and induction procedures, and of effective deselection judgement and disciplinary action when necessary.

All managers with subordinate managers have important duties to the immediate subordinates of the subordinate manager (i.e., to the feeder group for the work level they supervise directly). They must ensure the establishment of clear working relationships between all subordinates at the second level down (i.e. subordinates of their direct reports), maintain sufficient personal contact with each member of the feeder group to be an effective mentor, and decide and oversee their development programs.

Managers at all levels have important rights and duties in respect of the selection and deselection of staff. The key managerial prerogative is the authority not to have subordinates who are operating at a level below the bottom of the work band for the duties of their position. This flows directly from the principle that all managers in the organisation are accountable for the output of their subordinates.

This does not amount to a right to hire and fire. What it does amount to is the authority not to have a candidate the manager judges inadequate imposed by higher authority.

Managers must also have the right to initiate a deselection procedure, which is the authority to remove a subordinate from their role, in accordance with a prescribed procedure, when the subordinate is no longer working up to scratch for whatever reason, e.g. lack of commitment, external preoccupations or failure to keep pace with the evolving knowledge and skill requirements of the position.

Of equal importance to the definition of accountabilities within the managerial hierarchy is the clear definition of role relationships. Although large organisations are normally organised into vertical managerial silos, most work processes flow horizontally from silo to silo. For example, in a railway company infrastructure people inspect and maintain the track on which train services people operate the trains; passenger fleet maintenance people

maintain the trains that the train operations people drive; internal audit has rights of access to all parts of the organisation. Thus for most individuals there are people other than their supervisor who can initiate tasks that they are required to perform, and who will make a contribution to the evaluation of their performance.

It follows that as well as knowing who his or her manager is, it is important for each and every employee to know precisely what duties he/she owes to other people in the organisation, and what authority people in these task initiating roles have over them.

The question of requisite organisational design is not a trivial one. To quote Elliott Jaques:

> My view is that the way to get managerial leadership is through the development of the organization itself. Get the organization right, and the people and the managers who give leadership to them will be enabled to work together in full collaboration and with constructive mutual trust. Given half a chance, people are keen to get on with their work, and to have work to get on with. What is missing is an adequate organizational framework within which to work and cooperate with each other[11].

This accords with my own experience of over twenty years at senior leadership levels in the Australian Public Service. The prime sources of inefficiency and conflict are not unwilling, unable or difficult people; they are poor organisational design and the poorly specified accountability and authority that almost inevitably go with it.

Sources:

The principal sources for this paper are:

Elliott Jaques, *Requisite Organization: A Total System for Effective Managerial Leadership for the 20th Century,* Cason Hall & Co., Arlington VA, Revised Second Edition, 1996.

Special Commission of Inquiry into the Waterfall Rail Accident, *Final Report, Volume 1,* January 2005.

[11] Jaques, *op. cit.* page pair 2.