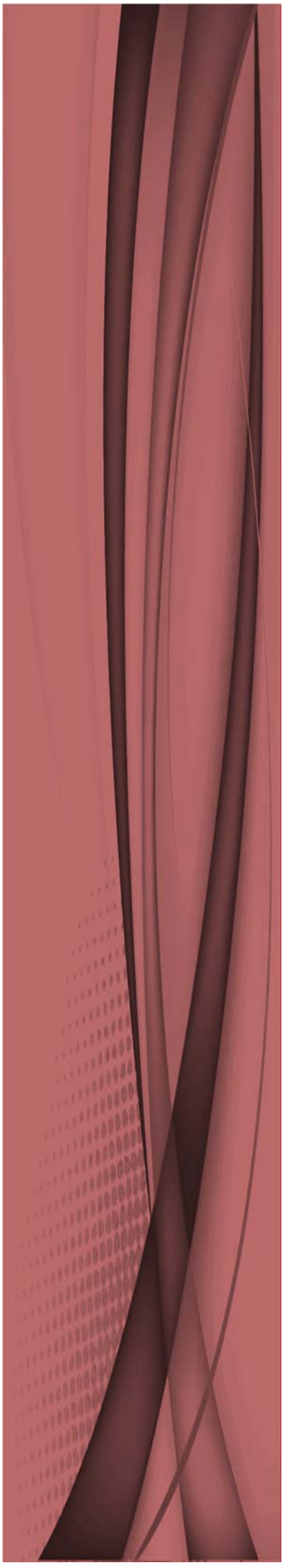
VANGUARD Scotland Ltd

IMPROVE PERFORMANCE AND RAPIDLY ACHIEVE YOUR STRATEGY

How to leverage operational capability and performance management to achieve your strategy faster, cheaper and with more staff engagement – real life stories from the sharp end.



Introduction

On the 10th of June 2013 Robert Carmichael called his wife from his car. He recalls that '*Carol had been unwell with depression so I'd given her a quick buzz to see how she was doing. She sounded very groggy and I couldn't get a proper conversation out of her. I left it twenty minutes and called back, I knew something wasn't right. But on the second call I couldn't get an answer. I was a three hour drive away from home so I tried to raise a neighbour to go and check on her but again I got no joy. I was really worried, Carol had once taken an overdose and as she'd had another bout of depression I was concerned she'd taken yet more pills.'*

Robert called NHS 24 (England & Wales) and, fearing the worst, asked them to send an ambulance to the family home immediately. What he didn't expect was the bizarre conversation that happened next:

NHS call handler: *'Is your wife breathing?'*

Robert: *'I have no idea; I'm not at the house.'*

NHS call handler: *'Are her lips blue?'*

Robert: *'I have no idea; I'm not at the house?'*

NHS call handler: *'Does she have a rash?'*

Robert: *'I have no…..wait, sorry I misunderstood your questions, could you just run through them again?'*

NHS call handler: *'Is your wife breathing?'*

Robert: *'No.'*

NHS call handler: *'Are her lips blue?'*

Robert: *'Yes.'*

NHS call handler: 'Does *she have a rash?'*

Robert: *'Definitely.'*

An ambulance was dispatched and thanks to the skilled staff at the NHS, Carol's life was saved (she had taken an overdose as Robert suspected).

It would be easy to assume that I'm having a go at the staff at NHS 24, I'm not; they do their job extremely well in particularly difficult circumstances. I am however being critical of any system which prescribes standardised scripts, targets or service standards as a means of attempting to improve service, cut costs, improve performance and ultimately attempt to reach their strategic objectives.

Through this report I'd like to explore two questions:

1. Why don't traditional approaches to implementation of standards and performance management work in service organisations?

2. Assuming you're someone who does want to improve service, cut costs, improve the performance of your organisation and link all of this to your strategy, what's a better way to do it?

Standards in the Manufacturing Sector

The concept of standards or standardised work started with, and is the bedrock of, the Toyota production system. Toyota has a standard for everything. How to polish a door. How to fit a windscreen. How to conduct a meeting. And not only does Toyota have standard for *how* to polish a door it has a standard for the *time* it should take to polish the door.

Although the genius of the Toyota production system has largely been credited to Kanban and just in time systems, really it's the work standards that make the rest of the system possible. What I love about the concept of standards in Toyota is that when senior management sit down to do their strategy and planning cycles they, with managers right down the hierarchy, make the links between the standards at the front line and the achievement of the strategy 5-10 years in the future.

For example when Toyota wanted to develop their first hybrid car, senior management started with the concept and then involved each layer downwards to build a plan for delivery that was connected from the boardroom to the person on the shop floor.

The other benefit of the Toyota standard is that once 'best practice' has been improved a new standard is developed.

However, what I believe is widely misunderstood is the amount of work that goes into making sure that people follow the standards.

Nigel Waring is a veteran of Toyota, having risen through the ranks from front line worker to manager then finally to Toyota internal consultant, a position revered within the company. Now a director with a large consulting firm he explained to me the importance of management's role in maintaining the standards.

'In Toyota, managers at all levels will spend up to 60% of their time on the shop floor and whilst there their first, and most important, task is the reinforcement of the standard work. Managers know that - unless they are constantly clarifying the definition of the standard, retraining people on how to meet the standard and changing the organisational system through problem solving to improve the standard - quality and productivity will regress and the future strategy will not be met. Every day Toyota managers know exactly their role in taking the company towards its future goals and strategy and they do it through the reinforcement and upgrading of the standard work.'

When I was discussing standards with Nigel we started talking about what happens during a visit from the Toyota directors or if the CEO turns up to visit a plant. *'Inevitably, they'll start their visit by making sure that a few of the standards are right and are being met, and they'll do this not just to remind people of the link between what happens at the front line and the attainment of the future strategy but because they're reminding all other managers that if it's good enough for the CEO it's good enough for the plant manager.'*

What I also found to be incredibly insightful is that front line staff are measured on outputs that they can control. There's no point in measuring front line on vehicle quality for example, there are too many different variables for them to be able to control that. But you can measure staff on their own contribution to the output i.e. the standard work (the input). Added together all these create top management's goal which is, in Toyota's case, to be rated as number one for quality in the annual JD Power survey. An accolade they've often achieved.

And if you're still in doubt about the results achieved through standard work and the Toyota production system consider these facts:

- Toyota is officially the world's largest and best-selling car manufacturer. 9.1 million vehicles are expected to be sold in the current financial year.
- Their projected net profit in the financial year to 31 March 2014 is 1.67tn yen ($16.9bn; £10.5bn)

Another important element of standard work is not just the way in which the work is done but the time taken do the work. All Toyota factories are run on what they call TAKT time. Seen as the heartbeat of the plant TAKT time specifies the rate at which cars should be produced, in line with market demand. Thus TAKT time can and will be increased or decreased depending on market demand. Further, it is not just the completed vehicles that are managed against a production rate but each element of standard work has its own TAKT time. And just as deviations from standard work practices are checked, reinforced and improved, any nonconformity from the standard time gets the same treatment.

Given the great success of the Toyota production system it would be sensible, would it not, to replicate exactly the same system in a service organisation?

No.

And let me explain why.

1. Whilst global production is largely based on the type and rate of customer demand, there are multiple variants going down a Toyota line and often multiple models. If Mr B ordered a blue estate, Mr F a white 4-door saloon and Mrs C a black 2-door soft top they would not be put on the line in the exact sequence they placed their orders, thus the production line is de-coupled from the customer.
2. Because of this Toyota can decide the order in which cars are made and know at the start of every month, week and day which cars will be coming through and in which order, thus it is simple to specify the standard work practices and standard times because you already know in advance what's coming.

For this to work in a service organisation the customer would have to let you know in advance when they'd be calling, why they'd be calling and how long they were going to be on the phone. And not deviate one inch from that specification. The fact of the matter is that service organisations are very different from manufacturing. For service demands the customer is present at the point of production, therefore different thinking is required to maximise service, minimise cost and optimise output.

The Problem with Service Organisations

In the 1960s Dr Genichi Taguchi created a concept called the loss function for manufacturing systems. His theory stated that, whenever two parts worked together to form a third part, the further they were away from the correct specification the greater the economic loss to the entire system.

For example, staying with the car theme, say you were making a tyre for the wheel of a new car. If the tyre does not fit the wheel it requires new plans to manufacture a tyre that does. And the further off it is from fitting, the more adjustment work will have to be done. This will require designer time, resetting of the tools to make the tyre (thus also taking up engineer's time) and new raw materials to replace the incorrect tyres already made, not to mention the time delay to remake the tyres. As Dr Taguchi correctly stated: the greater the difference from the correct specification, the greater overall economic loss to the system. And this happens even when you know in advance what's coming down the line!

Service organisations work the same way but it is the customer that sets the standard/specification and as I've explained above, the big challenge is that you can't always predict what that that will be until they call. In service organisations the standard should be 'do what is important to the customer'.

In Robert's case what was important was that an ambulance got to his wife, but because the system was not designed to look at the world from Robert's point of view he had to give the call handler the answers they wanted in order to meet the handler's standard to get the ambulance to the house. As such the following losses occurred: A) the call took longer than necessary - in circumstances like this that means patients could die and B) there's the immeasurable damage done to the reputation of the NHS by people like Robert complaining about the hoops they had to jump through to get the service they required.

It's a difficult challenge, on the one hand if you set standards in advance you can't know if they'll actually get in the way of serving the customer, but if you do nothing how can you have the systems processes and policies needed to be able to help the customer when they call?

The challenge is in handling the variety of customer demand types and customer call length. The assumption being that 'no-one' can know all the answers to all the questions, so by studying what works in manufacturing managers try to replicate the same kind of ideas, but because the requirements of the system are different the two ways of thinking are actually incompatible.

Standards & the Challenge of Variety

When Laurence Barrett took over the Operations Director's job at Velux he inherited one such challenge in his contact centre. In order to provide 'better service' the previous director had decided to break down the different parts of his contact centre into different specialisms. One part dealt with consumers, one with business customers, one with technical enquiries and one with billing, and then to add another layer of complexity the centre was further broken down to assign English, Scottish, Irish and Welsh customers their own agents. The concept came from a manufacturing plant where cells can deal with particular specialist parts.

Again the difference being the ease with which the incoming manufacturing demand can be directed to the different cells in advance, knowing exactly what each part needs and the time taken to do the work. As Laurence explained the same concept didn't work in service.

'What happened was that we spent more time trying to get the right call to the right team than we did serving the customer. And to make matters worse, if a Welsh customer had their call taken by the Irish team, only to then be told that they were 'in the wrong team', the phone system would register that they were no longer in the queue, even though they might have been put back in the queue for up to 18 minutes. Worst of all, we didn't know it was happening.'

Barratt changed how the system worked and over a period of 3 years managed to get what had become 16 different sub contact centres down to two. The results included a million pounds in savings and an increase in independent customer satisfaction scores of 40% over the rest of the group.

So before thinking about how the front line member of staff deals with the customer, the organisational system at the higher level needs to be designed in such a way that the standards, inputs or as we'll call them, 'the operating practices' allow for the maximum handling of variety in terms of both customer demand and what matters to each of those customers when they place that demand on the system.

In Robert's example the NHS 24 operating practices were so tight that front line members of staff could not deviate in order to handle the case of a customer making a demand on the system when they weren't with the patient.

In Barrett's case he not only designed a system that absorbed demand from different geographies, he also made sure that irrespective of the type of demand (technical, sales, pricing) it could be handled by the same agent, thus creating better service for the customer whilst lowering costs.

How Do You Create The Operating Practices?

When we start with a new client our first line of enquiry is to find out about the future strategy of the organisation, division or department. This is important because you have to work backwards from here to make sure that the new operating practices are connected to the future of the business.

Neil Ferguson is the forward thinking Business Strategy Manager for Trust Housing, an organisation that specialises in homes for the elderly. Before we started working with Trust we wanted to understand where the business was going in the future. Neil explained that there were three key strategic aims to support their new business strategy which can be summarised as:

'To continue to focus primarily on housing for older people but become a market leader in the field with products and services that meet and exceed the increasing and changing expectations of customers, while also being recognised for business excellence and innovation in order to provide the best value possible for customers.'

The 3 key strategic aims are:

1. To continue to develop the business sustainably by reducing operating costs, improving operational effectiveness and efficiency, and growing and diversify income streams.
2. To manage the asset base in a way that ensures the organisation's resources are invested in the right homes in the right geographies for the right customer groups, and that office space is used as efficiently as possible.
3. To meet and exceed customer demands and expectations by providing market leading services and quality homes, delivered by highly talented, empowered and engaged staff.

A key focus supporting the overall strategy, and the three underlying strategic aims, is to redesign their core processes so that they are market leading and work better for customers and staff, with the belief that better services cost less. Central to this is reducing the end-to-end time to let a house in order to improve the customer experience and reduce the costs associated with void properties.

Underpinning the strategy is the development of a culture of innovation and collaboration alongside an agile workforce that is supported by appropriate ICT.

Are You Clear On Your Future Strategy and Strategic Objectives?

Trust Housing obviously had a nice clear strategy and supporting objectives. But as Neil explained '*Our big question was, how are we going to do it? In addition we not only needed to be sure that we were going to hit our strategy three years from now but that we had a mechanism in place that made it very clear for our leaders:*

A. *What actions needed to happen every day to make sure our goals would be realised*
B. *If we were falling behind on our goals'*

To answer Neil's question we start with another insight. In their seminal book on Strategy, Professors Gary Hamel and CK Prahalad explain it like this. '*In order for any organisation to hit their future strategy they first have to understand what leadership thinking, core practices, capabilities and competencies they have to develop in order to be fit for the future.'* To do this the leader has to start by studying the organisation's operation as it is now. They need to get a real (rather than idealised) understanding of today's current thinking, practices, capabilities, and competencies in organisational policy, process, structure, leadership and measurement. Once you have this you can determine the gap from the current organisational position to achieving the future strategy.

In Vanguard we call this CHECK, understanding the **'what and why of current performance'** and it gives leaders insight into exactly **what needs to change**, and **what competencies have to be built** (and why), to achieve the strategy. If, for example those that manage NHS 24 in England & Wales want to make sure that fewer customers have the experience that Robert had, they'd first have to understand the thinking, policies and practices driving the current performance.

And I'd suggest that if they looked they'd find thinking built around the assumption that silo design, targets and specialisation drive policies that mean that the design is built around call times and scripts. Thus driving practices that create a culture of sticking to the script (even if it's the wrong thing to do), handling calls within certain time limits (even if it's the wrong thing to do), and only passing the call to the next level once certain boxes have been checked (even if it's the wrong thing to do).

Understanding the Current System

Without doubt one of the most ambitious leaders I've ever met was Colin Peebles. In 2006 he was the Director of Corporate Services for Lothian & Borders Police, the highest position a civilian could hold in the force.

Colin was hugely in favour of reform and after trying some initiatives quickly realised that change could only come if the whole criminal justice system was changed. This meant engaging partners in the process – in particular the Crown Office and Procurator Fiscal Service, the Scottish Court Service and social work services. With an eye on spiralling costs and increasing levels of reoffending Colin had a vision of a criminal justice system that was fair, fast and efficient. But just like Neil Ferguson's vision for Trust Housing, Colin needed to know what should change in order to deliver the future strategy.

To answer this question he put together a team headed up by Eileen Flockhart, a business manager, three police officers, a fiscal lawyer, two staff from the court service and a social worker. The objective the team was given was to answer the following questions:

1. How far away are we from the vision of a fair, fast and efficient system?
2. What exactly would need to change and what competencies should we build if we wanted to achieve our future vision?
3. How would we go about changing the system?
4. What would be the predicted results of such a change?

> If You Were Asked To Answer These Questions For Your Organisation, Could You?

Eileen and her team not only answered the questions, they got levels of data and insight never seen before within the system. To get the data they started by studying a chosen region of Lothian & Borders – West Lothian.

Here's what they discovered as they moved through the system:

- Accused people always left the custody suite not knowing when they would attend court
- Despite a service standard of 28 days for producing a police report, the actual available capability meant it could take up to 120 days (the fault of the standard not the officer)
- A fiscal (the public prosecutor) would only work on one type of court i.e. Q1 Pleading court, Q2 Intermediate court, Q3 Trials and Q4 Remand (sentencing) court, meaning that waste was introduced as information requests were changed in the handover of cases.
- 50% of accused individuals didn't enter any plea at their first appearance at court. In 36% of those cases the defendant's agent had not been given the details of their crime.
- 65% of those who did not enter a plea went on to 2 pleading courts, 22% went to 3.
- At the intermediate court date (the purpose of which is to plead or proceed to trial) 16% of those attending required a further date and another 25% required further intermediate court and trial dates. Some of the reasons were: Police statements not available, Legal Aid not in place and agents not prepared.
- 15% of those that required a further intermediate court date had to have another 4.
- On the morning of the trial, just before it begins, 42% of accused entered a plea of guilty, leaving empty court space which could not be filled at such short notice. The suggestion from those in the system was that an inequitable system for the payment of defence agents motivated deferment of guilty pleas.
- At the trial 26% required another trial date and went back to intermediate court. The reasons were: non-appearance of civilian witness (26%) and lack of court time (24%).
- 53% of trials that did not start or complete as per the schedule ended up requiring 2 trial dates, 28% required 3, 11% 4 or more and 8% 5 or more trial dates. The main reasons being the non-appearance of the accused or of civilian witnesses.
- 73% of remand courts were deferred. The main reasons being: the social worker's report was not in place, lack of court space, defendant showing up at subsequent meetings and a change of sheriff.
- As a result of the above the disposal of a case from start to finish could take up to 473 days, or 1.3 years.

Most of the above was avoidable. In fact it was directly as a result of the design and management of the system and in a later report written by Audit Scotland, it was found that the failings in the system amounted to a cost of around £60m per year of tax payers' money. So in answer to Colin's first question *'How far are we away from the vision of a fair, fast and efficient justice system?'* the equivalent to the kind of distance travelled by Bilbo Baggins in his search for the ring or to put it more simply… a very, very long way!

But more important is the answer to the second question: '*What exactly would we need to change in order meet our future vision'.* To fulfil this request, the team went back to the data and created what we call in Vanguard a set of 'de-facto' operating practices, in other words concrete statements to reflect current practice.

They were:

1. When someone leaves the custody suite they will know exactly what they're charged with, when they will go to court and their defence agent will be informed.
2. The officer should do their report immediately after the original incident.
3. A fiscal will be always be on duty should advice on a charge be required by a police officer.
4. All statements will be gathered at the time of incident.
5. At the time of the first court date the defendant should enter a plea, i.e. a deferment is not acceptable.
6. Full statements will be available and will reach the defence agent prior to the pleading court.
7. Legal Aid will in place prior to the intermediate court.
8. Defence agents will be paid the same fee for a guilty plea or a not guilty plea.
9. The social worker's report will be available for the start of the remand (sentencing) court, and where possible the report will be done on the same day and given back to the same sheriff presiding over the case.

Note that the team didn't sit in a room and 'blue sky' ideas about what should be changed, they used the data from the analysis to build a set of 'de-facto rules' which then guided the development of a new set of operating practices. Of course just saying that new practices would be carried out wouldn't make it so; work had to be done to change policy, processes, measures and job design in order to accommodate the new practices. For example the change to the payment of defence agents required the team to go to the Scottish Parliament to get an amendment to the Legal Aid policy. It was all made possible however with the presence of evidence, the quantitative data gathered at Check about the performance of, and reason for, the failures in the system.

The next job was then to link the changes back up to the strategy and make sure that they would deliver the end result of Colin Peebles' vision.

Let's look at an example.

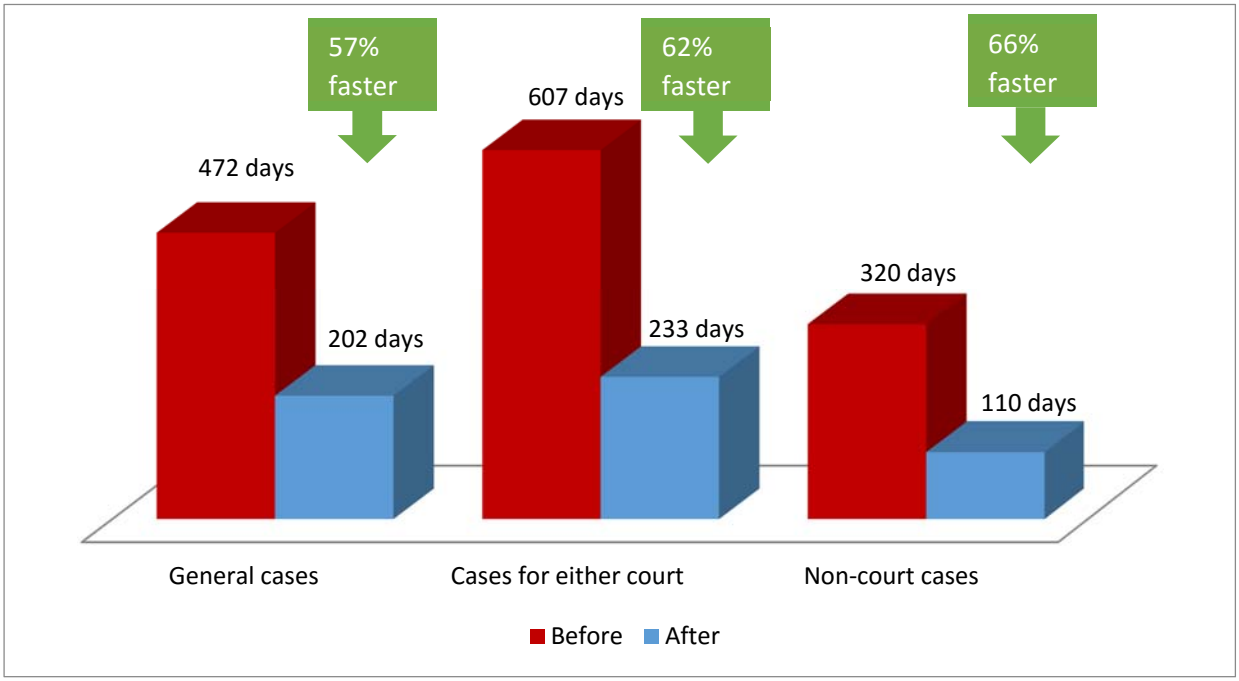
Take the decision to give all defendants a date for attending court, informing their defence agent about the charge whilst the defendant was in custody and making all statements available PRIOR to the pleading court.

Here's how the links in the chain work:

1. By giving the defendant a date prior to leaving the station, the design team's hypothesis was that more people would turn up at court, not being able to state that they never got the information.
2. By giving the defence agent the defendant's charge information at the time of their release from the police station and making the statements available prior to the pleading court the view was that more pleas would be entered i.e. the defence agent could not say that they were unprepared.
3. Having more defendants turn up at court and entering a plea would mean fewer repeat callings.
4. Fewer repeat callings would mean that cases would be processed faster and require less resource.
5. Faster disposal of cases and the use of less resource would mean a fairer, faster and more efficient delivery of justice.

And that's exactly what happened.

Immediately after the new system went live times from arrest to case disposal dropped:



Additionally:

- The number of repeat courts reduced, meaning that 70% of all cases were closed within 90 days.
- 75% of all police reports in the new system were error free, in comparison to 20% in the previous system.

Incredible results wouldn't you agree?

And as you can imagine we looked at the data, sat back and gave ourselves a very big pat on the back, success! However that is not the end of the story, nor is it the most important point in the story, because what happened next still gives me nightmares.

The Unravelling Of Change

What Colin, Eileen and her team (along with the Vanguard Method) delivered was not just better i.e. some process reengineering; it was a fundamentally different way of running the justice system in West Lothian. One that, yes, required new processes, but more importantly needed new policy making, new structure, new measures, job redesign, and new thinking from both management and front line staff. It needed people to turn their world upside down and inside out. And this was the problem; some didn't know how to, some needed new skills and knowledge and in some cases there were those who simply didn't want to…

A case in point was a Sergeant who was tasked to manage the initial trials but wasn't involved in the analysis. Let's call him Peter. *'I watched my team coming in from incidents and trying to sort out court dates and get information to defence agents. I saw time being wasted. I repeatedly challenged them and told them that this was not their job, they tried to explain but I had no notion of what they were trying to do, and I'd never seen the information about the problems that failing to do these tasks were having in other parts of the justice system. Over time I just got them to stop what they were doing and go back to their original jobs.'*

In other cases senior leaders, despite massive improvements in performance, couldn't understand why targets had been removed, *'surely'* as one explained to *me 'the new system would be working even better with performance targets…?'*

And in some cases officers simply didn't want to learn the new skills required to work in the new way. For example one of the new practices was to produce a report immediately after the incident, rather than waiting 28 days, however this meant officers would have to type their own reports rather than passing it to the typing pool, and some simply didn't want the hassle.

We were prepared for this and we counselled leaders on the need to reinforce the new changes. We'd tell them of the need to be in the work making sure that people were working in the new way and supporting them in doing so.

Great in theory, what I now know what we didn't do was give them a mechanism for HOW to do it.

Today there are many existing elements of the original design, for example the changes to the way that defence agents were paid are still in place and were rolled out to the high court as well as the summary justice system. However some of the gains have been lost. The losses were personally painful but caused us to embark on developing a system to make sure that A) when high performance gains are achieved they stick and B) that all changes are aligned to the future strategy.

We have that consistently working now and it's been the final piece of the puzzle that sealed sustainable change for our clients. I've laid out the whole system below.

What to Do Differently

Neil Ferguson at Trust Housing is one of the clients now benefitting from the insight. The Vanguard leadership and problem solving system is a management system with four goals:

1. That there is a mechanism in place to make the new operating practices clear and visible.
2. That there is a mechanism in place to ensure that those working in the new way are supported through continued clarity and upgrades of skills and knowledge to carry out the new practices.
3. That there is a mechanism in place to capture and fix failures in the practices, supporting processes and policies.
4. That there is a system in place to give people a way of dealing with customers whose need requires a departure from the practice.

1. There is a mechanism in place to make the new operating practices clear and visible

At this level the staff, who have been involved in the design of the new practice, develop checklists and guidance to remind themselves how to work in the new way. In his book the 'Checklist Manifesto', Atul Gawande, a New York Surgeon, writes about the value of checklists irrespective of the industry. Gawande explains the impact of his checklist system for reducing infections and improving outcomes for surgical procedures when it was trialled through seven hospitals over seven different countries in conjunction with the World Health Organisation:

- Reduced the rate of major complications for surgical patients by 36%
- Deaths fell by 47%
- Infections fell by around 50%
- And the number of people having to return to the operating room after their original operation fell by 25%

And some of our clients have taken the practice of checklists to a new level. Matt Sewell for example, a manager at Cooperative Financial Services had his staff use laminated checklists and flip over tent card systems so that it was easy to observe that the checklists were being used – something that Gawande also recommends.

In Neil Ferguson's case, the team at Trust Housing were already exponents of checklists. All they needed to do was to upgrade them in line with the new operating practices, policies and processes.

2. **That there is a mechanism in place to ensure that those working in the new way are supported through continued clarity and upgrades of skills and knowledge to carry out the new practices.**

Some of the biggest challenges with moving to a new way of working, even though you have checklists, are that despite extensive training and communications, sometimes those working in the new way get confused about what to do differently, find that the skills and knowledge that were good enough for the old way of working no longer suit the new ways or simply feel that it was easier to work in the old way. So the practice erodes.

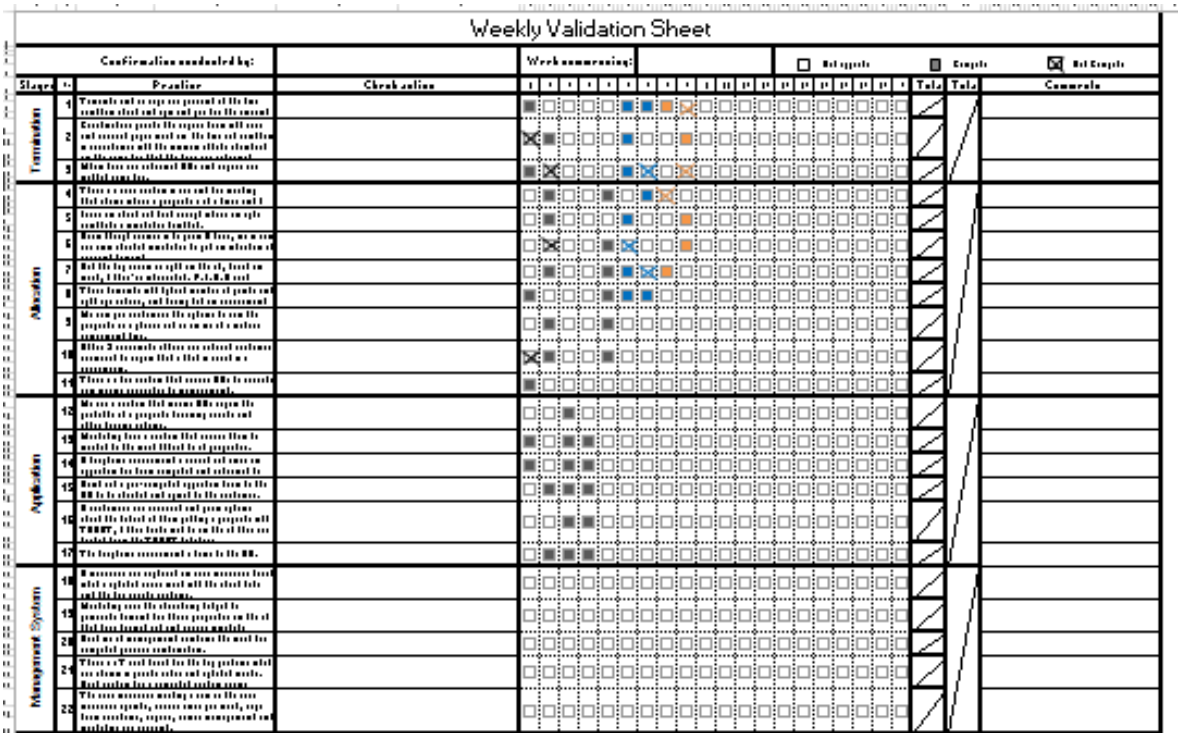
I found this recently on the family skiing holiday. I wanted to try to take my skiing to the next level so hired a private instructor every morning for five days. I tried to stay aware of the fact that I was being taught a new skill so I could observe myself going through the learning process, not always easy to do when you're face first in the snow.

The instructor spent endless hours, as you would expect, observing, coaching and reminding me what to do, and I wondered as my ability to ski slowly but surely improved, why more managers don't work this way. Too often a new practice is communicated via email then frontline colleagues are expected to know what to do!

I believe the problem is that, when learning to ski or operating a manufacturing plant, it's easy to know what to observe. Not so in a service organisation. That's why in what we've called level 1, validation is supported by a document that captures the high level operating practices (one level up from the checklist) and gives leaders guidance on how to validate that the practice works and that the front line staff member knows, and has the skills to carry out, the practice.

What also happened during my skiing lessons is that my Instructor, Didi – who constantly said *'are you surprised?'* when we peered over the edge of what looked like a vertical slope - would say '*the rule I taught you yesterday must be disregarded for this type of snow'.* In this step the same principle of adaptation applies, you have to constantly be on the lookout for changing trends in client needs and as such update and change the practices accordingly.

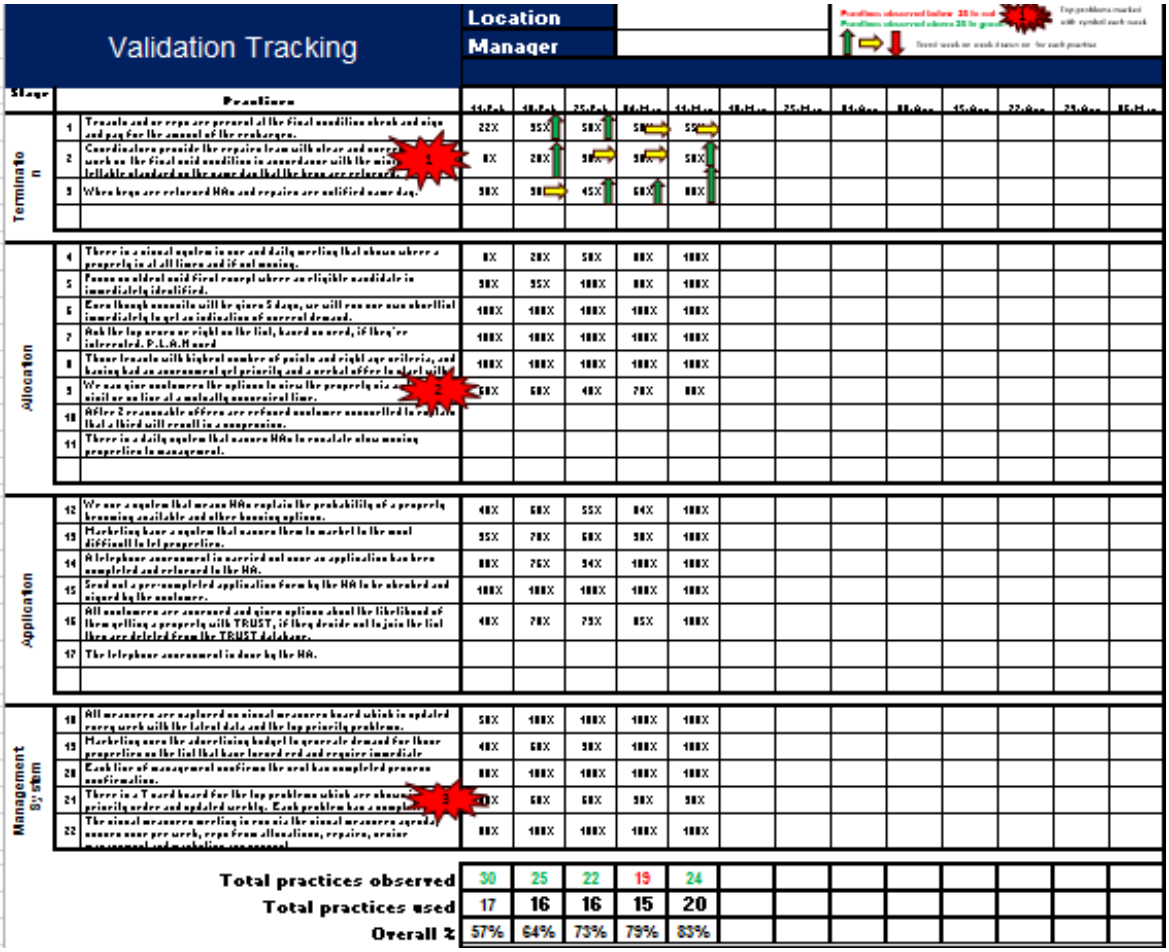
A copy of the level 1 validation form is shown below.



Validation level 1

The validation sheet shows the different practices on the left. The next column captures the method by which these practices will be validated, next is the number of times they are validated, then a percentage is allocated to give an indication of which practices need attention. And the different colours checked in the boxes represent the different levels of managers that did the validation.

One level up the figures are aggregated each week so that there is a focus for the business on those practises that are slipping and need attention - the red flash makes that easily visible. We call this validation level 2.



Validation level 2

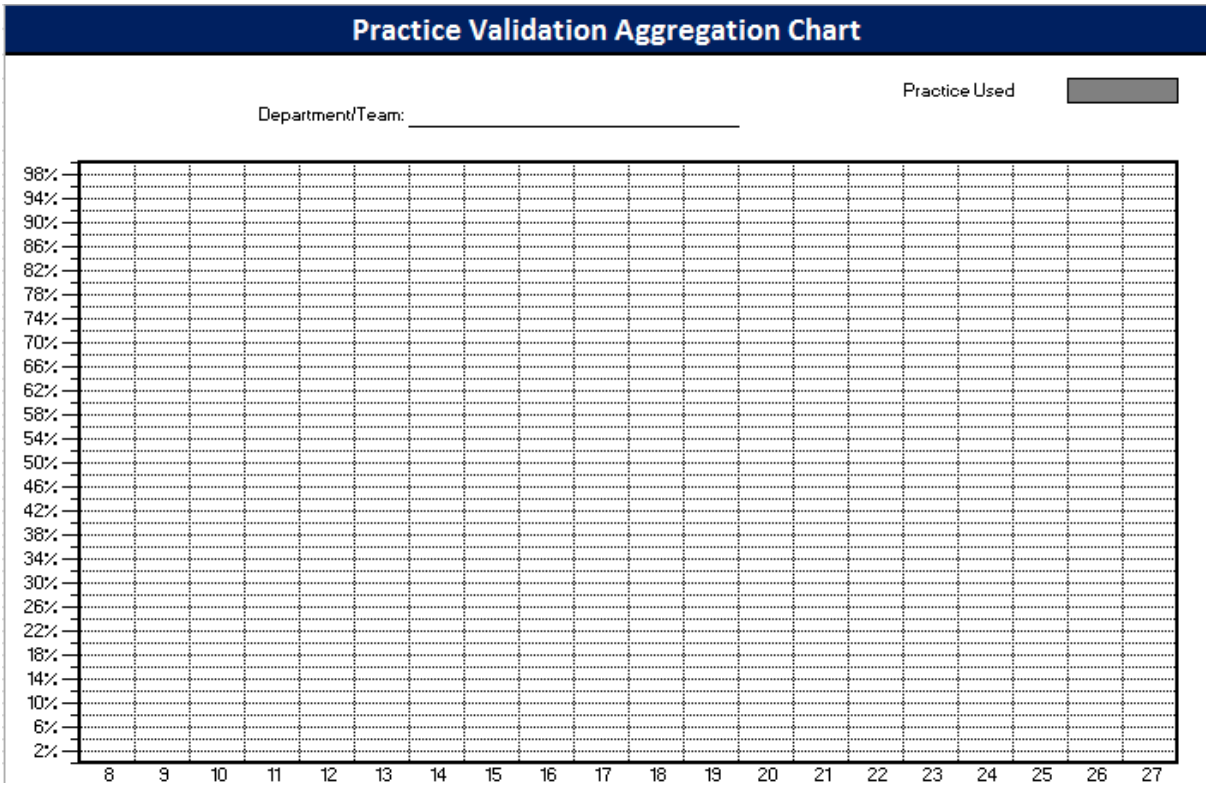
Do You Have A System In Your Organisation That Makes Your Practices Clear?

Do You Have A Method That Captures When There Is A Failure?

The next level up allows managers at every level to see exactly where the operating practices or INPUTS are failing up to the senior most level. Imagine for example that you were the CEO and you wanted to know where your delivery was failing or service scores were dropping. Assuming you knew which of the practices influenced those numbers all you'd have to do was look at the next chart and you could see exactly where your managers needed to act.

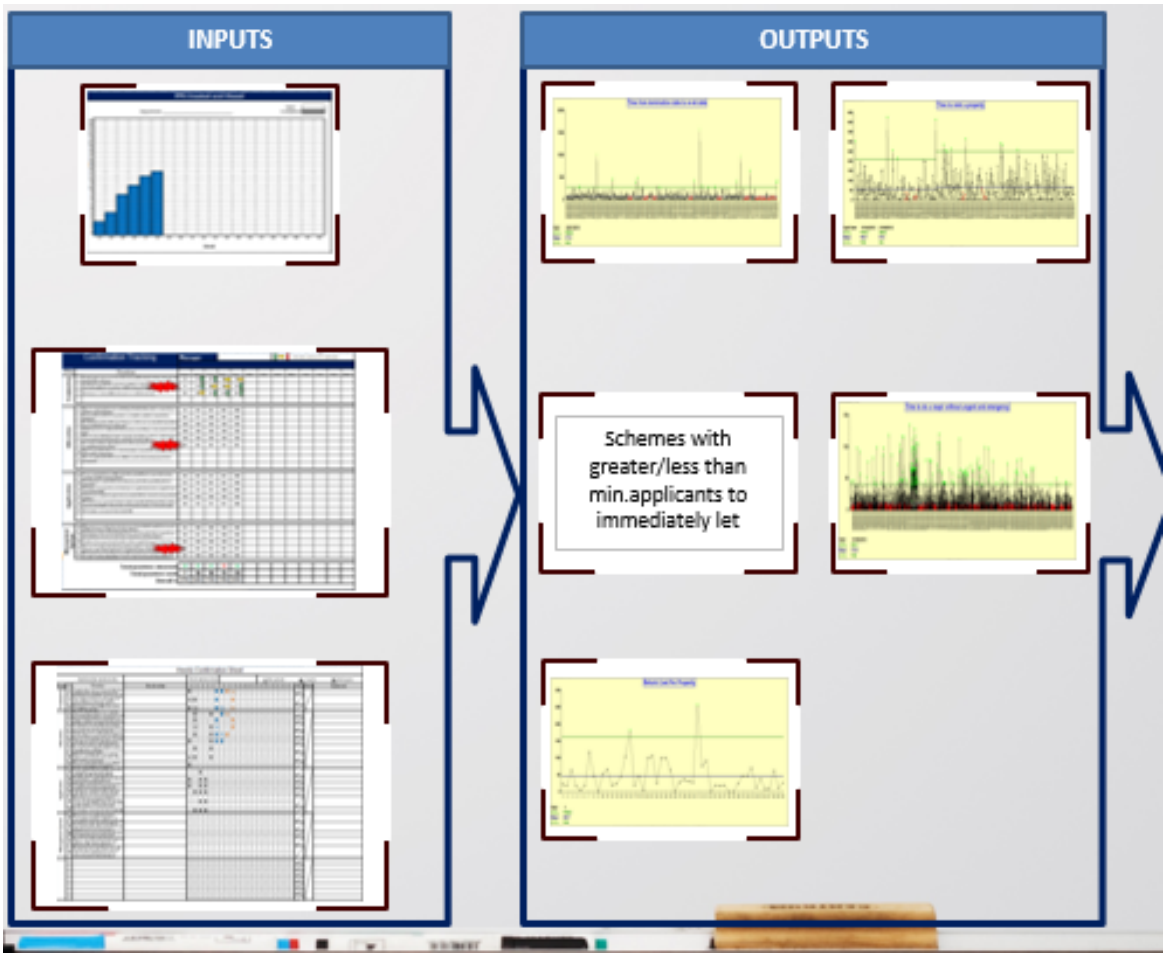
Take a call centre; if one of the practices was 'stay with the customer till their demand is met, don't pass the call on' and you knew that this influenced customer satisfaction, then you'd need only check this and the other practices/inputs connected to satisfaction and you'd know where to act. No longer would you need to spend months digging through data to find the problems.

Again the next chart is an aggregation of level 2 and is filled in by hand, that way the leader of the area/division is forced to go to the measures board and find out what's happening. Much better than getting their numbers by email and having no idea what's really going on.



Practice Aggregation Chart

As I've explained, each of these practices is linked to a measure or output or performance indicator. These outputs should be shown on a visual measures board next to the inputs so that there is a clear relationship between the two, as demonstrated in the next illustration.



A section of a visual measures board showing the relationship between the inputs (practices) and the outputs (performance indictors)

3. <u>That there is a mechanism in place to capture and fix failures in the practices, supporting processes and policies.</u>

Of course as Gawande found in hospitals, in many cases the checklists simply picked up an error and caused a staff member to take action. In one case he explains that the checklist caused the surgical to team to realise that the reserves of blood required, should something go wrong, were not in the theatre. A resident got the blood and put it in the room, it was just as well that he did for a complication did occur and without it, and the checklist, the patient would have died.

The next element of the system therefore captures these problems. When the leader is doing their validation practise they note any problems. These are captured on the action list on the next page.

The purpose of the action list is to capture issues that can be fixed there and then. But they are noted and not fully closed until the leader, through further validation, is confident that the issue is resolved.

Action list

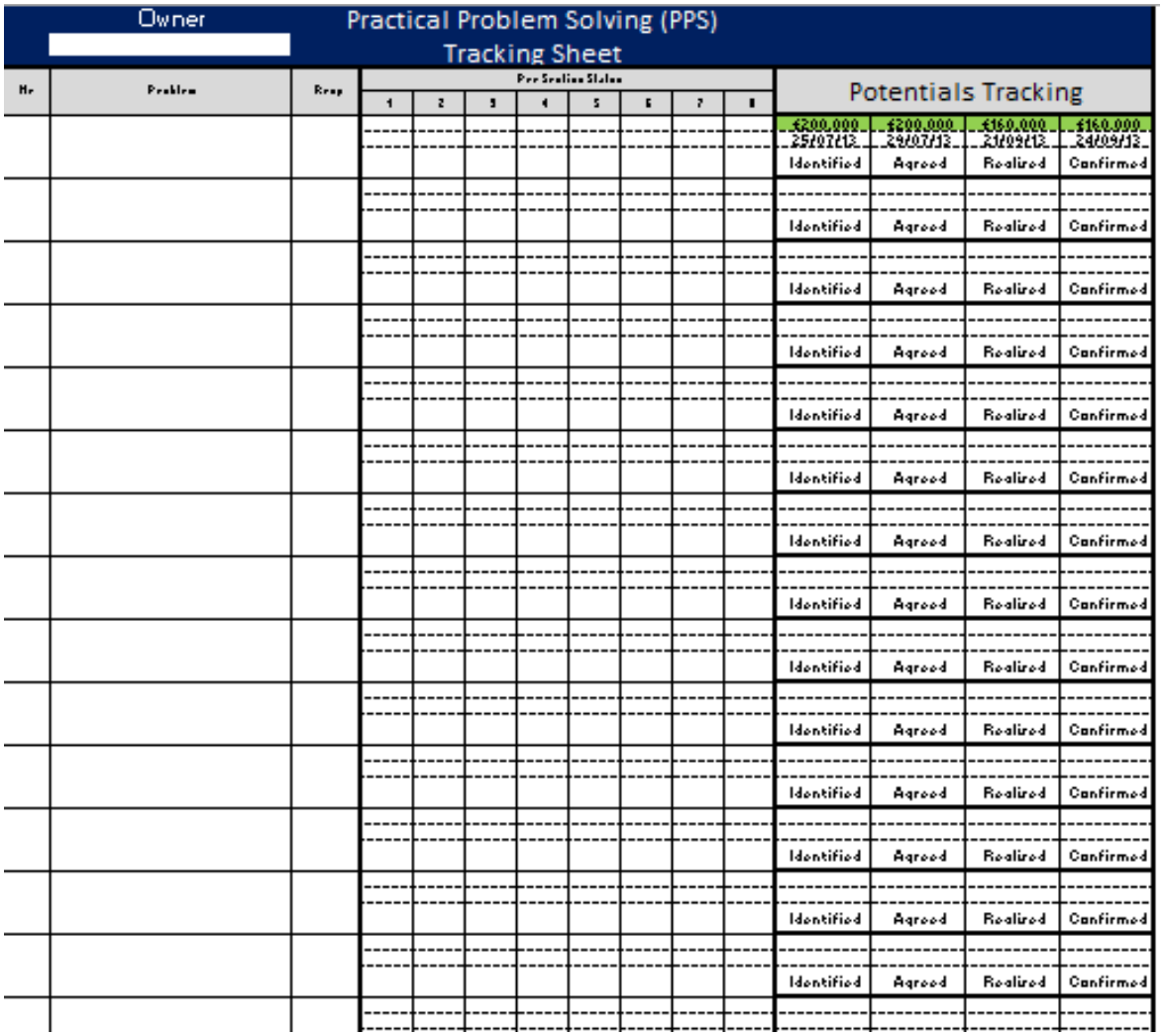
And those problems that are more complex? Simple, here we do more teaching and coaching of leaders to learn how to solve and track more complex problems. And just like the validation sheets, the action list feeds the complex problem solving list. Can you see how the whole system is connected?

Additionally each problem is assessed for its contribution to the strategy or revenue of costs etc. which also helps with decisions on what should be prioritised.

Do You Know Your Top Problems?

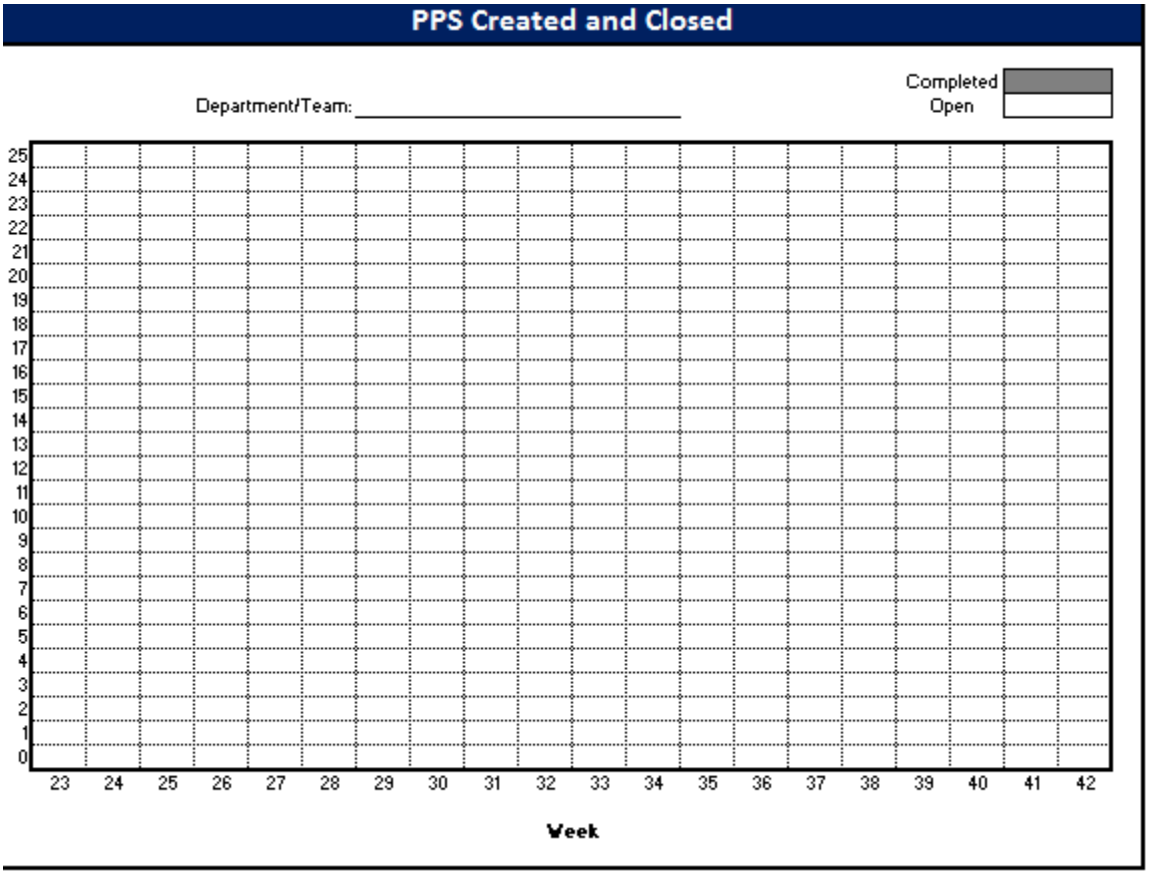
Do You Track Them?

Can You Tell What Each Is Worth or How It Will Contribute to Your Strategy If You Solve It?



Problem Solving Tracking Sheet

And finally, just like with the validation sheet, all problems are tracked on a master list to make sure that problems are not just being opened and never solved.



Practical problem solving tracking sheet

As they read this I can hear some managers exclaiming that this seems like a lot of work. Really? Some months ago I listened in to an executive weekly conference call. The subject was performance. The question was posed, '*why is it that our sales are down and our customer satisfaction is down?*' the answer *'I don't know I'll check it out'.* The answer should have been *'we've been failing to meet operating practices 3, 6, 10 and 11 (the inputs) and that's affecting our numbers, here's a plan to get us back on track!*' Or even better had the senior exec had this system in place he wouldn't have had to even ask the question he'd have known in advance!

And then there's the whole issue of corporate responsibility and executive stewardship. Don't you, as the senior executive, want to be connected to what's happening on the ground so that you can say to your regulator/the board/the police when they ask about whether the operation is acting in accordance with your values, *'yes we have a system in place that keeps our leaders abreast of any deviances from the system'.*

And on a more practical note do you want to spend your time acting on the top issues and biggest problems blocking your strategic goals? Or waste it trying to solve ALL the problems in your business, even the ones that have little impact on performance.

The system is interconnected. Everything feeds into everything else. The work is done mostly in the validation and problem solving, the rest is simply an aggregation to show you even at the highest level where to act.

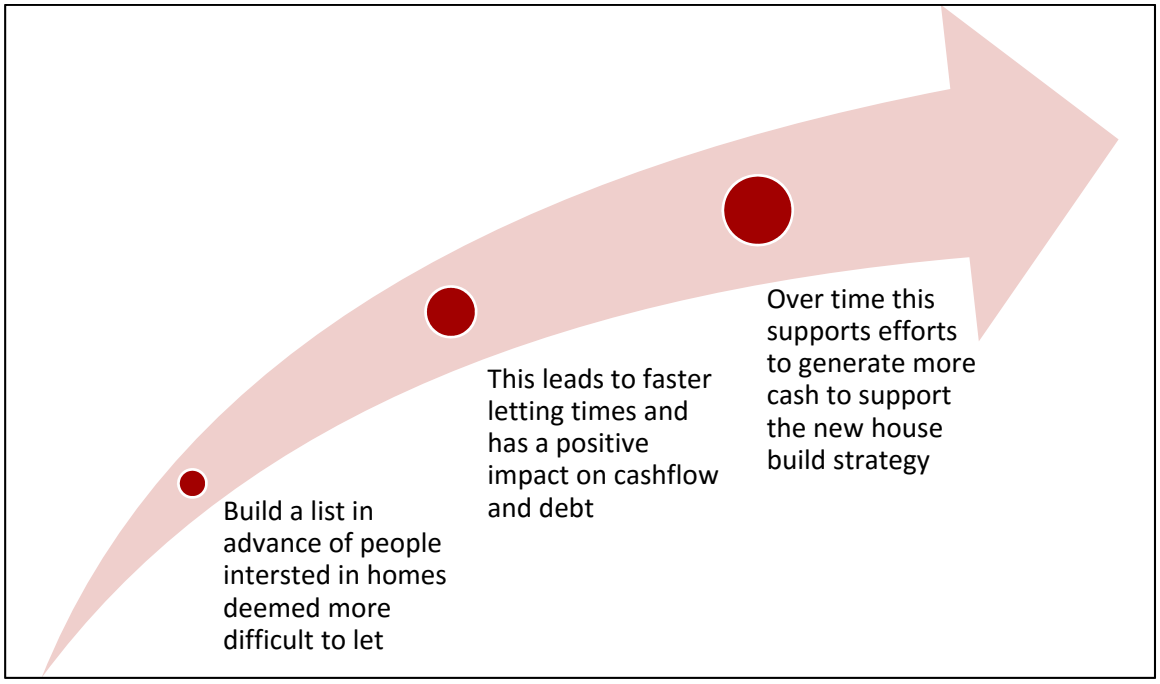
Let's take a practical example.

In Neil's case his system is designed to improve his housing voids situation. In housing associations and local authorities this is the process that kicks in when a tenant leaves their house and a new tenant has to be found.

Some of the new operating practices are:

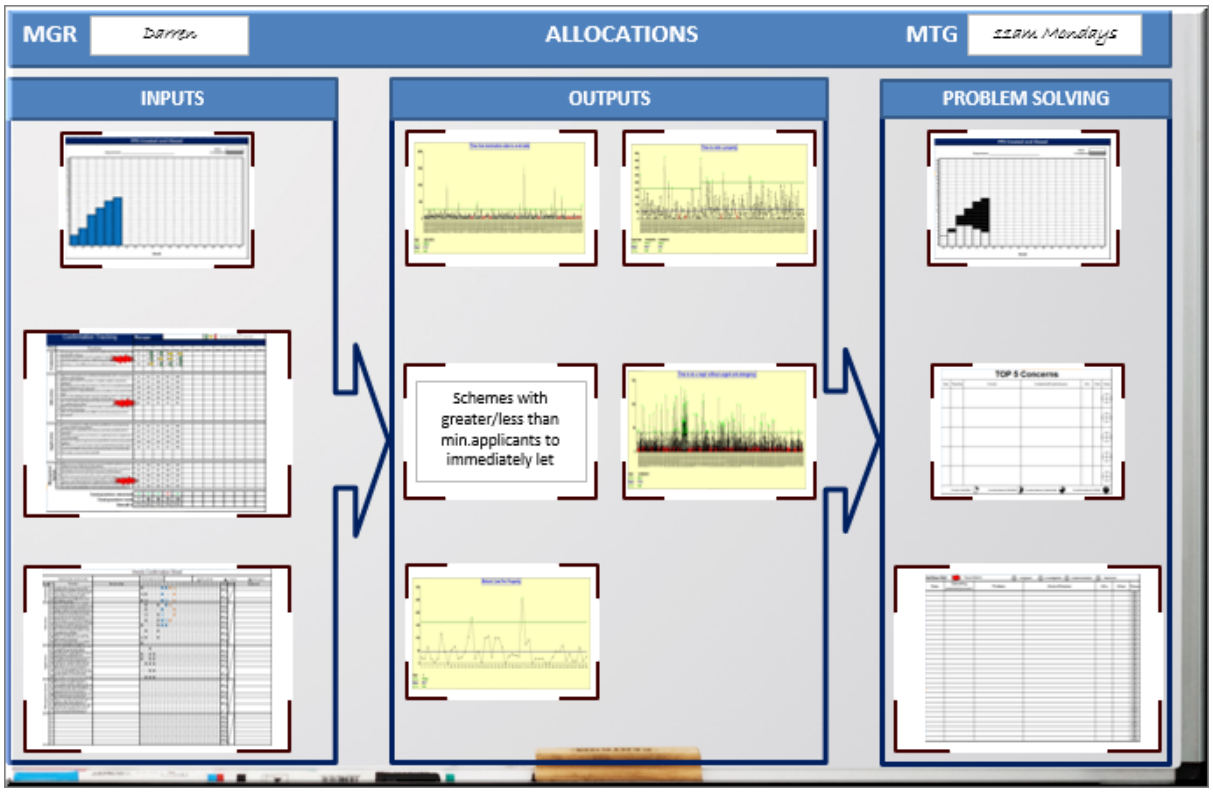
- Build a list of people interested in difficult to let homes even when those homes are not available, hence there are people ready to move in.

By building a list of those interested in the more difficult to let homes, those homes were let faster, this meant less lost rent which had a positive impact on cash-flow and debt. So in the long term there's more cash to support the strategy. As you can see below the input (the operating practice) is completely connected to the output (the letting times) which in turn is connected to the strategy (cash generation to build more houses).



The connection between the front line operating practice, the measures and the strategy

Here's the final version of what the whole system looks like, as you can see each part feeds the next so it works together to improve performance and support the strategy.



Can You Connect Your Strategy Right Down To Front Line Practice?

Do Your Staff Know What They Need To Do Every Day To Support Your Strategic Objectives?

NOTE: As we coach our clients through the use and implementation of this system we also draw on the principles outlined my previous white paper – 'How to Lead an Organisation…Properly'. If you don't have it you can get it here.
http://www.systemsthinkingmethod.com/downloads/Vanguard_leadership_report.pdf

4. **That there is a system in place to give people a way of dealing with customers whose need requires a departure from the practice.**

This then just leaves us one final issue to discuss. In Robert's case the NHS frontline person clearly had an absolute clarity on the operating practice he was to attain – get the answers to the exact questions about breathing and colour etc. before dispatching an ambulance. How then does this system work where what matters to the customer is not covered by, or requires a deviation from, the operating practice? In this case we use a system devised by John Little, Managing Director of Vanguard Ireland and an outstanding Vanguard consultant.

John's system is called P.L.A.N. and it is designed to allow front line staff to move away from the operating practice guidelines and do what matters to the customer.

P.L.A.N. is a decision making process that stands for:

- **Proportionate**
- **Legal**
- **Accountable**
- **Necessary**

In the case of Robert's call handler he would have on listening to Robert's request and asked:

Is it a PROPORTIONATE response to send an ambulance, is it LEGAL to do so, am I happy to be ACCOUNTABLE for my actions in this instance and is this NECESSARY so we can do the right thing for the customer? This process gives the frontline member of staff the empowerment to always do the right thing for the customer, and using the whole system shows leaders exactly what and how often the practices need to be upgraded, changed or simply thrown in the trash.

Robert's wife lived thanks to his ingenuity. My core argument in this paper is that not only by having measureable operating practices that can absorb variety are we able to deliver better organisational systems with more clarity for staff, but that the customers get better service and shareholders lower costs and better returns.

We use these principles as the foundation of our work with leaders in organisations; they form the basis of action learning - education when we are coaching leaders on how to deliver better inputs so that service, morale, cost and competitive advantage are all improved.

If you would like to contact us about helping your organisation you can drop us a line at office@vanguardscotland.co.uk or call us on 0131 440 2600.

Stuart Corrigan
Managing Director
Vanguard Scotland Ltd

Acknowledgments:

It is very rare that writing any document of this sort is a solo effort; therefore I'd like to thank the following people:

Eileen Flockhart of Police Scotland who kept me right on the technical details of the criminal justice system where the passing of time had made them hazy.

Nick Rich, the notable academic and author. Probably the best professor you could have, and without whom I would not have got my MBA. He put me right on the variants of vehicles that flow down a Toyota line.

Nigel Waring, my old friend and ex-Toyota Consultant, whom I still remember spending endless nights translating and explaining how Toyota would use 'standards' and measures etc.

Gillian Brown in the office, who publishes my blog and reports and picks up all the errors that I routinely miss.

John Seddon, without whose development of the model for Check there would be no call for a validation and problem solving system.

Denise, my wife, who remains supportive through endless late night edits of blogs and reports.

Jim Mather, Former Minister for Enterprise in Scotland, who though he has better things to do, makes mind maps of my documents and endlessly promotes Vanguard.

David Ness, who worked with me on the title.

Russell Clark, a client and friend, who inspired the report.

Colin Peebles MBE, who never gave up on the reform of the criminal justice system.

Eric McQueen, who, though he is not mentioned in the report, has as its Chief Executive brought huge reform to the Scottish Court Service and was, like Colin, pivotal in gaining the positive results of the trial.

Bob McDougall CEO, Neil Ferguson and the lovely people at Trust Housing Association who are mentioned in the paper.

My friend and fellow Vanguard consultant Kam Griffiths who, though we were working at different clients, often in different countries, has worked with me over the past two years to develop, test and implement the system I've written about in this report and who is without question more adept in its use.

And last but certainly not least I want to thank you the reader who has taken the time out of your day to read this report and my blog. I am forever grateful.