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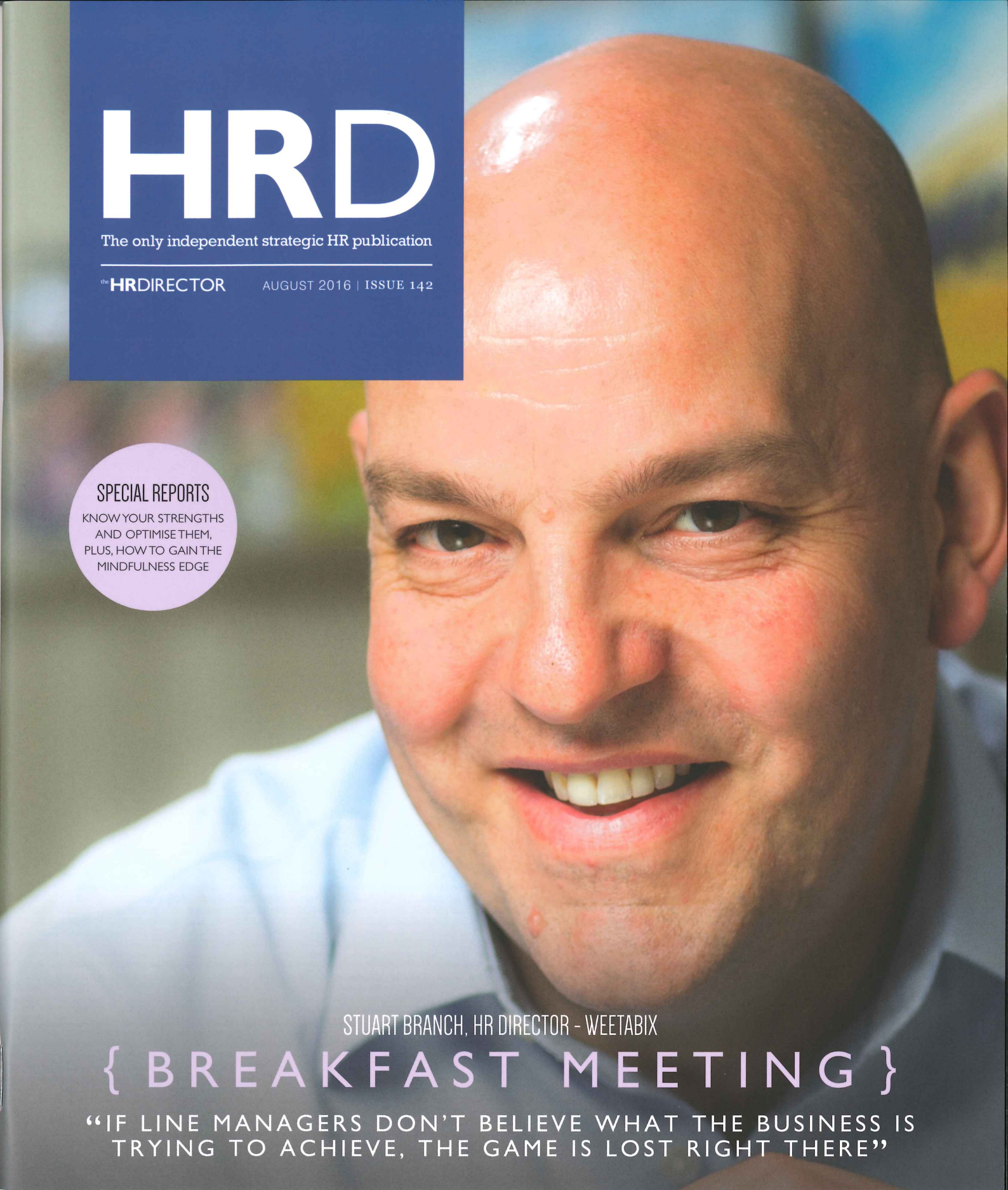

SPECIAL REPORTS

KNOW YOUR STRENGTHS AND OPTIMISE THEM, PLUS, HOW TO GAIN THE MINDFULNESS EDGE

STUART BRANCH, HR DIRECTOR - WEETABIX

{ BREAKFAST MEETING }

"IF LINE MANAGERS DON'T BELIEVE WHAT THE BUSINESS IS TRYING TO ACHIEVE, THE GAME IS LOST RIGHT THERE"

ALSO FEATURED IN THIS ISSUE

HR TECHNOLOGY

As the cloud radically rewires our world, does uberization spell the death of the middle-man

EQUALITY AND EQUALITY LAW

The social gulf is not diminishing. Consider class as a protected characteristic - would it work?

FLEXIBLE & REMOTE WORKING

Remove the confines of location and time and appraise achievement, not hours spent in the office

FUTURE PLANNING

Complex work platforms will start to parse, virtualise and distribute work to a blend of people and machines

FUTURE PLANNING

PASSING THE BUCK TO THE SCAPEGOAT

Future proofing your business is one of those massively laudable aims that seem crushingly simple in theory, but are a little more difficult in practice. All you need to do, after all, is replicate the successes and avoid repeating the mistakes. The entire raison d'etre of Lean Six Sigma is to create precisely that kind of virtual circle - breaking down the processes upon which your business relies into their smallest component parts.

ARTICLE BY MARTIN BRENIG-JONES, MANAGING DIRECTOR - CATALYST CONSULTING

Like any system, Lean Six Sigma is only ever as effective as the individuals applying it - even if promoting individual buy-in is a built-in component of said system. Whilst the second obstacle lies in the problems associated with differentiating success and failure. Highlighting the successes within your business is generally a simple process, being the stuff of every performance review, award ceremony and bonus scheme. Identifying the failures and mistakes can be more difficult, not least because people are generally loathe to admit to getting things wrong, either to themselves or, perhaps more pertinently, to their colleagues and superiors. Put simply, mistakes cannot be learned from and avoided unless they are recognised and owned up to in the first place. Lessons learned don't count as lessons unless they are then put into practice, and the HR department of your company can play a key role in dealing with both of these issues. The clue is in the name. The Human Resources department. Thanks to its continuous contact with individuals working at every level of an organisation, can play a key role in both gathering the relevant data on the problems which stand between you and the future proofing of your business, and then in spreading the solutions to these problems through every level, from management to 'shop floor'. The fact that the purpose of the HR department is to keep the people charged with delivering your business strategy happy means that it is a focal point through which they are most likely to give genuinely honest and insightful feedback regarding the things which your business could be doing better. However, this is only going to be the case if the culture of your business, spreading from the HR department outward, becomes a non-judgemental culture in which 'mistakes' can be admitted without fear of blame or scapegoating, and in which it is realised that every example of a process going wrong, once it has been eliminated, was simply a step toward the process being perfected.

There are examples to be taken from the worlds of both business and sport of this approach to aid the drive toward success. The most striking and probably well documented field within which the reporting of mistakes has become a virtual reflex action is aviation, a fact which is doubtless a reflection of the genuinely catastrophic consequences which can arise when the people in charge of an airplane in transit make mistakes. Pilots who do so - by flying at the wrong altitude, for example, or suffering a near miss - are given a ten-day period during which they can file a report of the incident under conditions of anonymity and

immunity. Thus the more traditional approach toward the making of mistakes, which might be characterised as 'What went wrong, who was to blame and how can we punish them' (which generally leads to never even finding out that anything did in fact go wrong), is supplanted by 'What went wrong and how can we stop it happening again'?. Ally this to the fact that the vast bulk of planes also automatically record data detailing and reporting problems, and you have an industry in which, in 2013, had a global accident rate of just 2.8 per million departures. This is clearly an approach which is HR driven, treating the staff in question - the pilots - as both a valuable source of data collection and as the driving force behind spreading the practices suggested by this data.

A similar approach was adopted by Virginia Mason, a hospital based in Seattle. The HR approach was, again, altered in order to encourage staff to report incidents when things went wrong. As with aviation, medicine is a field in which mistakes, due to the gravity of their possible impact, are less easy to own up to, whilst being, conversely, the kind of field in which the honest reporting of mistakes is of the utmost importance. After all, mistakes in the average business may well impact upon the bottom line or customer satisfaction, whilst those within aviation and medicine are, quite literally, a matter of life and death. This is all the more reason why it is a matter of some surprise, not to say embarrassment, that so many businesses still cling to the old approach of dealing with mistakes and of spreading a 'blame culture' from the HR department and its dealings with staff, on throughout the organisation.

The approach taken by Virginia Mason produced rapid and easily recorded improvements. The labelling on drugs being dispensed throughout the hospital was altered in order to reduce the likelihood of the wrong prescriptions being delivered under high pressure situations, whilst the system of giving coloured bracelets to patients upon admittance was changed to one of text based bracelets when it was realised that colour blind nurses might confuse, for example 'Do Not Resuscitate' with 'Allergic to Penicillin'. Checklists were introduced in the operating theatres (an example of the kind of improvement which seems blindingly obvious when viewed from outside the maelstrom of day to day operations), as were ergonomically designed surgical tools. The overall result of this change in culture was an increase in patient safety which heralded a massive 74 percent reduction in the liability insurance premiums the hospital was paying.

One company which is famous for creating an in-built system via which members of staff can report problems before they become a cemented part of the process is Toyota, which, under the auspices of the Toyota Production System, encourages even the smallest failure to be notified as soon as it occurs. Workers on the production line, upon spotting a mistake, were encouraged to pull the 'andon cord' suspended above them. Thus, a diagnostic process kicked off and help was summoned and, if the problem could not be solved more or less immediately, the production line was halted, under the reasoning that it was better to delay production and lose a strictly defined amount of revenue than to leave a mistake unreported and risk a much greater, less predictable loss in the future. It's interesting to note that the overhead cords themselves, from 2014, were being phased out in favour of waist high buttons, in order to create a more comfortable, less visually cluttered and, above all, safer working environment. A genuine example of a part of a process of continuing improvement actually being improved itself and, once again, with a HR focus - the comfort, safety and working conditions of the members of staff being the driving motivation for the change.

The use of the andon cords (or wireless buttons as they will now become), the reporting of aviation incidents and the changes brought about at Virginia Mason hospital are all examples of how systems need to be put in place, but will then only work if the culture of the organisation is such that no member of staff will be fearful of metaphorically 'pulling the cord'. Your HR department can play a vital role in ensuring that this is, indeed, the case. Not only should processes such as recruitment, training and staff reviews be subjected to the process of continual improvement - deciding whether it's necessary to have a three stage interview process, for example, or whether just the one interview, providing it asks the right questions, will suffice, but the HR department should be seen as a focal point for staff feedback and a department within your organisation through which staff will feel able to admit to things going wrong or challenges being impossible to surmount. The problems sometimes associated with bringing about change within an organisation will be minimised somewhat if the department tasked with pushing through that change is one which is regarded as being 'on the side' of the individuals responsible for embedding said change. Time and again, the lessons learned from process analysis and the changes decided upon flounder in the cold light of day, when the next bout of firefighting has to be engaged upon before genuinely new ways of thinking can be embedded. Putting your HR department at the heart of such change will help to ensure root and branch reform, driving your organisation into the future with a set of processes, and a workforce, ready and able to deliver.

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TWITTER POLL

Are businesses equipped to predict a future path in an era of constant change?

20% Yes
80% No

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